MENTAL HEALTH BILL 2013

Committee

Resumed from 18 September. The Chair of Committees (Hon Adele Farina) in the chair; Hon Helen Morton (Minister for Mental Health) in charge of the bill.

Clause 207: Psychosurgery on child under 16 years prohibited —

Progress was reported after the clause had been partly considered.

Hon HELEN MORTON: I would like to table documentation that was requested of us. It is the jurisdictional comparison of the penalties around electroconvulsive therapy and similarly for psychosurgery.

Leave granted. [See paper 1944.]

Clause put and passed.

Clauses 208 to 211 put and passed.

C**lause 212: Seclusion: meaning —**

Hon HELEN MORTON: I move —

Page 155, after line 9 — To insert —

(2) A person is not secluded merely because the person is alone in a room or area that the person is unable to leave because of frailty, illness or mental or physical disability.

This amendment was proposed following representation from the Royal Australian and New Zealand College of Psychiatrists about the treatment of elderly people with a mental illness. It wanted to make sure that if a person is alone in a room and because of frailty cannot move out, it is not considered as seclusion. We believe this amendment has been accepted by the opposition.

Hon SALLY TALBOT: Minister, I am very uncomfortable with aspects of clause 212 and the amendment, which I think we could talk about in tandem with proposed amendment 22/227, which refers to the definition of physical restraint; we are talking at the moment about the meaning of seclusion. Can the minister give the chamber a bit more of an understanding about exactly when somebody is placed in seclusion and its purpose? In other words, I guess I am asking whether it is treatment or a management tool. Could the minister start by giving us an outline of that?

Hon HELEN MORTON: Seclusion is referred to as an intervention. The criteria for determining that seclusion can be authorised is at clause 216, and basically it is around ensuring that a person does not injure himself or herself or persistently cause serious damage to property, and that there is no less restrictive way of preventing the injury or damage.

Hon SALLY TALBOT: Is the answer to my question that it is neither treatment nor a management tool? It is not managing somebody's condition, is it? Is there a time limit placed on a seclusion order?

Hon HELEN MORTON: There is a two-hour time limit; however, it can be extended after examination by a medical practitioner.

Hon SALLY TALBOT: A medical practitioner; so not necessarily a psychiatrist?

Hon HELEN MORTON: That is correct.

Hon SALLY TALBOT: I notice that the term "seclusion" is used here, but it is also called "isolation", I believe. Perhaps the minister could enlighten us as to whether that is a completely different thing? Is it fair to call it a method of last resort?

Hon HELEN MORTON: I am very clear that the criteria at clause 216(1)(b) make it absolutely clear that there is no less restrictive way of preventing the injury or damage.

Hon SALLY TALBOT: I will take that as a yes and that it is a management of last resort. Minister, is it a notifiable practice under schedule 9? I think that is the correct schedule.

Hon HELEN MORTON: I have two points in answer to that question. First of all, the seclusion rates will be published for all sites on the Chief Psychiatrist's website. That information will be constantly updated and made available to people, but it will not be specific to an individual. That information will be specific to the service provider providing the service. The second point about notification is that clause 285(1)(a)(v) indicates that carers will be able to access all information around that, but it is not a notifiable event—it is to the Chief Psychiatrist.

Hon SALLY TALBOT: I will briefly take up the minister's point about the making public of this data. Obviously, it will not have personal, identifying information, but when the minister said by a service provider, is that by the treating medical practitioner or by institution?

Hon HELEN MORTON: As I indicated, it is by individual site or authorised hospital, if that is what Hon Sally Talbot is referring to.

Hon SALLY TALBOT: Will there be information on the website that states who the order was issued by?

Hon HELEN MORTON: No, there will not be.

Hon SALLY TALBOT: Something troubles me. I make it clear that the opposition will support the amendment, but I think it is really important to tease out the detail. The thing that is troubling is that it could be seen that this amendment is making it possible to minimise the paperwork associated with making a seclusion order. How does the minister resolve the argument between a person who says it should have been a seclusion order, and therefore the person and practice should have been subject to this clause of the bill? How does the minister argue between that point of view, and the point of view that says this was not a seclusion order; yes, the person was, to all practical intents and purposes, secluded or isolated, but that was because they were frail, ill or had a mental or physical disability that meant the situation could not have been otherwise?

Hon HELEN MORTON: The issues around this are that seclusion requires the medical practitioner to notify or contact the psychiatrist as a matter of priority. It is not as if the psychiatrist will not be informed about that; they will be.

Hon Sally Talbot: But they're only being informed if the amendment is in place, because the amendment makes it possible to isolate somebody on other bases.

Hon HELEN MORTON: No; it is the other way around. The amendment enables somebody who is not being secluded for reasons of an intervention of seclusion to be able to be in a room on their own and for that not to be called seclusion; the reason is that that person is frail and cannot get up and walk out of the room on their own. The psychiatrists for elderly people with a mental illness wanted it to be clear that if an elderly person cannot get up and walk out, that is not in some way referred to as seclusion, even though they may be on their own in a room and not exhibiting any of the behaviours that we might normally think about in terms of requiring seclusion. The other issue is that any patient who is placed in seclusion will receive a copy of the forms that are required to be filled out; a patient, of course, has nominated persons, or advocacy or whoever they want to have, to follow that up on their behalf.

Hon SALLY TALBOT: Finally on this point, was the minister made aware by the stakeholders who approached her about this that a particular problem would arise without this amendment? Is that based on something that is currently happening with patients for whom the medical practitioner or the psychiatrist is not mandating seclusion but they have to be made the subject of seclusion orders for the wrong reasons, perhaps having an order issued because they are too frail to leave a room? Is that the problem?

Hon HELEN MORTON: Basically, it relates to the avoidance of doubt. Without this amendment, it was put to me—I believe it to be so—that there would be a mountain of paperwork for seclusion every time a person with dementia or a person in a wheelchair, for example, was left in a room on their own. That kind of concern was brought to us.

Hon SALLY TALBOT: I hope I have been able to indicate to the minister our unease on this side of the house. I hope that she would want to monitor very closely how this is unfolding in practice. I am not sure that the minister's assurance about the publication of very general data by institutions will help us satisfy ourselves that it is not being misused by practitioners to skirt around some necessary paperwork. I hope that at the end of the first year of operation of this act our fears are shown to be groundless and that it unblocks a system rather than gives rise to a situation in which some form of unfairness or abuse of the system is taking place.

Hon STEPHEN DAWSON: Obviously, the opposition will support this amendment. Maybe I am reading this wrong, but I am not clear on this point. Seclusion is not a notifiable event. However, under clause 224, when somebody is released from seclusion, that release triggers a report to the Chief Psychiatrist and the Mentally Impaired Accused Review Board. Is that right?

Hon HELEN MORTON: That is correct. It is done as soon as practicable.

Hon STEPHEN DAWSON: I am not sure why we do not advise them of the seclusion in the first place given that we are advising them that seclusion has ceased. I would like the minister's explanation of that.

Hon HELEN MORTON: We are collecting the information for statistical purposes. The member may be aware that our seclusion rates have recently been going down at a fairly rapid rate as more emphasis has been put on managing people more appropriately rather than using seclusion. We have the second lowest rate of seclusion in

the nation at the moment. The next lot of information put out by the Australian Institute of Health and Welfare basically shows that in WA the rate of seclusion has reduced from 15 episodes per 1 000 bed days in 2008–09 to six episodes in 2012–13, a 60 per cent reduction. That is the information that we are collecting. It is collected for those purposes so that we can monitor the seclusion rate. As was previously mentioned, the Chief Psychiatrist can look at the information on a facility-by-facility basis rather than on a doctor-by-doctor basis, so that we can continue the good work that we are progressing of looking at more appropriate means of managing difficult behaviours rather than using seclusion.

Hon STEPHEN DAWSON: Given that seclusion rates are going down and the numbers are low, surely it would not be an administrative burden if we were to also record when the seclusion order was made in the first place. Surely it would be a safeguard if it were reported on the way in and then reported when somebody was released from seclusion. We could check whether the numbers were the same going in as they were going out. The minister has said that numbers are going down and numbers are low. I do not believe it would be an administrative burden.

Hon HELEN MORTON: We want to record this information only once. Consequently, if it is extended, if we record the information at the time that a person is going into seclusion, we will not know how long a person has been in seclusion. The maximum amount of time is two hours, but, quite frequently, seclusion is less than that. It can be extended, as I indicated before. We will not know that information at the time a person commences seclusion. Consequently, it is far better for us to record it at the end of the seclusion process and forward that information appropriately.

Hon STEPHEN DAWSON: I did not intend to spend all afternoon on this so I will ask just a couple of brief questions and then move on. Can the minister advise whether children can be put into seclusion; and, if so, whether there are any extra safeguards for children or are they simply lumped in with everybody else who may receive this intervention?

Hon HELEN MORTON: Just in case the member was suggesting that somehow or other children are in the same seclusion area as an adult —

Hon Stephen Dawson: I was not.

Hon HELEN MORTON: — we do have specific hospitals for children.

Hon Stephen Dawson: I was simply asking whether the same issue applied.

Hon HELEN MORTON: The child and adolescent mental health service's seclusion is similar to what occurs in other states, and the numbers are also going down. The bill provides extensive safeguards before, during and after seclusion. Restraints are used for children, including requirements relating to authorisation, recording, monitoring the patient's welfare during and after seclusion or restraint, reporting to the Chief Psychiatrist and informing families and carers. The use of seclusion and restraint is a serious matter irrespective of the age of the patient and it is therefore appropriate that these safeguards apply to both adults and children.

Hon STEPHEN DAWSON: I think the answer was given in the minister's last few words; that is, the same rules apply whether it is an adult or a child. Is that what I am hearing?

Hon Helen Morton: Yes.

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 213 to 223 put and passed.

Clause 224: Report to Chief Psychiatrist and Mentally Impaired Accused Review Board —

Hon STEPHEN DAWSON: I do not want to sound like a broken record. I have made this point numerous times throughout our consideration of the bill. It relates to our view on this side of the house that the Chief Mental Health Advocate should have a stronger role in this bill and be made aware of certain actions, treatment or intervention as they occur under the bill. In subclause (2) we see, once again, that a report needs to be made to —

(a) the Chief Psychiatrist; and

(b) if the person is a mentally impaired accused—the Mentally Impaired Accused Review Board.

Yet again, no mention is made of the Chief Mental Health Advocate. Given the advocacy role of the Chief Mental Health Advocate on behalf of the patient, surely it would make sense for the Chief Mental Health Advocate to be notified in the same way as the Chief Psychiatrist and the Mentally Impaired Accused Review Board. I do not want to sound like a broken record, but I have made similar points previously. I move —

Page 164, after line 6 — To insert —

(aa) the Chief Mental Health Advocate; and

Hon HELEN MORTON: The government does not support this amendment. Clause 224(3) requires the Chief Psychiatrist to be provided with five different documents on an incident of seclusion. This will enable the Chief Psychiatrist to identify trends, report on statistics and conduct compliance audits. Specifics on the use of seclusion and restraint can be brought to the attention of a mental health advocate by the patient or the patient's nominated person, carer, close family member or other support person. In responding, I acknowledge that it is not likely—I am sure the member does not intend it by his amendment—that we would not be able to use seclusion until a mental health advocate was on site or able to be there, or something of that nature. That is not at all possible. As a result of that, and understanding that is not what is intended by this amendment, the mental health advocate can always pick up this information through the medical records or by contacting any of these nominated people at any stage in this process.

Hon STEPHEN DAWSON: I understand the point the minister has made. Earlier this afternoon we talked about the seclusion order being provided to the patient. This clause does not say that a copy is also provided to the patient's carer, support person or anyone else; it is simply provided to the patient. If the mentally impaired or mentally ill person knows enough to be able to pass on advice about this order, then perhaps the mental health advocate will become aware of it. Can the minister confirm our discussions already this afternoon that the patient, the support person or anyone else on the patient's side would not get a copy of the seclusion order unless the patient passes it on?

Hon HELEN MORTON: That is correct, and it is also placed in the medical records. As I indicated before, when responding to a request for assistance, an advocate may access seclusion and restraint forms via the patient's medical records. In addition, advocates can proactively obtain information about the use of seclusion and restraint in particular facilities by questioning staff members. Further concerns regarding the use of seclusion may be brought to the attention of Health and Disability Services Complaints Office with or without the assistance of a mental health advocate. These existing powers and processes will ensure appropriate external accountability without the need for an additional reporting requirement. I believe that sending an advocate to an authorised hospital every time a person is secluded or restrained would be an inefficient use of the advocacy resources. It follows that the member's amendment would create extra work for both clinical staff and the advocacy service without associated benefit to the patient.

Hon STEPHEN DAWSON: A few minutes ago the minister agreed that this amendment does not seek to have a mental health advocate there all the time, yet the advice the minister just read out refers to it being an inefficient use of resources to have a mental health advocate there all the time. I did not ask for that to happen. My amendment does not seek to have a mental health advocate there all the time, simply that the Chief Mental Health Advocate is made aware of this issue. I take the minister's point that it is in the patient's medical records, but I place on record that the comments the minister made a few minutes ago are contradictory.

Amendment put and negatived.

Clause put and passed.

Clause 225 put and passed.

Clause 226: Terms used —

Hon SALLY TALBOT: I quickly make the point that the same issues I raised about isolation ought to apply here and that somebody being subjected to bodily restraint should be a notifiable event under part 9. I make the more general observation that there is a curious omission here of chemical restraint. Can the minister tell us why division 6 does not mention the use of chemical restraint?

Hon HELEN MORTON: I am glad that the member raised this issue. The term "chemical restraint" is not used in the bill or in the 1996 act. Psychiatric and other literature around the concept of chemical restraint hinges on whether an agent is given as part of treatment of a patient's condition or merely to control a patient's behaviour. The bill allows treatment to be provided without consent only if it is treatment to alleviate or prevent the deterioration of a mental illness. This relates to the definition of "treatment" in clause 4. There are many circumstances in which calming a patient may be a legitimate object of treatment; for example, when the patient is experiencing acute mania, medication used to treat mental illness may have the effect of calming and stabilising a person, and medication can be provided only with the authorisation of a medical practitioner.

Hon SALLY TALBOT: We have on record now, tragically, a graphic account of what happened to Ms Williams when she was subjected to what one would call "chemical restraint". The minister will know of course, having studied the coroner's report of what happened to Ms Williams, that the sequence of events that led to her death, which of course was the only death in which the coroner found that there had been some failure of care on the part of the staff, started when she was sedated with haloperidol. As the minister will know, Ms Williams was given a massive dose of haloperidol—far more than she should have been given—but perhaps

the most serious element of that was that the overdose was then not reported to the people who should have known. The minister knows the rest of what the coroner called a "catastrophic outcome". At any point along the way it seemed to me, as a non-medical specialist, from reading that coroner's report that the situation could have been retrieved. There was clearly a failure of the monitoring process, when the nurse failed to enter Ms Williams' room and simply stood at a window. He admitted at the coroner's inquiry that he could not see her respirations to count them and made them up on the basis of what the previous observation had shown. All this is traced back to that huge dose of haloperidol she was given. It is of enormous concern to the opposition that in this bill no reference is made to the way that the use of that kind of drug is controlled or is made public in the sense of being a reportable event.

Hon HELEN MORTON: I am very familiar with this case. The member is referring to the emergency psychiatric treatment that this particular lady was provided with on a flight to a hospital in Perth. I am not disputing that a mistake was made in the dosage. If I recall rightly, the dosage was meant to be two milligrams but she was given 20 milligrams. A mistake was made because a zero or a decimal point—whatever it was—was in the wrong place. That, unfortunately, is something against which we cannot legislate because it was a human error in reading a document or in putting an amount of medication on a medical chart. I agree with the member that the circumstances are absolutely tragic. However, that medication was provided to that patient under the emergency psychiatric treatment section of the legislation. A similar form of emergency psychiatric treatment would be provided to a person required to be brought to Perth by the Royal Flying Doctor Service.

Hon SALLY TALBOT: I think the minister would agree that the coroner's report makes it clear that it was not the misreading of the decimal point that killed Ms Williams; it was the failure to notify the people who took over her treatment while she was on the ground in Perth that the overdose had occurred and to monitor the effects. In fact, if my memory serves me correctly, the coroner's remark was that she should not have been taken to Graylands because she was under sedation and should have been taken to a hospital.

Our point is simply that we can legislate for this kind of thing, because we can legislate for procedures. If they cannot be legislated for in statutory form, they can be legislated for in the regulations or in the standards, yet there is no reference to chemical restraint in the bill. I ask the minister one more time to respond to that, and then I know that we have to move on.

Hon HELEN MORTON: We are talking about a clause on bodily restraint. The member's concern is about the use of chemicals. As I have already indicated, the definition of chemical restraint is not provided in this legislation. However, a person can use a form of chemical restraint in emergency psychiatric treatment and can apply medication to a person who is at risk of harm to themselves or to other people. The member said that the tragic outcome of this case occurred because of something to do with the handover and the monitoring that took place once the person had already been brought to the metropolitan area. Once again, standard 6 et cetera in the National Standards for Mental Health Services covers handover, but it is not related to the legislation on restraint in this part of the bill.

Hon SALLY TALBOT: Is the minister saying that the use of chemical restraint is not covered in this bill or is not in this clause of the bill?

Hon HELEN MORTON: As I indicated, under the definition for emergency psychiatric treatment, medication is one of the treatments that can be provided in an emergency.

Clause put and passed.

Clause 227: Bodily restraint: meaning —

Hon HELEN MORTON: I move —

> Page 165, after line 17 — To insert —
>
> (2A) A person is not being physically restrained merely because the person is being provided with the physical support or assistance reasonably necessary —
>
> (a) to enable the person to carry out daily living activities; or
>
> (b) to redirect the person because the person is disoriented.

As Hon Sally Talbot has already acknowledged, this amendment relates to the discussion we had when we talked about persons being excluded or in a room on their own. This relates to a similar argument about a person being unable to move. I had better read the document I have with me; otherwise I will say something that I am not supposed to say.

The proposed amendment to clause 227 relates to the meaning of "physical restraint". Physical restraint is defined in the bill as —

> ... the restraint of a person by the application of bodily force to the person's body to restrict the person's movement.

As I stated in relation to seclusion, one thing the bill aims to achieve is to remove doubt for clinicians and patients in areas where there is currently uncertainty under the 1996 act. Clinicians are sometimes required to assist patients with daily living activities, such as showering and dressing, and this is particularly common in wards in authorised hospitals for older adults. Similarly, clinicians sometimes need to redirect disorientated patients—for example, patients with dementia who may wander into another patient's room. This sort of reasonable physical assistance should not be regarded as restraint for the purposes of the bill. The proposed amendment will remove any ambiguity and is drafted in a way to ensure that patients will continue to be protected. This will be achieved by the narrow scope of the amendment, including the inclusion of the words "reasonably necessary".

Amendment put and passed.

Clause, as amended, put and passed.

Clause 228: Principles relating to use of bodily restraint —

Hon STEPHEN DAWSON: Amendment 68/228 that stands in my name on the supplementary notice paper calls for the insertion of a line that states "bodily restraint should be regarded as a treatment of last resort". I understand from the minister's comments this afternoon that bodily restraint is not recognised as a treatment and is recognised in this bill as an intervention. However, I am sure that the minister would agree with me that bodily restraint should be regarded as a treatment of last resort. I am not clear that the definition does that at the moment. However, acknowledging that my amendment is technically incorrect, I would like the minister to let me know whether she agrees that bodily restraint should be regarded as an intervention of last resort; and, if that is the case, what might we do to acknowledge that in the bill?

Hon HELEN MORTON: One of the underlying objects of the bill in clause 10 is for the provision of treatment and care with the least possible restriction on freedom. This is reinforced in the principles relating to the use of bodily restraint in clause 228, which states —

> (a) The degree of force used to restrain the person must be the minimum that is required in the circumstances;
>
> (b) while the person is restrained —
>
> (i) there must be the least possible restriction on the person's freedom of movement consistent with the person's restraint; and
>
> (ii) the person must be treated with dignity and respect.

Most importantly, the criteria for authorising bodily restraint in clause 232 require that there be "no less restrictive way of providing the treatment or preventing the injury or damage". I repeat that restraint can be authorised under the bill only when there is no less restrictive option available. There is no need to restate this principle by a reference to restraint being a treatment of last resort, especially given that the definition of "treatment" in clause 4 expressly excludes bodily restraint. The criteria in clause 232 also require that the use of bodily restraint is unlikely to pose a significant risk to the person's physical health. On this basis I am confident that the criteria for authorising restraint under the bill are appropriately restrictive.

The CHAIR: Is Hon Stephen Dawson formally moving that amendment?

Hon STEPHEN DAWSON: No.

Clause put and passed.

Clauses 229 to 239 put and passed.

Clause 240: Report to Chief Psychiatrist and Mentally Impaired Accused Review Board —

Hon STEPHEN DAWSON: I move —

> Page 176, after line 31 — To insert —
>
> (aa) the Chief Mental Health Advocate; and

I have moved similar amendments earlier in this debate. I believe that bodily restraint is an extreme measure, and extreme measures call for extreme oversights. This side of the house believes that the Chief Mental Health Advocate should be made aware when reports are made. Given the small number of reports involved, we do not agree that it would be an administrative overload. We believe it would ensure that the patient's best interests are taken into account if bodily restraint is used under this clause of the bill.

Hon HELEN MORTON: Again, the government will not support this amendment. I think the member has already indicated that it is unclear what an advocate would do upon being notified that a person had been restrained, if the intent was to somehow or other make that notification before the restraint was applied; and I do not think that is what the member is suggesting, so I will just acknowledge that that is the case. Secondly, specific concerns can be raised with the mental health advocate by the patient or their support person; complaints can be made to the Health and Disability Services Complaints Office; and of course the restraint forms must be in the medical records, which the mental health advocate can access.

Amendment put and negatived.

Clause put and passed.

Clause 241: Physical examination on arrival at hospital —

Hon HELEN MORTON: I move —

Page 178, lines 16 to 20 — To delete the lines and insert —

(2) The person in charge of the hospital must ensure that a medical practitioner physically attends on the person, for the purpose of examining the person to assess the person's physical condition, as soon as practicable and, in any event, within 12 hours after the time when the person is admitted or received, and at reasonable intervals after that initial attendance, until the first of these things occurs —

(a) the person is examined by a medical practitioner;

(b) if the person is a voluntary inpatient —

(i) the person refuses to consent to being examined by a medical practitioner; or

(ii) if the person does not have the capacity to consent to being examined by a medical practitioner — the person who is authorised by law to consent to the provision of treatment to the person refuses to consent to the person being examined by a medical practitioner;

(c) the person is released or discharged by or otherwise leaves the hospital.

Clause 241 requires a medical practitioner to attend on a person who arrives at a hospital, for the purpose of examining the person to assess their physical condition. Of course, it may not be possible for the medical practitioner to conduct an adequate examination at the time of the initial visit—for example, if the person is highly uncooperative, or aggressive. Under the current drafting, the medical practitioner is under no obligation to try again at a later stage. The effect of this amendment is to require further efforts to be made at reasonable intervals until the physical health examination has been conducted. The requirement to attend at reasonable intervals is limited by proposed paragraphs (b) and (c). Paragraph (b) applies when the person is a voluntary patient and informed consent to examination is not provided by the person or the person authorised by law to consent on their behalf. The rationale is that a voluntary patient should not be physically examined without consent. Paragraph (c) applies when the person can no longer be examined because they have left the hospital, including when they have been released or discharged, or are absent without leave, or have been transferred to another hospital. The links between the mental and physical illness cannot be ignored. The proposed amendment will clarify the responsibilities of hospitals that are providing treatment or care to people with mental illness.

Hon STEPHEN DAWSON: The opposition supports this amendment. It is a sensible amendment, and we are pleased that the minister may well have taken into regard the comments made by the opposition spokesperson in the other place, who suggested and quite forcefully made the point that when doctors attend, they must examine the patient; they cannot simply just attend. Having listened to the minister, I believe that this amendment will ensure that the patient will be examined, so I congratulate the minister in that regard. However, I need to ask one question. Proposed subclause (2) refers to "at reasonable intervals". Is there a definition of "at reasonable intervals"?

Hon HELEN MORTON: Because each case will obviously be different, the condition of the patient will determine what is reasonable in that respect.

Hon STEPHEN DAWSON: I understand what the minister is saying. A patient might not get the physical examination in a number of minutes or a number of hours and might want to take some action about that. If someone were to go back to this debate sometime after the fact—after, hopefully, the bill has passed through this place—I do not think the minister's explanation of the words "at reasonable intervals" would give them much comfort. Are we talking about minutes or are we talking about hours? Can we at least for the record have some comment about what might be regarded as reasonable in this instance?

Hon HELEN MORTON: The advice I have is that there is no way to legislate for every clinical contingency. This is about good clinical practice. Medical practitioners are already bound by national standards—standard 9, regarding actions—if there is deterioration in the physical state of the patient.

Amendment put and passed.

The CHAIR: I indicate to members that I understand that Hon Stephen Dawson has on the supplementary notice paper proposed amendment 70/241. That amendment would fall away as a result of the change that has just been made to this clause. Hon Stephen Dawson is nodding, so I assume he accepts that.

Hon STEPHEN DAWSON: I will take your advice on that, Madam Chair. However, I make the point that the opposition argues that the medical practitioners who are currently treating people's physical or mental health should be made aware of what is going on. Although my amendment falls away and is no longer on the table, does the minister agree with its sentiment?

Hon HELEN MORTON: The assessment standard of the Chief Psychiatrist will include the requirement to get comment from and liaise with other health practitioners with whom the patient is working. I move —

Page 178, lines 21 to 23 — To delete the lines and insert —

(3) For the purpose of assessing under this section the physical condition of a person referred to in subsection (1)(a)(ii) or (iii) or (b), these things may be done without consent —

It is intended that the amendment will clarify that the medical practitioner is to attend for the purposes of examining the person to assess the person's physical condition.

Amendment put and passed.

Hon HELEN MORTON: I move —

Page 178, lines 27 and 28 — To delete "purposes of subsection (2)" and insert —

purpose of assessing under this section the person's physical condition

This amendment will also clarify the language for medical practitioners attending for the purpose of examining a person to assess the person's physical condition.

Hon SALLY TALBOT: Given that we have only just had a chance to look at these amendments, can the minister reassure us that we have not legislated to subject a voluntary patient to something that is done without his or her consent?

Hon HELEN MORTON: Paragraph (b) applies if a person is a voluntary patient and informed consent to an examination is not provided by the person or the person authorised by law to consent on their behalf. The rationale is that a voluntary patient should not be physically examined without consent.

Hon SALLY TALBOT: I need to check whether I heard the minister right. Did she say that even though a voluntary patient withholds his or her consent to be examined for a physical condition, the examination could still go ahead without the consent of that person?

Hon HELEN MORTON: Clause 241(2) states that the person in charge of the hospital must ensure that a medical practitioner physically attends on the person for the purpose of examining the person to assess the person's physical condition as soon as practicable and, in any event, within 12 hours after the time when the person is admitted or received, and at reasonable intervals after that until the first of these things occurs.

Hon Sally Talbot: Are they an involuntary patient at that time?

Hon HELEN MORTON: First of all, we are talking about a voluntary person. If the person is a voluntary patient and refuses to consent to being examined by a medical practitioner, nothing more can be done at that point. If the person does not have capacity to consent to being examined by the medical practitioner, the person who is authorised by law to consent to the provision of treatment —

Hon Sally Talbot: I've got it.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 242: Provision of urgent non-psychiatric treatment: report to Chief Psychiatrist —

Hon SALLY TALBOT: Under clause 242(1)(a), does the Guardianship and Administration Act apply when an order is in place under the GAA? Would that impact on the provisions of subclause (1)(a)? Clearly, it would under subclause (1)(b) when someone is detained or classified under the Criminal Law (Mentally Impaired Accused) Act.

Hon HELEN MORTON: We are talking about the use of urgent non-psychiatric treatment for involuntary inpatients and the mentally impaired accused. If the treatment being considered is for a person's mental illness, it can be provided without consent, but if the treatment is for a non–mental illness—for example, the person's appendix has to be removed—that would come under and be referred to the appropriate person under the Guardianship and Administration Act.

Committee interrupted, pursuant to standing orders.

[Continued on page 6662.]