PSYCHIATRIC HOSPITALS — PATIENT PROTECTION

Motion

Resumed from 14 May on the following motion moved by Hon Sally Talbot —

> That this house notes the findings of the Victorian Mental Illness Awareness Council, that 45 per cent of women who are inpatients in psychiatric hospitals in that state are sexually assaulted while an inpatient, and calls on the government to take urgent action to —
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> (a) establish the extent of similar problems in Western Australian psychiatric hospitals; and
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> (b) protect women in Western Australian psychiatric hospitals from sexual assault.

HON SALLY TALBOT (South West) [2.09 pm]: As honourable members would remember, about a month ago when this motion came to the top of the notice paper, I had only a couple of minutes to talk. I will remind honourable members what the motion is about before I get into the substance of my remarks.

Unlike some of the motions that we debate in this place the opposition is not trying to score political points here, it is bringing to the house's attention a potentially very serious situation on which we hope there will be an absolutely bipartisan response. Research done in Victoria a couple of years ago and published in the report "Zero Tolerance for Sexual Assault: A safe admission for women" revealed, as I have pointed out to the house several times before, some really quite astonishing and extremely troubling statistics. The headline statistic is that 45 per cent of women were sexually assaulted while they were inpatients in psychiatric institutions. I think we all agree that the disadvantage we have in this state is that we have not yet done research to show whether that statistic is replicated in Western Australia. Since I read the report a couple of years ago I have made the point that we do not have any reason to assume that the outcome of similar research would be substantially different in Western Australia from the situation in Victoria, and that is why the motion standing in my name is framed in two parts. Part A states that we should take urgent action to —

> … establish the extent of problems in Western Australian psychiatric hospitals;

We all know the frustration that we experience at times in this place about the length of time it takes for motions to work their way to the top of the notice paper. This motion is in exactly that situation, in that I placed it on the notice paper about a year ago. But we have the happy circumstance for this motion that it has once again become particularly topical, in the sense of interest in the issue and also in the sense that we can actually take action to address the situation, because we are in the process of considering the Mental Health Bill 2013. I await the minister's response to the terms of the motion with interest, but it is probably in the context of the Mental Health Bill 2013 and the rewrite of the Mental Health Act that we can put in place the steps to address this particular problem.

In the brief remarks I made a month ago, I said that I wanted to frame the discussion in terms of the forward to the Victorian Mental Illness Awareness Council report. I was halfway through reading that forward when my time ran out, so I will just put it on the record because I think it is a particularly moving way to focus our attention on the problem. The forward starts —

> As human beings, we are all "creatures of habit." If we do something often enough we do it without thinking. If we see something often enough we cease to see it. If we hear something often enough we stop listening and if we think something often enough we think it without question. This habitual way of seeing, listening, thinking and doing is in us all. It exists at a community, government, bureaucracy, management and employee level and affects not only the decisions we take, but also how we make them. Additionally, we usually only ever neglect or abuse the rights of those we see as having less power than we have and we tend not to get involved in trying to stop or prevent abusive or neglectful behaviour unless it is happening to a loved one. Put simply, "habits of practice" allow good people to do not so good things. Sadly, it would seem that the "habits of practice" that have been developed in psychiatric in-patient units are having a profoundly negative impact on women who use them. Additionally, the "habits of practice" problem solving techniques that have been developed and used to resolve the issues for women have had little to no positive impact. It is now time to rethink the way we do things because our Duty of Care must be that we do no harm. Doing no harm and reducing the negative impact of "habits of practice" means always asking the question! If this happened to me or someone I loved what would I expect and want to happen?

By way of a little bit more background about this particular research, I will continue —

> For many years VMIAC has been listening to women with a lived experience of mental illness talk about their experiences as patients in psychiatric in-patient units. As a consequence of these conversations, VMIAC has major concerns about the degree to which women with a lived experience of

> mental illness are expected to endure sexual harassment and assaults without any major interventions. Indeed, the level of harassment and assault would not be tolerated in any other area of health. While attempts have been made to resolve the issue with the introduction of female only corridors and women's lounges, gender sensitive training, etc., these well intentioned strategies have had no real impact on improving the right of all women to not only feel safe, but to be safe on psychiatric in-patient units. It is for this reason that VMIAC is strongly recommending a zero tolerance approach to what should be regarded as an intolerable situation.

It is that point that takes me to the substance of the remarks I want to make about the zero-tolerance approach to what is clearly an intolerable situation. I will review the statistics for honourable members who might have forgotten from nearly a month ago when I first outlined them. In Victoria, 85 per cent of women admitted to a mental health inpatient unit felt unsafe, 67 per cent of women reported harassment including sexual harassment and 45 per cent reported sexual assault. Of the 45 per cent of women who reported sexual assault, about 61 per cent reported the sexual assault to nurses on the ward, of which 18 per cent found that the response from staff on the ward was "slightly helpful" and 82 per cent said that the help was "not at all helpful". I think those statistics should send a shiver of alarm through us all. We have to look at what we do in Western Australia. I have already said that we have not got an equivalent body of research in WA that we can draw on, but I put to honourable members that what we do know does not suggest that we already have a mechanism in place that results in outcomes substantially better than those reported in Victoria. I say that because the evidence we have about the way our psychiatric institutions are run is the Stokes inquiry report. Professor Stokes's report showed that we have a very severe deficit of protocol in the area of uniform practices and general monitoring of patient safety—as inpatients and once they are discharged—in psychiatric hospitals. I think it is entirely appropriate in the context of this motion that we focus on safety practices and the area, which Professor Stokes talks about specifically, of the accountability of management in psychiatric institutions. We need to look at the way clinical governance is working. I suggest that if the Stokes inquiry had given us a report that stated that our clinical governance of psychiatric institutions was top notch or world class or world's best practice or whatever phraseology one wants to use, then perhaps we could look at the Victorian research and say that we already have in place measures, which suggest to us that we are already covering some of those problem areas and preventing these kinds of sexual assaults. But, of course, that is clearly not the case.

I want to again include quite a substantial quote in my remarks, because I cannot do better at paraphrasing than Professor Stokes does in the review. This section of the Stokes report is headed "Clinical governance". It reads as follows —

> The Review concludes that the governance of public mental health in WA is fragmented, variable in type and method of service delivery, and that there is no robust uniform clinical accountability across the system.
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> This results in the disparate application of protocols and policies. As the principal provider of public mental health care, it is essential that the Department of Health has responsibility for overall governance of policy setting in the provision of care for hospital and community clinic settings.
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> Currently, there are two types of mental health governance in the metropolitan area. One is program based; the other geographically based. This leads to confusion in governance, particularly as mental health patients tend to move frequently across the system.
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> Across the mental health system, overall leadership is lacking, as is the ability to make things happen. Many mental health facilities act as if they work in a silo. Their relationships with each other are fragmented so that patients moving from one facility to another are frequently subjected to repeated history taking and changing care.
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> There is disparate implementation of policies across sites even within the same area of mental health service. A stark example lies in the use of different risk assessment processes.
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> The Reviewer is concerned at the large number of managers in all mental health settings and is uncertain of the need for such numbers. A functional review of these positions and functions needs to be undertaken.
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> A significant number of management groups meet to discuss a variety of mental health management issues and yet little is seen to have altered as a result.

I know, from the comments that the Minister for Mental Health has made over the last 18 months or so since the Stokes report was made public, that she and the government have done some pretty rigorous work on the whole question of clinical governance of psychiatric institutions in Western Australia. We have not yet seen the 10-year mental health plan, but one certainly hopes that once comments like those I have just referred to land on the minister's desk and once they are put in front of a cabinet room, some pretty loud alarm bells will begin to ring

for the government. I am therefore looking forward to going through that 10-year mental health plan to see which specific improvements have been made in the area of clinical governance. However, my purpose in referring specifically to that section of the Stokes report in the context of this motion is that we will need to see whether those improvements in clinical governance, assuming that they are on their way to consideration by this Parliament, go to those issues of keeping women safe—not just feeling safe but being safe—when they are admitted as psychiatric inpatients. I am sure I do not need to point out, but I will briefly refer to it, that all the research suggests that many women admitted as inpatients have already been the subject of some kind of abuse—whether that be sexual, physical or psychological—and that, although sexual abuse for any woman in any circumstance is an immensely distressing and stressful experience, women psychiatric inpatients are particularly vulnerable.

One of the things that we need to look for very specifically when we see this 10-year mental health plan is whether there is a way to factor in the very troubling instances of women psychiatric inpatients simply not being believed when they report these kinds of experiences. I have drawn to the minister's attention on a couple of occasions in the last few months the very comprehensive report—I know the minister has seen it and has asked her department to do some work on it—into the way people with disabilities are treated when they come into contact with the justice system. I must say to the minister that I am not yet convinced that we have got to the bottom of this matter because, when I have raised it with the minister, she has referred to the disability justice centres, the establishment of which of course Labor has long supported. However, they address only a very small portion of the much broader problem that this human rights report refers to, which is that when people with disabilities appear either as people reporting crimes or abuse, or as witnesses to crimes or abuse, they are simply not taken seriously or their evidence is not given the same weight as that given to a person without a disability. That whole framework translates quite directly into the topic that we are discussing today, which is reports of abuse or assault that are reported by women inpatients in psychiatric institutions.

I return to the Stokes report. We heard from the Stokes report loudly and clearly this troubling manifestation of the inconsistencies of care, and it is the variability of the care that is so troubling. For me the message from Stokes would have been more straightforward if it had just said, "We are doing everything really badly." However, that was not what Stokes said. Stokes said, "We actually know how to do things really well." The difficult thing to pin down—this is the challenge for the government—is why, when we know how to do things really well, we simply do not do them to that standard. Again and again, almost on every page of the Stokes report, we see instances of national guidelines not being followed and instances of parameters set down by professional bodies being contravened because of the standard of care provided in the mental health system. This inconsistency of care, I suggest, is a good reason to think that we ought to be doing more to find out the extent of this problem of sexual assault in institutions in Western Australia.

When we do not do things well, even though we know how to do them much better, it is surely because the mental health system is seriously broken. With a system that is seriously broken, it is almost inevitable that we will find victims of the system, which is exactly what I am suggesting we will find if we have the means to do it for victims of sexual assault in psychiatric institutions.

There are other places where we can look to see the way the system is currently running in Western Australia. The other obvious place, apart from the Stokes report, is in the reports of the Council of Official Visitors. As honourable members know, the Council of Official Visitors is a statutory body established under the current Mental Health Act, and one of its main briefs is to make sure that involuntary patients are aware of their rights. There is a particular reason why I am raising this matter specifically in the context of this motion, but I want to draw the attention of honourable members to section 188 of the current Mental Health Act, which is the section that goes to the functions of an official visitor. It states —

> It is a function of an official visitor —
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> (a) to ensure that affected persons have been informed of their rights; and
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> (b) to ensure that the rights of affected persons are observed; and
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> (c) to inspect places where affected persons are detained, cared for, or treated under this Act and ensure that they are kept in a condition that is safe and otherwise suitable; …

I interrupt myself there to suggest to honourable members that this reference to being kept in a condition that is safe and otherwise suitable goes right to that Victorian research that shows that a very high proportion—85 per cent—of women admitted to psychiatric institutions do not feel safe. Section 188 continues —

> (d) to be accessible to hear complaints concerning affected persons made by those persons, their guardians or their relatives; and

(e) to enquire into and seek to resolve complaints concerning affected persons made by those persons, their guardians or their relatives; and

(f) if it would be appropriate for any other person or body to further enquire into or deal with any matter, to refer the matter to that person or body; and

(g) to assist with the making and presentation of an application or appeal under this Act in respect of an affected person or, where authorised by this Act to do so, to make any such application.

Section 188 is deleted in the Mental Health Bill, which we will shortly consider in this place. The government should note that it is one of areas the opposition will look at very closely, given that the role of the Council of Official Visitors is being abolished, to see whether these kinds of provisions are being picked up elsewhere in the bill and are adequately covered.

I refer to the statistics in the annual report of the Council of Official Visitors on complaints about the way people are treated in mental health institutions. Bear in mind that when I go through these statistics, we are not talking about just women or sexual assault; this is a guide to the complaints the Council of Official Visitors received in one year, 2012–13, which I think is the most recent year for which we have statistics. There were 37 complaints about rough treatment, 16 for seclusion and restraints, 102 about dignity, privacy and staff attitudes and 20 for serious issues. They are the most recent statistics presented by the Council of Official Visitors. That list is somewhat puzzling compared with the results of the Victorian survey. As far as I can establish—I am sure if I am wrong about this, the minister will put me right in her contribution to this debate—there were no prosecutions under the act for any of those incidents. Yet section 162 of the Mental Health Act makes specific provision and, indeed, outlines the penalties, for ill-treatment or wilful neglect of the patient, which indeed is the title of the section. It states —

> A person having any responsibility towards a person as a patient who ill-treats or wilfully neglects the patient commits an offence.
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> Penalty: $4 000 or imprisonment for 1 year.

Perhaps the minister will be able to help me out there, but I cannot find any documented evidence of any prosecutions in the past 12 months under section 162.

Hon Helen Morton: In fact, ever.

Hon SALLY TALBOT: Thank you minister. I suppose, given that evidence, we could draw one of two conclusions. One conclusion might be that, simply, no offences were prosecutable. One would have to conclude that was the case. We are not accusing anyone of concealing evidence here or not applying that section of the act when somebody thought it should be applied. We could assume that everything was hunky-dory in Western Australia and that somehow we have fixed the problems here that are still rife in Victoria. The problem I have with drawing that conclusion is that, given Professor Stokes has reported this kind of seriously broken system of clinical governance and the Council of Official Visitors is clearly signalling that some problems are manifested with that lack of clinical governance around patient treatment, it seems more likely that the broken system extends into the protection of women in psychiatric units and the processing of complaints by women who find that they have been subjected to some form of sexual abuse or, indeed, other forms of violent abuse. That is not the only law under which people can be prosecuted. There are also provisions under the Criminal Code and I understand sections of the Health and Disability Services (Complaints) Act that could be drawn on to prosecute people who were found guilty of assaulting patients in psychiatric institutions. The fact is that sexual assault is a crime; there is no dispute about that. Strangely, it seems that in Western Australia we are not picking up that crime. From the Victorian research it seems that might be a very substantial problem that we ought to be addressing.

I will run through a couple of other points that I think are very important when we consider this motion and, hopefully, I will have time to come back to some of them at the end of this debate. We are talking about a clear power imbalance. Many people would argue—I am one of them—that women often find themselves in positions of power imbalance. Most instances of assault, abuse and violence are in fact manifestations of that power imbalance. When we talk about women with psychiatric illnesses, we are talking about women who not only have a disease, but also suffer the stigma of that disease. As I have already indicated, they find that because of the disease and the stigma there is a question about the acceptability and credibility of the evidence they produce.

I move now to the second part of the motion about how we might protect women, and the arguments about the use of CCTV monitoring in psychiatric institutions, because this is one of the things, obviously, that will protect not only people who want to make a complaint about an assault or some form of abuse but also staff who are working in the institutions where those allegations are made. I came across a statistic that took me by surprise; that is, 50 per cent of workplace assaults—this is from the WorkSafe statistics—are in the health and community sector service delivery workplaces. When we talk about the installation of CCTV monitoring, we are talking

about protecting both staff and other people who have some contact with psychiatric institutions. It might be carers and supporters of inpatients and families. The minister will remember that when I asked a question about CCTV coverage, she was quite forthright about the fact that it is something we need to constantly keep our eye on—I am not trying to make a pun—to see whether we are accurately weighing up the patient's right to privacy and their right to a safe environment. When we look at that safety–privacy equation and the need to have some equilibrium there, I put it to honourable members that we are clearly failing on one of those parameters—the safety parameter. If women are being sexually abused in psychiatric institutions—we have no reason to think they are not—surely we ought to be looking more closely at those privacy issues to see whether we can go further than we might be comfortable with in other settings to ensure that the environment is safe.

Hon Nick Goiran interjected.

Hon SALLY TALBOT: I will not take that interjection, Hon Nick Goiran, because I am running out of time but I am happy to consider it later perhaps.

We now have the interesting situation in which both the Council of Official Visitors and the Mental Health Law Centre are arguing very strongly that CCTV coverage should be in places where we would, in other circumstances, not even contemplate having it. There are clearly downsides to that, and I want to go through some very quickly because they are not the immediate issues to do with privacy that we would all probably be familiar with. None of us would want to see closed-circuit television used in a circumstance where it was assumed to be a kind of magic bullet that could be substituted for fixing the governance system in the psychiatric institutions I have already referred to. CCTV would never be a substitute for rigorous safety practices, accountability mechanisms or audits of safety practices. We would not want to see CCTV used as a justification for staff reductions; it is not a replacement for the personal monitoring by staff of patient management. We also would not want to see CCTV used in circumstances where it would interfere with clinical practice. I know that practitioners have been quite vocal in saying that if everything is going to be monitored, it might alter the way clinical practice is undertaken.

I put it to honourable members that in all those circumstances it depends on the way the screens and monitors associated with CCTV are used. When we think of CCTV we automatically think, I suppose, of the kinds of ways it is used in public places; we think of malls, shopping centres and places where there have been violent incidences such as in Northbridge for example, or perhaps in car parks. We have a clear mental picture of a bank of CCTV screens, with people sitting there watching them all the time, monitoring people's behaviour. The Mental Health Law Centre and Council of Official Visitors have made it very clear in their submissions that that is not what they are talking about; they are talking about some kind of reference mechanism that could be used to produce evidence where there was a need to, not as some kind of avenue for third parties to have involvement in a situation in which they have no right, need or entitlement to. They say it should be used as a way of ensuring that when we need evidence to support something that is not clearly established, we have the ability to go back to a CCTV mechanism and say, "Okay; it is clear from this monitoring that that person was in that corridor at that time or entered that room at this time."

Hon Helen Morton: The corridors are already CCTV-ed.

Hon SALLY TALBOT: I have a document in which the minister outlined for me, in response to a question on notice, where all the CCTV footage was. I can probably refer people who are interested in the debate to that tabled paper that the minister gave me by way of answer to that question on notice probably about a year ago now. I noticed that in a number of those cases where we do have CCTV monitoring, there is no recording of the information. I am suggesting that although of course the privacy side of that equation is always going to be something we have to take very seriously, there is another step we could be taking so that we are able to say, in relation to a patient allegation, "We can see here that that person entered that room at that time." Again I say that it is actually about the evidence we can produce those in situations.

I believe that in a psychiatric institution setting, CCTV evidence should never be used to simplify a situation. It is not just a matter of running something on a screen and saying, "There you go; that did happen", but it might be used to clarify a situation. If we do not get the chance to explore this subject in detail in this debate, we might be able to come back to it when we debate the Mental Health Bill later in proceedings. I say again that this would be an obvious way of protecting not only patients, but also staff and other people who have an involvement with psychiatric institutions.

I will finish this part of my comments by referring to a couple of quotations from the Victorian report, "Zero Tolerance for Sexual Assault: A Safe Admission for Women", that I think are very telling. The first is on page 52, and the interviewee said —

> "Sometimes I just really think that crazy women don't matter. If the stuff that happened to us happened to non-crazy women, there would be a really big uproar"

I think that is a very telling and moving account of a number of different aspects of this debate. I put to honourable members that it is absolutely our responsibility to find a way of responding directly to that kind of attitude. I can assure members that anyone who has had anything to do with psychiatric institutions will know that that is not just a Victorian sentiment; that kind of sentiment would be found in Western Australia, just as it would be found universally amongst women who are inpatients of these institutions.

My final reference is to a comment made by Isabell Collins, one of the authors of this report, on *7.30* on 13 May 2013, which was just after the report was published. During one of its segments on this issue Isabell Collins said —

> To be quite frank, if this was happening to general patients, we would've fixed it immediately.

I think that is the key point. We cannot talk about this issue in Western Australia without raising the problems that have been so well canvassed by the Council of Official Visitors over several years now and without referencing the problems identified by Professor Stokes. We need to make sure that any steps the government takes to respond to both the Council of Official Visitors and to the Stokes report include measures that we can see will specifically go to addressing this problem.

HON HELEN MORTON (East Metropolitan — Minister for Mental Health) [2.48 pm]: I will start by thanking Hon Sally Talbot for raising this very important issue in this particular way, and basically giving people an opportunity to not only be educated and become more aware of a very important issue, but also perhaps become aware of some steps that have been taken and some background information that was sought following that particular report.

I particularly want to say again that sexual harassment or assault in vulnerable inpatient groups is a matter that mental health services in this state, the government and I take very seriously. I initially point out an important aspect of the research that the honourable member is referring to; that is, the findings of the report by the Victorian Mental Illness Awareness Council were based on a survey. I would have to go back and have another look now, but I am pretty sure that that survey was available online for people to respond to if they chose to. To the best of my memory, it was an online survey —

Hon Nick Goiran: It was online.

Hon HELEN MORTON: It was online?

Hon Nick Goiran: Yes.

Hon HELEN MORTON: The survey was completed by a total of 50 women out of a possible 30 000 women over a three-year period. That is a response rate of less than one per cent. Given the sample size, the findings need to be interpreted with caution and are not necessarily considered representative of the whole situation in Victoria. Although I am not diminishing in any way the seriousness around potential sexual harassment or sexual assault in this vulnerable group of people, I think we need to keep in perspective what that particular survey achieved in terms of a response rate. I believe that Hon Sally Talbot, with her background in university studies and whatever else, would be aware of the level of response that is in terms of the total potential response. However, I want to say again that I consider that any sexual assault is totally unacceptable. Despite the shortcomings of the report, we need to continue and remain focused on this really important issue.

Looking at it as a total response, firstly, it is worthwhile noting that each year there are about 10 000 separations or discharges from our mental health inpatient facilities here in WA, and approximately half of those are women. From 2010 to 2013, which is the time frame of this survey, the number of women who would have been discharged in Victoria is about 40 000. By far the majority of those cases have had very good, very productive and positive outcomes. The number in Victoria is approximately double that in WA. It has about 20 000 people discharged each year, of whom 50 per cent are women. In WA, from July 2010 to June 2013, there was a total of 23 claims of alleged sexual assault on women in public inpatient mental health services. Of the 23 claims, two were concluded as being delusional in nature—that is, no actual assault had occurred—while two were concluded to be consensual. I will talk a little later about how each of these claims is followed up.

So that members will understand a little more clearly, I need to be a bit explicit about what is included as a sexual assault in the guidelines for the mental health sector, "Responding to an Allegation of Sexual Assault Disclosed within a Public Mental Health Service". Sexual assaults include things such as —

- Being forced to masturbate or watch another masturbate;
- Being forced, coerced, or bribed to view pornographic images;
- Being forced to give or receive oral sex;
- Being forced to perform sexual acts on themselves or others; and

- Sexual penetration of a person by penis, object, or other part of a
- body into the vagina, anus or mouth.

Those are the sorts of things that have been put out in guidelines by the Chief Psychiatrist to services that I will refer to a bit later.

It is acknowledged, as I think Hon Sally Talbot did, that sexual harassment or assault may at times go unreported by individuals, so it is not always possible to get an absolute figure. I want to reiterate that I am not in any way indicating that this is not an extremely important issue, because it is, and I want to provide some contextual information on the numbers so that we do not take a mistaken approach or have a mistaken view of what is occurring in this space in Western Australia. When that review of the Victorian system first came out, I discussed it with the Chief Psychiatrist, and over the past year or so I have continued to provide and get additional information from him. I will go through the recommendations and the WA response to each of those recommendations in a little while. When I first became aware of that report, I requested the Chief Psychiatrist to review the recommendations and provide me with a briefing on how the recommendations were relevant to Western Australia, so I will go through those now. A number of recommendations came from that review. I am reading from a briefing note that I got on this matter shortly after the report was tabled or became known to me. That was in July 2013, but I have since had further updates.

The first recommendation was —

> A zero tolerance approach to sexual assault and harassment to be adopted by all Victorian psychiatric services.

I asked how that was being promulgated throughout Western Australia. A number of dot points sit behind it, but the relevant ones are that a zero-tolerance approach has been adopted by all WA psychiatric services. Guidelines have been updated to reflect that zero-tolerance approach. In fact, since that time, at least two letters have been sent to all the health services with the guidelines attached, absolutely and explicitly stating that a zero-based approach would be adopted. As I said, there are various other comments in the briefing note.

The second recommendation was —

> All AMHS be required to report all allegations of all forms of sexual assault and harassment and copies of mandatory Incident Reports be provided to the Office of the Chief Psychiatrist and Health Services Commission. Further, the Office of the Chief Psychiatrist be required to include data pertaining to sexual assault and harassment in their annual report.

Again, the response was that the Chief Psychiatrist currently does not receive information about final outcomes—that is, whether an allegation was substantiated—but the requirement of the new mandatory reporting resource is that all these alleged problems be referred to the Chief Psychiatrist. Within the Office of the Chief Psychiatrist, the mandatory reporting officer is now following up all outcomes relating to allegations of sexual assault. That is an update from when the original briefing note was sent to me.

The third recommendation was —

> All health services agreements which include psychiatric in-patient units be required to develop zero tolerance strategies to prevent sexual assault and harassment and provide bi-annual reports ...

I know that it will take me a lot of time if I read each of these recommendations, but these notes indicate that the recommendations were looked at in Western Australia and taken seriously, and a report was given to me by the Chief Psychiatrist on how those issues were being dealt with in Western Australia.

The next recommendation was —

> 4. Managers of Mental Health Services and Unit Managers of each psychiatric inpatient unit ensure that each patient has a Nursing History taken and a Care Plan developed ...

WA mental health services already utilise approved care plans, and these will continue to be used. Trauma-informed care training has been offered, and the seventh recommendation mentions the level of training that has taken place specifically in this area. Unit managers should ensure that a minimum of two nurses are on the ward. The WA model is already moving towards a range of staffing, rather than nursing staff alone, so we already accommodate at least two people on a ward.

The seventh recommendation was that all clinicians be required to undertake training on human sexuality. This has happened. So far, in 2013–14 alone, 267 Department of Health mental health staff have received training in trauma-informed care. More training continues to be rolled out; it is available on an ongoing basis. The eighth recommendation was that CASA—that is, the Centre Against Sexual Assault—services are offered to inpatients

in the event of sexual assault. In Victoria, CASA would be the equivalent of our Sexual Assault Resource Centre, which currently provides those services here in WA. The ninth recommendation was that consideration be given to a variety of things, but, again, that has happened. All the dot points listed under the ninth recommendation are occurring in Western Australia. The initial plan was to undertake a survey, as is suggested in Hon Sally Talbot's motion. However, instead of undertaking a survey, the Chief Psychiatrist wrote directly to Department of Health mental health services in March 2013 and April 2014, directing a repeat rollout of the guidelines to all mental health staff, and the rollout of trauma care training and other associated educational strategies.

Recommendation 10 was —

> The role of the Office of the Chief Psychiatrist be expanded to include continual random spot-checks and audits of in-patient units to monitor safety strategies.

The Chief Psychiatrist has a comprehensive monitoring program that looks at all components of service provision on a regular basis. The Chief Psychiatrist reports on this program to the Department of Health. The Chief Psychiatrist will incorporate questions in regard to sexual assault and harassment in future reviews. All of these issues will be covered in the Chief Psychiatrist's annual review to Parliament. There was a suggestion at recommendation 11 that —

> An all-stakeholder committee, to be formed through the Department, which is comprised of Health & Community Services Union members, the Australian Nursing Federation, senior departmental members and the VMIAC, in order to work through any impediments to the implementation of these recommendations —

In Victoria; this matter is already covered in Western Australia.

In the development of all new mental health inpatient units, including at Fiona Stanley Hospital, Midland hospital and Sir Charles Gairdner Hospital, the operational process to ensure the safety of sexually vulnerable individuals has been directly discussed between the Chief Psychiatrist and service planners. This is part of the work being undertaken in preparation for these new services as well as in existing services. That provides a flavour of the kind of recommendations that came out of that report and the ongoing work that is being followed up by the Chief Psychiatrist, the Department of Health and others.

Getting back to more general comments, the prevention of sexual assault in WA public mental health services is already addressed through the Department of Health's policies, guidelines, systems and reporting. Hon Sally Talbot leaned fairly heavily on the Stokes review, which I agree is a good review. I am in an incredibly fortunate position in that the acting director general of Health is the very author of that review. He undertook that review over a number of months. He, along with the new Chief Psychiatrist, Nathan Gibson, has a serious and keen interest in ensuring that issues around clinical governance and the follow-through of the issues he raised occur. I can assure members that all issues being discussed today are being taken very seriously and each and every one is being following through.

The overarching policy document within the Department of Health is the document I have in my hand. I cannot recall whether Hon Sally Talbot ever asked me for a copy of that. It is called, "Responding to an Allegation of Sexual Assault Disclosed within a Public Mental Health Service". It is quite a lengthy document.

Hon Stephen Dawson: It is on the website.

Hon HELEN MORTON: It is on the website; that is right.

It contains some quite detailed information about how facilities or services respond to sexual assault allegations. I will mention a couple of sections of this document. There is an introduction on page 7. I have already covered what is sexual assault and sexual harassment. The introduction states —

> The guidelines have been developed by a working group consisting of representatives from WA Health Mental Health Services …

It includes all the different service types, whether it is child and adolescent, adult or country services. It also includes the Sexual Assault Resource Centre, the Statewide Indigenous Mental Health Service, the Office of the Public Advocate and the Office of the Chief Psychiatrist. They have also used legal information from the State Solicitor's Office in determining their responsibilities and where those responsibilities lie around confidentiality and reporting requirements.

The large amount of research, literature and clinicians' experience in both the sexual assault and mental health areas demonstrates that clear link that Hon Sally Talbot made between sexual violence and mental health issues. There is no doubt that a high number of people who come into mental health services have been sexually abused at some time in their life.

The other thing the policy covers is a clear, step-by-step guideline about what to do and what should be the immediate response by mental health services if a person alleges sexual assault. I will not go through it all. It refers to the need for good communication and making sure that the client is given privacy to follow through their concerns. The summary states —

- Advise the client that they are entitled to access a support person of their choice and facilitate contact.
- Advise the client that they are entitled to speak with a doctor, have a general medical examination and receive advice …

That includes advice about things such as contraception and information on prevention of sexually transmitted diseases, if they wish. It continues —

- Advise the client that they have the right to a forensic examination and police involvement if they so choose.
- If the client wishes to have forensic evidence collected, a non-treating medical officer should be arranged (not their psychiatrist) to collect same.
- Arrange medical assessments as requested/needed by the client.
- The Sexual Assault Resource Centre can be contacted for advice and to provide a forensically trained medical officer and counsellor to assist with a medical and forensic examination.
- If the alleged perpetrator is a client, staff member, family member, relative or visitor they will require privacy, support and access to assessment and information and their physical and emotional wellbeing must also be considered.
- Where possible the forensic examination and collection of evidence should include SARC.

Another section refers to the response to an allegation of recent sexual assault. Allegations are not always made immediately; it is sometimes weeks or years later. It is made absolutely clear that sexual assault is a crime. Involvement of police must be considered in the event of an allegation of sexual assault. Here is where the legal advice makes it more complicated rather than straightforward. It is stated on page 12 of the policy document —

> It should be noted, however, that it is not the decision of the mental health service staff to report the incident to WA Police—this is the decision of the alleged victim; and

It then refers to how to provide support to that victim if they want to take that action. It is much more complex than straightforward. It is stated under the heading "Involvement of WA Police" —

> It is important that, in the event of an allegation of sexual assault by an individual over 18 years of age, any reporting to the WA Police be the decision of the alleged victm or where they are regarded as being unable to make a decision, the appointed guardian …
>
> In the event of the MHS staff member assisting or facilitating the report to WA Police, information should only be disclosed in accordance with the written consent of the alleged victim.
>
> If the alleged victim is undecided about whether or not to proceed with legal action, advice can be sought from SARC regarding the implications of whichever decision is made.

It then reiterates —

> If the alleged victim does not wish to report the matter to the police but staff think the matter should be reported in the public interest …

There is an opportunity for that to be reported to the Chief Psychiatrist. The Chief Psychiatrist would be able to get legal advice and would weigh up whether this is something that needs to go forward to police. It is actually quite a complicated area of work for people to be involved in.

Those guidelines that I referred to, along with the letters received, continue to reflect a zero-tolerance approach to sexual assault and require that any allegations be reported to the Office of the Chief Psychiatrist, which will then conduct appropriate investigations into matters and will take further action where relevant. I wanted to talk about some of the other supports that are available to people, but I seem to have lost that paper.

As I say, the guidelines reflect a zero-tolerance approach to sexual assault and they encourage services to be proactive in developing strategies to prevent sexual assault and harassment. The guidelines also contain advice about the provision of information, education and training about sexual assault, sexual abuse and sexual safety for mental health staff. The guidelines specify the role of the state Sexual Assault Resource Centre in supporting individuals, and the Western Australian Chief Psychiatrist has a comprehensive monitoring program of public mental health services.

I think it is also fair to say that the new bill does not mandate the reporting of sexual assault between clients, but it does mandate the reporting of sexual assault by a staff member. The bill defines specific events when notification to the Chief Psychiatrist is required, as well as new mandatory reporting requirements that are not in the current act. A staff member who reasonably suspects that there has been unreasonable use of force by a staff member, or unlawful sexual assault or contact with the person by a staff member, must report it to the person in charge of the mental health service or to the Chief Psychiatrist. The clinicians' guide will include more information in this regard, including hypothetical scenarios about what constitutes reasonable suspicion and at what point the matter should be reported to police. This requirement is in addition to other written laws, such as mandatory reporting of child sexual abuse.

Quite a lot of work that is still happening in this area makes me believe that, 12 months or even two years ago when this report hit the deck, there may have been more concern, in my mind, that things were not being followed through correctly, but that is not necessarily the case now. Since the Victorian report was released, these guidelines have been disseminated twice, as I indicated—once in February 2012 and again in March 2013—with a cover letter from the Office of the Chief Psychiatrist to ensure that all mental health services are aware of their obligations. In addition to these system-wide guidelines, some health services have separate policies relating to the management of sexual assault at the local level. They align with the system-wide guidelines or are being reviewed to align with the system-wide guidelines, but there may be some areas of work that are local to that particular health service.

That is not the only thing that is leading to the belief that this issue is known and understood widely by the system. Other methods to ensure the safety of vulnerable patients in our mental health inpatient wards include risk-assessment processes. I know that there is some concern that these may not be happening but, since the Stokes review, work has been done through the clinical governance structures and the statewide policy work. The risk-assessment processes are being undertaken, and there are one-on-one observations for vulnerable patients, especially in the secure areas of hospitals. In the most secure areas of the hospitals, the staffing requirement is to have one-on-one observations for vulnerable patients. Smaller psychiatric care units are being established that have the highest staff-to-patient ratios. Examples of that are the psychiatric intensive care unit at Graylands Hospital and the new mental health observation unit at Sir Charles Gairdner Hospital. All new units that are being built include single rooms with ensuites. I seriously do not believe that we can go down the track of having closed-circuit television in an individual patient's room, bathroom and toilet. CCTV covers passageways, common rooms and areas that are generally utilised by multiple people. I believe that if CCTV were installed in an individual patient's room, the issue of stigma associated with being a mental health patient would be enhanced. It is something that would not be done in other sections of a hospital; CCTV would not be installed in individual wards in other sections of a hospital. Whatever changes need to be made must be made around practice, staffing ratios, the size of health units and the design of mental health units, not around the encroachment of privacy into an individual person's bedroom and bathroom. Other methods include door alarms that are being built into the new units that can detect whether someone opens the door at night and that in turn can trigger awareness in the staff unit area and—members may not think they are useful, but I believe they are—patient contracts clearly outlining their responsibilities and expected behaviour. Further to this, the Chief Psychiatrist continues to monitor, review and further improve reporting processes and feedback loops with service providers involved in incidents of this nature.

I have talked about what is in the new bill. There are some difficulties with what is being suggested. Hon Sally Talbot has not indicated—I am not sure whether she is suggesting it; I do not think she is, but I just want to make sure that it is not being suggested by anyone else—that we should build separate female mental health units or separate female wards within mental health units.

Hon Stephen Dawson: We used to have separate wards, and in some places we still do.

Hon HELEN MORTON: There are a couple. There is one for men at Graylands.

Hon Stephen Dawson: I thought you told me earlier in the year in the answer to a question that there is still a female ward.

Hon HELEN MORTON: No, there is not a separate female ward. There is a separate ward at Graylands for men whose inhibitions are such that they need to be contained in a male-only ward, for example. I am in the process of seeking to have some changes made at the Frankland Centre, with a view to establishing a female-only area, a male-only area and a youth-specific area, and some dedicated funding has been put towards that undertaking through the health department budget. I have discussed the idea of segregated mental health units at length with the Chief Psychiatrist. I am informed that this approach does not necessarily sort out the problem, and I am convinced that that is not the way that we should be going. Despite this, as I said, Western Australia has a male-only secure inpatient unit at Graylands, which can separate males who are considered to have increased sexual aggression risk, and utilises the intensive care ward at Graylands for vulnerable patients. An intensive

care unit at Graylands is used for women, but it is not a women-specific area; however, it can be utilised in that way from time to time.

Hon Stephen Dawson: I have in front of me an answer to a question from you in February in which you said that the Pinch ward has six acute secure psychiatric intensive care unit female beds.

Hon HELEN MORTON: That was correct at that time.

Hon Stephen Dawson: This was post the clinical restructure, so it changed once last year and it has changed again.

Hon HELEN MORTON: That was correct at that time.

The difficulty in providing segregated secure wards across the board relates to the modern approach of the delivery of mental health services, and we are moving more and more towards services that are provided closer to people's homes. The Hospital in the Home program is an example of how we can provide far more security for people, with their family and friends and the services visiting their homes rather than them going to the hospital. Of course, as I have said, these services are sometimes provided in much smaller secure wards—sometimes as small as six beds—which makes it virtually impossible for us to put in place a split agenda. If we are serious about creating a mental health unit in Geraldton, Karratha or Port Hedland, by virtue they would need to be relatively small, dedicated units; therefore, it would be almost impossible to have segregated areas. Of course, there are segregated wards in that there are individual rooms, but in terms of having a separate wing or a separate unit for women, that it is much more difficult. It is also much more difficult from a staffing perspective. I still believe that if we need to go down that track, we are better off doing work to make sure that we have best practice.

Adding to the complexity of the issues is the consent between patients when one may be considered to have capacity and the other does not. This adds to a level of complication, but staff are aware of the issue and actively manage it on an ongoing basis. As I have mentioned, the Mental Health Act created the Council of Official Visitors, which has responsibility for, among other things, hearing and inquiring into complaints and determining whether patients are cared for in a safe environment. There frequency of visits made by the Council of Official Visitors has increased and there is a shorter time frame from the time a person is made involuntary to when the council will visit. In discharging these functions, the Council of Official Visitors may exercise a range of powers, including entering facilities at any time, reviewing documentation and requiring staff to answer questions. These functions will be further strengthened in the Mental Health Bill 2013, debate on which we have not had in the upper house. Under the bill, the Council of Official Visitors will be replaced by the Mental Health Advocacy Service under the leadership of a Chief Advocate. The advocacy service will be required to visit or otherwise contact all involuntary patients within seven days of their being made involuntary.

Another relevant change proposed in the bill is the introduction of mandatory reporting of unlawful sexual contact between staff members and patients. The new reporting requirements will complement existing incident reporting guidelines and enhance community confidence in the accountability and integrity of mental health services. The bill also clarifies how to make a complaint about a mental health service and gives families, carers and other support persons greater rights to be involved in a patient's treatment and care. On that basis, the significant involvement of a nominated person—all patients can have a nominated person working with them—or the involvement of family and carers in the treatment of a person with a mental illness again gives that person greater safety and enhanced rights to make complaints if they feel uncomfortable about something. These points work in favour of ensuring that we have a much safer system than would otherwise be in place, notwithstanding that it is worthwhile recognising that the so-called 45 per cent, or whatever the figure was, is a response by 50 people out of a few hundred thousand people, which we need to keep in context.

Amendment to Motion

Hon HELEN MORTON: I move —

To delete "calls on the government to take urgent action" and insert —

notes the action being taken by the government

I do not want to take away from the seriousness of the issue raised by Hon Sally Talbot. I reiterate my thanks to Hon Sally Talbot for bringing on this motion and giving members the opportunity to consider and discuss this important issue. I place on the record that the government, mental services across the state and I consider the sexual harassment and sexual assault of people in this vulnerable inpatient group a very serious matter.

The ACTING PRESIDENT (Hon Amber-Jade Sanderson): The amendment seeks to delete "calls on the government to take urgent action". The first question is that the words to be deleted, be deleted.

Hon SALLY TALBOT: The opposition will not accept the amendment. There are further speakers on the motion so do we need to vote on the amendment now?

The ACTING PRESIDENT: No. I give the call to Hon Stephen Dawson.

HON STEPHEN DAWSON (Mining and Pastoral) [3.28 pm]: I am not inclined to accept the minister's amendment to the motion, which seeks to delete "calls on the government to take urgent action" and insert "notes the action being taken by the government". Hon Sally Talbot's motion calls on the government to take urgent action to —

(a) establish the extent of similar problems in Western Australian psychiatric hospitals; and

(b) protect women in Western Australian psychiatric hospitals from sexual assault.

The minister spoke at length over the last while and told us some of the things that a range of Western Australian agencies are doing about this issue. I do not think she has established the extent of the problems in Western Australia, which are similar to those that occurred in Victoria. This debate is timely given the imminent commencement of debate on the new mental health legislation. Hopefully, debate in this place on the Mental Health Bill will begin shortly. I believe that the Mental Health Bill will go a long way towards improving the treatment outcomes for patients who are subject to mental health care in Western Australia. I will not go into the bill in depth, but I welcome the creation of the Mental Health Advocacy Service, which the minister mentioned in her remarks.

This new agency, as the minister said, will replace the existing Council of Official Visitors. However, the new Mental Health Advocacy Service will have expanded responsibilities and an expanded role and will certainly do more—hopefully, will potentially do more—to protect people in mental health care. However, I hope that this new Mental Health Advocacy Service will be properly resourced, given the extra responsibilities that will be given to the new organisation. The answers to questions I asked in this place in estimates last week about resourcing will come back to me in due course and I will scrutinise that information when it comes back to make sure that the mental health advocacy service will be properly resourced and will be able to do the job we want it to do if this new Mental Health Bill passes in coming weeks.

The trigger obviously for this debate today is Hon Sally Talbot's motion and the Victorian Mental Illness Awareness Council's report of March last year titled "Zero Tolerance for Sexual Assault: A safe admission for women". I note that the minister has said in this place that some work has been done in that time by a range of agencies in the state. However, it is important, given that the motion is about this report, to highlight some of the issues raised in the report, although I will be careful to not go back over too many of the points Hon Sally Talbot raised this afternoon. The report by VMIAC set out to determine through a survey the extent to which women experience harassment or assault in psychiatric inpatient units in that state. It also set out to determine —

> … whether nursing staff are complying with the National Competency Standards for the Registered Nurse in taking a nursing history from women on their admission to hospital and from the information gained, developing a nursing care plan that ensures an individualised and trauma-informed approach to nursing care activities;

I will ask this at a later date but I am keen to find out from the minister and from the government whether our agencies and nursing staff in the state's employ are complying with national competency standards. I am also keen to find out whether the state has a random auditing process of safety procedures. I am not convinced that we do, and in fact I am not convinced that the minister has addressed those issues. I think they go to the heart of this motion, which is to establish the extent of similar problems in psychiatric hospitals in this state.

Those are therefore two of the matters that the VMIAC report set out to determine. It also set out to —

> … provide the women surveyed with an opportunity to have input into identifying interventions that may lessen their likelihood of experiencing harassment or assault;

Also to —

> … appraise women's views about what might be helpful strategies if they have experienced some form of harassment or assault;

Also to —

> … facilitate … stakeholder discussion regarding the need to change clinical practice.

These are all very important matters. There is no doubt in my mind that the more we talk about and consult on issues of this nature, and the more consultation we have with stakeholders on these issues, the more we can only improve the system, the procedures and the standards. Again, I certainly welcome this motion from Hon Sally Talbot.

I will again touch on the report. The data analysed by the VMIAC in preparation of this report demonstrated that 85 per cent of respondents felt unsafe during hospitalisation; 67 per cent reported experiencing sexual or other

forms of harassment during hospitalisation; and almost half, 45 per cent, had experienced sexual assault during an inpatient admission. It also said that 61 per cent reported the assault to nurses; 18 per cent indicated that nurses were slightly helpful; and 82 per cent indicated that nurses were not at all helpful.

The minister gave us some figures earlier today on the number of people discharged annually by the mental health services in this state. I think she said that 10 000 people annually are discharged and that about 50 per cent are women. She then gave us figures on the number of reports of sexual assault and went through some of those issues. However, even if only 24 people were sexually assaulted in our care, particularly in a mental health facility —

Hon Helen Morton: Over how many years was that?

Hon STEPHEN DAWSON: I think the minister said 24. Was it in one year? I do not have the figure in front of me.

Hon Helen Morton: It was in either three years or four years.

Hon STEPHEN DAWSON: The minister said 40 000 in total over four years. Whether it was 24 over three years or 24 over a year—I do not have the figure in front of me—I was not going to talk about the issue but the minister raised it and I am replying to her. Whether the number is two, 10 or 24 people, we need to ensure that people in our mental health facilities are given appropriate care and are not put at risk while they are in our care.

I will come back to the "Zero Tolerance for Sexual Assault" report a little later. However, it is fair to say that if these concerns are being raised in Victoria, people in Western Australia may have the same concerns. I take on board what the minister has said in her comments this afternoon about the things the government is doing to mitigate the risks in this state. The minister drew our attention to the health department's "Responding to an Allegation of Sexual Assault Disclosed within a Public Mental Health Service" report, which is a very good report. Definitely things are happening in this state that need to be mitigated, but I am just not sure that anybody has established the extent to which similar problems exist in this state, and whether we are truly protecting women in Western Australian psychiatric hospitals from sexual assault.

I received an email and an attached document a couple of weeks ago on 8 May—I think all members received it—from Ms Sandra Boulter, the principal solicitor and general manager of the Mental Health Law Centre. The subject of the email was "CCTV surveillance and the MH Bill". I will read very briefly from the email that we received. It refers to Professor Stokes, as mentioned by Hon Sally Talbot earlier, and reads —

> Dear Upper House Member
>
> Please find attached the case for CCTV surveillance in WA's authorised psychiatric hospitals and hostels, and how the Mental Health Bill 2013 can be amended to help.
>
> Given the recent coronial findings and the report by Professor Stokes that finds that Professor Stokes (now the Acting Director Of Health) —

These are Ms Boulter's words —

> in his 2012 damming report into the practices of WA psychiatric hospitals where in he found that information management across mental health is a key area for improvement; that there is an absence of a single point of authority with described responsibility for accountability for patient care; leadership is lacking; relationships within the service is lacking; use of non-psychiatrist mental health clinicians increases the level of risk to patients, especially where there is the risk of self-harm; governance is fragmented and variable; there is no articulate Clinical Service Plan for delivering mental health services, and there was no robust uniform clinical accountability across the system.

They are the words that Ms Boulter has extracted from the report by Professor Bryant Stokes. Ms Boulter goes on —

> CCTV recorded surveillance but without monitors, that is simply saved and accessed under prescribed circumstances could make a sudden and substantial improvement in the standard of care delivered to involuntary inpatients.
>
> Yours faithfully
>
> Sandra Boulter

If we look at those points in Professor Stokes' report, we note the absence of a single point of authority with ascribed accountability for patient care; leadership is lacking and relationships within the service are lacking et cetera. They are concerns about the mental health system. I know when we get to the Mental Health Bill in a few weeks' time and the 500-odd clauses in the bill, many of those issues will be addressed. In responding to the 100-odd recommendations of Professor Stokes, the government is certainly looking at those issues at the

moment. Yet I am not sure that anyone—I have made this point before—has established the exact extent of the problems in Western Australian psychiatric hospitals. I think Hon Sally Talbot's motion is very valuable and the government should take it on board. I do not think we should amend it to make it some sycophantic-sounding motion stating that the world is wonderful and we have a jolly good system and a jolly good life and nothing bad is happening, because some of these things may well be happening in our system in this state.

A colleague of mine from the other place has spoken to me about a constituent of his and a petition she sought to present in the other place. I will speak briefly about this constituent and the issues she has raised. Although constituents have come to me with concerns about mental health facilities, as a local member, the concerns raised with me more often than not are about not being able to access those services in the region and having to go to Broome or Perth to access them. This issue has not been raised with me directly; however, the member for Gosnells has raised the issue. He spoke about his constituent, who has been a patient in the mental health wing at Armadale Health Service. The woman has recovered well, but she has concerns about her time as a patient in the Armadale mental health wing. She is determined to be heard on the issues that she experienced. Those issues relate to the problem of sexual abuse and harassment. She is keen to see a system in Western Australia in which we do not have those problems. Her concerns centre on the level of access other patients in the Armadale mental health wing have to rooms on the ward she was on. She said that as a female she was very concerned about the access other patients have to rooms on the ward. Male patients who were detained on the ward were able to wander into her room and many times she felt unsafe. The member for Gosnells' constituent proposed a petition along the following lines —

> That we are deeply concerned that male and female patients in the Mental Health Inpatient Facility at the Armadale Health Service are not segregated by gender.
>
> At the Armadale facility patients of both sexes are housed in individual rooms, however the doors of these cannot be locked making patients venerable to assault and harassment. While toilet facilities are gender specific doors cannot be secured due to the need to ensure staff access in case of emergencies and male patients have been found using the female facilities. Again this leaves female patients vulnerable to harassment and assault.
>
> Now we ask the Legislative Assembly
>
> To ensure that newly constructed mental health facilities include single gender wards. These could take the form of separate male and female areas separated by a common recreation area.
>
> To safeguard female patients in existing mental health facilities we ask that electronic locks be placed on the doors of patient rooms. These could be opened with a swipe card limiting access to the person residing in that room and to staff who would still be able to enter at will in order to respond to an emergency.

That this woman has recovered and wants action shows that there are problems and she certainly saw a problem in her case. There are problems of this nature in a range of our mental health facilities. We need to mitigate the abuse towards women. In her comments earlier the minister touched on Graylands Hospital and the Frankland Centre. I am not asking the minister to comment on this now but I am not sure the case has been made publicly of whether having female-only or male-only wards is of no benefit. Since I asked that question earlier this year the minister has said that the system has changed and the wards for a particular gender have changed. That particular ward—I think I referred to the Yvonne Pinch ward—is not a female-only intensive ward any more. I am hearing from my colleagues that constituents have expressed concern to them that there needs to be, in this case, female-only wards because people feel unsafe and at risk. Why do we not have those female-only wards?

I refer again to the email from Ms Sandra Boulter of the Mental Health Law Centre. The attachment I have includes a letter from the Mental Health Law Centre to the Mental Health Commissioner, Tim Marney, which makes the case for closed-circuit television surveillance in mental health wards. I am sure that the Mental Health Law Centre has written to the minister encouraging the use of CCTV surveillance in our mental health wards. I know from people on this side of the house asking questions of the minister about the Mental Health Law Centre that the minister is quite disparaging about the centre; it is not one of her favourite organisations.

Hon Helen Morton: Why do you say that?

Hon STEPHEN DAWSON: Because in this place previously the minister has been dismissive of issues raised by the Mental Health Law Centre.

Hon Helen Morton interjected.

Hon STEPHEN DAWSON: I do not have the questions in front of me but, from my recollection, they were asked by Hon Ljiljanna Ravlich and Hon Sally Talbot over the past while. I have been in this place for only a year but I am sure that the minister has been dismissive of that organisation. My point is —

Hon Helen Morton: That is unbelievable.

Hon STEPHEN DAWSON: No; it is not unbelievable; it is true. If we troll through *Hansard* —

Hon Helen Morton interjected.

Hon STEPHEN DAWSON: I will bring in some proof later today, minister.

Hon Helen Morton interjected.

Hon STEPHEN DAWSON: I can.

The ACTING PRESIDENT (Hon Amber-Jade Sanderson): Order, members! Hon Stephen Dawson has the call.

Hon STEPHEN DAWSON: Thank you, Madam Acting President, I will direct my comments through you, because I am sorry, I did encourage interjections.

The Mental Health Law Centre has written to us as members of this place, the minister and the Mental Health Commissioner laying out reasons for CCTV surveillance to be included in all authorised mental health hospitals and hostels.

Hon Helen Morton: They also want to ban ECT. Do you agree with that too?

Hon STEPHEN DAWSON: The minister knows that we are supposed to speak to the motion at hand, and this motion in front of me today does not mention electroconvulsive therapy and she is trying to get me into trouble by talking about it.

The ACTING PRESIDENT: Order! The member has the call and he is addressing the motion at hand.

Hon STEPHEN DAWSON: Thank you, Madam Acting President. I will keep addressing the motion at hand because I look forward to debating the Mental Health Bill and all its hundreds of clauses in this place in the coming weeks. We will have some interesting debates about ECT, but today's debate is about Hon Sally Talbot's motion, a copy of which I keep losing. In fact, at the moment it is about the minister's amendment to that motion which, of course, we do not support because certainly I—and others on this side, if I can speak for the rest of us—believe that as a state we need to establish the extent of similar problems to those in the Victorian system. I will not read the whole letter today, but I will outline the reasons for including closed-circuit television cameras in our mental health facilities. I think Hon Sally Talbot made the point that the Mental Health Law Centre is not asking for CCTV cameras to be put into facilities here that are to be monitored 24-hours a day; it suggested that CCTV cameras go into the facilities and stay in place, but are not monitored. If a complaint or an allegation of assault or sexual assault is made, somebody can go back and have a look at the recording and substantiate the case or not. On face value, that seems sensible.

Hon Helen Morton: Do you agree to it in all hospital wards then?

Hon STEPHEN DAWSON: Minister, there is a special case for mental health facilities. Quite often people in mental health facilities are suffering serious illnesses and they can be delusional. I certainly have not seen proof of high numbers of sexual assaults in general hospital wards.

Hon Helen Morton: Have you seen proof of it in mental health units?

Hon STEPHEN DAWSON: I have certainly seen in the Victorian Mental Illness Awareness Council's report that there are issues in Victoria that warrant investigating in this state. Hon Sally Talbot's motion is trying to get the Minister for Mental Health, to get the government and to get the commission or whomever to establish an investigation of these problems in this state. The minister is trying to whitewash that from the motion today by her amendment.

Hon Helen Morton: They are all reported. Any issue is reported to the Chief Psychiatrist.

Hon STEPHEN DAWSON: Yes, minister, things are reported, but we also see from this report that some of the patients who report issues do not feel like their issues were addressed properly by staff. Perhaps it is a conspiracy or not, but the perception is that these things are going on in mental health facilities and we have to mitigate —

Hon Helen Morton: Do you agree that it is perception?

Hon STEPHEN DAWSON: At this stage, in this state, yes, it probably is perception.

Hon Helen Morton: And even in Victoria?

Hon STEPHEN DAWSON: No, I am not agreeing it is perception in Victoria, because the VMIAC did a survey and some well-referenced work. It is not just newspaper articles. It is work from journals of mental health agencies, occasional papers, and the council has spoken to a range of government and non-government agencies about best practice and policies around this issue. I believe there is truth in this report. I do not think this stuff is

made up, and I think it is probably going on in our facilities in Western Australia. I think that this warrants investigation, and that to say that everything is fine and dandy with the system in this state is actually wrong.

Hon Helen Morton: Has anybody said that to you?

Hon STEPHEN DAWSON: Not in so many words, minister—no-one has said in so many words that everything is fine and dandy in this state. But by trying to amend this motion, the minister is trying to whitewash and stamp out the motion and put a line in the sand on the issue: "No, that's it. We're not considering it and we're not taking it any further; it is my way or the highway." I like Hon Sally Talbot's motion because I think it is an important matter and warrants an investigation to find out how prevalent the issue is in this state. I do not think that the Mental Health Law Centre just plucked the issue out of thin air. I spoke to Sandra Boulter some time ago about the issue of including CCTV cameras in mental health facilities, but I cannot recall whether I asked or whether she told me of specific cases in this state by which she thinks this policy is warranted. I cannot tell members that here and now, but I am sure the Mental Health Law Centre did not pluck the issue out of thin air. The Mental Law Centre gives the reasons by which this should happen in this state.

Let me continue, as I am running out of time—and easily sidetracked, as the minister knows. The Mental Health Law Centre's letter outlines the reasons for the installation of CCTV in public and private areas of hospitals; it states —

> … to protect patients against criminal neglect, and physical and sexual abuse.
>
> The Council of Official Visitors is authorised under the MH Act to ensure, among other things, that involuntary patients are aware of their rights, that places in which they are detained are safe and suitable, and to inquire into and resolve complaints. In 2010–11, there were 2,690 people detained in WA under the MH Act. The Council of Official Visitors received the following number of complaints in that one year:
>
> - 24 for rough treatment;
>
> …
>
> - 3 for discrimination;
> - 3 for sexual impropriety;
> - 3 for sexual violation;
> - 9 for physical assault;

There is a range of others. The Mental Health Law Centre letter goes on to state —

> In 2012–13, there were 2,627 people detained in WA under the MH Act. The Council of Official Visitors received the following number of complaints in that one year:

The letter outlines some of the complaints raised in that year. Granted, in that year, the Mental Health Law Centre's letter does not list any complaints of sexual impropriety or sexual violation, but it does have complaints about dignity, privacy and staff attitude, and there were 20 complaints for serious issues.

Hon Helen Morton: What year was that?

Hon STEPHEN DAWSON: That was 2012–13.

The Mental Health Law Centre's letter gives examples of abuse in mental health wards across the country and around the world, but I will not go into those today. The point the Mental Health Law Centre is making is that we know from Victoria that there have been allegations of abuse in mental health wards. The letter refers to allegations, investigations and the substantiation of complaints in Townsville, and these things have happened in Canada and London. I guess I am saying this afternoon that if they are happening elsewhere, we cannot just say they are not happening here. This motion seeks—the words of the motion say it—to establish the extent of similar problems in Western Australian psychiatric hospitals.

I might move on, but if members have not seen this email attachment from the Metal Health Law Centre, I am happy to table it or give them a copy. Equally, when the Mental Health Bill 2013 is debated in this place in the coming weeks or indeed the coming months—I hope it is weeks rather than months—we will return to this issue and canvas the submission from the Mental Health Law Centre on why it says CCTV surveillance should be in our mental health facilities. Minister, I have to say that I have an open mind on the issue. I know some of my colleagues think that it is a great idea and that it should happen, and obviously the Mental Health Law Centre thinks that it is a great idea, but I have an open mind on the issue. However, we need to talk about these things and we all need to put our opinions forward. We cannot just say no and rule it out from the outset. Let us have the debate.

I move on to a recent State Coroner's report into the tragic death of Miss Amanda Gilbert on 22 January 2010. I quote selectively from the report —

> The deceased was also found in sexually compromising situations with male patients while in Graylands … A letter apparently written in 1997 by a consultant psychiatrist at Graylands contains the assertion that there had been 26 reported incidents when the deceased was the victim of attempted sexual assaults by male patients over a six month period.

The coroner referred to the quality of supervision, treatment and care, stating —

> In my view, the evidence available to me makes clear that the staff at Graylands did what they could to manage the deceased appropriately with the resources available to them. Graylands was not an appropriate environment for her, but no other facility was willing or able to care for her. There was no facility in Western Australia that could provide suitable care for a relatively young person suffering from mental illness and brain damage.

The coroner's report also states —

> A letter apparently written in 1997 by a consultant psychiatrist at Graylands contains the assertion that there had been 26 reported incidents when the deceased was the victim of attempted sexual assaults by male patients over a six month period.

Granted, it is from a few years ago, but I think there were about 10 coroner's reports released during the same time and many of them referred to the sexual assault of female patients by male patients. Those female patients were in our care in Western Australian mental health facilities. The minister says we have great standards now—I pointed out the health department guidelines et cetera earlier on—but the fact remains that there is substantiated evidence of assaults on females by males in some of our facilities. This motion calls on the government to take action to establish its extent. How widespread is this? We cannot say it is not happening and has not happened, because it has. We should talk about this stuff. Let us establish the extent of it and work to mitigate risks. That is why I think the CCTV and footage issue warrants exploration. It is important. When these things happen and the media hear about allegations of sexual assault in psychiatric wards they tend to sensationalise the issue. But they certainly have shone the spotlight on the issue that it should have, because I do not believe that this should be happening in state-run facilities. I do not believe it should be happening to anybody. If somebody is in our care with a sickness or illness, we should be doing everything in our power to ensure that those people are safe. It is the same issue I have with children in the care of the chief executive officer of the Department for Child Protection and Family Support; time and again we come across children being abused while in care and it should not happen but it does. Granted, it is very difficult to stop people from doing things in their own homes or in private homes, but the difference in this case is that the allegations are of sexual abuse between patients in state-run mental health facilities. This is happening in facilities that we manage and run, and it should not be. We need to find out how big the problem is, and we should be doing more to ensure that it does not continue.

When I touched on Professor Stokes' report earlier I mentioned some of the issues he found in relation to the practices of WA psychiatric hospitals. I will keep making the point that I look forward to the minister and government responding to and acting on all the recommendations of the Stokes report. Those actions are overdue, necessary and needed.

In the last few minutes of my remarks I will touch on Graylands Hospital and its future. I raised a point of order this afternoon about the information given to me by the minister in answer to a question I asked earlier this year being different from what she was telling us today. The minister told us, in effect, that the plan had changed, and that what the government was doing then at Graylands is not what it is doing now. I am not very clear about what is going on at Graylands and I am not sure whether the government is very clear either. Over the past few years, during estimates hearings and in other places, we have had broad debates about Graylands. We have been told that the configuration of the hospital is still being determined and that the planning is looking at the needs of Graylands over the next few years. We were told that in 2009. In 2012 in this place during the estimates hearings, the then Greens member for East Metropolitan Region, Hon Alison Xamon, asked questions about the $16 million allocated to Graylands Hospital in that year's budget under "Redevelopment Planning". Bear in mind that there was a different minister at the time, but the answer to those questions were that, "The discussions and considerations are underway at the moment, as you would be aware." Although there was $16 million in the budget for the redevelopment of Graylands, I think about $600 000 was spent at the time. In a midyear review after that, $11.3 million of the $16 million was taken away.

This minister recently indicated that the future of Graylands is under serious consideration, as did a press release from the Western Australian Association for Mental Health. The press release states —

> Minister for Mental Health Helen Morton recently indicated the future of Graylands is under serious consideration, and there will be a need to restructure and reinvest, in order to achieve much needed

> reform. For this to happen, any resources currently invested in mental health must remain fully invested in mental health.

For the past five years we have heard the rhetoric of the government about the redevelopment and improvement of facilities at Graylands, and we are still waiting for action. There is a real need to do something with Graylands. I am concerned that some of the female-only wards do not exist anymore, for the reasons I have outlined today. We hear of cases of sexual abuse and sexual assault in WA's psychiatric hospitals, and we know from the coroner's report that there have been allegations of sexual assault at Graylands. I urge the minister to take note of this motion. It was not an attack on the government; Hon Sally Talbot did not move it that for that reason. I think she moved it because of the need to investigate this issue. There is a need to establish how widespread the problem is in this state and there is an ongoing need to protect women in our care in WA's psychiatric hospitals. I urge the minister to act and support the motion.

Debate adjourned, pursuant to standing orders.