

MENTAL HEALTH BILL 2013
MENTAL HEALTH LEGISLATION AMENDMENT BILL 2013

Second Reading — Cognate Debate

Resumed from 21 August.

HON SALLY TALBOT (South West) [3.23 pm]: When we finished this debate at the end of our last sitting week, nearly three weeks ago, I was about halfway through my comments on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. In my opening remarks I made the point that the Mental Health Bill 2013 is a very, very long bill, consisting of 400 pages and nearly 600 clauses, and that 45 minutes is no time at all in which to go into some of that detail. I certainly do not intend, in the rest of the time allotted to me, to restate any of the points I made in the first half of my contribution.

I finished by making some acknowledgements that I think are extremely important. As I and other members on this side of the house have noted, the Mental Health Bill 2013 has been around in one form or another for quite some time, having been through various draft and discussion stages on its long and winding way to this chamber. The four groups I made particular mention of—the Mental Health Law Centre, Arafmi, Richmond Fellowship, and the Western Australian Network of Alcohol and other Drug Agencies—have had major input into making this a better piece of legislation than it was at the beginning. I, and I know others, want to pay tribute to the effort they put into doing that.

It seems to me that there are a couple of odd things about the Mental Health Bill 2013. We, of course, are supporting the bill, as are the major stakeholders, and nothing we do on this side of the chamber will in any way hold up its progress through this place. But it does strike me as slightly odd that we are considering such a major piece of legislation before the government's 10-year mental health plan has been publicly released. We know, through the estimates process and work we have done in question time, that that piece of work has been completed. We know that several pieces of work in the lead-up to that have been completed and never made public. Two years after the Stokes report we are still in the same position planning-wise as we were when Stokes brought down such damning findings about the state of mental health care in Western Australia. It seems to me that passing 400 pages of legislation prior to any public discussion about a 10-year mental health plan is an odd way around to do it. I, for one, foreshadow that we will be back in this place many times in the next few years with the government making amendments to this bill to try to play catch-up with itself. Although I would not have wanted to see this bill delayed any further, I and others on this side of the chamber would certainly have expected to see the 10-year mental health plan given a public airing many, many months ago. According to all our information and the media reports, it is sitting on the minister's desk; I think it should get off the minister's desk posthaste and out into the public arena for discussion.

The process of getting the Mental Health Bill 2013 into this place was also slightly odd. A draft discussion paper that presumably went through the government's party room contained some extraordinary measures that were presumably given the tick by the Liberal Party meeting room. I cannot even pretend to guess what goes on behind those closed doors, but the minister walked out of those discussions with a document she was prepared to release publicly that contained a number of measures that caused frank community outrage, particularly in some of those very sensitive areas such as deep brain stimulation treatment and various other controversial treatments and things like the age of consent around those. Thankfully, many of those have been wound back considerably, largely because of the input from stakeholders and the public on those issues. That indicates to me that the Liberal party room is a strange place, where a document like that can be taken in without those objections being expressed openly to the minister in that forum.

I do, however, acknowledge that this is an area where, generally as a community, we are playing catch-up. As I referred to in the first half of my contribution, there is still a default position among many sections of society that mental illness is somehow self-inflicted, and that if people would only cheer up or pull themselves together we would have far less of a problem. By way of a segue to my next comments, one of the best descriptions of mental illness I have ever read, particularly relating to depression, which for people who have never experienced depression is one of the most mysterious of all mental illnesses, came from the comedian Ruby Wax, who said, "It is like my whole personality has left town and all that is left is a lump of cement."

We have a long way to go before there is a genuine, deep community understanding about the real nature of mental illness and what we can do to ease those terrible conditions and afflictions. Fundamentally, what we are looking at in these 400 pages, as I read them, is a kind of rights-based charter. That is welcomed by mental health consumers and advocates throughout the sector.

The bills seem to be deficient. Although they spell out a fairly rigorous set of rights or entitlements for people afflicted with mental illness and for people who care for the mentally ill, they are much less strong on the other wing of that charter-based framework, which is, of course, the duties and obligations that go along with rights.

We still do not see a framework that has genuine, deeply embedded accountability amongst mental health providers. That is the aspect of these bills that worries me, and I think that aspect will change significantly over the next decade. When we begin to move into a new era of the provision of mental health services, we will find that that aspect of the bills is simply too weak to give any real effect to the rights and entitlements that we are imparting to people with mental illness.

Those honourable members who know anything about the fraught field of rights talk, or ethics, will also know that they are indeed murky waters. It is not actually as difficult as all that. As long as it is always remembered that a right has to be matched with a duty or an obligation, it is not that hard to get one's head around it. When one looks only at the "rights" side of the equation, they are left with something that is too heavily weighted on one side to have any sort of stability. It is left without any mechanism, which leads me straight to a point that is a key concern of mine; that is, it is left with no way of formulating what to do when there is a conflict of rights and one right seems to cancel out another. Two examples that are directly relevant to the way things operate in a mental hospital, or any kind of institution that cares for people with mental illness, is the tension between dignity and liberty. A person with a mental illness needs to be treated in a dignified way. They need to be respected in a way that keeps their dignity intact as far as possible, but they also have to be granted their liberty the same as any other member of our community. When those two things conflict with each other—perhaps "tension" is a better way to express it rather than "conflict"—we do not really know what to do. Another way of expressing that is to ensure a person's safety and privacy. Those four concepts—dignity versus liberty and safety versus privacy—all arise in relation to the discussion about the provision of closed-circuit television security cameras in mental hospitals. We have canvassed that subject in depth in this place in recent weeks when I moved a motion. I have yet to hear the government make an adequate response to that whole question. Because I have canvassed those arguments quite thoroughly elsewhere, I will not go over them all now.

I want to bring to the Minister for Mental Health's attention an aspect of this that I have not raised before in this debate—that is, the comparison between the way we attempt to protect the privacy and safety of people in a mental hospital and the way we are trying to provide those same two things to prisoners in the Corrective Services system. It seems to me that we do quite a robust job of protecting vulnerable prisoners. Of course we do not always succeed, which is a fraught subject in itself. My understanding is that people who are kept in protective custody have a far higher level of scrutiny via closed-circuit television cameras than people in mental hospitals do. It is an odious comparison in some ways. I hope that anybody who is following this debate will not take offence. I am not comparing prisoners with mental health inpatients. I am saying that when the state accepts a fundamental responsibility to provide a safe environment for somebody who is under some kind of restriction, somebody who is in some sort of involuntary detention situation, two systems seem to be running in parallel. The level of protection provided to a vulnerable prisoner through CCTV scrutiny is much, much higher than it is for a person in a mental hospital.

My non-expert opinion would be that in many cases the person in involuntary detention in a mental hospital would be at least as vulnerable, if not, more vulnerable than the prisoner being kept in some kind of protection. I underline the point again, because I know that this is often misunderstood in the general wash of debate that goes on in this place. Those of us who are advocating a much higher level of CCTV coverage in mental health hospitals are not saying there should be monitors in every toilet; we are saying that cameras should be placed in all strategic places where it might want to be shown that somebody entered a room at a certain time. That would not have to be shown on a monitor anywhere. It would just have to be kept for a certain time so that if ever there is a complaint or an allegation, that evidence could be retrieved and used to resolve the matter. That is something we can take up in more detail when we go into committee. I will leave those comments there.

On the subject of the rights-based charter, we do not have any clear guidance about what we are supposed to do legally when rights conflict—that is, which rights might be given primacy. We do not have any clear indication that when the duty to respect those rights is neglected, action will be taken. Government members will know that one criticism that has been made of the government's response to the coroner's report on the 10 recent deaths at Graylands Hospital is that apparently nobody has been disciplined and nobody has been prosecuted; yet in at least one case a clear failure of care was found. I do not have time to go into the details of those 10 deaths, but two phrases jumped out at me when I read the coroner's report. This is such strong language to find in a report on deaths in a state-run institution. In relation to Amanda Gilbert, the coroner called her death an "unmitigated tragedy". If members are interested, the coroner's complete reports are all available electronically.

In relation to Ms Williams, there was a finding that there was a failure of care. This is what the coroner had to say —

... the deceased's treatment and care was beset with a series of errors and with failed opportunities to identify and correct the errors, which in sum were catastrophic.

That is a shocking indictment. I leave my comments there with the question of whether the proposed laws in these bills are strong enough. It is impossible to devise a law that is strong enough to stop unlawful behaviour happening, but my question to the Minister for Mental Health is: when we discover unlawful behaviour, are these bills as strong as we can possibly make them to ensure that people who are guilty of neglect or abuse, or in some way transgress those rights and entitlements of mental health patients, redress those wrongs? I want to raise a number of specific issues. Most of these I will leave until the committee stage, but I want to go over two or three of them if I have time. The first is the length of time for which a person can be kept in mandatory detention without any sort of order being made. I am raising this issue now because I hope that members of the National Party will make their views clear on this issue. I know that this is an amendment that was made in the other place. That amendment was a step in the right direction. However, I seriously wonder why the length of time in the regions should be 144 hours when in the metropolitan area it is only 72 hours. I can understand the rationale for doing this. However, I believe that rationale belongs to a time 50 years ago when it took people a long time to get from one end of the state to the other. That is simply not the case anymore. A person who lives in Esperance or Kununurra can now fly to Perth in only a few hours. The place at which I stay in East Perth, when I am working in the city, is right next to the Royal Perth Hospital helipad. I can tell members that a constant stream of helicopters lands on that helipad day and night. People can now get from one end of the state to the other in a matter of a few hours. I therefore wonder why it is necessary for people with mental illness in the regional parts of Western Australia to be detained for 144 hours without any sort of order being made. That is too long. I want to hear what the National Party members and the non-metropolitan members of the government have to say about that. It is simply not acceptable.

I also want to make a quick comment about the use of advance health directives by people with mental illness. This matter was first raised with me by the Richmond Fellowship, which has a test case of a woman who has episodic mental illness and who has made a very specific advance health directive about the people to whom she wants to entrust her care when she has an episode of illness. It has yet to be tested whether an advance health directive will hold up in the case of what I understand for her are pretty extreme circumstances. This bill acknowledges advance health directives, and that is certainly a step forward. I hope that the very acknowledgement of advance health directives will plant in the minds of people with mental illness and their carers the idea that advance health directives can be used to provide better care for people with mental illness. However, I do not think that the measures in this bill reflect the original intent of the advance health directives legislation. I am not comfortable about the fact that in the case of a patient with mental illness, an advance health directive can be overridden without appeal to the State Administrative Tribunal, when, from my reading of the legislation, that is not the case for other patients. Therefore, I will be taking up that matter in some detail when we go into committee. I will also be interested to hear the minister's comments on this matter when she gives her response to the second reading debate. With that, I will leave my comments on the second reading. This legislation is long overdue, but I believe this bill will enable the better provision of mental health services in Western Australia.

HON ALANNA CLOHESY (East Metropolitan) [3.43 pm]: I also welcome the opportunity to speak on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013. As other members before me have said, the Mental Health Bill is very welcome, particularly because it has been a long time in the making, but also because it contains a very important framework for the provision of mental health services in Western Australia.

The mental health sector considers that at times there were examples of good consultation on the bill. However, at other times, the sector was very frustrated with the whole process. I shared that frustration, particularly around the time frames. For the most part, the mental health sector not only welcomes the bill but also strongly supports large parts of the bill. I have talked to service providers, representatives of people with mental illness, and other organisations and agencies within the sector, all of which have urged quick passage of the bill through this place, but they have also urged us to look at some of the issues in more detail, and, of course, it is very appropriate that this place look at the bill thoroughly.

I have broadly grouped the concerns that I have collated from people in the mental health sector, and my own concerns, around services and treatment practices, rights and advocacy and implementation. Although we are not at this stage talking about implementation in a real sense, the issues of implementation are triggered in this bill, and I will address some of those issues later in my remarks.

This bill is particularly welcome because of what it sets out to do. It sets out to provide an operational framework that will ensure that people with mental illness receive the best treatment and care, that the least number of restrictions is placed on their freedoms and rights and that they are respected and treated with dignity. It is incredibly important that the objects of every bill are to recognise people's freedoms and rights, and to treat people with dignity, and I congratulate the government on doing that in this bill.

Importantly, the bill also recognises—probably for the first time—the intricate role of families and carers in the treatment, care and support of people with mental illness. Again, given that so much of that caring role goes uncommented upon and unnoticed, it is very important to recognise the role of families and carers in the treatment of people with mental illness. Another object of the bill is to ensure protection of the rights of people who have a mental illness, and protection of the community.

Schedule 1 of the bill enshrines a charter of mental health care principles. This is the first time such a charter of principles has been enshrined in legislation, and the government should be congratulated for taking that important step. The charter of mental health principles was developed in close consultation with the mental health sector, and it particularly reflects that close consultation and the importance of the work that is being done in this area.

The objects of the bill and the charter of principles provide a critical framework for the provision of services and treatment for people with mental illness in this state. Some parts of the bill will see Western Australia be a leader in providing rights and safeguards for people with mental illness, not only in Australia, but internationally, and the government is to be congratulated for that. The bill sets the standards by which we as a community expect people with mental illness to be treated—some of that for the first time—and that is very welcome.

This is a huge bill, and despite the immense complexity of the bill, there are some areas which, as I have said, I have some concern about and which require some clarification. For example, just to stay on the objects of the bill for a moment, one of the objects is to ensure that people who have a mental illness are provided with the best possible treatment and care. That is welcome, of course. But my question is about whether that is a guarantee of service provision. It is certainly a guarantee that when people get services, they will be the best possible services. But I do not think it is a guarantee that people will be able to access and get a service in the first place. Accessing and getting a service in the first place, and holding onto that service, is one of the most critical issues facing people with mental illness and their families in this state. We therefore need to look further at how we can better guarantee access to services for people with mental illness. I will talk about that further a bit later.

That leads to my next point, which is how we can make it easier for people with mental illness to get services in the first place. Every day we are confronted with examples of people with mental illness who are unable to find and access services, and because they have not been able to access treatment, their condition deteriorates to a point at which they are in crisis. That is shocking in the extreme. It is certainly something we see in our local area and in our electorate offices. People tend to ask me for information about how to access mental health services or what services are available because I have an interest in the area, and it is very difficult to identify entry points for services for people with mental illness. That point was amplified by the Mental Health Commissioner, Tim Marney, in recent media articles. In recent interviews, and in particular one in August with *The West Australian*, the Mental Health Commissioner highlighted that through his own experience he did not know how people found their way through the system. In the article he also pointed out that it was actually hard enough for a person thinking clearly to try to find and access services, let alone when they are in the middle of an episode or in need of high-level support. A second point he raised, which I applaud him for, is that mental health services in WA have relied far too much on acute services. He said people often get very, very unwell before they can access services because we do not have enough early intervention services. I do not think this bill gives us any focus or hope that any services, particularly prevention services, will be increased or that there will be an easier pathway to access those services.

I am referring to access to not only those prevention services in the mental health area, but also other services to keep people well and to make their lives better. I am talking about housing, for example. We know that there is a dramatic lack of affordable or public housing in Western Australia, with a dramatically long waiting list for public housing in particular. We know that trying to find houses, and low-cost accommodation in particular, is very, very difficult. That is made almost impossible for a person with a mental illness, particularly of an episodic nature. The lack of access to not only general services, but also services including housing makes it difficult for people. There is a lack of jobs available for people to have an income to assist them to stay well and there is a lack of services available to help people access those jobs. This bill will not help us address that. Of course, I am talking about whole-of-life issues, and this bill does not address those at all.

I would like to move on to other specific service and treatment issues, in particular electroconvulsive therapy and psychosurgery. I know the relevant parts of the bill have been debated in detail in this and the other place, so I will not dwell on them, but I feel the need to comment because unregulated and unmitigated practice gave us the horror that was Chelmsford Private Hospital in New South Wales and the subsequent royal commission that brought to light some of the horrific ways in which people were treated there. When I mention Chelmsford, people often say to me that it was not here, but that is the point: it could be here because of the way in which practice was let go unquestioned. I am not suggesting that deep sleep therapy is the same as ECT, but ECT was part of the deep sleep therapy treatment. However, that is not the issue. The issue is that those practitioners—

I will not call them clinicians—acted in a really closed way. There was no reference to any clinical, professional or regulatory body. In addition to that, the victims of the treatment had no-one to stand on their side and were not in a position to question the type and level of treatment that they were receiving. In addition to that, there was no clinical evidence whatsoever about the success of the supposed therapy; in fact, it was quite the opposite. There were no practice guidelines or checks on the treatment provided, and the practitioners were left to carry out the treatments as they saw fit. Patients were not informed in any way of the treatments or their effect, or that they were even receiving treatments; they were not given any information whatsoever.

As I mentioned, this practice was often carried out without their permission. I have worked with people whose lives were unquestionably ruined by this unethical and dreadful practice, and of course, people also lost their lives as a result of this practice. I know that such practice of operating in isolation and administering ECT has changed over the years; however, it was not that long ago, and the treatment has not changed all that significantly. In the course of briefings about this bill provided by the minister, for which I am very thankful, the Chief Psychiatrist briefed us about electroconvulsive therapy and psychosurgery, and we met a woman whose life has been changed for the better because she received ECT. In fact, she told us that no other treatments or no other therapies addressed her severe depression. As legislators, I am concerned that we do not deny people choices of treatment or access to treatments or therapies if they are the only thing that works for them and if that is based on all the best available evidence. I am concerned that there is transparency in the provision of all treatments, but particularly ECT and psychosurgery, that there are professional checks and professional accountability and that people make informed choices. When there is no decision-making capacity to make those informed choices, I am concerned that someone who stands on their side is able to do that.

As I mentioned, the briefings that the Chief Psychiatrist organised for us went some way to alleviating some of my concerns. I note also that the safeguards contained in this bill are a lot better than those in the Mental Health Act 1996. For example, in this bill, the approval of the new Mental Health Tribunal will be required before treatment is given to involuntary patients. I think that is an incredibly important safeguard. I also note that the Chief Psychiatrist can approve emergency ECT for adults in lifesaving situations and that the ECT can be administered only by a psychiatrist or a trained doctor under supervision. All those are important safeguards, including the penalties for breaching the bill—for example, a fine of \$15 000 or two years' imprisonment for ECT breaches, and five years' imprisonment for psychosurgery breaches. But I ask whether that goes far enough because, as I mentioned, I have worked with and known closely people who have suffered from the work at Chelmsford hospital. To say that there was no opportunity for them to return to any form of health other than, for many, severe psychosis is an understatement. Therefore, I do not think those penalties are a strong enough deterrent.

My second concern is that the bill indicates that ECT can be administered by a trained doctor under supervision. My question is: What does supervision mean? Does it mean that a psychiatrist needs to be in the room when the treatment is administered? Does it mean that there is some sort of peer review of the supervision? We need a lot more clarity around the meaning of supervision. My next question is: what public transparency will occur? If nothing else, the royal commission showed us that there needs to be open scrutiny of treatments and their effectiveness. Therefore, will the Mental Health Tribunal be able to publish its decisions, its reasons for decisions and clinical notes surrounding its decisions? Similarly, as the Chief Psychiatrist will be able to approve emergency ECT, will those decisions be, for example, peer reviewed? If they will be peer reviewed, how will they be peer reviewed? What other transparency and accountability mechanisms are there regarding the Chief Psychiatrist's decisions? My next questions about ECT and psychosurgery are: What type and level of information will clinicians be required to provide people with mental illness about these treatments and therapies? Will there be a standard of information required? Will there be a minimum of the type of information and how it will be given? There is no doubt that there need to be clear guidelines on the way in which people are informed in order to make informed choices, particularly about side effects. My next question about accountability is: will the Chief Mental Health Advocate be notified about all proposed uses of ECT or psychosurgery; and, if so, how and when will the Chief Mental Health Advocate be notified, and how will the advocacy on behalf of the patient be prescribed? I understand that some of those matters will be guideline issues but, at the very least, we need to ensure that there are very clear mechanisms for accountability and for peer review of the use of them.

I would like to move on to another issue regarding clause 28 of the bill, which is about the detention time to enable a patient to be taken to an authorised hospital or other place. I notice that Hon Sally Talbot raised this issue not long before I started my speech. Basically, the bill originally provided that people with mental illness could be detained for up to 72 hours when a referral was made for that person to be taken to an authorised hospital or other place—that was in both the metropolitan area and regional areas. I know that in the other place that was amended to 144 hours for areas outside the metropolitan area. Hon Sally Talbot raised some really valid points, and I will not repeat them, but I have my own concerns about that. For example, how is the metropolitan

area defined so as to decide whether a person is detained for 72 hours or 144 hours? If those regions are going to be the Department of Health's areas for definition, I must say that I tried to look them up and, quite frankly, I could not work them out. If a person is very unwell and someone has made a decision that they will be able to detain that person for 72 or 144 hours, how does that person know what their rights are when they live on a boundary line or in a region? For example, is Bullsbrook included in a regional area? Is Gidgegannup, Toodyay or Wooroloo included in a regional area? What is the difference for those areas and how will that be defined? We know that a lot of people in regional and, I will say, isolated areas will be subject to the provisions of this bill, so increasing the time for which someone can be detained so that it is up to 144 hours is a significant infringement on their rights. It seems to me that people in metropolitan and regional areas will be dealt with quite differently. I do not know how that figure of 144 hours was arrived at: Was it in recognition of the absolute lack of services in regional areas? Was it calculated that it takes 144 hours to get someone to a service? We also know that Aboriginal people, who are more likely to live in isolated and regional areas, will be disproportionately affected by this provision. My last point on this issue is that when we set the bar for the maximum period of detention at 144 hours, that is what people will work to. They know they have 144 hours, and they will go for that, rather than minimising the amount of time that people will be detained.

I move on to safeguards, rights and responsibilities. The minister's second reading speech focused on processes, safeguards and protections, particularly around involuntary detention. As I said before about the objects contained in the bill, I welcome the safeguards and protections in this bill, but the success of the bill will be judged on not only ensuring best practice and strong advocacy, but also the availability of services. That is why I was a bit surprised when the minister suggested in her second reading speech that the bill should not compel best practice. Hon Sally Talbot also argued this point, so I will not linger on it too much, but I add the point that if the legislation is to contain safeguards and rights, then surely the bill should specify not only minimum standards but also best practice. I argue that best practice is informed by guidelines, training and information provided. Best practice can and should change, just as legislation can and should change. Community expectations are based on best practice, and if that is not enshrined in the legislation, there are no signposts for the community about what is best practice. We also need to make sure that best practice is made very clear to practitioners right across the board.

I will move on to advocacy and identify a few points around that. As I said before, the linchpin of this bill is the provision of good advocacy. I am pleased that this bill will establish the Mental Health Advocacy Service, but it will also provide that the role of the Council of Official Visitors will be collapsed into that service. This gives me an opportunity to place on record the work of the Council of Official Visitors over the years. It is not an easy task, nor has it been easy for the council over the years. It is certainly not a task that is recognised sufficiently, which is why I want to place on record my thanks to the council for its many achievements over the years, not the least being the provision of individual advocacy to people with mental illness in boarding houses, hostels and health institutions, as well as a range of other services. Individual advocacy is about standing on the side of a person with mental illness, and its key role is to make sure that a person's rights are met and respected. That is the critical role of individual advocacy, but from the perspective of a person with mental illness what is really important about advocacy is knowing that they have someone standing beside them and supporting them, and acting in their best interests. That is the other really important part about individual advocacy. I do not downplay the role of families and carers in the provision of advocacy or support, because that is also critical to good outcomes, but in itself that is not individual advocacy. Families and carers experience difficulty in the provision of advocacy because sometimes they are completely tired from having to seek out services and provide support. They are simply exhausted by constantly taking on advocacy roles and having to battle the system and all of that. Individual advocacy can make the difference between accessing a service and receiving treatment, as well as providing support in all those roles.

I welcome the bill establishing the Mental Health Advocacy Service, but my concern is that all patients using the mental health system, whether voluntary or involuntary patients, should have access to the Mental Health Advocacy Service. I understand that a lot of focus will be on involuntary patients, which is as it should be; but the point is that we get good outcomes when we have good advocacy and provide access to advocacy. Another point about the advocacy service is that it is just not fair that one group of people will have more rights to advocacy than another group of people. I hope that the minister can guarantee access to the Mental Health Advocacy Service for all people with mental illness, including those who are voluntary patients who request advocacy.

My next comment on advocacy is about the independence of advocacy. One of the things I am concerned about is that the Mental Health Advocacy Service will be as independent as the Council of Official Visitors is now in the way it operates and its distance to service providers and government, because obviously independent advocacy ensures better advocacy. I want to make sure that the Mental Health Advocacy Service operates at arm's length from government and from services and in the best interests of a person with mental illness. When

we debate this, I will ask the minister to guarantee that the structure, role and relationships of the new Mental Health Advocacy Service will be especially independent.

The third level in advocacy is systemic advocacy. The Council of Official Visitors undertook a systemic advocacy role, which is as important to the delivery of services as independent advocacy. Systemic advocacy informed by evidence-based research and by the views and experiences of people with mental illness will make a better and stronger service system. My concern for the proposed Mental Health Advocacy Service is that it gets to undertake a systemic advocacy role based on its experiences in individual advocacy in particular. I am also concerned that there will be a loss of other advocacy agencies as a result of a focus on the Mental Health Advocacy Service. Many non-government agencies play a critical role in the provision of independent and individual advocacy, legal advocacy and systemic advocacy. Of course, they all had a significant impact on the development of these bills, so I would like to get a guarantee that there will be no reduction in the provision of advocacy services across the state because of the new Mental Health Advocacy Service.

Related to my concerns about advocacy are questions about when the Chief Mental Health Advocate is notified; these are concerns that may be ably addressed during Committee of the Whole. Who can make a referral to the Chief Mental Health Advocate? For example, in its submission to the Legislative Council, the Health Consumers Council—endorsed by Consumers of Mental Health WA, the Mental Health Law Centre and Mental Health Matters 2—argued that in relation to the powers to restrain and detain patients, and the transportation of patients, there needed to be a process through which these decisions were reviewed in a quick and expedient manner. I support its concerns in relation to that. It also argued that any detention or transportation instigated by a medical practitioner or authorised mental health practitioner should be reported to both the Chief Psychiatrist and the Chief Mental Health Advocate as a matter of course. I think that is a worthwhile argument. It further argued that the Chief Mental Health Advocate should, in such situations, be able to initiate a visit to the detained person without deferral to any other person, simply because that person has been detained; that should be the point at which the advocacy process is triggered. Again, I also support that argument and look forward to exploring it a little more with the minister during Committee of the Whole.

I want to now talk about transparency and accountability, because this is linked to what I was just talking about. When the Chief Mental Health Advocate is notified, there should be ways to ensure that decisions by advocates and the Chief Psychiatrist are transparent and accountable at all times. A lot of issues are reported to the Chief Psychiatrist, including breaches of the act, reportable matters and allegations of assault, particularly sexual assault. It is really important that there is a transparent process with regard to what the Chief Psychiatrist does about those reportable matters. Good accountability means being open to the scrutiny of the Parliament, and I hope that the Chief Psychiatrist and the Chief Mental Health Advocate are, at the very least, required to provide annual reports to Parliament. Moreover, they should be required to provide reports on practice and detailed notes on the ways in which cases are being investigated. I hope that there will be an opportunity to discuss other accountability mechanisms as we move along.

I want to briefly mention some implementation issues. The success of the implementation of the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013 relies on more than just adequate resourcing; it relies on proper resourcing. I note that there has not as yet been any comment about the resourcing under the bills or details about the agencies that will operate under the bills. I am also concerned about the implementation committee. I understand that an implementation committee has been established and its role will be to oversee the implementation of the legislation, which will be a mammoth exercise, given its complexity. I would like to have an opportunity to discuss who will be on the implementation committee and what the process will be for advertising and selecting members, assuming that there will be some non-government representation, as I hope there will, and how the work of the implementation committee will relate to the 10-year mental health strategy. Obviously, significant overlapping issues need to be addressed. When will the 10-year mental health strategy be released? How will it ensure that there is increased access to services and increased availability of services?

I am running out of time, but another implementation issue of great concern is how people with a mental illness, their families, staff and mental health workers will get to know and understand their rights and responsibilities under the legislation. I also want to know how staff members are going to change their practices to ensure that they treat patients with dignity and meet the other requirements of the legislation. How will mental health practitioners get to know what their responsibilities are in the provision of clinical practice under this legislation? I am hoping that that will be part of the implementation committee's work, but they are very explicit concerns in relation to implementation.

These are just some preliminary concerns in relation to the legislation, and I look forward to the opportunity to discuss them further.

HON AMBER-JADE SANDERSON (East Metropolitan) [4.27 pm]: I will make a start on my contribution to the debate on the Mental Health Bill 2013 and the Mental Health Legislation Amendment Bill 2013, which are being debated cognately in this house. We have heard some good contributions so far. The current legislation is

obviously the Mental Health Act 1996, which essentially provides for the involuntary treatment and detention of people with a mental illness and other related matters. It is broadly recognised across the sector that there are serious shortcomings in the act and that a number of things have arisen over the years, such as changes in clinical practices and best practice, which have made it necessary for this legislation to be reviewed in its entirety.

I remember the 2008 election campaign when the Liberal Party announced that if it were elected to government, it would create a Minister for Mental Health; it did that, and I congratulate it on that. I think that mental health is an incredibly important portfolio and should stand on its own, outside the incredibly demanding health portfolio. The government was also responsible for establishing the Mental Health Commission, and I give credit to the government for that.

We obviously are looking at these bills in the context of the current act, but there have also been a range of reviews and proposed legislation over the last 12 years. There was the Holman review, conducted by Professor D'Arcy Holman in 2002–03; a bill drafted by the previous Labor government in 2007; the exposure draft mental health bill in 2011; the Stokes report, delivered by Professor Bryant Stokes, into the admission, discharge and transfer practices of mental health services; a green bill tabled in Parliament in November 2012; and the more recent coroner's report into the death of 10 Graylands Hospital patients who committed suicide, which, in and of itself, makes for quite harrowing reading.

Debate interrupted, pursuant to standing orders.

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