

MENTAL HEALTH BILL 2013

Consideration in Detail

Clause 1 put and passed.

Clause 2: Commencement —

Mr B.S. WYATT: I have a couple of questions about the commencement of the operation of legislation. In her reply to the second reading debate, the parliamentary secretary outlined the implementation process and I note that clause 2(b) states —

the rest of the Act—on a day fixed by proclamation, and different days may be fixed for different provisions.

I would like a bit more information about this implementation process, and I know the parliamentary secretary said it would be chaired by Judy Edwards. Does the government have a particular time frame in mind at the moment; and does the government anticipate that the entire legislation will come into operation together or will it be staggered, as is allowed under clause 2? If so, in what order is it anticipated that the staggered legislation will come into operation?

Ms A.R. MITCHELL: A large amount of training is involved—it starts with the general practitioners as well as others—and as that training occurs and is completed, then it can come on board. It is difficult to say at the moment exactly which bits will start today because it is a sequential sort of thing. As we get those through, they will come on for use. We are saying 12 months. We certainly do not want it to extend past 12 months, but we recognise that considerable training is required to make sure that people are fully aware of the changes without causing anyone any problems.

Mr B.S. WYATT: Has the training of general practitioners already commenced with the knowledge that by and large, although the opposition has some amendments, the legislation will be supported by it? Will that training be conducted by the Department of Health or is that something that you anticipate the Australian Medical Association will be involved in in respect of the legislation? If the department is involved in the training, have additional resources been allocated? The parliamentary secretary referred to additional resources in the budget. Will that be for training of GPs and other related mental health practitioners about what this legislation does? The government has in mind a 12-month period, and it does not want to wait for 12 months before the legislation comes into operation. I assume the entire bill will come into operation at the same time as opposed to individual chapters or sections. Could the parliamentary secretary clarify that for me?

Ms A.R. MITCHELL: The AMA is not involved in the training, but the Mental Health Commission and the Office of the Chief Psychiatrist are. At the same time, it would be nice to bring everything on at the same time, but if it is possible to bring other things forward that will not impact on anything else, we want to get things started.

Mr B.S. Wyatt: Is the only issue in the coming into operation of the act, the training of the GPs or the mental health practitioners, or is there something else that has to happen before the act can come into operation?

Ms A.R. MITCHELL: There are the clinician guidelines and standards, and the regulations for the transport officers. A number of things are being developed concurrently and will occur.

Mr B.S. Wyatt: Presumably happening now?

Ms A.R. MITCHELL: Yes, absolutely.

Clause put and passed.

Clause 3 put and passed.

Clause 4: Terms used —

Dr A.D. BUTI: Before I put a couple of questions to the parliamentary secretary I would like to acknowledge that no National Party member spoke on this bill during the second reading stage, which I find appalling when we understand the mental health issues in the rural area.

There are a number of issues in the definition part of the bill and some are just flagging future sections. However, at page 4 of the bill “close family member” is defined as “of a person, has the meaning given in section 281(1)”. That is further referred to at page 202 of the bill, and we can discuss that when we come to that clause. My query, which I will be expanding on when we get to that clause, is that, as the minister you would know that there are now a number of African communities living in Western Australia and their definition of a

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close family member would not correspond to all to the criteria used here as “close family”. The government should be congratulated for including the Indigenous family scenario, or community family scenario, but it is an oversight not to include other cultures, such as those of a number of African countries, which may have different family structures than those described in clause 281.

Ms A.R. MITCHELL: We have tried to ensure that a person will always have the opportunity to decide which family member they want. The bill gives a definition, but it does not preclude someone having whom they see as their family member there.

Dr A.D. BUTI: Of course they do not necessarily have the right protection as prescribed in the legislation, but we will talk about that later on.

I was interested to hear the parliamentary secretary’s comments about “informed consent”, which we will deal with later. I do not need the parliamentary secretary to comment on the words “informed consent, to the provision of treatment means consent to the provision of the treatment given in accordance with Part 5, Division 2”, but I do want to say that the definition is incredibly weak because we do not believe “informed consent” in part 5, division 2 matches what we consider to be informed consent. But I will leave that for now.

I have a minor point about the definition of “social worker”, at page 9, that I would like clarified. The bill states —

social worker means a person who is a member of, or is eligible for membership of, the Australian Association of Social Workers;

It is fine they are a member, but what does “eligible for membership” actually mean and do they eventually have to become a member?

Ms A.R. MITCHELL: The definition of “social worker” is very broad and wide-ranging because of the work social workers do, as the member can imagine. It means that they meet the definition or the requirements for registration.

Dr A.D. BUTI: That is quite alarming, because social workers have been given, as the parliamentary secretary would know, quite strong powers—powers that medical practitioners have in some instances. The parliamentary secretary has just stated that it is a very broad criterion and I find that disconcerting, because social workers will be given increased powers that I find alarming, and even more alarming now that the parliamentary secretary has said that it is a broad definition. May I say, considering the history of social workers in regard to the stolen generation history, I find it very disconcerting that the parliamentary secretary is saying that “social worker” will have such a broad definition given the powers of this bill.

Ms A.R. MITCHELL: Any social worker who wants to come under the banner of a recognised mental health practitioner goes through very considerable training to make that category. I think the member’s concerns probably do not need to be there.

Mr B.S. WYATT: Further on that point, and following up from the member for Armadale, who is quite rightly concerned about not only being a member, but also the fact that a person is eligible for membership, can the parliamentary secretary advise the house whether, to be eligible for membership, at the very least a person has to have the qualifications of a social worker to therefore join the association? For example, if I were a social worker student, am I eligible to join the association?

Ms A.R. MITCHELL: Yes, a person would need to have the qualification to become a member.

Mr B.S. Wyatt: So you are saying that if you are a student, that does not give you eligibility to join?

Ms A.R. MITCHELL: No.

Dr A.D. BUTI: The parliamentary secretary referred to the definition of “staff member”, also on page 9—the next definition. I understand that of course if a person is employed by a mental health service or a hostel under a contract of employment they are employed for providing a service under a contract for services. I understand those parts of the definition, but what if a person is employed by a hire company where the contract is between the hire company and the hospital or the health service, and not the person providing the service? Under that definition, they will not be covered.

Ms A.R. MITCHELL: Parliamentary counsel has advised that those statements are encompassing.

Dr A.D. BUTI: Parliamentary counsel may have provided that advice, but I once again ask the question about the individual who provides the service. There may be a contract with the body corporate that is providing the service, but what about the actual individual who provides the service? Are those individuals going to be covered by this legislation? There may be some ground for complaint against the body corporate that provided the service, but what about against the actual individual who provided the service?

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Ms A.R. MITCHELL: My advice is that a person in this situation is covered by their registration and also under the Health Practitioner Regulation National Law (WA) Act 2010.

Clause put and passed.

Clause 5 put and passed.

Clause 6: When a person has a mental illness —

Dr A.D. BUTI: I refer to subclause (4), which I flagged in my contribution to the second reading debate. It states —

A decision whether or not a person has a mental illness must be made in accordance with internationally accepted standards prescribed by the regulations for this subsection.

I have quite a few comments to make about this subclause. As the parliamentary secretary would know, a petition was presented today by Hon Bill Marmion. I would like to read out that petition because it is quite important. The petition reads —

To the Honourable the Speaker and Members of the Legislative Assembly of the Parliament of Western Australia in Parliament assembled.

We, the undersigned, say that the new Mental Health Bill 2103 currently before the Legislative Assembly lacks of awareness of the real possibility of citizens being misdiagnosed as having a mental illness when they are NOT mentally ill. It is a terrifying and damaging experience to be treated involuntarily for mental illness in error. Citizens who have been misdiagnosed can be imprisoned without trial and given “treatments” which themselves are hazardous and traumatic. The current criteria for determining if a person presenting has a mental illness are subjective and dangerously imprecise. The Bill, through the regulations, refers to “international standards” such as the DSM 5 for these criteria which themselves have received extensive international criticism. The Bill as it stands tries to legislate certainty into a process that by its very nature is extremely uncertain and has led to the Bill giving no recognition of the possibility of diagnostic error and the need for vigilance. What is needed is a change in attitude similar to “safety in the workplace” that has occurred in industry over the last 40 years. Instead of their being a cavalier attitude of denial with a worker almost having to be a whistleblower to identify a safety hazard, sometimes risking his own employment, it has become a duty on everyone to identify safety risks and take action. An erroneous mental illness label has adverse impacts on the recipient with regard to restrictions on career paths, insurance, relationships, and the person’s view of themselves which not only comes at a great cost to the person but also at a huge cost to the state budget. More recognition of this situation is needed if the truth is to be honoured and the freedoms of speech, thought and person, which Australia aspires to, are to be achieved and protected. The change in attitude regarding vigilance towards identifying misdiagnosis starts with the objects of the bill.

We will get onto that in due course. That petition specifically mentioned DSM–5. As we know, the explanatory memorandum refers to it as the “American Psychiatric Association’s Diagnostic and Statistical Manual V”. As I mentioned in the debate, DSM–5 has received quite in-depth international criticism. There is no more learned person in this area than Allen Frances, the chair of the DSM–IV task force. It is quite alarming that this government believes that DSM–5, which is the subsequent edition to DSM–IV, is internationally recognised as good practice. As members would know, during my contribution to the second reading debate I quoted an opinion piece by Mr Frances that appeared in the *New York Post*, in which he said that someone can go to bed normal and wake up to be considered mentally ill because of the increase in the number of new diagnostic mental illness categories. As mentioned by others, this psychiatry manual seems to be getting longer and larger as each volume comes out.

Mr D.A. TEMPLEMAN: I am very interested in this argument that the member for Armadale is pursuing.

The ACTING SPEAKER (Mr I.M. Britza): I can see that, member; thank you very much.

Dr A.D. BUTI: I will not, of course, repeat what was stated in the *New York Post* article, but I urge the parliamentary secretary to read what I quoted from it, because it is really disconcerting that the government considers DSM–5 to be internationally good practice. Mr Frances was the author of the edition prior to the one that is now in use in America. We should really be careful when we seek to take our lead from the USA, which is probably the most overmedicated, over-diagnosed society in the world. I will quote from page 170 of Mr Frances’ book *Saving Normal: An Insider’s Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life*, which states —

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DSM-5 HAS JUST been published—not a happy moment in the history of psychiatry or for me personally. It risks turning diagnostic inflation into hyperinflation—further cheapening the currency of psychiatric diagnosis and unleashing a wave of new false epidemics. The economic equivalent would be printing up loads of new money when prices are already rising way too fast. DSM-5 is a cautionary tale of soaring ambition, poor execution, and a closed process. The good news is that a last-minute reform effort, instigated by a new leadership team at the American Psychiatric Association, eliminated about one third of the worst changes that would have opened the floodgates of diagnostic inflation even further. The bad news is that, despite this, DSM-5 kept the other two thirds and will significantly add to, not correct, the already existing problems of overdiagnosis and overtreatment.

Considering the opinion piece written by Allen Frances and the comprehensive critique in his book, the petition that was tabled today, and that there is not international consensus on whether DSM-5 should be recognised as good practice, why would this government consider DSM-5 a good reference point? Surely the alarm bells should be ringing.

Ms A.R. MITCHELL: I must apologise to the member for Armadale; I did mean to respond to his questions and comments on DSM-5 during my reply speech, but somehow that one slipped past me. I am sorry the member had to bring that up again. In Western Australia, we tend to follow the ICD standards—that is, the International Classification of Diseases, and it is the World Health Organization classifications. One of the authors is a Western Australian. It does not mean that we do not look at DSM-IV or DSM-5, but in Western Australia we tend to follow the ICD standards. At the same time, we have the standards of assessment that are done by the Mental Health Review Board and the Chief Psychiatrist, so I think the member can be reassured that despite what might be in DSM-5, it is certainly not stated in this legislation that that is the assessment tool to be used. It is one of those that people may refer to, but it is also a very broad one, whereas this bill is focusing only on severe forms of mental illness.

Dr A.D. BUTI: I hear what the parliamentary secretary is saying, but as she very well knows, if this matter comes before the courts, the courts look at the intentions of the legislators, and the explanatory memorandum forms part of that. It clearly states that DSM-5 is one of the internationally recognised standards that the government will follow. It does not say that the government will follow the World Health Organization standard and give it priority over DSM-5. Could the parliamentary secretary at least acknowledge that there is no international consensus over DSM-5 so that can be placed on the record? Hopefully, in the other place the Minister for Mental Health will likewise do that. I think it is important that this Parliament and this house recognise that there is controversy over DSM-5, and that should be recorded.

Ms A.R. MITCHELL: Certainly, I am very happy to put on the record that DSM-5 is not a preferred classification for us to use and that ICD, the Mental Health Review Board and the current procedural technology standards of assessment will figure prominently.

Mr B.S. WYATT: Can the parliamentary secretary confirm that it is the ICD?

Ms A.R. Mitchell: Yes.

Mr B.S. WYATT: The ICD has a narrower definition of mental illness than DSM-5; is that correct?

Ms A.R. MITCHELL: Obviously, the definitions and the forms of mental illness are very, very broad, but in terms of the forms of mental illness that we are dealing with in this legislation, they are very consistent through ICD, and that is not just within Australia, but across the world. So, there is agreement on that around the world.

Clause put and passed.

Clause 7: Matters relevant to decision about person's best interests —

Dr A.D. BUTI: This clause deals with matters relevant to decisions about a person's best interests. Subclause (2) states —

The person or body making the decision must have regard to these things —

- (a) the person's wishes, to the extent that it is practicable to ascertain those wishes;

The bill then outlines a number of other parties, which include the enduring guardian or the guardian; and, if the person is a child, the child's parent or guardian. If that is the case, why does there not appear to be a parental veto at all? I cannot see a parental veto in this bill. In particular, when we are looking at issues of, for instance, psychosurgery or electroconvulsive therapy, there does not appear to be any room to move to allow parental involvement. I may have that wrong, and I look forward to the parliamentary secretary's explanation. As I mentioned in my second reading contribution, as did the member for Victoria Park, there may be times when it would not be appropriate to allow the parent to interfere because the parent is not considered to have the

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capacity, but there does not even seem to be the capacity for a parent who does have the ability to present their views on what is in the best interests of their children.

Ms A.R. MITCHELL: The mature minor concept, as the member is well aware, is very much embedded in common law, and clause 301 makes that quite clear.

Mr B.S. WYATT: Following on the question asked by the member for Armadale, I am curious. Clause 7(2)(b) states —

the views of each of these people —

...

(ii) if the person is a child — the child's parent or guardian;

I am curious about how that may work in conjunction with subparagraph (v), which states —

if the person has a close family member — the close family member;

This flows from the question of the member for Armadale about the lack of a parent veto. When there is a concerned parent, a child is also likely to have close family members. If there is a difference of opinion between a parent and a close family member of that child, the parent's position is not given any extra weight or priority over that of a close family member. I raise that simply because within family relationships there may be very strong and different views about what may be in the best interests of a child. Bearing in mind some of the comments that were made in the second reading debate by the member for Armadale concerning the lack of a parent veto within the legislation—there will be situations in which a parent is not in a position to make a veto decision—in this clause we are effectively equating any other close family member the same weight as the parent of that child will have. I am curious about why that is the case.

Ms A.R. MITCHELL: Can I just confirm that if the parent is the guardian, their view is the one that will prevail. In most circumstances the parents are the decision-makers, but, on occasion, unfortunately, there are situations in which the child may be estranged from their parents and they are not able to be found or may not want that decision to prevail.

Clause put and passed.

Clause 8: Matters relevant to ascertaining person's wishes —

Dr A.D. BUTI: This clause mentions any treatment decision in an advance health directive made by the person that is relevant to the matter, an enduring power of guardianship, and anything that the person says or does that is relevant to the matter et cetera. A person may be diagnosed, especially in an involuntary scenario, as having a mental illness. We are concerned that not enough weight is given to their wishes when they do not have that mental illness and that their advance health directives are not given the strength or the opportunity to play out. As a result of that I will move to insert new clause 8A. We are asking that this bill provide for the same scheme that is in the Guardianship and Administration Act 1990 on advance health directives to provide greater strength. It seems absurd that people who are later determined to be mentally ill will not have the same opportunity to determine their treatment as when they were not ill. When they are well and make decisions, those decisions should be allowed when they are determined not to have the capacity to make them. That is why we are seeking to insert new clause 8A. If a psychiatrist is not happy with the advance health directive that is the wish of the person being treated, the psychiatrist can seek a different determination from the State Administrative Tribunal, and that is how it should work. An independent body should determine whether the advance health directive should be allowed. As the parliamentary secretary stated, and as is contained in clause 10, we are trying to respect the wishes and dignity of the person being treated so that when they are not ill and are perfectly capable of making a determination of future treatment, why should it not be given the same strength other people enjoy under the Guardianship and Administration Act? If the treating psychiatrist is not happy with it, they will have the ability under our amendment to seek a different direction at the State Administrative Tribunal.

The ACTING SPEAKER (Mr I.M. Britza): Before I give the call to the parliamentary secretary, I want to confirm that we are dealing with clause 8, not the amendment.

Dr A.D. Buti: That is right.

Ms A.R. MITCHELL: As I think I indicated, there are times when it is important for people to make decisions. Often within this situation, someone might be detained who has an AHD, but it might not be possible to provide them with any treatment. While they are being detained they may be at risk to themselves, to other patients and to staff or family. We do encourage people to go to the State Administrative Tribunal for many other reasons, but these situations often require something to be done fairly quickly—it is urgent—and the State Administrative

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Tribunal does not convene urgently for these situations, so to get a decision within a week would be very difficult, let alone within a day. That can mean that people could be caught when they require treatment.

Dr A.D. BUTI: I understand what the parliamentary secretary is saying, but there would be no reason why an urgent hearing and decision of the State Administrative Tribunal could not be sought. The situation the parliamentary secretary is presenting may happen, but that may not be the case in many other situations. Why should everyone who has a mental illness be punished by not having the right that others have under the Guardianship and Administration Act, which is a very powerful act? It is not every day that an order is made under that act; therefore, generally, people who are caught by that act have problems, as may be the case with people who have a mental illness. In most cases, there may not be need for immediate action. There may be a period when there will not be a need for immediate action; for instance, a person who has made an advance health directive, may say when they are capable that they do not want to be subjected to electroconvulsive therapy. It is highly unlikely that someone who is detained will be subject to ECT within 24 hours. It may happen, but I would find it to be rare. I would also find it to be even rarer for someone to need psychosurgery within 24 hours. The government should not use the most extreme scenario to justify its legislation; legislation should be in place to cover the most likely outcome. The most likely outcome is that people will probably not need extensive major treatment within 24 hours. An advance health directive may not cover the whole field, so with an advance health directive it may still be possible to provide emergency medical care. In the example the parliamentary secretary used, our amendment may not prevent emergency care. As long as emergency care is not inconsistent with the advance health directive, nothing will prevent that treatment taking place. It will be the case only when there is inconsistency. It seems absurd that one of the government's guiding principles is to uphold the rights and freedoms of those who are considered to be mentally ill, but it is taking away the possibility of the advance health directive to operate to the same extent as the provisions of the Guardianship and Administration Act.

Ms A.R. MITCHELL: I would like to mention to members that the current act does not protect AHDs. This bill strengthens their use and provides them with some protection.

Dr A.D. Buti: By way of interjection —

Ms A.R. MITCHELL: May I finish, please? Thank you, member.

The member referred to psychosurgery, but that does not come into it because informed consent is required. In most of these situations we are talking about the requirement for urgent treatment, but safeguards require the Chief Psychiatrist to report. Often those treatments are required urgently. Sometimes treatment is required within 24 hours and, once again, we are talking about doing the best for the patients. We have strengthened the AHD provisions. They will always be taken into reasonable consideration but we need to make sure we have an opportunity to provide treatment if and when required.

Dr A.D. BUTI: It may not apply to psychosurgery but it can apply to ECT. As the parliamentary secretary knows, clause 199 provides for emergency ECT on adult involuntary patients or mentally impaired accused; therefore, an advance health directive that states that a person does not want ECT treatment may not have any strength under the bill. The parliamentary secretary stated that the current act does not provide any protection for the advance health directive, but considers that it is worthwhile being included in this bill. In that case, the parliamentary secretary must see the merit in an advance health directive; therefore, why not give it the strength it deserves by allowing it to have equal standing to the provisions in the Guardianship and Administration Act?

Ms A.R. MITCHELL: My advice is that it is very rare for ECT to be given under emergency conditions.

Dr A.D. Buti: It's in the bill.

Ms A.R. MITCHELL: If it is, it is given for life saving reasons. Yes; we recognise the AHD and we have given it more status within this bill, when it had none before, but at the same time people need the opportunity to make urgent decisions to save a person's life and that is what this clause does.

Dr A.D. BUTI: To say that something will not be used very often is quite a flimsy defence when we have just heard the experience as outlined by Mr Frances with regard to DSM-5. Because of the way in which the psychiatry world has been moving, and particularly if we are going to take our lead from the United States, although ECT may not be used much today, we do not know what will happen tomorrow. It does not give us much confidence, and it does not give the people of Western Australia much confidence, particularly those who suffer from mental illness, that just because a certain procedure is not in common usage today, it will not be in common usage tomorrow. We as legislators have a responsibility to provide the legislative framework that governs the mental health system. It is irresponsible for us to say that just because ECT is not used much today, we do not need to worry about it in our legislative framework. I urge the parliamentary secretary to reconsider what appears to be the government's opposition to our proposed amendment.

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Ms A.R. MITCHELL: Member, I did refer to ECT only, but I have been assured that there are many other forms of mental illness that are urgent and occur on a daily basis, and for which emergency treatment is required. If those AHDs were in place, there would be numerous situations in which treatment would not be able to proceed. If an AHD is overridden, it will need to be reported to the Chief Psychiatrist and the Mental Health Review Tribunal. It cannot just be overridden and then forgotten about. So the necessary protections are in place.

Dr A.D. BUTI: We are not talking just about emergency situations. The current clause 8 does recognise advance health directives, which, as the parliamentary secretary has said, is an improvement on the current situation. However, an AHD is just one of the things that is considered. It is not given any greater weighting. Although the parliamentary secretary's emergency scenario has, *prima facie*, a lot of strength to it, not every person who is made an involuntary patient requires emergency treatment. In that situation, if we are to uphold the rights and freedoms of the person as much as possible—which is the object of this bill, as stated in clause 10—and if an advance health directive was made when the person was considered to have capacity and was not in a medical condition that would result in the person becoming an involuntary patient, we should give that AHD the force that it should be given.

Ms A.R. MITCHELL: An AHD that precludes some forms of treatment but allows reasonable alternatives would always be supported. The problem is that a patient may have an AHD that precludes all treatment, and that would make things unworkable. That sort of AHD unfortunately may need to be overturned at times. That is the concern about the proposed amendment.

Mr W.J. JOHNSTON: Subclause (1) states —

This section applies whenever a person or body is required under this Act to ascertain the wishes of a person in relation to a matter.

Why is the word “body” used? The word “body” is not defined in the bill. The word “person” is not defined either. However, everyone knows that it means both a person and any organisation that is recognised by law. I am concerned that there may be some confusion about what is meant by the word “body”, whereas everyone knows what the word “person” means.

Ms A.R. MITCHELL: The word “body” refers to an organisation such as the Mental Health Tribunal.

Mr W.J. JOHNSTON: Could the word “body” refer, for example, to an unincorporated organisation? As I have said, the meaning of the word “person” is well established. I am suggesting that the inclusion of the word “body” may cause some confusion, because the bill does not define what “body” means. I did look that up the moment I saw that word. I want to make sure that we know what we are saying. If the parliamentary secretary has particular advice about why we need to include the word “body”, it would be very helpful if she would provide that, because I do not want there to be any confusion when the bill leaves the house.

Ms A.R. MITCHELL: The term “body” in this bill refers to organisations that will be acting under this act.

Mr W.J. JOHNSTON: Obviously the body will be given powers under the act. I understand that. The problem is that we do not know what a body is, because it is not defined. Okay, we are supposed to use the common meaning of that word. But the word “body” could mean something other than a registered organisation. It could mean something that is unincorporated. It could mean all sorts of different things. The word “person” is understood. If the parliamentary secretary has advice on this, please let me know. I am not an expert or a lawyer. I just want some clarification of why the word “body” has been included in addition to the word “person”, which would include any organisation that exists at law. Sorry. That is a very technical question. I understand that. But I want to ensure that we know what we are doing so that when the courts get to interpret this, there will not be any difficulty.

Ms A.R. MITCHELL: I appreciate that the member does not want to make things difficult, but the advice that we have received from Parliamentary Counsel is that the term “body” as used throughout the bill refers to organisations such as the Mental Health Tribunal.

Mr W.J. JOHNSTON: I will move on to a different area. The parliamentary secretary said in answer to a question from the member for Armadale about advance health directives that a determination may need to be made about whether the advance health directive contemplated all the treatments that might be available. My colleague the member for Armadale probably understands this better than I do. I am paraphrasing what the parliamentary secretary said. I am not trying to put words in the parliamentary secretary's mouth, but I think those are the words that she used. The parliamentary secretary said that a treatment may need to be used that was not contemplated when the person made the advance health directive. I am trying to establish how the people who will be making that decision would know whether the treatment was or was not contemplated when the person made that advance health directive. What procedure will be used to determine whether the person or body that is making the decision knows that the advance health directive did not contemplate a certain treatment? For

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example, the advance health directive might say that the person does not want treatment A. But there may also be treatment B, which is similar to treatment A. How would the person who is making the decision know that the person had not contemplated treatment B when they used those words? I am not sure how it goes together that the parliamentary secretary wants to give these people the power to make a decision—which has to be based on the best interests of the patient—when the patient may not have contemplated that treatment.

I will put it another way. A person may say they want only treatment X, and the person who is making the decision may say that when the person contemplated only treatment X, they did not know about treatment Y. How would the person making the decision know that the person who made the AHD did not know about treatment Y? The whole purpose of making an instrument such as an AHD is so that there will not be any doubt about what treatment will be given to the person. How would the person who was making the decision know that the person who made the AHD did not contemplate the treatment that the person making the decision is saying the person needs, when that is contrary to what is said in the advance health directive?

Ms A.R. MITCHELL: I said to the member for Armadale that there was a concern that an advance health directive precludes some treatments, but it allows reasonable alternatives that are considered to be fine. An AHD can be overridden only when someone who refuses all treatment has an AHD and could be dangerous to themselves, staff or other patients. There are some other alternatives—absolutely. Remember that if that is done, it has to be reported to the Chief Psychiatrist and the Mental Health Review Board.

Mr W.J. JOHNSTON: That overrides someone’s clear intentions and there may be good reasons for that, but there is no procedure to decide that. I made my comments in my response to the second reading speech that if I was the treating physician, I would want something to be looked at by somebody else before I did the treatment so that no-one could ever accuse me of getting it wrong. Why would we give the power to the person who does the treatment? It does not seem sensible. Why would we not say that before X can happen, Y must occur? The government says that they need to report it, but what about seeking approval or seeking a second opinion and giving notice within a specified period? There are so many easy ways to include a guarantee by another decision-maker. As I said, if I were a medical practitioner, I would not want to potentially have to front a court to argue whether the decision I made was reasonable, because the defence when they end up in court will be under clause 8(2)(d), which provides —

any other things that the person or body considers relevant to ascertaining those wishes.

I am not a lawyer, but I have dealt with enough court cases to know that the court will interpret that provision widely, because that is what courts do. The court will say that even though it is the person giving the treatment making the decision about what is relevant to ascertaining those wishes, the court will want to know the justification and detailed thinking behind how the decision was made. Health practitioners will not thank the minister for not having that done that through a process that shows the practitioners did X because of Y; that is, they got a second opinion and referred the matter to the Mental Health Commission and they took this step because it was in the best interests of everyone. We could include the specific provision, “Notwithstanding this, if a doctor in an emergency situation in the hospital acts in a reasonable manner”, and the courts would accept that. It is not hard to come up with provisions that recognise the interests of the patient, takes into account the advance health directive and also protects medical practitioners from ending up in court arguing about why they made a decision, because they could say what the procedures were and that they followed the procedures, rather than it being just about their decision.

Ms A.R. MITCHELL: I have been informed that it would be almost impossible for an AHD to cover all the possible scenarios that could arise in a person’s wishes and life. Normally, AHDs are focused on a couple of areas. However, the member is right that there needs to be protection for the person who may be considering overriding the AHD and also the patient. The Chief Psychiatrist will be providing guidelines on how to work within that area. Also, the psychiatrist has to notify the Chief Psychiatrist if he overrides, or intends to override, an AHD. The Chief Psychiatrist can override that decision and take it back to follow the AHD. There are those protections.

Mr W.J. Johnston: Obviously, when they have done it, it is too late for the Chief Psychiatrist to override it, but if they are intending to override it, that can be a notification and the Chief Psychiatrist can override that decision. Can you direct me to that provision?

Ms A.R. MITCHELL: I will just get clarification. They can notify the Chief Psychiatrist but they do not have to. It is not in the legislation so I cannot direct the member to that at the moment. The member is fairly close —

Mr W.J. Johnston: The power to override that is what I was interested in. Is it not in the bill?

Ms A.R. MITCHELL: The Chief Psychiatrist can override the treating psychiatrist.

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Mr W.J. Johnston: Which clause is that?

Ms A.R. MITCHELL: It is mentioned in clause 517(1) and 517(3)(c).

Ms M.M. QUIRK: I am sorry if this has been dealt with previously, but we would expect the phrase “must have regard to” to have its normal meaning. However, it seems that the decision-maker can have regard to something by acknowledging its existence but making a decision that is inconsistent with these other things. Why was not the phrase “consistent with” used or that these things must have precedence? The phrase “must have regard” implies that someone can have regard to it but then totally ignore it.

Ms A.R. MITCHELL: Yes, it is a difficult area. Unfortunately, treating mental illness is a very difficult area, and this legislation is often involved with acute situations. Certainly the regard is there, but sometimes decisions have to be overridden and action taken to save people’s lives.

Mr W.J. JOHNSTON: The section that the minister referred me to in answer to my last question was clause 517. I will read clause 517(1) for the benefit of *Hansard* —

The Chief Psychiatrist may review any decision of a psychiatrist about the provision of treatment to —

- (a) an involuntary patient; or
- (b) a patient who is a mentally impaired accused required under the MIA Act to be detained at an authorised hospital.

Clearly, those words do not include a patient who is not an involuntary patient or a mentally impaired accused person. What happens in the case of a person who is a voluntary patient? Is that to say that the treatment decisions of the medical practitioner who elects not to have regard to the advance health directive are not reviewed? Maybe I misunderstand them, but it appears those words are restricted to only those two types of people and not to other patients. I want to clarify whether I am right or whether I have perhaps misunderstood something.

Ms A.R. MITCHELL: Can I first clarify that all advance health directives are binding for voluntary patients except under emergency conditions.

Mr W.J. Johnston: Where is that, sorry? I am looking at clause 8, and it does not say that.

Ms A.R. MITCHELL: If a patient is voluntary, they need to give informed consent for treatment and under emergency conditions it is a different scenario. Also, clause 512(1) states —

The Chief Psychiatrist is responsible for overseeing the treatment and care of these people —

- (a) all voluntary patients being provided with treatment or care ...
- (b) all involuntary patients;

Mr W.J. JOHNSTON: Is the previous reference to clause 517 to be read in concert with the reference to clause 512 that the parliamentary secretary has just given? The parliamentary secretary only previously referred to clause 517. This is not my answer; I am just trying to clarify what is being said to me. When the parliamentary secretary referred to clause 517, she also included a reference to clause 512; is that right?

Ms A.R. Mitchell: I am just showing you that it is covered throughout the bill. They do not go together necessarily, but in the context of the reference to clause 517 a question was specifically asked and I supplied general information.

Mr W.J. JOHNSTON: There is another issue involved, which is fine. Is the parliamentary secretary saying that the provisions of clause 8(2) will not apply to a voluntary patient in a mental health situation because they would have to separately consent to treatment and that is why there does not need to be a provision that protects the advance health directive? Therefore, is the parliamentary secretary only talking about involuntary patients? Is that the argument?

Ms A.R. Mitchell: That is correct.

Mr W.J. JOHNSTON: To seek completeness, why would clause 8(2) not just make that clear? There would then be no discussion or argument from me. I understand the argument the parliamentary secretary has made and it is quite a reasonable position to say that someone who is not an involuntary patient has to consent to treatment, and so, QED, everything is fine. Why would it not be made clear that that is what is occurring? The problem is that the wording is about obtaining consent, but if someone is an involuntary patient, the question of consent is different from that of a voluntary patient. If it is only intended that the treating physician have the right to choose to do something separately to an involuntary patient, why would the clause not state that? It would clarify things for everybody and no-one would ever have an argument with it. It is not about the intention; it is about the words

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on the piece of paper. As I have said in this chamber a number of times, all we can deal with are the words on the paper and not the intention, and I just wonder why this was not clarified.

Ms A.R. MITCHELL: Clause 8 is not actually about informed consent; it just refers to patients' wishes. Informed consent comes later in part 5 of the bill and this clause is just about patients' wishes.

Dr A.D. BUTI: That is an interesting answer because the parliamentary secretary used informed consent to explain why there is a difference between voluntary and involuntary patients. The parliamentary secretary mentioned that a voluntary patient would have to consent to the treatment. The fact that someone is a voluntary patient does not mean that they are well, and the whole idea of an advance health directive is that a decision is made when a person is well or in a better situation. A voluntary patient is often not very well; they are just not in a condition that would make them involuntary. Why would greater force not be given to a directive made by the future patient when they are well? The safeguard the parliamentary secretary refers to is that a voluntary patient has to consent, which is the same as a health directive. However, that is not the same as an advance health directive because the health directive is made in advance of treatment; it is not contemporaneous with the treatment. Therefore, greater force should be given to the advance health directive. The example that the parliamentary secretary used in regard to the amendment that we will be dividing on is that there may be an emergency situation. There probably will not be an emergency treatment situation for a voluntary patient; therefore, the defence of emergency treatment would not be able to be used in regards to voluntary patients. In clause 8, why is greater weight not given to the advance health directive? As the member for Girrawheen mentioned, the words "must have regard" should mean that something is mandatory, but what do we mean by "regard"? It could mean someone has looked at something and does not agree with it. Under the provision that wording is sufficient, so the words "must have regard" are really superfluous to any mandatory requirement because they mean someone must just look at something without necessarily having to do anything. In the case of voluntary patients that the member the Cannington brought up, why would we not give more of a mandatory applicability to the advance health directive? In that case there would not be emergency treatment. What examples are there of emergency treatment for voluntary patients? There may be some, but they would be very, very rare. Why are voluntary patients being discriminated against? Why has greater weight not been given in the bill to the advance health directive?

Some of the most vulnerable people in our society—those with mental illness—are being discriminated against. In the case of a voluntary patient the advance health directive should be given greater weight. I also argue that they should be given greater weight in the case of involuntary patients because they are making a decision when they have the capacity to do so. By not allowing that, the whole object of the bill is being contravened. The whole object of the bill is the dignity of the patient and not to restrict their freedoms or rights, or at least to restrict them to the minimum possible extent. More of a mandatory consideration should be given to the advance health directive, otherwise why have advance health directives at all?

Ms A.R. MITCHELL: Firstly, the AHD does not require assessment by a medical practitioner; it is a statement. The member was talking about capacity of the patient to make a decision and I suppose there is always that question about whether that person actually had the capacity if there was no formal medical assessment of them. That consideration is always there. I confirm again for the member that the AHD is given much greater weight for a voluntary patient—there is no question about that—and it must be listened to except in an emergency. There is concern that if that AHD for an involuntary patient is not overridden at some point, there will be a greater risk to that person's life and also the lives of people around them. The critical point is that change in safety to that person and to others.

Dr A.D. BUTI: These advance health directives need to be taken on face value and in good faith. The parliamentary secretary said that the actual capacity of the patient was not known when they made their advance health directive. If there are going to be advance health directives and if they are going to be recognised in the bill, as is done in clause 8, it will have to be accepted, unless there is contrary information, that when those advance health directives are made, the people who made them had the capacity to do so; otherwise, the health directives have no meaning if that is the attitude it is thought will be taken in determining whether they should be followed or not.

Ms A.R. MITCHELL: Unfortunately, it is very difficult that under very urgent circumstances and with the best of intentions, sometimes for the safety of people and to save lives, an advance health directive will sometimes be overridden with protocols in place to ensure that there is a record of that and even a chance to overrule it, but in these circumstances that has to be recognised.

Clause put and passed.

New clause 8A: Advance health directive —

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Dr A.D. BUTI: I move the opposition's new clause —

Page 14, after line 2 — To insert —

8A. Advance health directive

- (1) Notwithstanding anything in this Act to the contrary, the scheme of the *Guardianship and Administration Act 1990* relating to advance health directives must be followed in its entirety in order to give them full force and effect.
- (2) A psychiatrist must not act contrary to an advance health directive unless the State Administrative Tribunal has determined that the psychiatrist can do so.
- (3) The State Administrative Tribunal shall have jurisdiction to make a determination in subsection (2) and shall, in exercising this jurisdiction, follow the provisions of the *Guardianship and Administration Act 1990*.

Division

Question put and a division taken, the Acting Speaker (Mr I.M. Britza) casting his vote with the noes, with the following result —

Ayes (14)

Dr A.D. Buti
Mr R.H. Cook
Ms J. Farrer
Ms J.M. Freeman

Mr W.J. Johnston
Mr F.M. Logan
Mr M. McGowan
Mr P. Papalia

Mr J.R. Quigley
Ms M.M. Quirk
Mrs M.H. Roberts
Mr C.J. Tallentire

Mr B.S. Wyatt
Ms S.F. McGurk (*Teller*)

Noes (27)

Mr P. Abetz
Mr F.A. Alban
Mr C.J. Barnett
Mr I.C. Blayney
Mr I.M. Britza
Mr G.M. Castrilli
Mr M.J. Cowper

Mr J.H.D. Day
Ms E. Evangel
Mr J.M. Francis
Mrs G.J. Godfrey
Dr K.D. Hames
Mr C.D. Hatton
Mr A.P. Jacob

Dr G.G. Jacobs
Mr S.K. L'Estrange
Mr R.S. Love
Mr W.R. Marmion
Mr P.T. Miles
Ms A.R. Mitchell
Mr N.W. Morton

Mr D.C. Nalder
Mr J. Norberger
Mr D.T. Redman
Mr A.J. Simpson
Mr M.H. Taylor
Mr A. Krsticevic (*Teller*)

Pairs

Mr P.C. Tinley
Mr D.J. Kelly
Ms L.L. Baker
Ms R. Saffioti
Mr D.A. Templeman
Mr P.B. Watson
Mr M.P. Murray

Mr T.K. Waldron
Dr M.D. Nahan
Mr T.R. Buswell
Ms W.M. Duncan
Mr R.F. Johnson
Mr J.E. McGrath
Mr V.A. Catania

New clause thus negated.

Clause 9: Language, form of communication and terms to be used —

Mr W.J. JOHNSTON: I seek clarification of the words in subclause (2), “terms that the person is likely to understand”. How is that to be ascertained?

Ms A.R. MITCHELL: The term would be used as a reasonable person would be able to understand what was being referred to. For example, if it were a child, the communication would have to be at a level that a child would understand. If it were a person who was deaf, the communication would have to use another form of explanation. If it were someone from a culturally and linguistically diverse community, there would need to be an appropriate interpreter. The Chief Psychiatrist will be developing guidelines so they will be incorporated.

Mr W.J. JOHNSTON: It is reassuring if there are going to be guidelines. I do not think one has to be a child, from a culturally and linguistically diverse background or an Indigenous background to not understand medical terms. I doubt I would have much hope of understanding many of the terms. Will the Chief Psychiatrist have some way of consulting with the community so that there is some process of input into the terms to be used? What is the intention?

It is one of the problems that occur with all things medical. If we were talking about service stations, the problem would be, of course, that the people who know about service stations talk jargon to other people who know about

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service stations. The problem here is that mental health people talk jargon to other mental health people about mental health. I wonder what process is intended to enable a conversation with the broader community to make sure that it is not just medicos talking to medicos. With all due respect to medicos, like all of us, they can get caught up in jargon et cetera. We can use the corridor conversations in this place as an example; we are all into that ourselves. What process will the Chief Psychiatrist use to make sure that there is some understanding of these terms?

Ms A.R. MITCHELL: The important point, which I made in my reply to the second reading debate—the member may have missed it; I am sorry about that—is that there is an implementation working group and that consumers, carers and families are actively involved. They would also be involved in the formation of all guidelines, including these. One group that is working on these is what I would call a lived experience advocacy group. We will have its input as well. I think we are covering the concerns that the member has.

Mr W.J. JOHNSTON: I just want to say that I have a good relationship with the Bentley Mental Health Consumer Advisory Group and that I hope it will be included in those to be consulted. Members of the Bentley Mental Health CAG regularly come to my office. I have spoken about the high demands of mental health in my electorate. Bentley Hospital is divided between my electorate and that of the member for Victoria Park; the general hospital is on the western side of Mills Street in the electorate of the member for Victoria Park and the mental health unit is on the eastern side of Mills Street in my electorate. The Bentley Mental Health CAG is a group with which I try to work closely. I support its Mental Health Week barbecue each year. It is a good group, and I want to make sure that it will be one of the groups included in the consultation process.

Ms A.R. MITCHELL: The Chief Psychiatrist has informed me that he has already had discussions with the Bentley group, perhaps not on that particular section the member raised, but he will include that in future discussions.

Ms M.M. QUIRK: Again, I think we fall into the same category of the mandatory directory dichotomy. Clause 9(2) contains the words —

Any communication with a person under this Act must be in a language ...

What is the consequence if that does not occur? In my contribution to the second reading debate I also spoke about principle 6 of the Charter of Mental Health Care Principles, which states —

A mental health service must recognise, and be sensitive and responsive to, diverse individual circumstances, including those relating to gender, sexuality, age, family, disability, lifestyle choices and cultural and spiritual beliefs and practices.

What status does the charter have, what relationship does it have with this clause and what will the sanctions be if this clause is not complied with?

Ms A.R. MITCHELL: If a person believes that they have not received that clear information, they can complain through the Health and Disability Services Complaints Office, which I mentioned in my reply to the second reading debate. They do have powers; the member was concerned that they may not.

Ms M.M. Quirk: Where is that contained in the legislation?

Ms A.R. MITCHELL: It is covered by part 19.

Ms M.M. Quirk: What is the relationship between that part and the charter, and what status does that charter have in terms of any inconsistencies between the bill and the charter itself?

Ms A.R. MITCHELL: I will just sit down as that got a bit long for an interjection.

Mrs M.H. ROBERTS: I would like to hear the minister's answer when she is ready.

Ms A.R. MITCHELL: Clause 319 states that if a service does not comply with the charter, they can go to HADSCO.

Ms M.M. QUIRK: Does that apply to both voluntary and involuntary patients?

Ms A.R. Mitchell: Yes.

Clause put and passed.

Clause 10: Objects —

Dr A.D. BUTI: Clause 10 is important in the overall scheme of the bill as it goes to the objects of the bill. I earlier quoted from a petition that was submitted today by Hon Bill Marmion. He also submitted a petition yesterday. I just want to finish off the second part of the petition that he presented to this house this morning.

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The first part of the petition, as the parliamentary secretary would remember, was about DSM-5. The second part states —

Now we ask the Legislative Assembly to pass amendments to the Mental Health Bill 2013 before the house to help raise awareness and increase vigilance regarding misdiagnosis by adding the following “Object” on part 3 clause 10 of the Bill namely:-

- g) to reduce the incidence of misdiagnosis to a minimum and to provide a framework that will encourage continual vigilance regarding identifying situations where misdiagnosis has occurred thus ensuring that the freedom of citizens is protected.

I would also like to read out the petition presented yesterday by Hon Bill Marmion, which states —

We, the undersigned, say that the new Mental Health Bill 2103 —

It should be 2013 —

currently before the Legislative Assembly lacks awareness of the real possibility of citizens being misdiagnosed as having a mental illness and treated involuntarily when they are **NOT** mentally ill. Errors do occur and can result in gross breaches of natural justice. In keeping with Australia’s commitment to process fairness and the value it places on freedom of speech, thought and person, we the undersigned believe that there is a need for additional protection to be extended to involuntary patients that would take advantage of technology to record diagnostic interviews (with appropriate cautions) that could result in involuntary incarceration and treatment.

Now we ask the Legislative Assembly to pass amendments to the Mental Health Bill 2013 before the house to help raise awareness and increase vigilance regarding misdiagnosis by adding the following provisions in the Bill namely:-

1. Add a clause in the Bill stating that all diagnostic interviews, the outcome of which could result in involuntary treatment, are required to be recorded on video and kept on file for future reference by the patient and as evidence that involuntary incarceration was warranted should it ever be contested.
2. Add a specific clause to address cases of misdiagnosis of mental illness when they do occur and provide assistance to people to review and correct their medical records.

Those two petitions that were presented to this house on consecutive days by Hon Bill Marmion attest to the fact that people out there are not overly confident about the contents of this bill and would not agree that the objects that are prescribed in this bill will protect their rights and their freedoms and have respect for their dignity. Paragraph (b) of the objects of this act states —

to recognise the role of carers and families in the treatment, care and support of people who have a mental illness;

In a previous answer, the parliamentary secretary mentioned that under clause 301 there is a common law parental right, but that is not a right of veto. All that that clause states is —

In performing a function under this Act in relation to a child, a person or body must have regard to the views of the child’s parent or guardian.

The child, person or body must “have regard” to the views of the child’s parent or guardian; that is all they have to do. The parents do not have a right of veto. I go back to the point that I and other members on this side of the house have made. Parents should have a right of veto, which, of course, can be subject to an independent examination by an independent body if it is felt —

Ms S.F. McGURK: I am interested in what the member is saying.

Dr A.D. BUTI: Thank you very much, member for Fremantle. If we are to give proper consideration to the role of carers and families in the treatment, care and support of people who have mental illness, there should be a right of veto. In the end, there is no doubt that the treating psychiatrist will have a point of view on how the person should be treated. It would be highly unlikely that the treating psychiatrist would give significant weight to the views of the family and, in a child’s situation, to the views of the parent, because the treating psychiatrists would consider that they are the ones who are the professionals and have the expertise to decide what is best for the patient. They would have made a decision because they believed it was in the best interests of the patient. I may be cynical, but in those cases I doubt that they would give appropriate weight to the views of the carers and families. That general provision in clause 301, particularly in regard to children, is just something that they have to consider. That is one of the weaknesses of this bill. It refers to a mandatory regard. A mandatory regard is

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worth nothing more than the paper it is written on. There is no compulsion to give the wishes of the carers or family members the due weight that they should be given. There is a major inconsistency and contradiction in the way the legislation is presented vis-a-vis the objects. The objects sound beautiful; they sound fantastic. They refer to the least possible restrictions on freedom and the least possible interference with the person's rights, but the legislation will not give due consideration to an advance health directive. It will recognise the role of carers and families. All that means is that people just take into consideration those views. Another object is —

to recognise and facilitate the involvement of people who have a mental illness, their nominated persons and their carers and families in the consideration of the options ...

But we will not give due weight to the advance health directive or the views of the parents, particularly in regard to children, because a legislative parental veto is not provided. As we have stated time and again, we are not asking for a blanket parental veto stipulation. There should be a parental veto, but subject to independent scrutiny. Our concern is that the objects, although they are all nice and fuzzy and woolly, do not measure up to many of the clauses in the bill before us.

Ms A.R. MITCHELL: The member raised a number of points and I will try to pick up all of them. The first one was legislation for good diagnosis. Unfortunately, the best diagnoses only come from training and treatment and things like that. We cannot legislate for that, unfortunately. Otherwise life would be a lot easier. If someone is concerned about a misdiagnosis, certainly they can go to the courts. They can go to the advisory advocacy service, the Mental Health Tribunal, the Health and Disability Services Complaints Office and even the Chief Psychiatrist. So there are avenues for people who believe they may have been misdiagnosed. No single diagnostic tool is used for everybody to decide what is going on. There are a number of things, and obviously each one will be different. It is done on a case-by-case basis. Patients are interviewed to get a bit of family history to ascertain what long-term processes might be best suited to the treatment of that person.

I come back to the concept of a mature mind in common law. It is very important to follow that concept. A number of people spoke previously about mental health having a stigma. If the opposition wished to bring that change into this legislation, we would continue that stigma, because if it is recognised throughout common law, in the situation of the Mental Health Bill, we believe that concept should apply as well. There is no question that parents' views will be taken into great consideration and will be adhered to. They will be overruled only if the person is a mature minor or the person becomes an involuntary patient and there is a serious risk to that person's health and life.