

# Annual Report

2020-2021



MENTAL HEALTH  
ADVOCACY SERVICE







The Mental Health Advocacy Service acknowledges all First Nations Peoples of Australia as the traditional custodians of the lands and waters on which we live and work. We acknowledge their ongoing connections to country, their 60,000-year-old Dreamtime belief system and their desire for a better future for their forthcoming generations. We pay our respects to their Elders past, present and emerging.

We value the contribution made by those of us with a lived experience of mental ill-health and recovery and those who are or have been carers, family members and supporters. We hold that we will progress when there is a space for all voices to have a say on what matters and what works. We welcome people from all cultures, sexualities, genders, bodies, abilities, ages, spiritualities and backgrounds to our service.

Hon Stephen Dawson MLC  
**MINISTER FOR MENTAL HEALTH**

In accordance with sections 377 and 378 of the *Mental Health Act 2014*, I submit for your information and presentation to Parliament the Annual Report of the Mental Health Advocacy Service for the financial year ending 30 June 2021.

As well as recording the operations of MHAS for the 2020-21 year, the Annual Report reflects on a number and range of issues that continue to affect consumers of mental health services in Western Australia.



Dr Sarah Pollock  
**CHIEF MENTAL HEALTH ADVOCATE**

September 2021



# Contents

<b>Chief Advocate's Foreword</b>	<b>iv</b>
<b>Key areas of focus for Advocates' work in 2020-21</b>	<b>1</b>
<b>About us</b>	<b>2</b>
<b>The Year in Review</b>	<b>4</b>
<b>Distribution of Advocates and Authorised Hospitals</b>	<b>5</b>
How many people we supported	6
Who we supported	6
<b>Service access and experiences</b>	<b>6</b>
<b>Service access and experiences: adults</b>	<b>10</b>
Accessing mental health care via EDs	10
Delayed discharges and unsuccessful transfer of care	12
<b>Service access and experiences: older adults</b>	<b>14</b>
<b>Service access and experiences: children and young people</b>	<b>19</b>
Systemic problems lead to tragic death	19
ED blockages and the need for improved youth patient flow	20
Delayed discharge	22
Fragmented transitions to community care	23
Eating disorders – room for improvement	27
<b>Supporting consumers in regional WA</b>	<b>30</b>
The impact of poorly managed transfers	31
<b>The rights of Aboriginal and/or Torres Strait Islander people</b>	<b>35</b>
Inquiry into Aboriginal and/or Torres Strait Islander consumers' rights	35
Culturally appropriate care	36
Aboriginal Mental Health Liaison positions	36
Rights of Aboriginal forensic consumers	36

Aboriginal visitors to hospitals	37
Getting it right: working with Community in regional WA	37
<b>Forensic consumers' human rights</b>	<b>39</b>
Forensic inpatient crisis	39
Transitioning out of bed-based forensic services	40
Criminal Law (Mentally Impaired Accused) Act reforms	41
<b>Safety on wards</b>	<b>42</b>
Use of security guards	42
Undue force in restraints during medical admissions	44
A trauma informed approach	44
<b>Licensed psychiatric hostels and their residents</b>	<b>46</b>
Insufficient advocacy services for hostel residents	46
Protecting rights and safeguarding residents	47
Completing the closure of St Jude's Hostel	48
The future of psychiatric hostels	49
<b>Mental Health Tribunal hearings</b>	<b>50</b>
Conducting hearings by video or audio	50
Other long-standing problems impeding natural justice	51
Advocate representation in hearings	52
<b>Accessing consumer rights</b>	<b>53</b>
Involvement in treatment, support and discharge planning	54
Access to a further opinion	55
Health Service Provider notifications to Personal Support Persons	56
Errors, oversights and failure to listen	57
<b>The interface with the NDIS</b>	<b>59</b>
Difficulties at the NDIS-forensic interface	61
<b>Resourcing, data and disclosures</b>	<b>62</b>
Budget and expenditure	62
Resourcing	64
Business systems	66
Records management	66
Electoral Act Requirements	67
Quality assurance	67
Ministerial directions	68
Committees, submissions and presentations	68
<b>Appendices</b>	<b>70</b>
<b>Glossary</b>	<b>76</b>



# Chief Advocate's Foreword

I am pleased to present the sixth annual report for the Mental Health Advocacy Service (MHAS), my first since taking on the role of Chief Mental Health Advocate earlier this year. The trust bestowed upon me to serve the people of Western Australia in this capacity is a responsibility I am proud to take on.

Being admitted to hospital for mental health reasons is often a distressing experience, to say the least. Hospitalisations for illness and injury are difficult enough, let alone having to navigate the process when one's mental acuity is compromised. Whilst much of this report brings to light the problems in the current mental health system, in turn it shows the value of having an Advocate walk alongside a consumer to help them navigate their path to recovery.

Over and again, the report provides examples of how MHAS Advocates help to amplify consumers' voices, so their views and preferences are not only heard - but

respected; enhance their experience of treatment, care and support and improve their recovery outcomes. I am proud of how our Advocates negotiate relationships within and across services with skill, patience and persistence to ensure that consumers can access their rights under the Mental Health Act.

Our impact is both individual and systemic. On almost every day of every week and in every public mental health unit in WA, an Advocate will be visiting a consumer and assisting them to get the treatment, care and support that is theirs by right under the Act. This report brings together all the components of our system improvement advocacy work: our reach, our strong relationships with treating teams and staff, our reputation, and the trust we foster amongst consumers.

With a critical lens, the report also reveals opportunities for MHAS to improve the services we deliver. The technologies that support our work with consumers

need modernisation. Our data system will benefit from an overhaul. And most importantly, we are poised to review our governance and to integrate lived experience voices and ways of knowing into how we drive and improve our service delivery.

Development, and indeed some service delivery, has been hampered in the past by funding constraints. These continued during the 2020-21 year. I am confident that the funding provided to MHAS for 2021-22 will be sufficient for us to address our most pressing priorities and ensure that more vulnerable and underserved consumers are supported to exercise their rights, to speak up and out, and to be heard and respected.

None of what we do, nor the changes we seek for the system, nor the improvements for MHAS itself can be achieved without collaboration, partnership and goodwill. I thank the consumers, families, supporters, treating teams, management and executive in health and other services for

their ongoing willingness to work with us through thick and thin. We are stronger together.

I take over a service with firm foundations, enormous passion and clear purpose. I thank my predecessor, Debora Colvin, for the commitment and expertise she has invested in MHAS. Her legacy is one that will be held close to the heart of MHAS, as we continue to grow, learn, listen and advocate.



Dr Sarah Pollock  
CHIEF MENTAL  
HEALTH ADVOCATE

A photograph of a large baobab tree in a savanna landscape. The tree has a thick, textured trunk and a wide, spreading canopy of green leaves. In the foreground, there is a field of tall, golden-brown grasses. The ground is rocky and uneven. The sky is a clear, bright blue with some light clouds. The overall scene is a natural, outdoor setting.

The artwork used on the front cover of the Annual Report is called 'Kija Country' and has been reproduced with the permission of the photographer.



MHAS seeks to present the experiences of consumers we assisted during the past year. As such, this report may contain information that is distressing for some people. Identifying information has been removed to help ensure individuals are not identifiable.

MHAS is committed to transparency and seeks to ensure accuracy of data quoted in this report. MHAS' database is constantly being updated and figures may be revised over time, however, the integrity of this data cannot currently be guaranteed.



# Key areas of focus for Advocates' work in 2020-21

In 2020-21 Advocates from the Mental Health Advocacy Service (MHAS) repeatedly reported issues and concerns for consumers in the following areas:

- Demand remains high for MHAS services driven by children and young people, people in EDs, and people with outstanding unresolved complaints
- Protracted stays in Emergency Departments (ED) and Mental Health Observation Areas waiting for beds, complaints of rough handling including by security guards, restraints and lengthy sedations
- Conversely, people are stuck on mental health wards due to lack of appropriate accommodation, support and coordination
- The availability of forensic beds is worsening with prisoners and people in the court system unable to access inpatient care
- Most older adults (65 years and over) on authorised mental health wards are voluntary but can be restrained, secluded and have their calls and visitors restricted yet don't have important rights protections
- A dire lack of mental health services for children is exacerbating existing mental health problems. This is compounded when young people have intersecting issues such as intellectual disability, autism or being in the child protection system
- The statutory rights of Aboriginal and Torres Strait Islander people to culturally appropriate care is not improving
- There are growing concerns about the need for additional training for security guards following complaints of rough handling, excessive force, restraints and seclusions leading to trauma
- Lengthy delays in transfers for people coming from the regions for examination and treatment in Perth, and use of intubation and sedation
- Conduct of Mental Health Tribunal hearings by video conference is disadvantaging consumers and impeding natural justice
- Reporting notifications of family or carers about involuntary orders is not improving
- There is minimal improvement in treatment, support and discharge planning and in involving the consumer and their support people in the process
- Serious allegations about the treatment of hostel residents at a time when insufficient funding prevents Advocates from proactively visiting
- The rescinding of the Department of Health's operational directive on further opinions raises questions about how system performance will be monitored.

The annual report expands on the issues and illustrates the problems faced by mental health consumers in the past year and the work done by Advocates to help.



# About us

**The Mental Health Advocacy Service exists to amplify the voices and protect the rights of people using, and seeking to use, mental health services.**

---

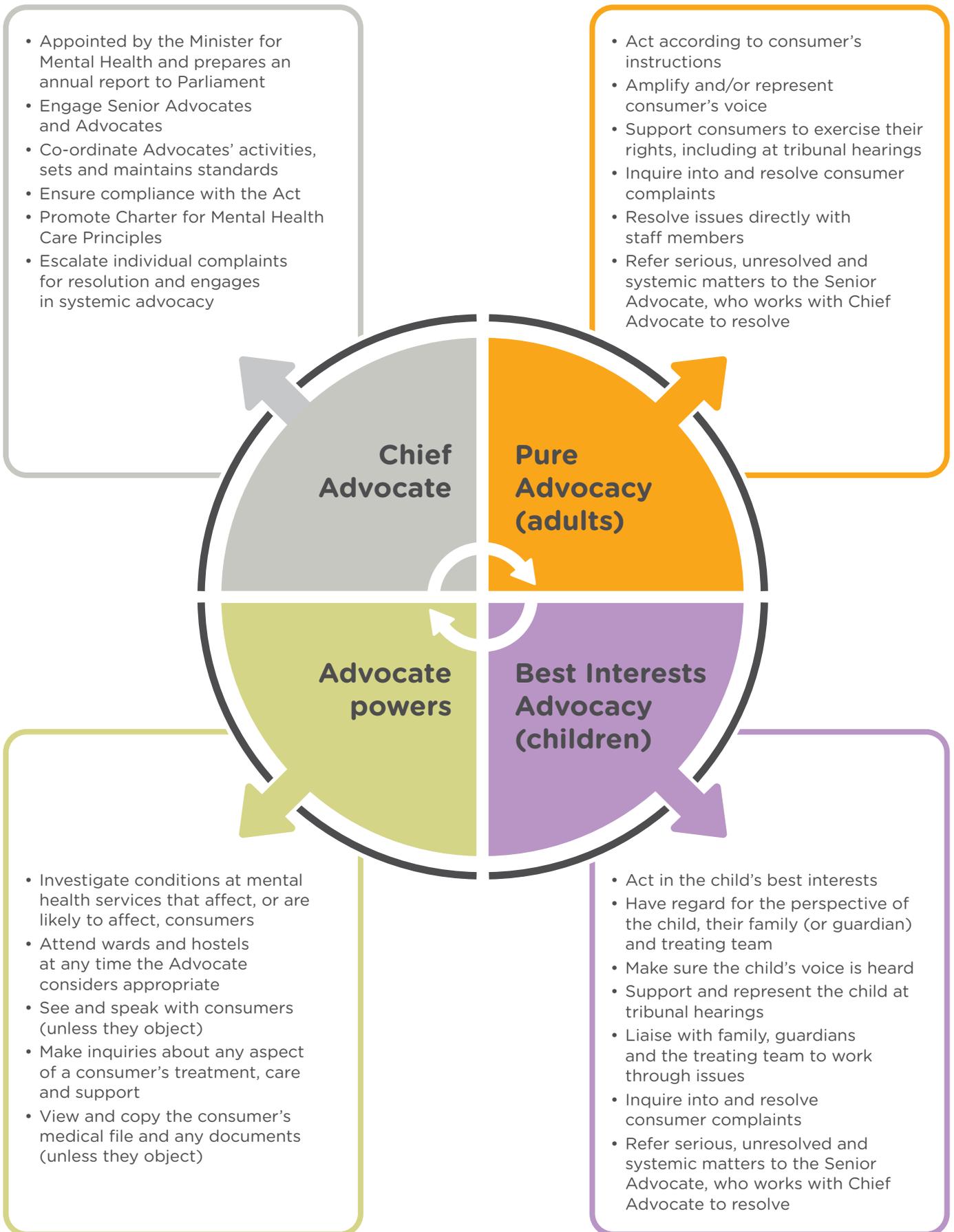
MHAS assists all people on involuntary treatment orders, those referred for psychiatric examination, those subject to custody orders and required to undergo treatment, psychiatric hostel residents and some people who are voluntary patients.

The functions and powers are set down in Part 20 of the *Mental Health Act 2014* (the Act). This requires the Chief Mental Health Advocate (Chief Advocate) to ensure advocacy services are delivered to the above groups of people, called 'identified persons' in the Act and referred to as 'consumers' throughout this report. The Act requires the Chief Advocate to be notified by mental health services of every person made involuntary. Advocates must contact all adults within seven days after they have been made involuntary, and all children within 24 hours. Advocates also make contact at the request of consumers or others acting on their behalf.

The Act confers considerable powers on Advocates, who may do 'anything necessary or convenient' for the performance of their functions relating to advocacy for individual consumers. The powers extend to inquiry into or investigation of conditions that are impacting, or are likely to impact the health, safety or wellbeing of identified persons.

The graphic alongside highlights some of the key powers and functions of MHAS Advocates.

**FIGURE TWO - About us**



# The Year in Review

## 2020 - 2021



<sup>1</sup> Data is based on MHAS' data as recorded by Advocates and is understood to under-represent the number of hearings attended. The number cannot be compared to data reported in previous years which was supplied by the Mental Health Tribunal.

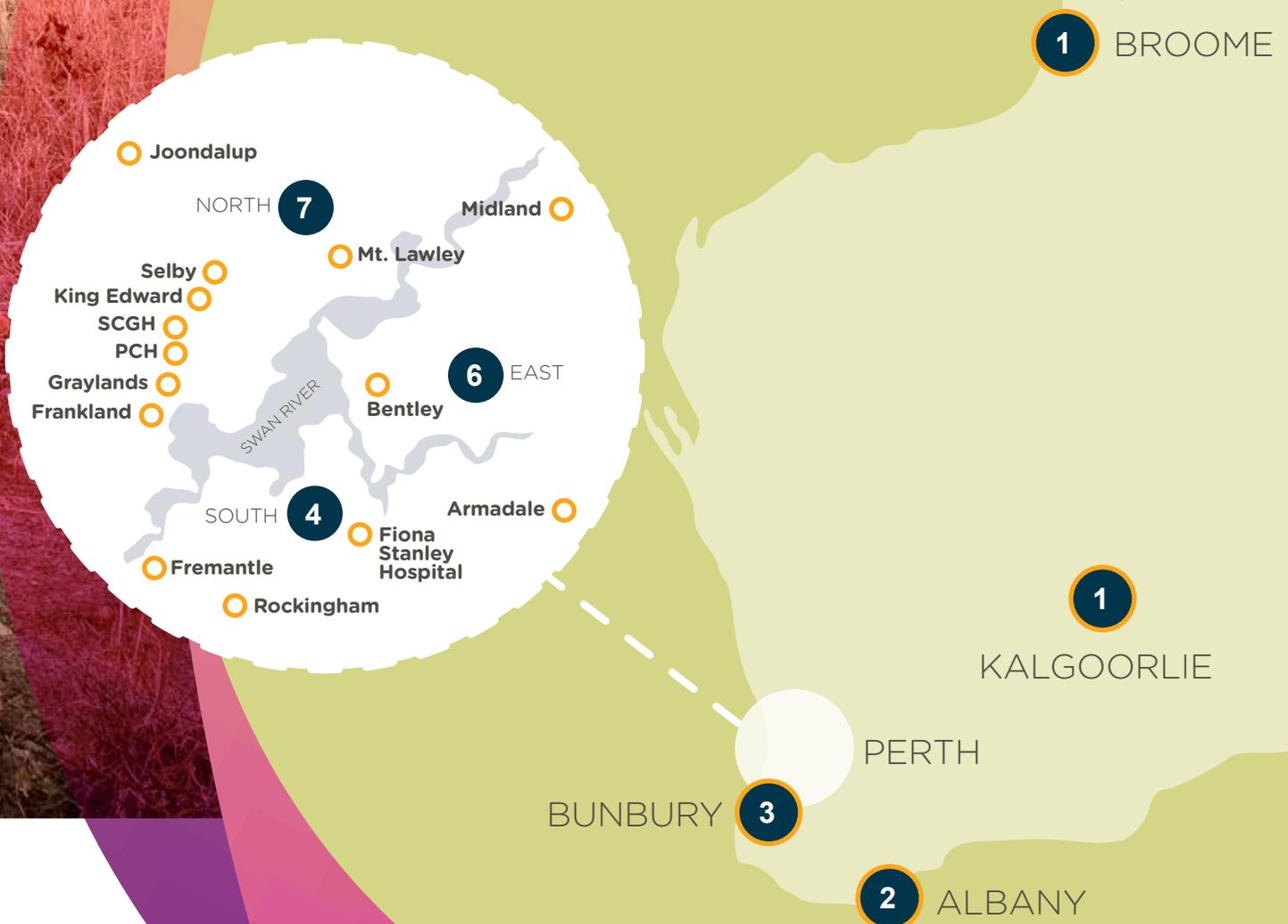
Authorised hospitals  Number of active Advocates 

# Distribution of Advocates and Authorised Hospitals

## STATE-WIDE:

- 4 YOUTH
- 2 ABORIGINAL
- 1 WEEKEND PHONES

Advocates work varying hours so the number of Advocates do not represent FTE. Numbers as at 30 June 2021.





# Service access and experiences

## How many people we supported

In 2020-21, 3,605 people's<sup>2</sup> voices were better heard and better represented through their access to an MHAS Advocate. This figure has been steadily increasing over the past few years (by 5.2% this year, and 9.1% in the previous). Our expertise and deep excavation into many of these consumers' experiences give us unique insight into the current landscape of the mental health system in Western Australia.

**TABLE ONE - Number of identified persons assisted, and issues and complaints recorded by Advocates**

	2016-17	2017-18	2018-19	2019-20	2020-21
<b>Total number of identified persons<sup>3</sup></b>	N/R	3,132	3,141	3,427	3,605
<b>Number of issues and complaints recorded by Advocates</b>	6,038	7,373	5,081	8,970	7,581

## Who we supported

### Children and young people

MHAS has seen a seven-fold growth in demand for services for children and young people over the past four years. This significant growth is in part due to the Ministerial Direction<sup>4</sup> to assist voluntary children that came into effect in January 2017. Since that time, MHAS has developed the calibre and capacity of the MHAS Youth Advocate team to meet this demand. Significant growth is also seen in the continued increases in the numbers of involuntary orders for children and young people over the same period (152%).

<sup>2</sup> Those who met the definition under the Act of an identified person.

<sup>3</sup> Numbers of consumer are based on 'contact' made by Advocates and differs from data on the number of involuntary treatment orders.

<sup>4</sup> A Ministerial Direction issued on 1 January 2017 enabled Advocates to assist voluntary children who were being treated, seeking admission or had been assisted by an Advocate in the previous six months, and consumers who were previously involuntary where a complaint remained unresolved and there was further action that could be taken.

## New consumers

MHAS expected the number of consumers new to its service to progressively decrease as its database matures due to the limited groups of people who can be assisted. However, the opposite has been the case in the past two years, with an overall 15.2% increase in new consumers. Most of this increase is accounted for by the increases in children assisted who are new to MHAS. This is concerning and likely reflects the lack of early intervention and options for children and adolescents outside of the hospital setting. It also raises questions about how the system is adapting to meet the changing needs of the community.

## Voluntary consumers

MHAS is also able to work with people who have been made voluntary when they have ongoing or unresolved issues from the period when they were on an involuntary order because of the 2017 Ministerial Direction. Usually the issue is a serious one resulting in a complaint or inquiry (all other voluntary patients are referred to the Health Consumers' Council or Helping Minds for advocacy). This cohort reflects a growth in demand for advocacy services, concerning because it reflects the entrenched nature of some issues that are not readily resolved within the mental health system.

## Referred persons and other consumers assisted

Referred persons are on orders for a compulsory examination by a psychiatrist (a Form 1A) and often in EDs. The right of referred persons to an Advocate was introduced as part of the 2014 Act and as awareness of the service has grown, so has demand for MHAS' services (40.0% increase over four years). The increases also reflect the sometimes long waits that people have in ED.

**TABLE TWO - Five-year trend in consumers assisted<sup>5</sup>**

	2016-17	2017-18	2018-19	2019-20	2020-21
<b>Referred persons assisted</b>	41	238	212	303	333
<b>Voluntary children assisted (0-18 years)</b>	15	59	59	278	460
<b>Voluntary consumers assisted with ongoing issues (adults)</b>	37	62	86	94	135
<b>Consumers new to MHAS</b>	1,629	1,560	1,566	1,798	1,876

<sup>5</sup> Data is drawn from the MHAS ICMS database of notifications sent by facilities and work recorded by Advocates and extracted as at July 2021; data is subject to change. Consumers may be assisted in multiple categories during the financial year. MHAS started providing advocacy services to voluntary children and consumers with ongoing issues via a Ministerial Directive on 1 January 2017.

## Involuntary treatment orders<sup>6</sup>

The number of involuntary orders has increased by 5.7% over the past five years and appears to have stabilised at 4,273 orders in the past year.

**TABLE THREE - Five-year trend in numbers of involuntary treatment orders<sup>7</sup>**

	2016-17	2017-18	2018-19	2019-20	2020-21
<b>Number of involuntary inpatient orders</b>					
All ages	3,245	3,337	3,226	3,443	3,389
0-18 years	51	75	81	107	122
<b>Number of community treatment orders</b>					
All ages	796	817	850	839	884
0-18 years	14	13	24	28	42
<b>Number of custody orders (in an authorised hospital)</b>	<b>5</b>	<b>9</b>	<b>11</b>	<b>22</b>	<b>29</b>

In terms of involuntary orders (refer to appendix 1 for data by type of involuntary order), the decrease in inpatient orders (Form 6A) this year, has been offset by increases in:

- inpatient orders made on general hospital wards (Form 6B) increasing by 7.7% compared to the previous year (noting these have almost doubled since 2016-17)
- consumers put on involuntary community treatment orders (Form 5A) increasing by 5.4% compared to the previous year (noting these have increased by 11.1% increase since 2016-17).

The number of consumers on custody orders in authorised hospitals who can access advocacy services doubled in 2019-20 and increased by about a further one third in 2020-21. This is significantly restricting access to inpatient services for people in prisons and in the court system.

<sup>6</sup> Involuntary treatment orders comprise community treatment orders (Form 5As), involuntary inpatient treatment orders on an authorised mental health ward (Form 6As) and involuntary inpatient treatment orders on a general medical ward (Form 6Bs).

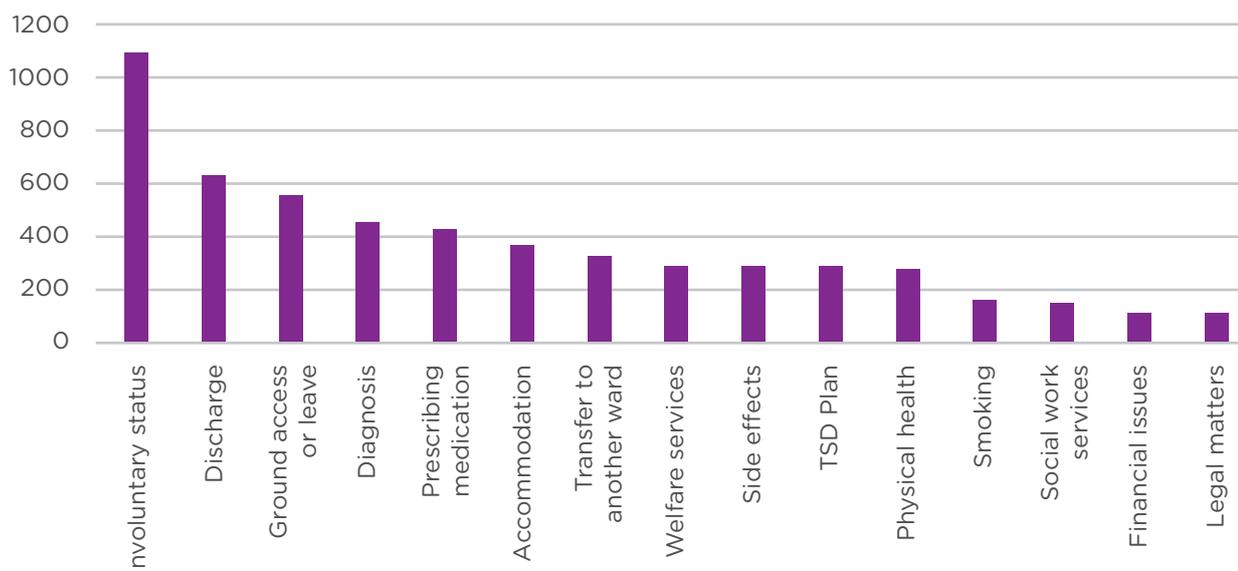
<sup>7</sup> Data is drawn from the MHAS ICMS database of notifications sent by facilities and work recorded by Advocates as at July 2021; data is subject to change. Involuntary consumers assisted may be on multiple orders during the financial year.

## What their concerns were

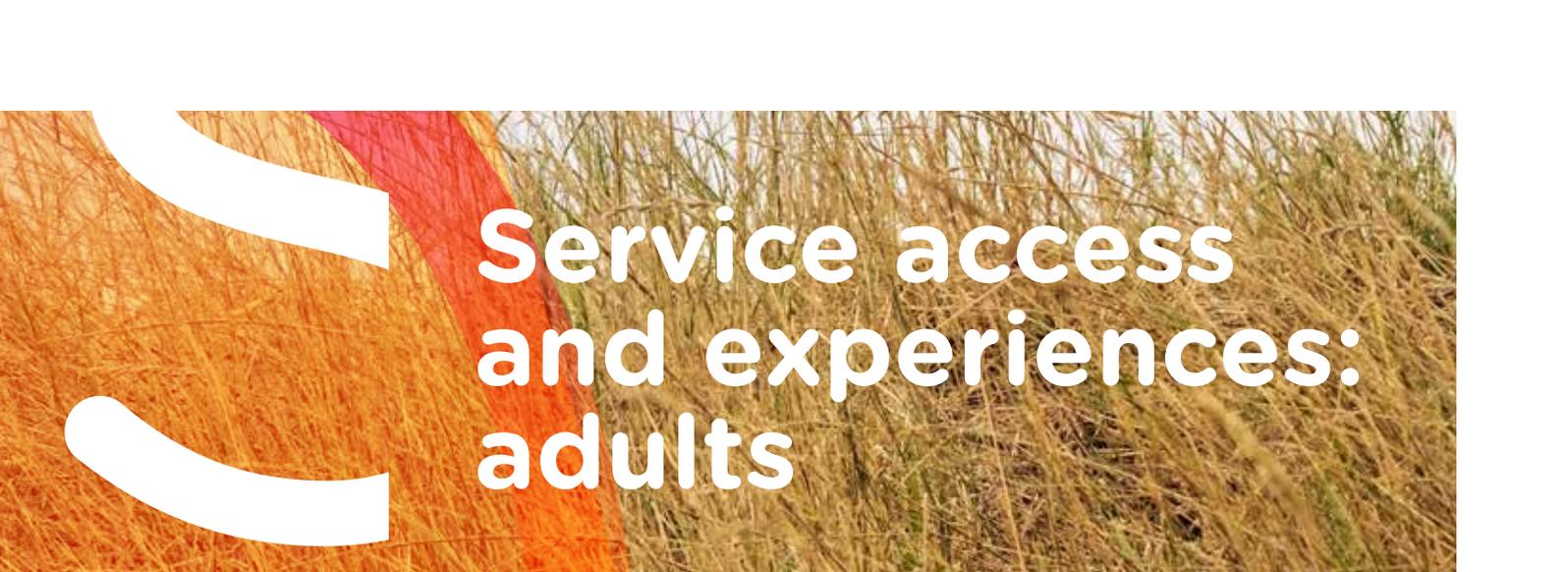
The MHAS complaints and issues categories are structured to reflect Advocates' work in the field. The data on issues is dependent on what the Advocates enter. We are aware that our practice in this regard is inconsistent; some Advocates record more issues than others. Nevertheless, the issues data is a sufficiently large body of data to provide an informal indication of what consumers experience and raise with Advocates.

In 2020-21 Advocates recorded 7,581 complaints and issues regarding consumers' treatment and care under the Act. The chart below gives an indication of main issues for consumers over the past year.

**CHART ONE - Most common consumer complaints and issues in 2020-21**



In addition to specific issue codes, MHAS uses a discreet code for serious issues. In 2020-21 there were 171 alleged serious issues and reportable events that required Advocate intervention. The majority of these related to allegations of physical abuse, misconduct, wilful neglect or ill-treatment, sexual safety and other allegations that resulted in (or potentially could have resulted in) a serious and imminent risk to the health, safety or wellbeing of consumers.



# Service access and experiences: adults

## Accessing mental health care via EDs

Once again, Advocates continued to work with adults spending long periods in Emergency Departments (ED) waiting for a bed to become available. One of the longest was a person who waited over eight days in a regional ED for a bed to become available at Graylands hospital. Each day, a Senior Advocate checks the bed report to identify any person who has been in ED for a protracted period, and then arranges for an Advocate to make contact and to ensure that the person is aware of their rights. The Advocate can assist them with any problems or complaints they have.

Referred persons<sup>8</sup> have fewer rights protections available compared to people who are made involuntary under the Act, yet they can still be restrained and secluded for example. Thus, it is not just the frustration of a protracted wait for bed – and access to specialised treatment, care and support - that is at issue here, but the restrictions on their rights and lack of protection and oversight that are of concern to consumers and Advocates alike.

When the 2014 Act was drafted, the scenario where protracted stays in EDs were commonplace may not have been anticipated. The forms that enable a referred person to be held in an ED whilst they await examination have statutory timelines. However, when these expire, and no examination has taken place, they may be re-issued rendering the current timeframes within the Act meaningless.

Many hospitals now have Mental Health Observation Areas (MHOA) or Mental Health Emergency Centres (MHEC) to provide an alternative setting to EDs for people who present in mental distress. Although a preferable environment to an ED, they are still busy, noisy places with no fresh air and often small windows. However, along with the same lack of access to rights protection as referred persons in EDs, people in MHOAs and MHECs are removed from the daily bed report, meaning that delays in receiving treatment for this cohort is not centrally monitored.

### Minimising time spent in ED and de-escalation

Advocates' work is often focused on getting the consumer assessed quickly so they can be admitted and access treatment, or be sent home. Patient welfare matters, such as being able to go to the toilet rather than using a bedpan or being allowed to return home to collect clothes and belongings for an admission, form an important part of

<sup>8</sup> Adults in EDs placed on a Form 1A for referral to an authorised hospital or other place for examination by psychiatrist to determine whether they meet the criteria for an involuntary treatment order. Form 1A made in the metropolitan expire after 72 hours (up to 144 hours in regional areas) but can be re-issued.

Advocates' work. Trying to find alternatives to having security guards in their ED pod or being moved to a quieter part of the ED are also frequent aspects of Advocate work.

### **The too hard basket?**

*A consumer with complex medical and mental health issues spent more than four days in an ED, most of the time under sedation to keep them calm. For some of the time they were also placed in a four-point restraint (where all four limbs are restrained /chained to the bed). During the whole 98-hour period, they continued to be treated for their medical issues. Because they were sedated, the Advocate was not able to take direction from the consumer but worked to try to secure a bed on a ward. One hospital refused to take them because of their behaviours, despite their medical needs. At this point, the Advocate escalated matters to the medical Head of Service (at the hospital where admission was sought), and then to the Chief Executive (of the hospital whose ED the consumer was in). A mental health bed was finally secured when the consumer was medically cleared, but a dispute remained over the length of the stay in ED. Was it 98 hours in ED as MHAS argues, or only the three hours (ie post-medical clearance), as the hospital maintains?*

*MHAS referred this matter to the Chief Psychiatrist.*

Because the ED environment is an inappropriate place for any mental health consumer to spend more than a few hours the longer a stay becomes, the more likely that the environment will become unsafe for everyone concerned. This may lead to consumers being restrained, sedated or placed in 'safe' rooms – akin to being placed in seclusion. These actions take place under duty of care provisions rather than under the Act, meaning that consumers may have no or very little access to the rights and protections offered by the Act.

## **Limited knowledge of the Mental Health Act**

Advocates report that consumers' communication needs are often overlooked or misjudged, where everything the person says is interpreted as a symptom of their illness. This in turn leads to frustration and escalating behaviours as people try harder and harder to get themselves heard or don't speak up about things that are troubling them. The longer someone spends in an ED, the more important the observation of their rights becomes.

*A consumer on a Form 1A complained that they had told ED staff they wanted to talk to an Advocate, and that this had not been facilitated. When the Advocate investigated the complaint, ED staff said they felt that they had met the requirements of the Act by giving the consumer the MHAS contact details and explaining the process. They did not make contact with MHAS as soon as possible or within the 24 hours of the consumer's request, as required by the Act<sup>9</sup>.*

As this, and the subsequent example makes clear, ED staff do not always know about their obligations under the Act, nor the need to inform consumers about their rights and the process for contacting MHAS or other family members. They can become obstructive when the Advocate arrives in the ED, signalling the need for ongoing communication between MHAS and EDs, and the important role that MHAS Advocates play in educating staff about their responsibilities under the Act.

*MHAS received a call from an ED consultant at a metropolitan ED raising concerns about four adults who had been there for over 48 hours, with one being held in a four-point restraint for almost three days. Each was being held on a Form 3A (detention order). Two Advocates*

<sup>9</sup> Refer to section 356 of the Act.

*visited the ED and were able to speak to three of the four consumers, advising them of their rights, asking basic welfare questions and checking that their personal support person had been informed as required by the Act.*

*Despite the initial call from an ED consultant, when the Advocates arrived at the ED the psychiatrist involved in the four cases initially told the Advocates that they should not be in the ED unless directly requested by the consumer (and that they should be elsewhere advocating for better patient flow). However, the Advocates were able to explain the role successfully and were able to continue with their duties. The Chief Advocate followed up with the psychiatrist to ensure that staff in the ED understood MHAS powers and functions.*

## Heavy-handed practice

Complaints to Advocates about rough handling from clinical and security staff in EDs are not uncommon, and sometimes form the basis for further inquiries and investigations. Advocates have responded to consumer and family concerns about people who were sedated for days or were so heavily sedated that they had to be intubated, giving rise to further medical risks. In August 2020, the Chief Advocate contacted the Chief Psychiatrist to raise her concerns about the use of sedation and intubation. In February 2021, the Chief Psychiatrist wrote to all hospital Chief Executives asking about the use of intubation for mental health consumers for behavioural reasons. This inquiry was ongoing at the end of June 2021.

## The benefits of advocacy for people in crisis

Unfortunately, EDs remain the major access point to specialised inpatient mental health treatment, care and support for people when they are probably at their most unwell and need compassionate and expert help immediately. Access via ED impacts significantly on consumers, as well as families and ED staff. This happens on a day to day basis in the majority of EDs across the state. To manage this situation with compassion and dignity would take significant, high-capability

resources (for instance specialist staff trained in mental health crisis management and trauma-informed care along with peer workers). These are not available in most EDs, resulting in high demands on other staff who are not generally mental health trained, for instance emergency clinicians and security staff.

Advocates play an important role in accessing the forms the consumer has been placed on and making sure that the rights associated with each stage in the process are observed. Some ED staff work well with Advocates and recognise the role they can play in ensuring consumers and families are informed of what is happening. This reduces distress and anxiety for the consumer and their family (where relevant), assists the patient flow process and protects consumer rights.

# Delayed discharges and unsuccessful transfer of care

Again this year Advocates have worked with inpatient consumers whose mental health has reached an optimal level, but who cannot be discharged because they have nowhere safe and appropriate to live, lack the supports they need to live in the community, or both. Whilst the lack of supportive housing is a major barrier, the insufficient development of a rehabilitation pathway as outlined in the Chief Psychiatrist's review, *Building rehabilitation and recovery services for people with severe and enduring mental illness and complex needs – including those with challenging behaviour* (2020) is also a significant factor in these unnecessarily prolonged stays.

## Lack of suitable accommodation driving re-admission risk

Working to overcome issues with lack of affordable housing, unclear responsibilities for placement and tenancy support, and hand-balling between responsible departments and agencies all form part of the standard Advocate workload.

Consumers have raised issues about long wait times to see a social worker who could help them access accommodation or social workers who are, on occasion, reluctant to assist. Advocates are aware of occasions where consumers have been discharged into cars, backpackers or caravan parks. At times, Advocates have supported people to be discharged into less than adequate accommodation because the consumer would prefer this rather than to remain in hospital. This is an unacceptable situation.

Whilst the Act contains a provision for Advocates to assist consumers access other services (s352(1)(h)), there have been numerous occasions where the boundary between advocacy and case co-ordination has blurred and Advocates have taken on a workload beyond their formal role. MHAS contends that this work, alongside the increase in number of orders and complexity of problems, the number and duration of Mental Health Tribunal hearings and people seeking assistance including while stuck in EDs is contributing to the increase in Advocate hours over the past five years (and thus to MHAS costs).

The combination of the pressure on beds and inadequate support in the community leads to a situation where consumers are discharged, only to be re-admitted within a short period of time. Western Australia (WA) has the highest rate in Australia of re-admission within 28 days of discharge<sup>10</sup>. At least in part, this is a demonstration of the critical gaps in community treatment, care, support and supplementary services.

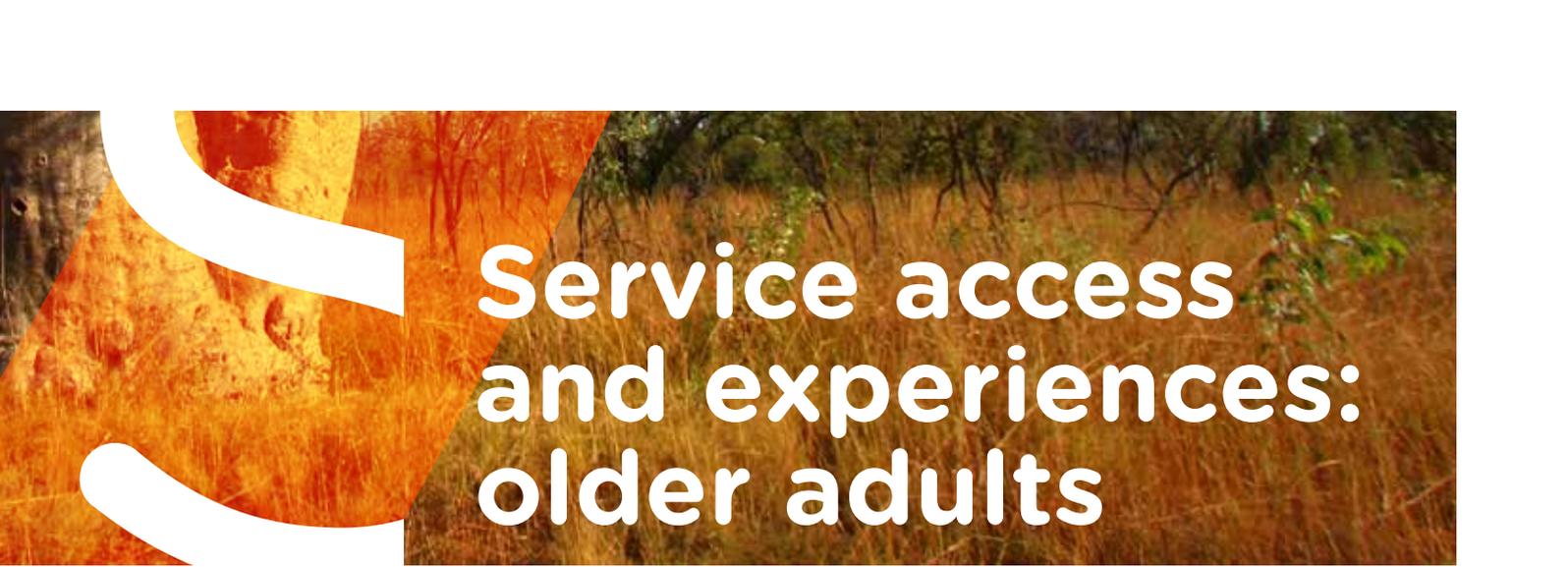
## Possible solutions and future directions

MHAS welcomes the plans for medium-term residential rehabilitation models such as a community care unit that we understand is currently being developed. These represent important interim services that bridge the gap between acute inpatient care and long-term supportive accommodation in the community.

The capability to work with consumers with higher acuity and complex support needs impacts a broader range of services in non-government organisations (NGOs) and is key to ensuring an equitable and safe standard of care across the state. Advocates already report 'cherry-picking' and refusal of service access for consumers with complex support needs, dual disability and/or alcohol and other drug use, and MHAS has seen examples of this in both the hostel sector and step-up step-downs.

MHAS contends that selective acceptance of consumers may relate to service provider capability and confidence, suggesting an opportunity for a sector development plan to enable NGO services to safely work with a wider range of consumers. In addition, building design needs consideration and plays a role in being able to safely support consumers with higher acuity. Investment in purpose-built facilities for short- and medium-term residential rehabilitation should be a part of a more consistent and comprehensive pathway from acute care to independent community living.

<sup>10</sup> Chief Psychiatrist's review.



# Service access and experiences: older adults

*“I think the indignity for some people of being under the Act for the first time in their lives in their seventies and eighties is more traumatising than the admission itself. They are often there because they are depressed generally through recent loss and grief, lonely or struggling with basic daily tasks because they are old. Some home care, companionship and counselling should be the first options.”*

## **(Advocate from older adult wards)**

MHAS has advocated for rights protections for voluntary consumers on authorised older adult wards since 2016, but this is the first annual report to highlight these concerns. The *Commonwealth Royal Commission into Aged Care Quality and Safety* has thrown a spotlight on the ways in which older adults may suffer from rights abuses in the very systems that are supposed to support them. Some of the concerns identified by the Royal Commission in the aged care sector are reflected in the issues that Advocates encounter in their day-to-day work with older adults seeking treatment or being treated under the Act.

## **Dignity, decision-making and self-determination**

One of the most common complaints that older adults raise with their Advocates is the lack of dignity with which they are treated. This is unacceptable and inexcusable and plays out in diverse ways.

Decision-making is crucial to self-determination for older adults. Retaining control over decisions about accommodation, medication and how they spend their money is critical to their wellbeing. Unfortunately,

differing opinions both within families and with treating teams can lead to applications for guardianship and/or administration orders to the State Administrative Tribunal. The process can take a long time, during which the older person remains stuck in hospital losing skills, confidence, mobility and relationships and holding up decisions about accommodation. In these situations, Advocates support involuntary older adults to access the services of the Mental Health Law Centre for assistance and representation at the State Administrative Tribunal.

Once well enough to return home, older adults may experience age-based discrimination – with treating teams and families arguing that they would be unlikely to be able to manage on their own at home and pushing for a transition to residential aged care. In this situation, Advocates can support the involuntary older adult to: seek a second (further) opinion and/or a functional assessment by an occupational therapist; or support them at a Mental Health Tribunal hearing. When older adults are made voluntary but remain in hospital, the Advocate can continue to assist them resolve outstanding matters from their involuntary admission.

*Shortly after admission, an involuntary consumer on an older adult hospital ward was told their Independent Community Living Service housing and support service would be discontinued. Instead, aged care funding for accommodation and support services should be sought. The waiting list for aged care community funding meant this was not a feasible option. The consumer had been living for 10 years in their own home, and this*

*action would mean they were homeless. The Advocate worked with the consumer, their family and the treating team, advocating for their housing to be retained and support services re-instated. While still being treated in hospital, the consumer was made voluntary, allowing the Advocate to continue working with them. Following a meeting of all parties and the Mental Health Commission, it was decided that the consumer's housing and support services be retained. They were discharged and was able to maintain their home, and independence in the community.*

Whether voluntary or involuntary, older adults' wishes may not be adequately recognised or considered by their treating team, which damages their dignity. A dementia diagnosis, cultural and language issues, hearing impairments, physical health issues all make it easy to ignore or overlook an older adult's voice.

In these situations, Advocates make sure they spend time with an older person in face-to-face communication, use interpreters where necessary and liaise with the treating team if necessary to ensure that the older adult is heard, and their wishes respected.

*“Often when I go to visit a consumer on the older adult ward, they will either tell me they can't hear me speak as they haven't got their hearing aids with them, or they can't read their rights on the MHAS brochure because they don't have their glasses. Trying to get this fixed is more difficult than it should be: the nurses say it is the social worker's job to chase up glasses and hearing aids. The social workers say it's the welfare officer's job. The welfare officer asks why the nurses can't just call the family/nursing home and arrange for the glasses/hearing aids to be picked up and/or delivered to the hospital. And so nobody makes a phone call to ask for these items to be brought in to the consumer. Without an*

*Advocate to raise the problem, and to speak up for the consumer, the admission can be much harder than it needs to be.”*

### **(Advocate from older adult wards)**

## **Rights and regulations**

Most consumers on older adult mental health wards are treated on a voluntary basis, so are not an 'identified person' and therefore not entitled to an Advocate. Over 80% of adults admitted to these locked older adult mental health wards in 2019-20 (around 965 people<sup>11</sup>) were voluntary and thus not entitled to the assistance of an Advocate, nor could access the wider protections of the Act. Many of these older adults have not made the decision to seek admission but been admitted by family, carers or guardians (including public guardians). All older adult mental health wards are locked so these patients are not free to leave.

Older adults who are voluntary in locked wards may not know they are voluntary, nor do they necessarily understand their rights as a voluntary consumer. Although termed a 'voluntary patient', the Act allows them to be restrained, secluded and restricted from using their phone, communicating with people outside the ward or receiving visitors. Voluntary consumers can also be given ECT and psychosurgery provided there is informed consent by a guardian and approval is given by the Mental Health Tribunal.

Older adults who are voluntary patients can approach the Health Consumers' Council for assistance. The Health Consumers' Council is an opt-in service without the statutory powers that MHAS Advocates have. The Council does not advertise in mental health units; thus consumers, families and carers may not know about the service.

<sup>11</sup> Source: Department of Health, Hospital Morbidity Data System - coded separations. The number of patients admitted to authorised older adult wards in 2019-20 by legal status. MHAS notifications of involuntary older adults for the same period was 191.

Despite the human rights implications when these conditions are imposed on them, voluntary older adult consumers have no automatic review by the Mental Health Tribunal<sup>12</sup> nor a statutory right to a further opinion. They cannot be assisted by an Advocate to ensure they are aware of their rights, assisted with complaints or supported to assert their rights. There is little or no oversight for a very vulnerable group of people who are in effect being detained.

In December 2020 the Chief Advocate responded to a request for comments on an open tender process for the provision of individual advocacy services to consumers of mental health and alcohol and other drug services. In her response the Chief Advocate suggested that an efficient solution would be to provide funding to MHAS for advocacy services to voluntary consumers on authorised older adult wards as an extension of scope<sup>13</sup>. She followed her feedback up with a letter reiterating her suggestion to the Mental Health Commissioner in February 2021. The correspondence included a business case for advocacy services for voluntary older adults in authorised hospitals that had been prepared in 2020 as part of the MHAS 2021-22 budget submission.

The initial response from the Mental Health Commissioner was positive, acknowledging the risks posed to older adults and the need to act. However, the consultation on the open tender drew concerns from NGO providers about a wide range of individuals who would also benefit from individual advocacy. In February 2021, the Commissioner expressed her intention to collaborate with the Department of Communities to run a workshop to explore community needs pursuant to designing an appropriate advocacy response.

The incoming Chief Advocate continued to advocate for an immediate response for voluntary consumers in older adult authorised hospitals, noting MHAS' readiness to undertake this work. She indicated willingness to be involved in the collaborative process to examine wider needs. In April the Commissioner confirmed that the Mental Health Commission and Department of Communities would be planning a workshop to 'strengthen individual advocacy services in Western Australia'. In June, the Commissioner reiterated this intention and suggested that in the meantime the Chief Advocate might address the Mental Health Leads committee of the Mental Health Executive Committee on the urgent and pressing issues in older adult wards to encourage practice change at a facility level.

Whilst this offers a possible pathway to some local remedy, it does not address the systemic problems relating to rights protection for voluntary consumers on older adult wards. Further, MHAS is already visiting authorised hospitals, it has statutory powers, and Advocates are experienced in engaging with mental health consumers and trained in the requirements of the Act including providing support at Mental Health Tribunal hearings. The Commonwealth Royal Commission makes it imperative to address rights abuses in facilities that treat, care for and support older adults. This is an area where prompt action is required.

<sup>12</sup> Long term voluntary consumers (admitted for more than six months) may apply to the Mental Health Tribunal for a review to decide whether there is still a need for admission. The Tribunal may recommend the need to reconsider the admission, the psychiatrist to prepare a Treatment, Support and Discharge Plan, or discharge the consumer. In 2019-20 one review was conducted of a long-term voluntary patient as per the Tribunal's Annual Report.

<sup>13</sup> Section 348(j) of the Act provides for the Minister to direct MHAS to assist certain classes of voluntary consumers by consulting with the Chief Advocate and tabling the direction in Parliament.

“

# I WANT MY LIFE. I WANT MY *OWN* LIFE.

I first saw a psychiatrist in 1967.

I did need help then. I was given electric shock treatment and sent home to look after my two children. There was no follow-up care or support then. I couldn't cope and I was back in hospital within a week or two.

I continued to get help in the years that followed, but stopped seeing the psychiatrist in 1984 and had no more contact with mental health services for the next 26 years, until 2010. I was caring for my husband from 2002, and they said I had a relapse of mental illness. I was just tired and run down!

My husband died in 2015, after we had been married for 60 years. For

the first time, at the age of 82, I had to handle money myself and I went out and bought some new clothes and new drapes. This was seen as overspending and a sign of mental illness!

I came home one day, and outside my house were police, St John's, psychiatry staff and my daughter, all waiting. I was taken to hospital. Same again - relapse, they said. I was down for being "irritable, angry and hostile" - and they were right! I was, and I still am!

In 2016, I decided to fight them, to fight for my rights.

In '17, I was taken in again, for what they said was another relapse. I refused to be given medication and they dragged me to

my room and injected me while I kicked them. I won't go along with treatment I don't need.

When I left hospital, the medication they were forcing me to take was giving me tremors. I had people coming up to me in the shops, asking if I had Parkinson's and if they could help me. I asked for the medications to be reduced, but the psychiatrist had made her mind up and that was it.

They came to my house to take me in again. I wouldn't let them in. I went for a shower and



they came in and threw me a towel and clothes and told me to get dressed, but I wouldn't. So they turned off the water mains. I held out for another hour but it was very cold. I went with them to the hospital and they told me to go to my room but I said I would wait to see the doctor. I waited, and I stayed in the lounge till the next day. I told them I was quite fine, but they kept me in for two and a half months.

If you disagree with a psychiatrist's findings and state this, you are labelled "argumentative".

We need better psychiatrists, who listen and hear. They need better training. The standard of psychiatry they have to attain is not high enough for the qualifications they receive.

**All they do is write up medication. There is too much medication, and not enough dialogue.**

I have written to ministers, to the Premier, to the Chief Psychiatrist, complaining about the way I have been treated. I have argued at Mental Health Tribunals and at the State Administrative Tribunal, and I will keep fighting.

I cannot compromise on this. I want my life. They are trying to run my life. I want my own life.





# Service access and experiences: children and young people

Last year, the Chief Advocate reported 'there are some tragic gaps in mental health care for Western Australian children'. Over the past twelve months the situation has not resolved, and the system is now in a state of crisis. We are hopeful that this crisis will be addressed through the *Infant, Child and Youth Taskforce* that is now established, but our work during the 2020-21 year reflects the dire state of the child and youth system as it currently stands.

Previous annual reports have outlined service system factors that have contributed to the current situation, notably a lack of prevention and early intervention responses, insufficient services in the community to meet demand and most crucially, insufficient beds for young people aged between 16-17 years. The trends reported in previous years have continued throughout 2020-21. Community services are insufficient in both volume and type, so children, young people and their families are not able to get timely help when they need it. Without the treatment, care and support they need their mental health worsens to the point that a hospital ED is the only place to go to seek the help. For those who need a hospital admission, this can often mean a lengthy wait in the busy and stressful ED environment until a bed becomes available, perhaps at another hospital, which means more delays whilst a transfer by ambulance can be arranged.

The issues compound once they are ready to transition from hospital settings to care in the community. Inability to access clinical mental health treatment, as well as difficulties accessing housing and support (NDIS for those who are eligible, and limited state-funded

alternatives for those who are not) leave young people stuck on wards, despite their mental health being stable. This also leaves stressed and worn-out families fighting for services to fill the gaps of a sub-optimal system.

MHAS included the issues raised in this section in our input to the Mental Health Commission's *Young People's Priority Framework*, drawing on feedback that consumers, families and carers had provided to Advocates during their work together to protect their rights under the Act, including the Charter of Mental Health Principles.

## Systemic problems lead to tragic death

The start of the 2020-21 year began in tragic circumstances for Kate Savage and her family. As has been widely reported, Ms Savage died by suicide in July 2020 following an appointment at community Child and Adolescent Mental Health Services and after long and frequent engagements with mental health services. Her parents had contacted MHAS for the first time in June because they held a differing view to that of her treating team about the nature of Ms Savage's distress and the treatment planned.

On 23 July, the day that Ms Savage was declared brain dead due to traumatic brain injury, MHAS sent a contentious issue

briefing note describing the Savage family's experiences and the Perth Children's Hospital responses to Minister Cook, the Minister for Mental Health at the time. It set out a series of questions that MHAS felt needed to be answered and recommended that an independent inquiry be undertaken.

The briefing note highlighted that Advocates regularly see suicidal children on wards, suggesting that the case highlighted systemic issues that needed further investigation through an inquiry.

Supporting this briefing note, MHAS made a submission to the Chief Psychiatrist Targeted Review that was initiated in response to Ms Savage's death. MHAS identified 11 other contemporaneous cases where children and/or families and carers had raised issues with their Advocate like those raised by the Savage family. The ages of the children ranged between 7-15 years. The MHAS review of similar cases highlighted the following:

- Poor communication between treating teams and families about the child's mental health and treatment; families feeling like they are in the dark.
- Families' views about the nature of their child's distress and effective ways of alleviating it ignored in favour of the views of treating teams; distress labelled as 'bad behaviour' and the pathologising of the child (and sometimes their family).
- Families being insufficiently involved in treatment planning and discharge, and their concerns about their ability to safely care for their child and/or remain safe themselves being ignored or downplayed, including when the child is still expressing suicidal or self-harm intentions.
- No continuity of support between inpatient and community care, long waits for community services or lack of access to the required type of service leaving families without support themselves sometimes for months, until such time that community care is available.

- Exacerbation of these issues when Department of Communities' Child Protection and Family Support (CPFS) are involved.

In these cases, families, who could play such a vital role in the quality and continuity of care, reported feeling marginalised and left alone to manage high levels of risk that place them, and their child, in danger. In such circumstances while a child is in hospital, the Advocates go between the family and treating team trying to ensure that families' concerns are heard, and their knowledge of their child is made available to clinicians, so they can provide the best treatment, care and support possible. Sadly, in the cases highlighted in our submission to the Chief Psychiatrist, the Advocates struggled to achieve better outcomes for the children whose best interests they represented.

## ED blockages and the need for improved youth patient flow

A major part of Youth Advocates' work last year involved assisting children and young people who were stuck in an ED. Prolonged stays in ED generally have a negative impact on the child or young person and their family and carers. This is particularly the case for those who live in the catchments without child or youth specific mental health beds, namely Joondalup and Sir Charles Gardiner hospitals and in regional WA. Most EDs are ill-equipped, from both a staffing and environmental perspective, to manage children and young people's distress. This then frequently results in a reliance on medication to manage agitation and distress, the presence of security guards, or the use of restraints and seclusion (or being placed in a 'safe room' designed for adult consumers). Youth Advocates also report



numerous examples of children who present to ED voluntarily seeking admission but due to extended delays causing distress are referred for psychiatric examination on a Form 1A including with an order that they be detained (Form 3A). This then remains on their medical record for life.

Whilst more beds for youth are planned, these will not be available until 2024.

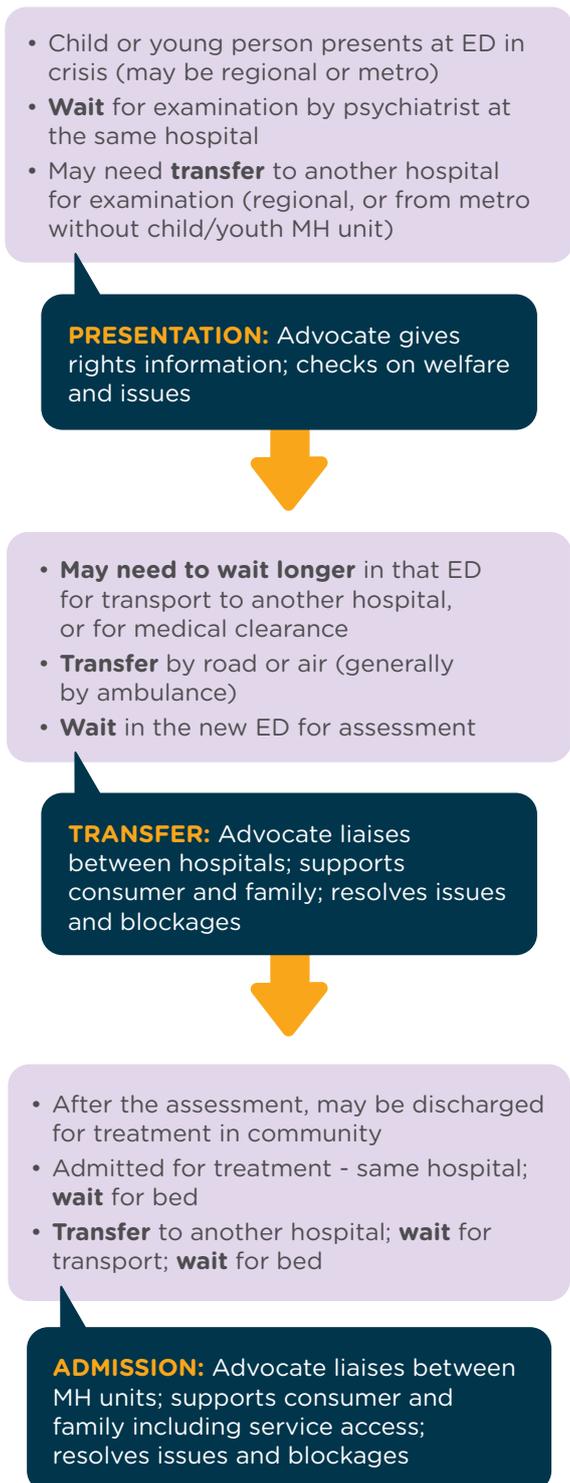
During the past year MHAS Youth Advocates have, with increasing regularity, found themselves caught between ED and ward staff, trying to negotiate a child or young person's admission to an appropriate ward. Sometimes, this has been in the same hospital as the ED, and other times it requires a transfer to another hospital. The *Mental Health Bed Access, Capacity and Escalation State-wide Policy* was developed to tackle the issues of delays in EDs. Despite being in place for nearly two years the situation remains grave for younger Western Australians.

The policy uses a four-colour traffic light system, called BRAG (black, red, amber and green), where each colour reflects differing demand and capacity, and triggers a different level of state-wide response. Even when the bed report status shows the overall system operating within capacity but with escalating demand pressure (amber) or demand exceeding active bed capacity (red), MHAS observes that it has frequently remained black for children and young people. Demand for child and youth beds is such that Health Service Providers are unable to place internal transfers or emergency admissions. At this point, the system for young people is effectively in gridlock. In these cases, achieving an appropriate admission requires substantial advocacy from the Youth Advocate often with involvement of the Senior Advocate.

Along with access to services on discharge, access to an appropriate admission is the most frequent situation where a matter is escalated to the Chief Advocate to seek a resolution.

There are multiple points between arriving at an ED to being admitted or discharged where bed block can delay the consumer's journey. The Youth Advocate's role always focuses on consumer and family rights, their welfare and ensuring timely access to treatment, care and support.

**FIGURE FOUR - Child and youth patient flow**



In January 2021 the Chief Advocate wrote to the Chief Executives of each of the five Health Service Providers (HSP) seeking clarification on apparent differing thresholds for admissions across facilities, a clearer process for decision-making and a clearer escalation pathway. The letter set out a range of options and called for the development of a youth specific patient flow process also encompassing the Youth Hospital in the Home (HiTH) program.

The initial response was promising, with the Chief Executives of North, South and East Metropolitan HSPs showing willingness and urgency to address this problem as a state-wide issue. Some activities were planned, and work progressed, but currently work has stalled whilst waiting to see whether the *Infant, Child and Adolescent Taskforce* will recommend a youth specific patient flow stream.

## Delayed discharge

At the other end of the patient flow process, children and young people can get stuck on wards even though, in the views of at least one of the decision-making parties involved, they are well enough to be discharged.

Advocates encounter barriers that include lack of access to appropriate accommodation and support and differing views between the treating team and the child's parents or guardians about the child's readiness for discharge. In these situations, working with different views about the child's best interests can be difficult and time-consuming for Advocates, more so when there is CPFS are involved or where the child or young person has complex, multi-agency support needs.

For young people with a dual disability (mental illness along with intellectual disability, autism, acquired brain injury, or other neurological conditions impacting on cognition) there are no clear pathways or service options. This

has two consequences: frequent delays in admitting children with dual disabilities to mental health units, particularly when there is a query as to the core presenting issue; and, once admitted to a mental health unit, there can be delays in discharge due to no suitable supported accommodation options or delays in National Disability Insurance Scheme (NDIS) funding processes.

Funding has been committed to a long-term housing and support program for young people, with service provision anticipated to commence in 2021, as well as a youth step-up step-down facility estimated to be ready in 2024. The provision of these services will be a welcome addition to the continuum of care for young people.

The example below is indicative of these problems and illustrate the work that Advocates do in supporting children and young people whose discharge is delayed.

*A young person with a long history of voluntary and involuntary admissions and complex, multi-agency support needs was admitted to a youth unit in December 2020. At the same time, their accommodation with their family broke down, exacerbating their distress and leaving them with nowhere to be discharged to. The young person spent over seven months in hospital due to failures and delays in the NDIS application process, and disagreements between services regarding diagnostic clarification and functional needs for supported independent living. The delays caused immeasurable distress to the young person who was a child when the process began. Throughout this time, they were supported by their Youth Advocate who helped them remain engaged in activities and advocated to get a more timely response from the NDIS.*

## Fragmented transitions to community care

Over the past year Youth Advocates have frequently found themselves assisting children, young people and their families to resolve issues that arose when transferring between acute and community services. Conflicts between treating teams and poor co-ordination typify consumer and family experiences. Differing clinical opinions between services regarding diagnosis and acuity, and consequently who is the lead agency or service responsible for care, account for much of the conflict between clinical teams. Resource constraints and clinical capacity issues all compound the situation and result in extensive waiting list times.

The result is delays in services accepting referrals and engaging with the consumer – in other words, a delay before the child or young person gets the help they need. During this time, their mental health can often deteriorate. In worst case scenarios, services refuse to accept referrals resulting in delays in discharge from inpatient admissions. This is particularly evident for youth with complex presentations who require support from multiple agencies such as community mental health services, CPFS and disability service providers.

Because only two HSPs currently have inpatient beds for 16- and 17-year old, when adolescents are admitted to these facilities they may be a long way from where they live and where they will eventually need to access mental health treatment, care and support in the community. The situation is now critical for 16- and 17-year olds, who may be reliant on access to services across multiple Health Service Providers and NGOs. A significant proportion of these young people are also engaged with CPFS, and disability service providers or awaiting NDIS application processes. In such situations it appears that the system ‘slows down’ its decision-making

process as there is a lack of willingness by services to 'take the lead' in the interim until issues of funding and service eligibility are resolved.

Currently demand for community Child and Adolescent Mental Health Services (CAMHS) exceeds capacity. Some consumers wait up to four months for therapy services following discharge. Community CAMHS has extremely long wait times for the initial appointments, and then further waiting periods for ongoing treatment. This leads to high readmission rates and risk in the community following discharge from acute inpatient admissions.

*A young person under the care of the state who lives in 24x7 supported accommodation funded by CPFS services and who has a complex trauma history, significant child protection issues, developmental disability, and significant mental health issues was assisted by a Youth Advocate. Early in 2021, the young person was admitted as an involuntary patient on a secure ward at a youth unit. This was not their first admission, and treating teams were aware that it was counterproductive for them to have prolonged admissions as this had resulted in a deterioration of the young person's mental state. However, once they were ready for discharge, numerous multi-agency meetings were required to arrange transfer of care to community services. Timely discharge was critical as the young person was becoming increasingly agitated by being held on a small*

*secure ward. Conflicting views about the young person's diagnosis and thus the most appropriate model of community care meant there was no identified service at discharge. The Youth Advocate provided direct support to the consumer and liaised closely with the treatment team to facilitate discharge planning and community follow up. MHAS escalated concerns to clinical leads in multiple services highlighting the need for interagency collaboration and identification of a lead community service, advocating strongly for a referral to the Young People with Exceptional and Complex Needs (YPECN) program. In the end, they were discharged without an identified community mental health service - and a re-admission occurred within a matter of months. Following further advocacy YPECN is now engaged in a care co-ordination role.*

Advocates' functions include advocating for and facilitating access by identified persons to other services in consultation with treating teams. A great deal of Youth Advocate time is spent liaising with treating teams, social workers and staff in external agencies to facilitate access to services. Youth Advocates attend case conferences, and in some cases call for case conferences to be organised to resolve problems. Restrictive eligibility criteria or insufficient volume in case management and/or care co-ordination services (such as the YPECN program) has meant that our advocacy is increasingly filling the system gaps relating to care co-ordination and system navigation.



# FINDING THESE SERVICES IN OUR REGION... THEY DON'T EXIST

I wonder if we should turn our backs on my son when he turns 18 next year, so that the system has to help him. He has been pushed from service to service, bounced around from mental health to disability and back to mental health.

He was diagnosed with an intellectual disability when he was five or six years old. He's in year 12 now and has hardly been to school this year.

We live outside Perth and the local hospital hasn't been able to help. He has had dozens of admissions. The first major one was in October 2020, when he was sedated for seven days in the ED. There is no suitable facility in our region - they stay in ED,

where there is so much going on, or in the short stay unit.

He was transferred to a youth mental health unit in the city. Little did I know, he would pick up habits there - he came out with a smoking addiction, an eating disorder and more hacks, tricks to work the system. It didn't pan out the way we expected.

He would cut himself, run in front of cars, say he doesn't want to go home. He has presented himself to hospital, saying he felt suicidal, that he didn't feel safe. He felt he couldn't fix himself, and he still feels that he can't.

He has absconded from the local hospital and the police said they would bring him home as the hospital couldn't deal with him. Our local police are always very kind, but they can only take him to the hospital, where they sedate him and send him home.

**He needs a behavioural psychologist, but finding these services in our region...**

**it doesn't exist.**

There has been no mental health diagnosis – they always say it’s behavioural. I don’t know if it’s behavioural or not, but he’s got to live with it and we’ve got to live with it. He doesn’t understand, he doesn’t get it, how to change.

I’ve had to push for him constantly to get help, with a lot of help from the Advocate. I have to be the driving force or nothing happens – it sits in bureaucracy. I know there’s other families in the same situation, being flipped from service to service.

There’s a knock-on effect on our whole family – me, my husband, our other children. We’re still not supported. Everything we do is just aimed at mitigating risk.

Going to a youth mental health unit wasn’t helpful. We’ll do everything we can to support him within our family and our community, but not going back to the youth unit.

There’s nowhere that’s a safe place where they can get calm without medication. He has been to a detox centre, where they take phones off them, and

that is helpful. But we are always waiting for the call that there is a problem.

It would be really nice to have something like a home, that’s secure and safe. It would mean the world for our family if we could even have a break for two weeks.

If disability supports had been delivered when he was much younger, we wouldn’t have the same problems now. I feel being outside the city has had a big effect, particularly in not being to access services. But in a small town, there is the positive that people know him and know us.

My son obviously can’t find any peace, and that’s all we want for him.



# Eating disorders – room for improvement

Around a third of Youth Advocates’ contacts with young people<sup>14</sup> were for consumers receiving treatment for, or related to, eating

disorders. This represents around 15% of children and young people assisted.

Children and young people with eating disorders often receive treatment on a medical ward, under a Form 6B (inpatient treatment order in a general hospital). Over the past three years there has been a huge increase in the number of children aged between 0-15 years on a 6B, and a marked increase for those aged 18-24 years.

**TABLE FOUR – Involuntary inpatient orders made in general hospitals (Form 6Bs) for children and young people<sup>15</sup>**

Age Range	2018-19	2019-20	2020-21
0-15	3	4	19
16-17	25	28	26
18-24	43	44	60

As table four shows, there has been a steady increase in the number of Form 6B orders and a large proportion of these are young people with eating disorders. Accompanying this has been increased requests for Youth Advocate assistance for voluntary children on medical wards regarding the use of restraints and undue force, communication breakdowns between treatment teams and families and problems with Treatment, Support and Discharge Plans (TSD Plans). The lack of compliance with the requirement for TSD Plans to be developed and reviewed in collaboration with consumers and their family is a breach of rights under the Act and a missed opportunity to facilitate discharge. Development of TSD Plans in consultation with consumers and family could result in significant improvement in outcomes for children, young people and their families.

The mismatch between service supply and demand is particularly concerning for young people aged between 16-24 years. Inadequate specialised community services places increasing demands on general practitioners to manage consumers in the community, often in isolation, without specialised mental health support. This can result in young people becoming unwell and requiring readmission. This also results in poor continuity of care with consumers being shuffled between different services based on bed availability. Last year, MHAS worked with ten consumers who were admitted to between three and five different facilities, and a further 19 consumers who were admitted to two different inpatient facilities.

<sup>14</sup> Those aged 0-24 years, including involuntary consumers aged 0-24 and voluntary children and adolescents aged 12-17 years. ‘Contacts measure the number of separate reports completed by Advocates.

<sup>15</sup> The data for Form 6Bs is for all children and young people. Based on our experience in facilities, we suggest that the majority will have been applied to children and young people with eating disorders, and thus is indicative only.

“

## I WAS YOYO-ING IN AND OUT OF HOSPITAL

I was first admitted to Princess Margaret Hospital for an eating disorder when I was 14. I remember my first (nasogastric feeding) tube, getting it shoved down by this nurse who didn't tell me what they were doing. And going to the bathroom, and seeing a nurse in the mirror, watching me - the loss of any privacy.

And after that, I was yooyoing in and out of

hospital till I became non-compliant, staying longer each time. When I was 15, I was admitted to a youth mental health unit and stayed there for nine months. I spent my 16th birthday there. Being in hospital exposed me to a lot of new things, and taught me a lot of new things - not necessarily good things.

I relapsed in 2018 but, after that, wasn't hospitalised again till August in 2019, when I was formed under the Act for the first time and was in a youth unit for one month. Until then, I had been going along with things, and decisions were made for me as a child.

I was in and out of medical wards, but also

mental health units, and from August till November 2020 was in an adult mental health ward. I've been in both the public and private systems, both as an inpatient and an outpatient.

PMH was the most useful and was quite well targeted. Overall, the private system is better. There is still accountability but you are making your own decisions - it's a middle ground between autonomy and accountability. In the public system, I have experienced restrictive practices - they've taken my phone, blocked visitors. There are punishments. If you pull your tube out, visitors will be banned. The two have nothing to do with each other!

I did my final exams in hospital and succeeded



in getting into a very competitive course at university.

Being in an adult mental health unit was really confronting. There were criminals on bail, there was one man stalking me and sending messages on Facebook. I was 18 then. They wouldn't transfer me to a youth unit - they said I was manipulating the system.

It was a general and unspecialised adult unit, and I think it was highly inappropriate for a young girl with an eating disorder to be exposed to severe and persistent mental illnesses in older adults.

I don't think forms are necessary for eating disorders. Once you start with a form, there is no going back. It makes you think that everyone is against you. Now I think about winning and losing - who is on my side and who is against me. I couldn't express that I'm struggling because it will be used against me and put on paper. I just say: "Yes, I'm fine."

From the outside, it might seem that having large multidisciplinary treatment teams on my back is extensive support. But the larger and more restrictive

my treatment teams have been, the less supported and able to express myself I've felt.

**At the end of the day, I don't want to be like this. I'm going to recover for myself.**

The consequence of not being well is going to hospital and disrupting uni and work, the things I want to do.

Obviously patients' safety is priority, but freedom shouldn't be taken away to an extent that you're damaging them in other areas and removing any sense of self efficacy and responsibility. I think there needs to be a way to be less restrictive, and keep people safe.



# Supporting consumers in regional WA

There are four hospitals in regional WA with authorised mental health wards: Bunbury, Albany, Kalgoorlie and Broome. Advocates are engaged in each of these centres to support consumers. Over the last three years there has been a small but consistent increase in the number of involuntary inpatient orders made in these regional authorised hospitals. This may not reflect the number of people from regional WA who receive involuntary mental health treatment as they may be transferred directly to metropolitan authorised hospitals before an involuntary order is made. However, it does demonstrate MHAS has done more work in regional hospitals.

**FIGURE FIVE - Inpatient treatment orders made in regional WA**



# The impact of poorly managed transfers

When people are very unwell they may need to be transferred between regional hospitals or be sent to Perth. This can result in several days lapsing between the time that a person first presents at an ED and arriving where they will be admitted for treatment.

Whilst the movement of patients across a jurisdiction the size of WA is complicated, the work of Advocates suggests that more can be done to lessen the impact on consumers and their families. Crucial communication improvements throughout this process are also necessary, as the cases below demonstrate.

## **A pointless weekend in a Perth ED**

*A consumer was transferred from regional WA to a Perth hospital on a Form 1A and spent several days on a medical ward awaiting an older adult bed in an authorised hospital. The Advocate escalated the matter within the patient flow process, with the agreed outcome that the delay in finding a bed needed to be addressed urgently. Initially the consumer was allocated a bed the following day, but this was cancelled because there was no psychiatrist available at the authorised hospital to examine the consumer. Because it was a Friday, the consumer spent the weekend on the medical ward without specialist treatment, and then was discharged on the Monday to be returned home to regional WA. This caused a great deal of frustration for both the consumer and their family, who were angry about the delay in access to treatment, and the waste of resources involved in the transfer to Perth and back home again.*

## **Around and around...**

*A difference in clinical opinion about the best course of treatment for an Aboriginal consumer in a regional authorised hospital led to them being transferred to Perth, discharged on arrival, left to make their own way home only to be returned to the regional hospital ED by their family and transferred back to Perth. A lack of family involvement contributed to this unacceptable situation; the family were not informed that the consumer was returning home, and they were totally unprepared to support the consumer.*

## **The impact of a long wait in ED**

*An adult consumer with complex treatment, care and support needs had a long stay in ED whilst waiting for transfer to Perth. During the wait, the Advocate liaised with the family and addressed the consumer's basic needs like having a shower. Unfortunately, the wait was so prolonged that eventually the consumer expressed their rising frustration and security guards were called. The consumer and family had already developed a plan to manage agitation whilst in ED, but this was not activated. The Advocate escalated concerns about the delay for transfer through the patient flow channels.*

The cases above indicate that there is more work to do to refine the implementation of the *Mental Health Bed Access, Capacity and Escalation State-wide Policy* to ensure efficient and effective decision-making in cases where there is disagreement with local treating teams.

Over the past year MHAS has initiated several inquiries concerning individual consumers who experienced prolonged wait times, indirect transit to the final admitting hospital, and/or sedation (often with intubation). In these cases, MHAS has been concerned about the stress of unclear arrangements on consumers and families and the physical and mental toll of these less than optimal transfers.

Likewise, there is opportunity to improve the involvement of families and carers in planning for transfer, so their valuable knowledge of what helps when the consumer is acutely unwell can increase the likelihood of a smooth transfer. Resources and training to support clinicians and families to work together to support the consumer are available and could be implemented immediately with relatively minimal resource impact.

*In May 2021 Advocates took part in the South West Inpatient Admissions to Mental Health Services (SWIM) project at Bunbury Hospital. Advocates focused on the right of patients in EDs to be made aware of their rights, and to be assisted to contact an Advocate should they request this. They also focused on the specific rights of Aboriginal consumers to involve an Aboriginal mental health worker.*

*One of the suggestions at the workshop was education on these rights for all staff involved in the consumer's journey, including the requirement to notify their personal support persons of incidents. As security guards are utilised throughout the hospital, MHAS advocated that they should receive training on trauma informed approaches to people experiencing mental distress. Advocates also suggested that additional resources to assist people with communication challenges should be available at every stage of a person's journey.*

## **Making up for the challenges**

The challenges of providing specialised and intensive services to people when they are unwell in the largest health jurisdiction in the world are not to be under-estimated. At the same time, local communities and services show creativity and innovation in tackling these challenges. The following is one example of how Advocates, consumers and service staff work together to ensure the best outcomes for consumers and their families.

*A consumer in a regional area of WA was ready to be discharged from an inpatient setting but required support while living in the community. They wished to stay in the area to remain close to their family, including their children. Unfortunately, they were considered not to meet the intake criteria of any of the nearby residential mental health services. An inpatient referral to the Hospital Extended Care Service at Graylands Hospital in Perth was being considered which was very distressing to the consumer. With the assistance of the Advocate, a further opinion was sought which contributed to the team being able to make a community treatment order. Accommodation was sourced in a private psychiatric hostel, which the consumer preferred to an inpatient setting. Despite best efforts to secure a hostel place locally, the consumer was still required to move to the metropolitan area, away from their community and their children to access this supported accommodation service.*



# A LOT OF UNNECESSARY PAIN

**W**e feel like our family's been put through a lot of unnecessary pain. We lived in the country and it is hard to access support in regional areas.

My son was diagnosed with autism at three years old. We moved to Perth to access school services to help him. But autism therapies and strategies didn't work.

Back in the country, the local high school didn't work out and we did distance education. Then, in 2017, he became more aggressive.

My husband had mental health issues but had been largely okay for 20 years. He began to deteriorate as our son's behaviour escalated. In January 2018, my husband was admitted for what would be three months of treatment.

When we asked for help for our son, who is non-verbal, the police said they would need to use a taser, and the ambulance had no sedation. He was taken to Perth by the Royal Flying Doctor Service. He was grabbed by a security guard at the hospital in Perth and held down to be sedated, then transferred to another hospital.

He was just medicated – medications, not investigations.

After that, we went back home to the farm. My husband never recovered, and neither did my son. I was trying to support them, and my other children, while also managing the farm. My son went to a regional hospital, where they just wanted to send him home with more medication.

This continued until July 2020, when he was intubated and taken back to Perth by the Royal Flying Doctor Service. He spent four weeks in the Intensive Care Unit (ICU). He was transferred to another ICU and began ECT (electroconvulsive therapy), then transferred again to a

mental health locked facility, with the ECT continuing. He has been there since.

My husband was readmitted and discharged again. He then took his own life. My husband always had mental health issues, but this just wore him down. It broke his heart to see his son like that.

A mental health unit is not the right place for my son. The medications are not helping. He is becoming institutionalised, he's incredibly overweight, he's so heavily medicated. And when he gets out of there, he's going to be doing all the same things.

**His freedom was taken away. He doesn't have a voice; he's not listened to. His needs are not met - his autism needs.**

In the last year, he has lost his father, he has lost his grandmother - who he was exceptionally close to - and he has lost his grandfather. He's not been able to grieve. He has great relationships with a lot of the staff. And I think the staff have always had his best interests at heart, but they don't have

the training in autism and disability. He needs a specialist psychologist. He needs support from autism specialists that won't give up. Where is there for someone like that to go? Nowhere.

The plan is to place him in supported living, but the places available are not in appropriate locations - they are too far from any family support. Providers have proven difficult to source with appropriate housing, staff, or the level of NDIS funding has not been enough to meet the needs

of providers. So he remains in a mental health locked ward.

I've moved to Perth to be near my son. It kills me to visit him in hospital every day. But if he was discharged

without proper supports, I'd be back to square one.

I'm fighting a losing battle everywhere I go. He has always been put in the too hard basket.





# The rights of Aboriginal and/ or Torres Strait Islander people

The Act affords additional rights for Aboriginal and/or Torres Strait Islander people to have a significant member of their community including Elders and traditional healers and Aboriginal mental health workers involved in their assessment, examination and treatment. These rights are in addition to the rights of all consumers subject to involuntary orders to have their family, carer or nominated person informed of events such as the making of an involuntary order and involved in their care and treatment unless the consumer objects.

Advocates are required to ensure that consumers have been informed of their rights and that those rights are observed. To do this, Advocates need to confirm if a consumer is of Aboriginal descent and they record this in MHAS' database. In 2020-21, 6.9% of consumers subject to involuntary inpatient treatment orders, and contacted by Advocates, identified as being Aboriginal; this was down from 8.5% the previous year. The proportion of people on involuntary inpatient treatment orders however remains higher than the proportion of Aboriginal people estimated to be living in WA (3.9%<sup>16</sup>).

The involvement of family members for all consumers is an area of the Act that has not been well implemented. For Aboriginal consumers the impact of this is amplified, particularly when they are receiving treatment far away from Country and Community. In a system overwhelmingly catering to non-Aboriginal people, access to culturally safe

and appropriate treatment, care and support remains a scarce experience.

To be compliant with the 2014 Act, much more needs to be done to ensure that treatment, care and support is delivered in ways that respect Community protocols and engage Community members.

## Inquiry into Aboriginal and/or Torres Strait Islander consumers' rights

In 2019-20 MHAS undertook an inquiry into the rights of Aboriginal people under the Act and reported on this in July 2020<sup>17</sup>. The report found that overall the Act is not being complied with. The 15 recommendations of MHAS' report were supported (or supported in principle) by the Director General of the Department of Health, the five HSPs, the Chief Executive of St John of God Midland Hospital, the Mental Health Commissioner, the Chief Psychiatrist and the President of the Mental Health Tribunal.

<sup>16</sup> Australian Bureau of Statistics estimate, based on the 2016 census, adjusted for net undercount as measured by the Post Enumeration Survey: <https://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001>

<sup>17</sup> The *Inquiry into Services for Aboriginal and Torres Strait Islander People and Compliance with the Mental Health Act 2014* is on MHAS website: [mhas.wa.gov.au](https://mhas.wa.gov.au).

The then Minister replied in September 2020, acknowledging the findings that Aboriginal mental health consumers' rights are not being met. The Minister referred the report to the Mental Health Executive Committee chaired by the Mental Health Commissioner to develop an action plan to address the findings of the inquiry and report back in 12 months. The Committee were also directed to provide the Minister with a proposal to resolve funding issues. To achieve this, the Minister supported the establishment of an inter-agency working party of the Mental Health Leads Sub-Committee. The working party would be chaired by the Chief Medical Officer, Mental Health and include representatives from the Department of Health and HSPs and include consumer and carer representatives.

MHAS will follow up progress in the coming financial year with the new Minister for Mental Health.

## Culturally appropriate care

In response to MHAS' inquiry into Aboriginal rights the Chief Executive of the East Metropolitan Health Service advised in July 2020 they were undertaking a review of the Wungen Kartup Specialist Aboriginal Mental Health Service. The model of care and model of service was being reviewed to strengthen access and minimise delays in providing services to the Aboriginal community. The next phase of review would include broader consultation and they welcomed the input of Aboriginal Mental Health Advocates and would contact MHAS for input.

There was a meeting in November 2020 and MHAS was advised the outcome of the review and given a presentation about the models of care. Advice from this meeting indicated that East, North and South Health Service Providers are expected to employ their own Aboriginal mental health workers to comply with

the requirements of the Act for Aboriginal consumers.

## Aboriginal Mental Health Liaison positions

Following a meeting with the Executive Director of Mental Health in February 2021, the Chief Advocate wrote to the Director of Aboriginal Health at North Metropolitan Health Service outlining the rights and providing a copy of our report *Inquiry into Services for Aboriginal and Torres Strait Islander People and Compliance with the Mental Health Act 2014*<sup>18</sup>. Following this, MHAS was invited to attend a working party to begin the process of creating two Aboriginal Mental Health Liaison Officer positions to cover Sir Charles Gardiner and Graylands hospitals. These positions were established in May 2021.

## Rights of Aboriginal forensic consumers

In the past year the Aboriginal consumers at the Frankland Centre who have sought assistance from an Advocate have not generally received culturally appropriate input into their assessments/examinations or treatment. Consumers frequently have limited contact with family and/or Elders or are unable to provide contact information to staff. In the past, staff from Wungen Kartup Specialist Aboriginal Mental Health Service were often able to identify contact information of family.

<sup>18</sup> The report was released in July 2020 and is available from MHAS's website: [mhas.wa.gov.au](http://mhas.wa.gov.au).

However, with this loss of service Aboriginal consumers are frequently going without any culturally appropriate input into their care and treatment. In some instances, facility staff are not aware that a consumer is Aboriginal, which may be compounded by problems with record keeping processes and/or procedures at admission.

In September 2020, lack of ground access and outings for two Aboriginal consumers on Custody Orders was raised with the health service. Previously the consumers were accompanied by Aboriginal staff from Wungen Kartup, but this service ceased. At a meeting with Wungen Kartup in December 2020, MHAS was advised that Wungen Kartup would not provide services off-campus for the Frankland Centre due to safety risks. Outings were therefore dependant on the availability of nurses or occupational therapists from the facility. As a result, one consumer is now not able to visit their family home, with the family visiting the hospital when they can. Neither consumer has yarning time.

This systematically disadvantages all Aboriginal forensic consumers at the Frankland Centre and does not consider statutory and international responsibilities and obligations to non-discrimination. The systems failures to treat all people equally in terms of their cultural needs has wide-ranging impacts on the individual and their ability to recover.

## Aboriginal visitors to hospitals

In February a Senior Advocate and Aboriginal Mental Health Advocate met with the heads of Graylands Hospital and North Metropolitan Health Services and discussed the cultural needs of Aboriginal consumers. The meeting followed discussions between the Aboriginal Advocate and a psychiatrist about the need for an Aboriginal Visitor Service (AVS). An

AVS operated by the Department of Justice provides culturally appropriate support and counselling for Aboriginal people in prisons.

The Aboriginal Mental Health Advocate put forward arguments about how the Aboriginal Community takes care of people when they are not able to function to their full abilities. The lack of contact with Community exacerbates Aboriginal consumers' suffering by adding loneliness, rejection and stigmatisation when people are trying to recover from chronic mental illness. A similar AVS to that offered to prisoners could be considered for the mental health system to help meet the social and spiritual needs of Aboriginal consumers.

The North Metropolitan Health Service executive advised they are aware of the proposal for an AVS but needed to undertake consultation and advised of other work underway through Wungen Kartup and an Aboriginal Elders Council to help meet the needs of Aboriginal consumers.

## Getting it right: working with Community in regional WA

Given the high proportion of regional consumers who are Aboriginal and recognising the strengths that Aboriginal kinship systems and values bring, ensuring that Community is involved in treatment decisions is paramount to improved consumer outcomes. The following provide examples of what good engagement can look like, for individuals and at a service level.

*In one case, the Advocate was supporting a consumer who was in a regional hospital away from Country and family. The consumer wanted to go home and wanted support from their family for their upcoming Mental Health Tribunal hearing. The Advocate took*



*the time to get to know the consumer, so that they could understand the supports that were available to them in their community back home. The Advocate then worked with the case manager in the community mental health service to ensure that the consumer's grandmother could be on the phone to participate in the Tribunal hearing. The grandmother was able to describe the amount of support that would be available to the consumer if they returned home. Based on this, the Tribunal members were convinced that a Community Treatment Order was appropriate, and the consumer was able to return to their community rather than remain in hospital.*

In September 2020, the Advocate in Broome participated in a quality improvement exercise called the 'Patient Journey Initiative', a 'deep dive' into the experiences of people using mental health services in the Kimberley. The Advocate joined a consultation session and MHAS provided a written submission. The initiative focused on ensuring that Aboriginal consumers have access to an Aboriginal mental health worker when requested, encouraging the use of non-clinical language in meetings with consumers and on documentation such as the TSD Plan and the medical report for Mental Health Tribunal hearings. It looked at ways of improving consumer access to non-medical treatments including those that are more culturally appropriate, and increasing staff understanding of the powers and functions of Advocates.

# Forensic consumers' human rights

Despite statutory and international responsibilities and obligations to provide equitable, non-discriminatory treatment to all persons - prisoners and others in the criminal justice system have often been denied this fundamental right. Access to specialist forensic mental health inpatient treatment “remained at crisis point”<sup>19</sup> in 2019-20 and the availability of beds has since reduced.

## Forensic inpatient crisis

Since the establishment of the 30-bed Frankland Centre in 1993, the prison population has increased from 1,800 to 7,100 with no increase in dedicated forensic mental health beds<sup>20</sup>.

Currently the Mentally Impaired Accused Review Board (MIARB) has orders in place to detain 29<sup>21</sup> people at an authorised hospital, compared to 22 people at the same time last year. The MIARB can only detain people to prison, a declared place or an authorised hospital under the *Criminal Law (Mentally Impaired Accused) Act 1996* (CLMIA Act) and generally detains people to the Frankland

Centre when they require treatment for a mental illness. There are currently 34<sup>22</sup> beds available to the Frankland Centre. Some are occupied on a semi-permanent basis<sup>23</sup>, and due to the increasing number of people on Custody Orders detained at Frankland there is minimal and decreasing capacity to accept prisoners and people from the courts referred for inpatient treatment.

The ongoing bed crisis means fewer prisoners referred for psychiatric examination (ie on a Form 1A) and fewer people referred by the courts on a Hospital Order can be examined and receive inpatient treatment when necessary. MHAS can assist people subject to Hospital Orders (and many are subsequently made subject to an involuntary inpatient treatment order) but Advocates have noted a declining number of people subject to Hospital Orders at the Frankland Centre. It is unclear what is happening for these people.

It is also worth noting that in September 2018 the Inspector of Custodial Services reported<sup>24</sup> that one third of prisoners who were referred on a Form 1A for inpatient care to the Frankland Centre never got there, and 61% of all referrals (or 195 Form 1As) lapsed without a hospital placement. As the Inspector put it three years ago, this “demonstrates the scale of the crisis”.

<sup>19</sup> MHAS Annual Report 2019-20.

<sup>20</sup> Forensic consumers are people with mental health issues who are in the criminal justice system.

<sup>21</sup> As advised by the MIARB on 22 July 2021. Note, a further seven people are on Conditional Release Orders however their Place of Custody Order remains an authorised hospital and if their release is cancelled they will be returned to the Frankland Centre.

<sup>22</sup> There were 30 acute, locked beds at the Frankland Centre and four forensic beds at Murchison Ward East of Graylands Hospital.

<sup>23</sup> One bed at Murchison Ward East is occupied by five consumers subject to Custody Orders. The consumers were on a leave of absence for 13 out of 14 nights from the hospital and it is only by staggering bed occupancy that this is managed. The remaining three beds are occupied full-time by consumers on Custody Orders.

<sup>24</sup> Inspector of Custodial Services, *Prisoner Access to Secure Mental Health Treatment*, September 2018.

In August 2020 the then Minister for Mental Health advised that when demand for beds at Frankland exceeds capacity, patients with the lowest clinical complexity and acuity are returned to prison and referred to the relevant prison mental health team for continued care. The Minister acknowledged the need to significantly increase forensic services and referred to budget submissions including from the Department of Justice for reforms to the CLMIA Act. Plans are linked to the decommissioning of Graylands Hospital, which was put on hold due to COVID-19, and subject to a business case, master plan and building new facilities. Therefore, in the meantime the Mental Health Commission, and Departments of Justice and Health were actioning short- and medium-term options and MHAS notes the pre-election commitment to funds for youth forensic outreach service for young people who are at risk of, have been or are currently in contact with the criminal justice system.

The office of the Minister for Corrective Services responded advising that as the matter is outside his portfolio the matter has been referred to the Attorney General and Minister for Health. The Chief Advocate wrote back seeking advice about the plan for people with a serious mental illness on Custody Orders once the Frankland Centre is full as the Minister is responsible for people in prison. The Chief Advocate also advised that six prisoners had recently been returned to prison and the psychiatrist refused to revoke the involuntary order because they still required inpatient treatment and were only being returned to prison due to a lack of beds. As involuntary patients they are still entitled to assistance from a MHAS Advocate.

The letter to the Attorney General was followed up by another letter outlining the specific case where emergency medical treatment was delayed while a leave of absence order was considered. The Attorney General's office replied with the dates that each of the parties to a decision, the MIARB, the Attorney General and the Governor at Executive Council, expeditiously handled the

matter and noted that the case “demonstrates that the statutory obligations to obtain such an order from the Governor [...] is inappropriate”. They note that the issue will be addressed as part of the Government's reforms of the CLMIA Act.

It is widely understood that Frankland Centre is inadequate to meet the needs of a population and the problems with prisoner access to mental health care have been raised, including at the most senior levels for years. The government established the *Graylands Reconfiguration and Forensic Taskforce* in January 2021 to undertake planning and investment decisions regarding the Graylands Campus, including forensic services. The then Chief Advocate, Debora Colvin was appointed to the Taskforce and has remained part of that group following her retirement from MHAS. The anticipated recommendations of the Taskforce, and subsequent decisions and actions to redress the mental health needs of forensic consumers are long overdue.

Appendix Two contains a table showing the location of Mentally Impaired Accused Persons over the past four years.

## Transitioning out of bed-based forensic services

A major issue for forensic consumers is access to supported accommodation and/or step-down supports following inpatient admission. For those people on a Custody Order with mental health as their prime disability, there is no facility for them except a hospital ward at the Frankland Centre (or the forensic open beds in the Murchison Ward of Graylands Hospital) or prison before release into the community.

The only facility which comes close is the Bennet Brook Disability Justice Centre<sup>25</sup> (DJC)

<sup>25</sup> The DJC is run by the Department of Communities. MHAS is also required to provide advocacy services to DJC residents pursuant to the *Declared Place (Mentally Impaired Accused) Act 2015*.

which only takes people on Custody Orders who have intellectual impairment as their prime disability<sup>26</sup>. The DJC provides a ten-bed residential style facility, however, there is no equivalent for people whose primary diagnosis is a mental illness.

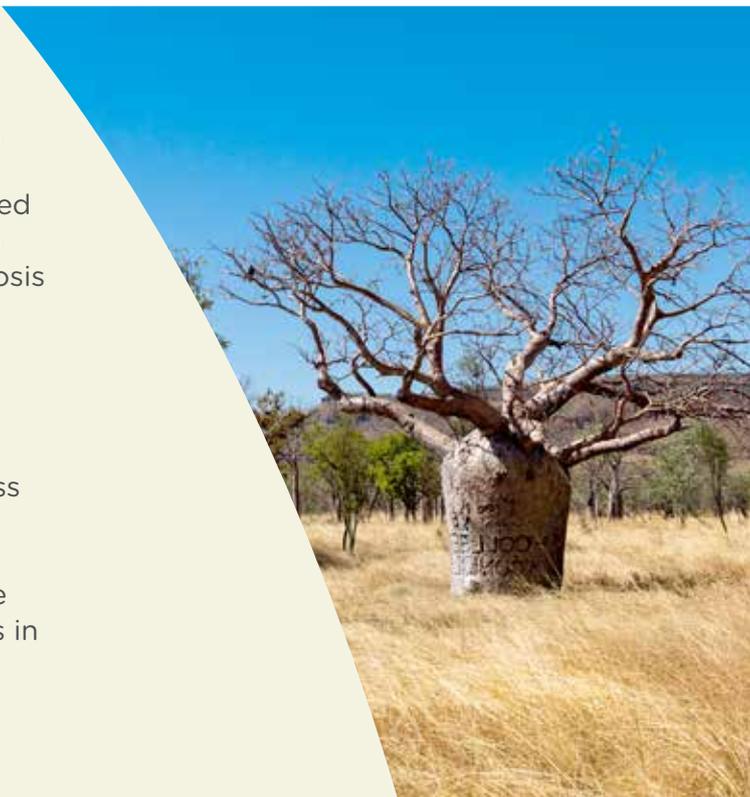
If a step-down facility for people whose disability is primarily due to mental illness has similar overheads as the DJC then it is expected that this could cost up to \$550 less per day than a specialised forensic mental health hospital bed. On a purely financial argument this could save money, but for the individuals involved potential improvements in the quality of their life could be enormous.

## Criminal Law (Mentally Impaired Accused) Act reforms

The government's 2017 pre-election commitment to reforms to the CLMIA Act were delayed in 2020 due to COVID-19. MHAS has since received funding for April to June 2021 as part of the project implementation phase of the reforms (see *2020-21 Budget and Expenditure*). Work commenced on critical pre-implementation activities; MHAS awaits information about the next phase and funding of the government's proposed reforms.

In the meantime, the number of people on Custody Orders whose Place of Custody is in the Frankland Centre continues to increase with no apparent plan for prisoners or people on Hospital Orders when the Frankland Centre reaches capacity with people on Custody Orders.

<sup>26</sup> Acceptance to the DJC is based on 'disability' as defined in the *Disability Services Act 1993*, which is not the definition used under the CLMIA Act for Custody Orders.





# Safety on wards

MHAS has raised safety issues about wards in its annual reports every year and the same issues continue to arise. Advocates deal with not just physical and sexual safety issues but hear about the emotional and psychological impacts of a lack of trauma informed care and witness the impact of unsuitable environments on people's wellbeing and recovery. Issues often involve a breakdown of communication between staff and the consumer, perhaps because staff are under pressure and/or consider what the consumer is saying is due to their mental illness and not true. Complaint resolution is often significantly delayed, and the consumer too often not adequately involved in or updated about the process. There is significant room for improvement in the respect and dignity afforded consumers at an individual and a system level.

## Use of security guards

Advocates are reporting an overreliance on security guards to try to maintain safety on mental health wards, security guards being used to 'special'<sup>27</sup> consumers – often with unchecked force - and a lack of consistency in training for security guards. The example below illustrates the impact on consumer wellbeing when security is provided with insufficient oversight and/or training.

*A consumer's complaint was raised with the hospital about the way a security guard restrained the consumer. The Advocate sought an investigation of the incident and for CCTV to be preserved. This led to broader questions being raised by the Advocate about a series of seclusions and restraints by security guards that appeared not to have been authorised<sup>28</sup> or documented. During their initial inquiries, the Advocate asked nursing staff if there had been a restraint and was told there had been no restraint despite the Advocate subsequently finding the incident in the consumer's notes stating the consumer 'was immediately restrained in [their] bedroom'.*

*In one instance, the consumer was spending time alone in a room to settle down but was told they could leave by nursing staff, and the door was left open. It was reported to the Advocate that during the shift handover attended by nurses the security guard locked the consumer in the room as they tried to leave. Nursing staff did not know how long the consumer had been secluded and had not authorised the seclusion. The hospital's investigation found conflicting information about whether the door had been locked however the definition in the Act only requires that it is 'not within the person's control to leave'.*

*In three other separate incidents security guards restrained the consumer. In one of these instances the guard touched the consumer which escalated the situation, resulting in the guard restraining the consumer and subsequently a 2:1 'special'*

<sup>27</sup> 'Specialling' is used in nursing and is broadly considered to be close, one-on-one nursing care. It generally involves keeping the consumer in sight at all times to manage risk and can involve differing ratios of staff to patient(s).

<sup>28</sup> The penalty for restraining and/or secluding a person without oral authorisation is \$6,000.

*with a nurse and security guard shadowing a consumer. In another incident the alleged use of a head-lock<sup>29</sup> by a security guard was not addressed in the response by the facility.*

When inquiring into this series of incidents, MHAS was advised that there was no documented plan of the expectations of security staff in 'specialling' the consumer and no consistency in training. The Health Service Provider was unable to confirm whether training had been provided, nor whether there was a consistent approach to training. The inquiry revealed the HSP relied on security guards having experience because they had worked in other hospitals.

The incidents raise the question whether the actions of security guards unnecessarily escalated the situation resulting in the (unauthorised) seclusion, subsequent (unauthorised) restraints and combined nurse/security 'special' and whether a staff trained in de-escalation techniques could have better managed the situation and avoided a restraint.

Five months later, and long after the consumer was discharged from hospital, MHAS was given the four recommendations that resulted from the investigation. The recommendations included support, education and monitoring security 'specials' (namely for clinical staff to develop an orientation checklist and information sheet for security guards on the use of 'specials'), and a presentation on the 'lessons learnt'.

*In a complaint about the conduct of security guards that was escalated to the facility, the consumer alleged the guard intrusively monitored them, and told them 'you are under the Mental Health Act - we can do what we like'. The consumer also stated that the guard's actions while medication was being administered provoked them, resulted in them being restrained and likely caused them to be made involuntary. They further asserted that the male guard involved in restraining them*

*had pulled down their trousers and underwear so an injection could be administered. Two months later MHAS (and the consumer) were advised that the guards could not recall making the statement, watching the consumer get undressed, laughing or provoking the consumer. The facility advised that security staff are regulated by the Security and Related Activities Control Act 1996, 'are subject to police scrutiny' and the facility requires a current Working with Children Check.*

The responses to the complaints demonstrate the differing site requirements of security guards and training provided. It raises questions about training provided in working with people when they are experiencing mental illness, the requirements of the Act and ward procedures.

The Chief Psychiatrist's *Standard 6: Seclusion and Bodily Restraint Reduction* requires training programs with 'all relevant staff' that focuses on de-escalation and incorporates trauma informed care principles with ongoing ward training. MHAS remains highly concerned about the use of security guards with mental health consumers and seeks urgent whole-of-health initiatives to assess compliance with the Chief Psychiatrist's standard to ensure the illegal restraint and seclusion of mental health consumers is avoided.

<sup>29</sup> The Chief Psychiatrist's *Standard 6: Seclusion and Bodily Restraint Reduction* states 'neck holds' should not be used.

# Undue force in restraints during medical admissions

Youth Advocates have been increasingly involved in assisting children or young people who have been injured during the process of restraint on medical wards while being treated involuntarily under a Form 6B. MHAS has submitted multiple complaints about the use of excessive force by nursing and security staff during bodily and mechanical restraints. Injuries have included excessive bruising and one who experienced a partial dislocation of their shoulder during a forced feeding regime. In all cases the consumers reported to staff that they were in pain and being hurt during the restraint process.

*A young person was admitted to a medical ward after they initially presented with an asthma attack. Further investigation revealed physical health concerns related to disordered eating. The young person had no previous history of mental illness or involvement with mental health services, was studying for a degree and had a highly supportive network of family and friends. The young person was admitted for over five weeks and continually expressed a desire to be treated in the community, as a voluntary patient. Until late in their admission, there were no problems with administering treatment.*

*However, the young person became so distressed by their prolonged admission they attempted to leave the ward but voluntarily returned after becoming faint. On return to their room, the young person was stripped of all their belongings, and their phone and laptop were also removed. They attempted self-harm to alleviate their distress. A code black was called, and they were physically*

*restrained by three security officers, injected several times, and placed in four-point mechanical restraints. The young person reported that they were in significant pain. A review by a psychiatrist recommended that their right arm be released however, this did not occur until sometime later. The young person was kept in the three-point restraint for four hours, and then discharged later that day.*

*A Youth Advocate provided support and commenced an inquiry into the use of mechanical restraints in collaboration with the consumer. The young person reported that undue force by security staff, excessive use of mechanical restraints and the unnecessary prolonged admission caused significant ongoing trauma and a deterioration in their mental state.*

## A trauma informed approach

A trauma informed approach to mental health care and treatment encourages safety and respect and can lead to better outcomes. Many people on mental health wards have experienced chronic or complex unresolved trauma during their life, which, if not tended to with sensitivity, can be amplified in acute settings, potentially further traumatising the person and slowing down their recovery.

Advocates often liaise on behalf of consumers who feel physically and/or sexually unsafe or who require trauma informed care. These conversations can result in things like a room change so they are closer to the nursing station, a change of ward to avoid a certain person or the provision of gender specific staff members. It is unfortunate that it takes the involvement of an Advocate to listen to the consumer and build trust so that they

disclose their concerns and/or so that staff do something to alleviate their concerns. The compounding effects of trauma due to lack of appropriate care is best illustrated by the following examples.

### **Traumatic past admissions**

*An adult consumer was being assisted by an Advocate during an involuntary admission and wanted the Advocate's assistance to relay their experience from a past admission to hospital management. The consumer was a child when admitted for the first time with psychosis. While in a common area the consumer was approached by a male and there was non-consensual sexual contact. The consumer felt unable to protect themselves due to their mental state. Staff intervened and encouraged the consumer to avoid the male patient but there was no further assistance provided. The consumer was further traumatised by the lack of privacy as showers did not have curtains or doors for example.*

*This experience was 'at the forefront of the consumer's mind' during their latest admission, they did not feel safe and it was making accessing and accepting treatment difficult.*

*The HSP responded apologising and acknowledging the suffering and enduring distress because of the admission and suggested the consumer seek to get a copy of their medical records. They advised that the [facility name] now has single rooms with lockable doors on all bathrooms.*

### **A traumatic presentation**

*A young consumer with a history of complex trauma attended an ED with their support worker following an overdose. They were attended to by a doctor known to the consumer and who spent time building rapport. The consumer felt able to "open up" to this doctor.*

*The consumer was later attended by another doctor who did not introduce themselves and insisted on speaking to the consumer alone in another room, despite the consumer asking for their support worker to accompany them. The consumer felt the doctor was not listening to their explanations of their mental state and found the doctor to be dismissive and disrespectful. The consumer maintained that they repeatedly told the doctor that the interview was causing them stress and asked for their support worker to come in but each time the request was refused. At the end of the interview, the support worker reported that the consumer emerged distressed and crying.*

*The situation escalated, and support worker was escorted out by security guards, but managed to get the original doctor to intervene, attend to the consumer, and ultimately de-escalate the situation. The original attending doctor confirmed the consumer was not subject to orders and was free to leave the ED.*

*The consumer told an Advocate the experience was traumatising and felt they could no longer seek help at that ED. The Advocate assisted the consumer to make a formal complaint and request an independent investigation. The matter has been referred to the Australian Health Practitioner Regulation Agency who advised the matter will take between six to twelve months to investigate and MHAS will be advised of the outcome.*



# Licensed psychiatric hostels and their residents

Licensed private psychiatric hostels (hostels) offer accommodation and support to people in a congregate living arrangement. Most people who live in hostels have very high levels of need, often from multiple sectors, limited engagement with formal and informal supports and lack visibility. Psychosocial disability is often compounded by learning disabilities, poor physical health, chronic social isolation and for some, histories of homelessness and institutionalisation (eg out of home care, prison, long hospital stays etc).

Hostel residents are a marginalised group whose voices are easy to ignore and who have a high risk of neglect, abuse and exploitation.

## Insufficient advocacy services for hostel residents

At the end of June 2021, there were 31 licensed hostels with 703 beds<sup>30</sup>. One is youth-specific, providing 16 beds to young people. Four hostels are located outside the Perth metropolitan area in Albany, Geraldton, Bunbury and Busselton.

The amount of funding hostels receive from the Mental Health Commission varies, with significant impact on the quality of

accommodation and amount of support provided; many residents still only have access to shared bedrooms and bathrooms and live alongside many other people. The largest hostel houses 92 people, and the average size is 22 beds.

In 2020-21 MHAS received 378 requests for assistance, and Advocates provided services to 76 residents. Whilst the number of residents assisted remains comparable with last year (79 residents), the number of requests for assistance has risen considerably, up from 285 in 2019-20. MHAS stratifies the hostels into three tiers, based on historical data relating to the number of issues raised and residents assisted. As might be expected, the requests and residents assisted were not spread evenly across the three tiers of hostel. More than half of requests and residents came from the Tier One hostels (those with the highest level of historical issues).

The residents MHAS assisted ranged from 19 to 82 years old with a wide spread of ages. It is sometimes assumed that hostel residents are largely elderly, but a significant number of residents that MHAS Advocates assisted were between 25 and 55 years.

As noted in last year's report, the number of residents assisted by Advocates fell markedly in 2017-18 when MHAS had to implement cost-cutting measures to try to remain within budget. One such measure was the move from a regular hostel visiting program to visiting only in response to requests and complaints. Given how marginalised the hostel resident

<sup>30</sup> Report provided by the Department of Health, Licensing and Accreditation Regulatory Unit, June 2021.

population is – and thus how difficult it can be for them to get their voices heard – we remain extremely concerned that we are only seeing the tip of the iceberg of issues in hostels, particularly those classified as Tier One.

## Protecting rights and safeguarding residents

Of the various oversight agencies involved in the delivery of hostel services, MHAS is the only one which has Advocates on the ground and in the hostels on a regular basis. Advocates are aware of the ways in which residents' rights are infringed daily often in seemingly small ways but nevertheless with an impact on their quality of life that accumulates over time. At times, the infringements are major and represent significant risks to residents' health, safety and wellbeing.

*In January 2021 a hostel resident told their Advocate that the rent had increased while the quality of the food had gone down. Beans on toast was the evening meal that day. The resident wanted to take a petition to the other residents, but said they thought most other residents would be too timid to sign. The Advocate immediately spoke to the cook, who agreed that baked beans was not sufficient and said she would try to add a salad, if she had the ingredients on hand. The resident also told the Advocate that there was no consultation with staff or residents about the menu, and the kitchen staff were given the menu by management and only provided with ingredients for the approved menus.*

*The Advocate spoke to the supervisor who said that there had been no complaints about the previous menu but agreed there had been*

*no consultation around the changes. When pressed, the supervisor told the Advocate that the changes had been made to save money. The Advocate then encouraged him to discuss the menus at the next residents' meeting, which they agreed to do.*

*The resident organised a petition, and the meeting occurred within days. As a result, the menu has been changed, making a huge difference in the daily lives of all residents at the hostel.*

In most cases, matters brought to MHAS' attention were able to be resolved with hostel management. In some cases where issues indicated a breach of relevant standards MHAS also raised concerns with the relevant oversight agencies<sup>31</sup>.

In January 2021 the Chief Advocate wrote to the other oversight agencies with concerns about a hostel that had been brought to MHAS' attention by various parties and called for an urgent meeting to discuss what should be done. Some of the more concerning allegations included:

- errors with medication and medication processes
- a lack of dignity shown to residents and verbal abuse
- poor quality and insufficient quantities of food
- discrepancies between the accommodation and services that residents paid for and what the hostel provided
- safety issues
- insufficient care taken of people's physical health, and inadequate support for disability needs
- poor quality and 'cut and paste' care plans
- issues with people's NDIS packages.

The outcome of this meeting was a confidential investigation into the allegations undertaken by the Chief Psychiatrist and the Licensing and

<sup>31</sup> Agencies with oversight of hostels are: the Department of Health's Licensing and Accreditation Regulatory Unit; the Chief Psychiatrist; the Mental Health Commission and MHAS.

Accreditation Regulatory Unit, with a range of remedial recommendations currently being implemented.

What is most concerning about the allegations is that they align to MHAS complaints data on issues raised by Advocates who have visited other hostels. The most common were: accommodation and the desire to move out; financial issues (especially for people on administration orders); lack of dignity and respect from staff; unaddressed concerns about physical health; dissatisfaction with food and beverages; unable to access or choose their own clothing; and conflicts within the hostel.

The prevalence of these issues across the Tier One hostels suggest a systemic problem with poor standards of care and breaches of people's basic rights.

Some of the issues in hostels involved the Advocate liaising with an external agency or collaborating with one of the other hostel oversight agencies to ensure resident safety and wellbeing.

*In October 2020, a hostel resident received medication from a staff member that was prescribed for another resident. The staff member called an ambulance and the resident was admitted to hospital where they remained in the Intensive Care Unit for five days. Follow up regarding this incident was undertaken by the Chief Psychiatrist, Licensing and Accreditation Regulatory Unit and the Mental Health Commission to identify the cause of the error and to ensure steps were taken to prevent a recurrence.*

*MHAS was contacted when eviction proceedings were initiated by hostel management. Eviction was delayed as the resident was still impacted by the medication error and was readmitted to hospital. The Advocate gathered clinical information which demonstrated that the behaviours for which the resident was being evicted had been*

*exacerbated by the medication error. The Advocate, at the direction of the resident, bought together the relevant hostel staff and the resident's inpatient clinical team. A greater understanding of the needs and wishes of the resident emerged which resulted in the resident choosing to move to an older adult facility where additional support was provided.*

## Completing the closure of St Jude's Hostel

The closure of 16 beds at St Jude's Hostel between May and August 2020 was poorly communicated to residents, who expressed fear, anger and a sense of being kept in the dark about what was going on.

Advocates made multiple attempts to inform facility management about the negative impact the perceived lack of transparency was having on residents. Unfortunately, the Advocates were not able to get the facility management to work in a more consultative way. Notwithstanding, the Advocates played an important part in making sure the residents were supported and their voices heard throughout the closure process. Given the regular presence of Advocates at that facility and the established relationship with the residents who were being reallocated due to the closure, the Advocates were able to inform the operational team about the wishes of the residents about where they wanted to live, what was important for them and more importantly where they did not want to go.

*Following the closure of St Jude's Hostel, the Advocate realised that a resident who had chosen to stay on was consistently isolating in their room and only seemed to be emerging for meals. Previously the*

*Advocate would have found them in the TV room in the company of other residents. They had noticeably lost weight and were neglecting their self-care. The Advocate asked what was worrying them, and they said they were not leaving the room for fear of people stealing or throwing away their things. They said they had been in their room when other residents have opened their door to peer inside. They were unable to lock their room and had lost many of their treasured belongings in the past when they were moved from one hostel to another. They refused to complain for fear of losing their accommodation.*

*The Advocate wrote to the facility manager requesting that a lock be installed on the resident's door, to give them peace of mind and allow them to reconnect with others at the hostel. The Hostel installed a lock on the resident's door. The resident expressed their gratitude for MHAS support to get this to happen, and said they now felt they could leave their room when they wanted to without fear that other residents would enter the room, and that their things were safe. As well, they said they felt safer when they were in the room.*

Unit and Chief Psychiatrist were not isolated and were encountered by Advocates in other hostels.

The need to transition to contemporary models which would afford residents better enjoyment of their human rights is not new and has been raised over the years by MHAS. The previous Mental Health Commissioner had told MHAS that the intention was to support residents to access the NDIS and then to review this as a pathway to contemporary independent living. Despite this being a consideration for the Psychiatric Hostel Advisory Committee<sup>32</sup> for the past three years, this appears not to have reached priority status on the Mental Health Commission system development agenda.

## The future of psychiatric hostels

In February 2021, the Chief Advocate wrote to the Mental Health Commissioner suggesting that it was time to consider a transition away from the current private congregate care arrangements to more contemporary models of accommodation and support that promote greater choice and control for residents. She noted that the issues raised through the confidential investigation undertaken by the Licensing and Accreditation Regulatory

<sup>32</sup> The Psychiatric Hostel Advisory Committee includes representatives from the Licensing and Accreditation Regulatory Unit, Chief Psychiatrist, Mental Health Commission, a Health Service Provider and MHAS.



# Mental Health Tribunal hearings

Mental Health Tribunal hearings concern the fundamental rights of consumers subject to an involuntary order under the Act<sup>33</sup>. Involuntary orders provide the authority for one psychiatrist to:

- compel a person to take medication - which can be forcibly given to them
- detain them against their will
- or compel attendance and treatment in the community (on a Community Treatment Order) and have them picked up by police and detained in hospital if they refuse.

These are fundamental changes to a person's freedom and rights, so strong protections are needed.

The Mental Health Tribunal has the responsibility of ensuring this authority is properly exercised with natural justice so that parties including the consumer have the right to be made aware of and respond to information used by the Tribunal to make a decision about them. Consumers have no choice of psychiatrist<sup>34</sup> and commonly disagree with their detention, diagnosis, and/or medication (including having problems with the side-effects of medication). The importance of hearings for individuals, and the mental health system cannot be understated particularly in WA where only one psychiatrist's decision is needed to make a person involuntary.

## Conducting hearings by video or audio

The impact of the Mental Health Tribunal's move to greater ongoing use of video-conferencing for hearings has had an enormous impact on natural justice for consumers.

The Tribunal has long conducted most hearings in person except for hearings in regional areas which were conducted by video-conference but began conducting all hearings by video-conference from 1 April 2020 because of the COVID-19 pandemic. Face-to-face hearings have not yet fully resumed.

Advocates advise of many problems commonly experienced with relying on technology that make it difficult for consumers to understand proceedings and fully participate in their own review. The situation is compounded for consumers who are not familiar with Tribunal procedures and who are experiencing the effects of acute/chronic illness and the side effects of medications. Problems reported include:

- general technology problems such as not having the correct software or missing pieces of hardware

<sup>33</sup> The Mental Health Tribunal must also review long term voluntary admissions in authorised hospitals on application.

<sup>34</sup> Consumers can request another psychiatrist provide an opinion about their treatment (and if they are subject to a community treatment order, they can request another opinion about the continuation of the order).

- difficulty making and maintaining the internet connection. Hearings are interrupted which can make it difficult to follow the proceedings
- the screen freezes but disembodied voices continue to be audible which is distracting and unsettling
- no access to video-conferencing facilities resulting in consumers, their family, members of the treating team and/or Advocate huddling around a laptop or even a mobile phone (including the Advocate's personal mobile phone)
- a very narrow camera view which does not show who is in the room and people are often not on camera - for example the Tribunal members will be able to see the consumer and family but not the treating team, and vice versa
- problems with volume. It is not uncommon for consumers to be forced to use laptops which have limited speaker quality and everyone having difficulty hearing the parties
- distorted sound. For example, sometimes, the audio is so bad consumers cannot hear the questions properly, or when they give evidence they have to repeat themselves because they aren't heard properly
- the distance between the camera and the consumer is important and where the consumer is muted it is very difficult for Tribunal members to discern consumers' small nods and shakes of the head, which results in unnecessary repetition of questions and can create unnecessary frustration.

These problems can have a far greater impact for people who are already unwell, taking medication (often with unpleasant side effects) and residing on a ward with other patients.

Advocates always aim to be physically present with the consumer during a hearing so they can be accessible and better support the consumer. Advocates can recommend the consumer seeks an adjournment due to the poor quality of the hearing (usually the sound but also multiple internet 'drop-outs'),

arguing lack of natural justice, but this leaves consumers subject to involuntary orders for a further week or two while a new hearing is scheduled, and hoping for better technology on the day.

Whilst we acknowledge that the problem of poor audio and video-conferencing does not rest with the Tribunal alone and the connection and quality of equipment made available by Health Service Providers is a major factor, the situation for consumers remains unsatisfactory.

## Other long-standing problems impeding natural justice

The Mental Health Tribunal makes available a template for medical reports for doctors to use. The template includes a statement that the report be provided to the consumer at least 72 hours before the hearing. Advocates and the Chief Advocate have been raising and reinforcing the importance of the consumer having access to the report, and ideally a member of the treating team discussing the contents of the report with the consumer for many years. Yet consumers are too frequently blind-sided by information just prior to, or in hearings that can be upsetting. This is procedurally unfair and a denial of their right to natural justice.

Medical reports also often contain inaccurate information, historical information that is no longer relevant or is not recovery focused. If the report is discussed with the consumer prior to the hearing, these concerning communication problems can be resolved, ultimately improving the therapeutic relationship.

*During the year an Advocate assisted a young person to raise inaccuracies in the medical report, which had been raised in a previous Mental Health Tribunal hearing, but not corrected. The errors included statements that the consumer refused to take any medication and was deemed to be non-compliant, however the consumer could demonstrate they initially accepted an antipsychotic medication but had ceased due to side effects and continued to take other prescribed medication. The report also stated the consumer was not included in their own recovery planning (as required by the Act) due to a lack of insight, but the consumer had previously discussed their views with their Advocate, occupational therapist and case manager. The Advocate raised the errors at the hearing and sent an email listing the errors. The registrar who subsequently attended the hearing issued an apology to the consumer and their family and changed the report.*

## Advocate representation in hearings

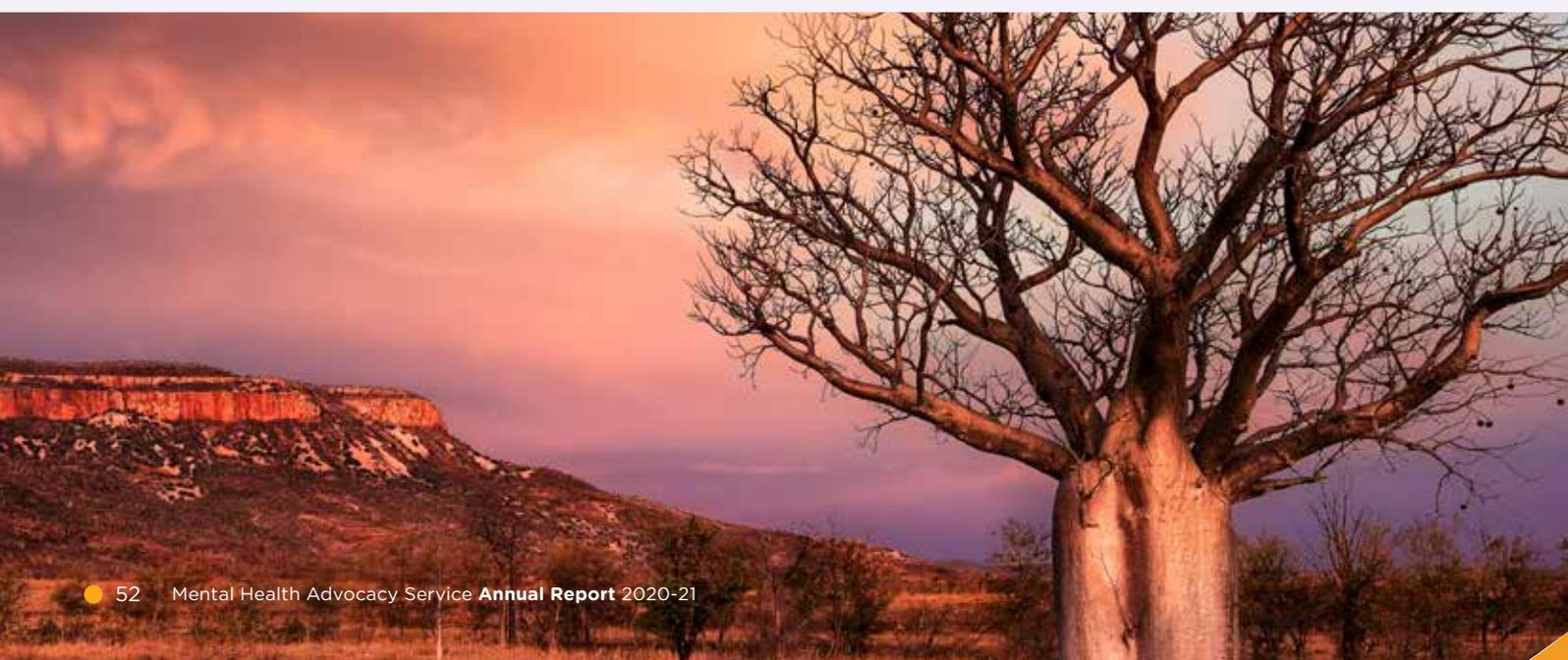
In 2019-20 there were 2,627 hearings conducted and Advocates represented people in 40% of them (an increase from 36% of conducted hearings the previous year)<sup>35</sup>. The fact that such a high proportion of people use

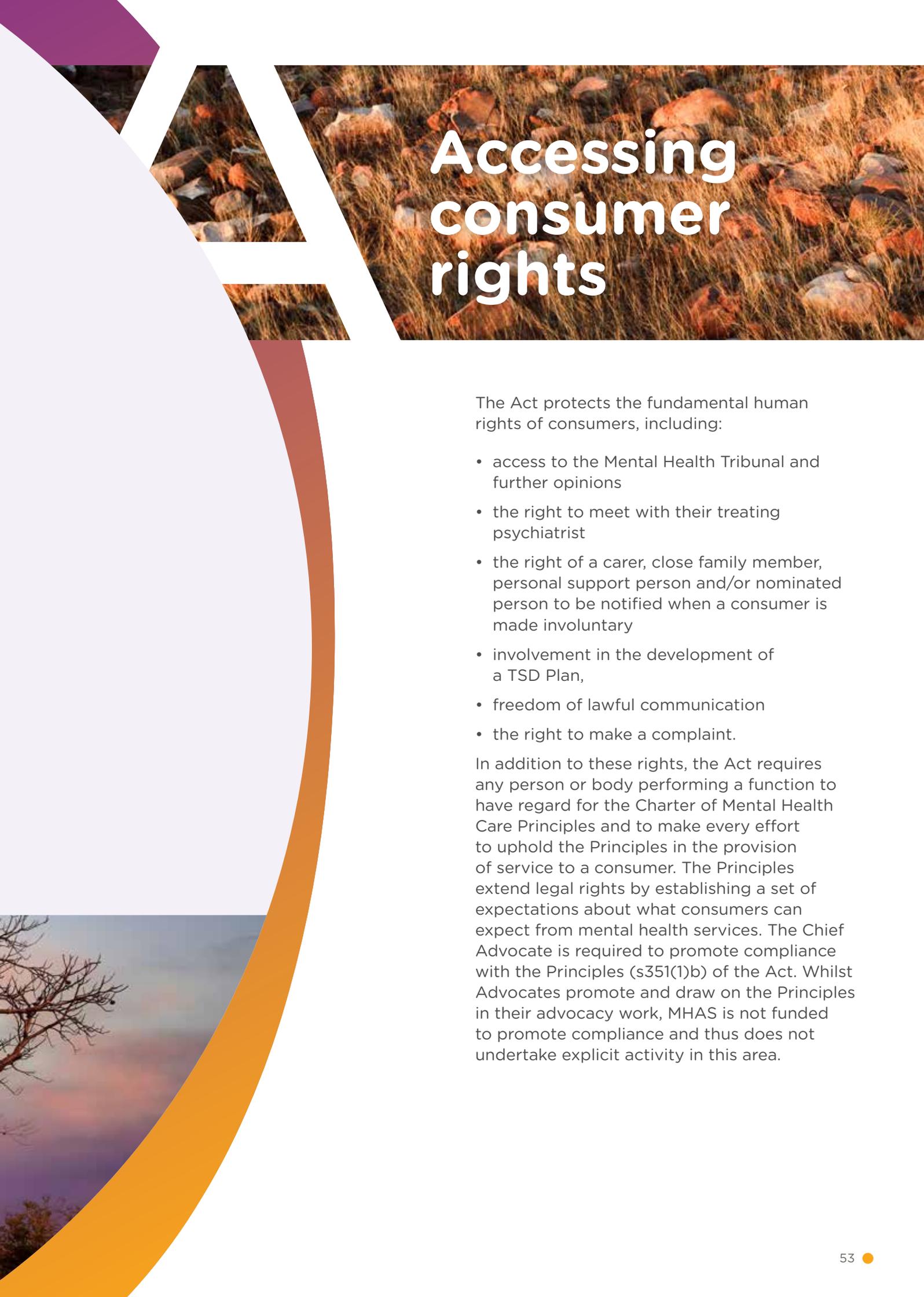
Advocates is indicative of the un navigable nature of the system. A small proportion of consumers are represented by Mental Health Law Centre lawyers (8% in 2019-20). In these cases Advocates do not generally attend the hearing along with a lawyer. Considering these figures together, it seems that a growing proportion of consumers require some form of advocacy support in this environment.

Despite the prevalence of consumers' requests for Advocate involvement in hearings, in late 2020, the Mental Health Tribunal advised MHAS that it would no longer forward a schedule of upcoming hearings. The schedule was previously circulated to Advocates twice a week to enable them to follow up with consumers to ensure they understood their rights and had access to assistance or representation. The Tribunal instead now copies MHAS into the emails sent to the treating teams notifying them of scheduled reviews. With 4,253 listed hearings in 2019-20 and with many cancelled, adjourned or rescheduled further communications are exponentially triggered. This has resulted in MHAS staff having an untenable workload in managing multiple emails for every hearing.

Whilst these issues are frustrating, MHAS notes that the Mental Health Tribunal has made some accommodations to lessen the impact on Advocates. We also note that, similar to MHAS' own situation, the Mental Health Tribunal is working with computer system that is not fit for purpose.

<sup>35</sup> Mental Health Tribunal Annual Reports for 2018-19 and 2019-20. At the time of going to press, this was the most recent data available.





# Accessing consumer rights

The Act protects the fundamental human rights of consumers, including:

- access to the Mental Health Tribunal and further opinions
- the right to meet with their treating psychiatrist
- the right of a carer, close family member, personal support person and/or nominated person to be notified when a consumer is made involuntary
- involvement in the development of a TSD Plan,
- freedom of lawful communication
- the right to make a complaint.

In addition to these rights, the Act requires any person or body performing a function to have regard for the Charter of Mental Health Care Principles and to make every effort to uphold the Principles in the provision of service to a consumer. The Principles extend legal rights by establishing a set of expectations about what consumers can expect from mental health services. The Chief Advocate is required to promote compliance with the Principles (s351(1)b) of the Act. Whilst Advocates promote and draw on the Principles in their advocacy work, MHAS is not funded to promote compliance and thus does not undertake explicit activity in this area.

# Involvement in treatment, support and discharge planning

The recognition and facilitation of the involvement of people with mental illness, their nominated persons, families and unpaid carers in considering the options for their treatment and care is one of the Objects of the Act. Prioritising the voices of those affected is central to person-centred care and recovery-focused practice and compliance with human rights obligations, as it gives people control and choice, regardless of their involuntary status.

The Act makes very clear as does the Charter of Mental Health Care Principles that all treatment, care and support must be governed by a TSD Plan (see ss186 to 188 of the Act). The consumer must have input to the TSD Plan and must be given a copy of the TSD Plan. Along with the consumer, relevant personal support persons must also be involved in, and given a copy of, the TSD Plan.

As reported in previous years, achieving compliance with the Act for TSD Planning has a long way to go. After several years of advocacy and education by MHAS aimed at mental health services and psychiatrists, only minimal uptake has been achieved. One of the major barriers to a more consistent approach and improved practice is the lack of a dedicated TSD Plan document on PSOLIS<sup>36</sup>. Psychiatrists and clinicians adapt the Client Management Plan to try to capture the more person-centric focused intentions of a TSD Plan. However, the Client Management Plan is a clinical document, and does not reflect the wider scope of a consumer-led TSD Plan.

Thus, in July 2020 the Chief Advocate wrote to all Health Service Providers, the Director General of the Department of Health and the Mental Health Commissioner asking that a comprehensive, system-wide approach to training on TSD Plans be implemented to coincide with the upload of new TSD Plan documents onto PSOLIS, scheduled for November 2020. The letter proposed a system-wide approach to training through a 'roadshow' delivered to all Health Service Providers, thus avoiding the duplication of effort of each site developing their own training.

The Mental Health Commission responded positively in August 2020, suggesting that the item would be included on the agenda for the newly formed Mental Health Executive Committee or one of its sub-committees in September. The Mental Health Unit of the Department of Health also responded to explain that they had been funded to deliver e-learning modules for the new forms to coincide with their upload to PSOLIS. The training would be focused on how to use PSOLIS and would not cover the intent of the TSD Plan nor how to involve consumers and their personal support person in development of the plan.

The Chief Advocate followed up the inclusion of TSD Plans on the Mental Health Executive Committee agenda with the Mental Health Commissioner in November 2020. The latter advised that it would be best addressed via the Mental Health Leads sub-committee, and this could be facilitated via the Mental Health Commission's Chief Medical Officer – Mental Health. However, because of the COVID-19 pandemic, this is yet to be followed up.

In addition, unforeseen events within the Department of Health PSOLIS team have meant that the forms have not been developed and the treating team continues to try to utilise the Client Management Plan to capture the practice and output of a co-developed TSD Plan. MHAS advocacy has continued at facility-level, making TSD Plans an item on facility meeting agendas to push for local action.

<sup>36</sup> PSOLIS (Psychiatric Services Online Information System) is the mental health patient management and clinical information system used by Health Service Providers. In the absence of a dedicated form for TSD Plans, the system uses a modified version of a template for the Client Management Plan, renamed as a TSD Plan.

In response some facilities, for instance Fremantle Hospital, have consistently kept working on improving the quality of their TSD Plans through ongoing education sessions for staff and monitoring of the forms by the coordinator. Armadale Hospital undertook a robust clinical review of care which focussed on developing TSD Plan guidelines and discharge template. They also have plans to audit the TSD Plans in the next financial year.

While these two facilities have gained ground, MHAS remains concerned that there is not a sufficiently supported system-wide approach to practice development in this area. We contend that significant gains could be made to consumer outcomes through the development of a dedicated TSD Plan form, comprehensive system-wide training for staff, and monitoring and reporting on compliance in this aspect of consumer-centric treatment, care and support.

## Access to a further opinion

Consumers have the right to request a further opinion about their treatment<sup>37</sup>. This is one of the cornerstones of the protection of rights under the Act. The further opinion must be based on an examination of the consumer and not just on what is written in their medical file and must be given to the consumer in writing. The independence of further opinions is governed by the Chief Psychiatrist's guidelines and the timeliness, flexibility and choice was governed by a mandatory operational directive from the Director General of the Department of Health until the directive was rescinded on 17 June 2021.

MHAS has long lobbied for timely access to an independent opinion and the operational directive provided guidelines around the process and timeframes. This is particularly important given the consumer has no choice about their treating psychiatrist. Consumers may request a further opinion directly or may ask an Advocate to facilitate the process.

*A consumer was unhappy with their diagnosis and treatment regime, wanted to change psychiatrist and requested a further opinion. The Advocate facilitated this and supported the consumer during the review of the further opinion with the treating psychiatrist. The review enabled a direct and frank conversation between the pair after which the consumer withdrew their request to change doctor and decided to take medication willingly so that they could return home as soon as possible and be with their family.*

*A consumer was due to be discharged on a Community Treatment Order which required medication by depot (an intra-muscular injection in the buttocks) which they were strongly opposed to (as are many consumers). The Advocate facilitated a further opinion from a private psychiatrist, and as a result the consumer was discharged without a Community Treatment Order and on oral medication, giving them dignity and a greater sense of control over their own health. In addition, the Advocate negotiated with the psychiatrist providing the opinion to bulk-bill the consumer.*

During the past year Advocates have encountered problems identifying psychiatrists who are able to give further opinions in a private capacity. Given the general shortage of psychiatrists across Western Australia, availability changes frequently and it has proved difficult to maintain an up-to-date register, despite liaison with the Royal Australian and New Zealand College of Psychiatry.

As noted in previous annual reports there have been difficulties in meeting the requirements of the Act. Independent opinions by psychiatrists from outside the hospital the person is being treated in, for example, are almost impossible to achieve, let alone in a timely manner. This considerably reduces the value of the further opinion as a rights protection mechanism for consumers. In February 2021, the Department of Health wrote to Health Service Providers seeking comment on the need for the mandatory policy, given the requirements of the legislation and Chief Psychiatrist's Guidelines. Responses indicated funding and resourcing were impediments to

<sup>37</sup> The Act also provides for a further opinion about whether it is appropriate to have continued a community treatment order.

the review process itself and its administration. An inability to get consistent data from Health Service Providers prevented the Department of Health from seeking funding from the Mental Health Commission to address this situation. As a result, the Department of Health rescinded the operational directive to remove the additional compliance burden from Health Service Providers and to look at how to support Health Service Providers to meet the requirements of the Act.

MHAS responded to the Department of Health's proposal strongly advocating for retention of the operational directive and that the funding and resource impediments be addressed. The rescinding of the directive has resulted in a lack of guidance on timeframes and no apparent system level accountability for their completion.

MHAS will continue to pursue an accountable approach to the provision of timely further opinions through the current Statutory Review of the Act.

## Health Service Provider notifications to Personal Support Persons

Family members and other unpaid carers are often important participants in supporting consumers when they are unwell, and to maintain good health at other times. They can play a vital role in ensuring a smooth transition across inpatient and community settings, and often have a wealth of information about the consumer that is useful to teams in treatment planning.

The Act recognises this, and places an obligation on Health Service Providers to notify the consumer's personal support person at certain points in their engagement with the health system. Adult consumers must agree to this contact being made (with some exceptions).

Health Service Providers must notify the Chief Advocate of the contact details of personal support persons contacted when a consumer is made involuntary. Notifications to the Chief are made through PSOLIS, and include situations where the treating clinician does not consider it to be in the consumer's best interests to notify a support person (and the reasons why).

In 2019-20, MHAS investigated what appeared to be widespread non-compliance with the requirements in the Act to notify personal support persons that involuntary orders had been made. The Chief Advocate wrote to Health Service Providers in January 2019 asking for an explanation of low rates of notification. In October 2020, MHAS once again examined the notification rate and once again found a high rate of non-notification as reported in PSOLIS (65%) when a consumer was put on an involuntary treatment order. The Chief Advocate began working with Health Service Providers to raise awareness of this apparent systemic failure and breaches of the Act.

As a result of this work, four Health Service Providers responded positively to the concerns:

- WA Country Health Service initiated their own investigation and found that while personal support persons were being notified this was not routinely being recorded in PSOLIS. The Service issued a directive to all mental health staff requiring recording in PSOLIS and committed to providing training to Kalgoorlie Mental Health staff.
- Ramsay Health Care Joondalup responded with site data demonstrating a 99% compliance rate with PSOLIS data entry and

99% compliance with notification of personal support persons, with only 9% recorded as 'not relevant'.

- The Child and Adolescent Mental Health Services developed plans to remove PSOLIS data entry barriers, to conduct regular audits and report on findings.
- Graylands Hospital implemented a project in May 2021 focussed on improving notification of personal support persons. As part of this, a new form is being trialled to documents notifications. Informal feedback suggest that the project has been well received.

Despite these responses, there remains a notable gap in the total number of reported notifications of personal support persons following involuntary order (Forms 5A, 6A and 6B) through PSOLIS. Further work is being conducted by MHAS to increase compliance with notifications and/or recording in PSOLIS.

## Errors, oversights and failure to listen

Sometimes it is seemingly small things that cause a lot of distress for consumers who are involuntary. These often stem from errors and oversights with the technical aspects of the implementation of the Act. The examples below indicate how the Advocates can work with the protections in the Act to facilitate consumers' access to their rights.

### **Illegal extension of involuntary status**

*The involuntary order for a consumer had expired but the consumer remained on the ward believing they were unable to leave and were subject to other restrictions. When the error was picked up incidentally by a hospital clerk, the patient was put on a Form 1A (used for referral for examination by a psychiatrist and without the authority for involuntary*

*treatment associated with involuntary orders). However, the patient was not informed of this at the time and continued to be treated as an involuntary patient under the Act.*

*An Inquiry was conducted by MHAS. The finding was that the errors had occurred because of process failure. Changes were made at the facility level to reduce the risk of this happening to others, including a notification system for the treating team about consumers whose orders are due to expire.*

### **Inappropriate restriction to communication**

*The Advocate was approached by a consumer who was extremely upset that they had not been given their phone and laptop back following a restriction on their access to communication under a Form 12C. They could not understand why the restriction had not ended because they had not received a further Form 12C. When the Advocate asked to see the Form 12C they were informed it had expired. The Advocate told the staff that they had no right to restrict the consumer's freedom of communication, and the nurse replied, "The consumer didn't even know about his 12C until I asked him if they had a copy of it!" The Advocate ensured that the consumer had access to their phone and laptop. The consumer received an apology from the coordinator and an explanation from the psychiatrist about why a Form 12C had been required.*

### **Not Listening**

*In a review by the treating team a consumer was advised that medication would be increased slowly and the psychiatrist agreed to the dose and timing requested by the consumer. However, when the medication was dispensed, it was contrary to the consumer's understanding. The consumer raised it with nursing staff who checked the medication chart and 'insisted' it was correct but did not check the medical notes which confirmed the consumer's understanding of the conversation with the psychiatrist. The consumer took the incorrect dose of medication under protest and raised the matter with their Advocate.*

*The consumer reported they felt 'knocked out', unusually drowsy and their face and mouth muscles felt lax; they wanted the matter investigated and the side effects monitored.*

*In the facility's response they confirmed the error in the medication chart and dispensing over two days and provided an apology to the consumer. It was disappointing that staff did not give more credence to what the consumer was saying and undertake more checks including of the medical records.*



# The interface with the NDIS

Last year we reported that Advocates were becoming involved in assisting consumers with issues relating to the NDIS, primarily with hostel residents. This year we have seen an increase in the work that Advocates are doing with people in hospital, as part of their function to facilitate access to other services. The work has increased sufficiently so that, in June we added an NDIS-specific complaint code to the MHAS database to track NDIS issues and actions in the future.

Advocates have worked with inpatient consumers to resolve issues with:

- delays in hospital social workers processing NDIS applications
- hospital social workers failing to follow up on slow applications in a timely fashion, or failing to keep the consumer informed about the progress of their application
- applications that have not considered the extent of the consumer's needs, particularly accommodation
- inaccurate or incomplete advice from hospital social workers in relation to what the NDIS provides, particularly relating to the supports available for independent living
- confusion amongst those people supporting consumers to make an application around what is provided by the NDIS and what is the responsibility of the State Government, and difficulties in accessing and co-ordinating services from different funding sources
- loss of NDIS accommodation due to a lengthy inpatient stay and/or delayed discharge

- inability to utilise all or some of their package due to an inability to find service providers with expertise in complex support needs.

The following examples illustrate some of these issues with NDIS and the work of Advocates to identify solutions.

## **Lack of support with an NDIS application**

*A consumer on an involuntary inpatient treatment order who had lodged an NDIS application prior to a period in prison asked for the application to be reactivated. Their needs included accommodation. The Advocate asked the treating team to support them to resubmit their application, but the treating team refused to assist because they felt that the consumer was 'functioning at a high level' and therefore not in need of NDIS support. The treating team recommended that the consumer re-apply once they were discharged. After further advocacy, the allied health staff gave contact details for community support with an NDIS application but were not able to provide further assistance.*

## **Cancelled service agreement**

*A consumer lost their accommodation when the guardians cancelled the agreement with the service provider. The guardians assumed that the consumer's admission would be long because the previous one had been. They did this without consulting the treating team. Six weeks after admission, they were well enough to be discharged, but had nowhere to go. It took two months to arrange accommodation and support, during which the Advocate liaised with the family, social worker and*

*treating team to ensure that the consumer's wishes were heard and to ensure that the consumer was not discharged to a long-term rehabilitation bed, which neither they nor their family wanted.*

### **Difficulty identifying service providers**

*A consumer with complex support needs has been an inpatient for more than two and a half years, despite having a sizeable NDIS plan. Numerous specialist assessments were conducted to ensure the right supports were included in the plan. Notwithstanding the Advocate's work to facilitate support to be activated, they remain on the ward because it was not possible to identify providers who can deliver the accommodation and supports required.*

Consumers with dual disability (generally intellectual disability, acquired brain injury or other neurological condition impacting on cognition and functioning) who have complex support needs may find it especially difficult to get enough, well co-ordinated supports. In these instances, Advocates' work to assist the consumer access services can be prolonged and complicated. In the meantime, consumers' capacity to live independently may deteriorate resulting in an increase in the support they need once they finally leave hospital – and as a result, an NDIS package that is no longer adequate to meet their needs.

In April 2021 the Mental Health Commission requested MHAS involvement in a major project to encourage Western Australians with psychosocial disability to test their eligibility for the NDIS. Advocates are present in every authorised mental health facility in the state, have established relationships with staff and know many of the inpatient consumers and hostel residents who may be eligible for NDIS and are therefore uniquely positioned to help facilitate targeted assessments and referrals.

Access opportunities would be expanded if there was investment in building the capability of the NGO sector to support people with primary psychosocial disability. There is a need to focus on those with multi-agency needs – including those who regularly need treatment, care and support from acute mental health services and those in the forensic mental health system. It is important that supports are provided by organisations with expertise in psychosocial disability, and not only from generalist disability providers.

In addition, there appears to be confusion as to what the NDIS could, or should, fund in relation to the combination of accommodation and support that some consumers need to be safely discharged from hospital. A clearer distinction between psychiatric rehabilitation and psychosocial disability accommodation and support would assist design appropriate models of care, consumer pathways and workforce capability. In turn, a clearly defined continuum of care would support more consistent consumer outcomes and greater accountability.

### **A co-ordinated support to clinical treatment and psychosocial support**

*Last year's annual report contained a case study about 'Kathy' and her son 'Gavin'<sup>38</sup>, a young man with a diagnosis of autism and schizophrenia. A theme in the case study was the lack of co-ordination between services supporting Gavin. During an admission, Gavin's Advocate liaised with his consultant to arrange a case conference involving Gavin, his mental health treating team, his NDIS support workers and his mother. The meeting was a success in developing a more co-ordinated approach to his treatment, care and support for his upcoming discharge, and the Advocate pushed for a monthly case conference involving the same participants. Since then, Gavin's care has been well co-ordinated. During a recent admission, his NDIS team continued to provide support to him while he was in hospital and have attended his Mental Health Tribunal hearings.*

<sup>38</sup> These are the names used in last year's MHAS Annual Report, and not the real names of the consumer and his mother.

# Difficulties at the NDIS-forensic interface

There have been delays in identifying suitably skilled NGO service providers for consumers with a forensic history who have approved NDIS packages. Advocates report that staff express concerns about service providers' ability to work with forensic consumers, namely their level of skills and training in behaviour management. Similarly, a reluctance by service providers to work with forensic consumers has also been noted. This has resulted in unnecessary barriers and delays to the consumer accessing the services they have been assessed as needing and has held up much needed acute beds at the Frankland Centre.

*An Advocate assisted a consumer on remand at the Frankland Centre on multiple occasions to follow up the progress of their NDIS application. They were keen to be able to go out into the community and they were working toward discharge to supported accommodation. When the funding was finally approved there were further delays in getting support staff to take them out and the person was understandably frustrated with the ongoing delays. Throughout the process the person was subject to assaults and altercations on wards and absconded. At one point the person had to be escorted by staff to another ward during the day as they were not safe on the ward, but due to a lack of available alternative beds the person was forced to sleep on the ward where they had been assaulted and verbally abused. More recently the person moved ward and has been going on outings such as for general and food shopping, to get haircuts and for recreational activities. The community access for the person is more flexible and more frequent and the consumer has told their Advocate they are happy with their NDIS support.*

With the right supports good outcomes can be achieved:

*An Aboriginal consumer at the Frankland Centre with a mental illness, a forensic history and childhood trauma and been repeatedly imprisoned, was at risk of being made subject to a Custody Order. The Advocate reported staff made a "valiant" effort in linking the person to a NDIS coordinator who found the right service provider and accommodation and included culturally appropriate care planning and maintained links with family.*

*Discharge was held up as the community mental health service refused to take-on the consumer. The Advocate got the Chief Psychiatrist involved in a meeting where the community team reluctantly agreed to a three-month trial. The consumer is thriving! They are undertaking further studies to complete formal education requirements and living successfully in the house with supports.*



# Resourcing, data and disclosures

## Budget and expenditure

### 2020-21 Budget and Expenditure

In 2020-21 MHAS' total allocated budget was \$3,315,724, which comprised:

- \$2,858,000 under direct control of the Chief Advocate for statutory advocacy services
- \$77,724 for preparatory work for CLMIA Act reforms from April to June 2020 (approved through the 2020-21 mid-year review process under the Treasurer's Delegated Authority)
- \$380,000 (or 11.5% of the overall budget) to cover the cost of corporate services provided 'free of charge' by the Mental Health Commission<sup>39</sup>.

MHAS aims to work within the budget allocated, however expenditure was \$3,523,625<sup>40</sup>, which was \$207,901, or 6.3%, over budget. Similarly, MHAS exceeded the budget under its direct control for statutory advocacy work<sup>41</sup> by \$237,685 (or 8.3%) as its expenditure was \$3,095,685. Note, the true cost of advocacy services is not fully apparent as the cost of providing corporate services was less than budgeted by the Mental Health Commission (budget \$380,000; cost \$355,209) providing MHAS with almost \$25,000 (which

roughly covered the cost of Advocates' (unfunded) pay increases in the year).

MHAS has had increasing difficulty working within its allocated budget in each year of its operations and considers that it was underfunded from inception in November 2015. The inadequate funding means that MHAS is not able to completely fulfil its statutory responsibilities, particularly systemic inquiries and investigations. Since then the lack of funding has been compounded by unfunded pay rises for Advocates and significant increases in the numbers of:

- involuntary treatment orders
- referred persons assisted and bed shortages
- voluntary and involuntary children assisted
- increased numbers of Mental Health Tribunal hearings, the duration of hearings and representation rates by Advocates
- the complexity of complaints raised.

The Chief Advocate advised the Minister in October 2020 and March 2021 that MHAS would not be able to come within budget.

<sup>39</sup> MHAS pays a proportion of the cost of the Mental Health Commission's corporate, audit and executive salaries as estimated by the Mental Health Commission. Services include payroll and human resources support for staff, processing some invoices and some financial services, and IT infrastructure, some of which is provided by Health Support Services.

<sup>40</sup> MHAS's expenditure may be adjusted as the audited had not been completed at the time of going to print.

<sup>41</sup> For comparison with previous years the project funding for the CLMIA Act reform has been excluded.

**TABLE FIVE - MHAS allocated budget and expenditure 2016-17 to 2020-21**

	2016-17	2017-18	2018-19	2019-20	2020-21
<b>Expenditure</b>	\$2,702,375	\$2,651,988	\$2,724,443	\$3,017,802	\$3,095,685
<b>Budget</b>	\$2,654,000	\$2,627,000	\$2,668,000	\$2,719,000	\$2,858,000

Cost-saving measures are explored every year, but they impact on the range and quality of statutory services available to consumers. In 2018 MHAS implemented widespread cost-saving measures and undertook a functional review of support services to try to remain within budget. Further cost-saving measures are increasingly difficult to identify and place greater pressure on those who work for MHAS who are repeatedly compromised in the services that can be provided. The turnover and burnout rates across the organisation are increasing and the impacts of repeated recruitment on workloads and juggling people to backfill have an increasingly negative impact on wellbeing, organisational effectiveness and on service delivery.

The cost of Advocates, including the Chief Advocate, comprised 73.8% of the expenditure and increased significantly from the previous year (65.7%) indicating a greater proportion of funding was channelled into service delivery. The remaining costs were for corporate services from the Mental Health Commission, Advocacy Services Officers' salaries and on-costs, building lease, travel, training and other goods and services.

## Remuneration

Advocates (including the Chief Advocate and Senior Advocates) are entitled to remuneration as determined by the Minister; the Chief Advocate's remuneration is determined by the Minister on the recommendation of the Public Sector Commissioner.

## Advocate Remuneration

The Advocates and Senior Advocates are paid an hourly rate plus superannuation and can claim mileage (and, in limited circumstances, some Advocates can claim travel time). As they are engaged on contracts for service, they have no entitlement to paid leave and must supply their own car and mobile phone, although a laptop is provided to maintain security of information.

In October 2018, the Minister approved the first pay increases for Advocates and Senior Advocates since commencement of operations in 2015. The increase is in line with the salary increases under the government's *Public Sector Wages Policy* and resulted in:

- Senior Advocates' rate increasing from \$61.30 to \$61.95 per hour
- Advocates' rate increasing from \$51.30 to \$51.95 per hour.

## Chief Advocate Remuneration

The Chief Advocate's annual salary was established in November 2015 as the equivalent of a level 9.1 under the Public Service Agreement with four weeks annual leave and 12 days personal leave per annum; there was no mechanism for salary increases.

In August 2018 it was recommended to the then Minister for Mental Health that the Chief Advocate's salary should be increased in line with the WA government's *Public Sector Wages Policy 2014* and the remuneration package should be reviewed. The remuneration was considered inequitable when compared to the heads of other, equivalent accountability agencies. In July 2019 the Public Sector

Commission recommended the annual remuneration of the Chief Advocate was to be increased by \$1,000 (effective from April 2019 which was the first increase since November 2015) and a submission be developed to enable the remuneration to be reassessed.

An external review of the remuneration of the Chief Advocate was submitted to the Minister in December 2019 and recommended an increase to a Class 2 under the Public Sector CSA Agreement 2019 as an interim measure. While an increase on the previous salary, this would have set the new level at less than similar statutory positions where remuneration is determined through the Salaries and Allowances Tribunal.

On 24 August 2020 the then Minister determined the Chief Advocate was entitled to remuneration and conditions equivalent to a Class 1, less than the recommendation from the external review.

## Resourcing

### Recruitment and induction of new Advocates

A restructure of MHAS during 2019-20 prioritised effective and balanced workload allocation across all services, service areas and service recipient categories. In 2020-21 there was some movement of Advocates; four resigned (or their contracts were not renewed) and two were engaged. Advocates were not replaced in regional areas as part of a specific strategy to manage costs, leaving only one Advocate located in each of Broome and Kalgoorlie. Time will tell if there are negative consequences.

The net effect of these movements is that there are four fewer active Advocates as at 30 June 2021 compared to the previous year (and nine fewer than in June 2019) which effectively

reduces costs due to the reduced costs from recruitment and the overheads of engaging each individual. At 30 June 2021, MHAS comprised:<sup>42</sup>

- the Chief Advocate
- three Senior Advocates
- 32 Advocates:
  - 18 general Advocates in metropolitan Perth
  - 7 general Advocates across Albany, Broome, Bunbury and Kalgoorlie
  - one Advocate providing a weekend phone service (youth and general)
  - four Youth Advocates
  - two Aboriginal Mental Health Advocates
- nine Advocacy Services Officers (7.0 FTE) who are public servants and include a Manager and the Principal Project Manager for CLMIA reforms.

In terms of the hours worked by Advocates, there was a slight decrease from 29,204 hours annually in 2019-20 to 28,431 in 2020-21. Given the continued increase in demand for services by youth (and the levelling of demand amongst adults) this is not sustainable.

Attraction and retention of Advocates has been difficult over the years particularly Youth Advocates who require specific expertise in working with children and young people and must respond in tight timeframes under the Act for contacting children on orders and attending Mental Health Tribunal hearings. As Advocates are paid on an hourly rate this can put unreasonable demands on their availability at short notice and has proved unsustainable. The Act requires Advocates to be engaged on a maximum three-year contract-for-services. The majority are employed on zero minimum hours contracts, which do not provide the income certainty that many people require. They are currently paid an hourly rate with no leave provisions. In the past year, these

<sup>42</sup> The Advocates, including the Senior Advocates, are engaged on a contract for services at an hourly rate, with one exception they do not work full-time hours, are not guaranteed work, do not have any leave entitlements and can make themselves unavailable at any time.

employment provisions have been raised by Advocates and Senior Advocates in exit interviews as problematic.

New Advocates generally undergo an intensive four-day, in-house training program and complete a four-hour e-learning program on the Act and an e-learning program on aggression prevention. This was reduced this year to contain costs with one Advocate participating in the training by video-conference and induction training of the other Advocates being condensed. New Advocates are mentored by experienced Advocates in the field who observe them for several weeks and attend at least one Mental Health Tribunal hearing before working alone with consumers.

## **Attracting Aboriginal Mental Health Advocates**

MHAS created a specialist Senior Advocate position in 2019 to oversee advocacy for Aboriginal people in response to expansion of its service and recognition of the need to ensure we offer Aboriginal consumers, where possible, the opportunity to engage with an Aboriginal Mental Health Advocate. We currently have two dedicated Aboriginal Mental Health Advocates and hope to engage more in future.

MHAS continues to refine the approach to recruiting Aboriginal Mental Health Advocates to ensure we are working in ways that are culturally appropriate. In 2020-21 MHAS conducted a comprehensive review of its recruitment material and strategy for future rounds of recruitment.

## **Advocate training and development**

Advocate training and supervision has been severely and increasingly limited due to budget constraints in recent years. The impact of an ongoing lack of training for Advocates is both increasing inconsistency in practices and decreasing the quality of advocacy. A lack of training is reducing awareness of MHAS

protocols and adherence to these protocols, and reduced data quality impacting on our reporting. This also has a profound impact on Advocate retention and job satisfaction (bearing in mind Advocates work alone in the field and complete reports from home).

The new Chief Advocate has committed to improving Advocate retention with a focus on improving support for Advocates. The initial changes included a two-day formal skill building and reflective practice workshop. The training was based on issues identified by Advocates that significantly impacted consumers accessing their rights. It focused on developing Advocates' skills in supported decision making to assist consumers access other services. The training included presentations regarding NDIS complaints processes and referral mechanisms, connecting with Aboriginal consumers and elements within TSD Plans that support recovery focussed care.

## **Advocacy Services Staff**

The Chief Advocate must be provided with Advocacy Services Officers to assist her to perform her functions under the Act. The full-time equivalent complement of staff remained unchanged from the previous three years and the permanent compliment of staff was 6.0FTE<sup>43</sup>. MHAS operated above the FTE compliment for Liaison Officers (2.0FTE) repeatedly during the year due to the high turnover of staff and difficulty recruiting and retaining people in the position. It is estimated that it takes on average three to four weeks of one-on-one training with a Liaison Officer when an additional/supernumerary Liaison Officer is required, therefore during the year there was an additional Liaison Officer for between 18-24 weeks. This has placed the entire service under increased pressure with increased errors and flow-on effects to consumers, Advocates, Senior Advocates and other support staff of a service that has been chronically underfunded.

<sup>43</sup> From April 2021 MHAS received three-months funding via a Treasurer's Delegated Authority for a 1.0FTE Principal Project Manager to prepare for CLMIA Act reforms and scope the database requirements.

MHAS operated with a very stable workforce at the commencement of operations but has experienced a high turnover of staff following an office restructure in 2018 designed to cut costs. This has had a significant impact throughout the agency.

## Business systems

The chronic under-resourcing since 2015 has negatively impacted multiple core business systems. MHAS has been unable to take advantage of contemporary technology for its mobile and dispersed Advocate workforce to enhance services for consumers. The following are examples of current systems that are not fit for purpose.

- The client management system (a 2013 Microsoft Dynamic Customer Relationship Management software called ICMS) requires an urgent upgrade. The software is no longer supported creating security risks plus there has not been a support contract in place since 2019 significantly hampering system maintenance and making it impossible to make any improvements to the system. Producing reports is both limited and extremely resource intensive, commonly exceeding 60 hours staff time per month of manual data extraction and manipulation, due to the very limited reporting capabilities. This impacts on MHAS' ability to monitor operations and report on system performance. The quality of the data is of increasing concern as the operational suitability of the system is increasingly compromised with the lack of system maintenance.
- The payroll function in the ICMS system was never completed which has resulted in a complex process requiring 18 hours staff time every fortnight to manually process and verify Advocate pays. This does not include the time each individual Advocate uses to complete their time sheet (which they cannot charge for). The overly administrative

burden in completing pay claims has been cited in Advocate exit interviews as needing urgent improvement.

- The phone system is unreliable, maintenance intensive and hinders Advocate contact with consumers. It relies on an office-based receptionist transferring calls back and forth from Advocates' private mobiles to consumers which creates double-handling. It means the consumer is potentially telling their story twice. It also precludes the use of text messages or SMS which is increasingly a preferred communication method for many consumers as Advocates must use their private mobile phones (as their personal phone number will be disclosed).
- MHAS has many ad hoc processes for monitoring and managing operations to try to supplement the outdated business systems.
- MHAS's website has fundamental problems and ongoing management is problematic. In order to contain costs, MHAS discontinued the support contract for the website in 2017, instead opting to patch the system on an as-needs basis. The site can no longer be maintained due to haphazard operations of the site. MHAS does not receive support or assistance from the Mental Health Commission with website maintenance or management despite the cost of corporate services being incorporated into MHAS' costs.

Work continues with the Mental Health Commission to determine priorities and strategies to resolve the infrastructure issues hampering efficient service delivery.

## Records management

In accordance with section 19 of the *State Records Act 2000*, MHAS has a record-keeping plan governing the management of all its records, which was approved by the State Records Commission in August 2018.

The plan required MHAS finalise its Record-keeping Procedures Manual and classification system of functional keywords by mid-2018. The Procedures Manual was completed in July 2018, however the classification system remains outstanding due to resourcing issues and is now having a major impact on operations.

Cost containment strategies over the past six years have also meant the electronic record management system has not been maintained and the classification system is not fit for purpose. While MHAS received expert record keeping support from the Department of Health until 2018 as a legacy of previous support arrangements, the Mental Health Commission has provided sporadic support and only in emergency situations since then.

MHAS operated for several years on the corporate knowledge of highly experienced individuals however, high turnover of staff has exposed the extent of the problems with the retention and retrieval of documents. The classification system is hampering the retrieval of records and staff have been poorly trained in the records system resulting in failure to capture records or the use of inappropriate labels. The ability for MHAS to follow through on its statutory advocacy responsibilities is severely compromised, resulting in further inefficiencies. In addition, the annual report to Parliament this financial year has been compromised by the inability to retrieve complaint information. MHAS may no longer be compliant with the requirements of the *State Records Act 2000*.

An evaluation of MHAS's Record-keeping Plan is scheduled for 2023, in accordance with the State Records Commission Standard 2, Principle 6.

# Electoral Act Requirements

As required under the *Electoral Act 1907*, section 175ZE(1), MHAS recorded \$4,500 in expenditure related to the designated organisation types between 1 July 2020 and 30 June 2021, which is broken down as follows:

- Advertising agencies: \$4,500 (WACOSS)
- Media advertising organisations: nil
- Market research organisations: nil
- Polling organisations: nil
- Direct mail organisations: nil.

# Quality assurance

MHAS is committed to continuous quality improvement in its service delivery and welcomes feedback of an informal and formal nature regarding its operations. In past years MHAS has applied for \$25,000 funding to have an external party conduct an evaluation of its service. Significant savings could have been achieved as the work would have been based on a reduced version of an evaluation for a similar advocacy service funded in another state. Unfortunately, due to the time elapsed since the initial review was completed and changes within the university who provided the original quote, the evaluation would now cost \$100,000. The funding was not granted again this year.

## Complaints

MHAS identified four complaints about its service during 2020-21. This is compared with 14 complaints the previous year and is considered to under-represent the number of complaints received. Problems with our record-keeping systems and procedures, coupled with high staff turnover and high

workloads, meant that some complaints could not be identified for inclusion in this report.

Complaints were handled according to MHAS' complaints protocol. A copy of the protocol has previously been available on the MHAS website. However, due to resourcing problems MHAS internet has become unstable and public access to the protocol has been inconsistent. Copies of the protocol are provided on receipt of a complaint and can be made available on request until the website is fixed.

### Advocacy Service breaches of the Act

It is a right of all consumers to be contacted by an Advocate within seven days of an involuntary treatment order being made for an adult, and within 24 hours of an order being made for a child. Consumers were contacted by an Advocate within the statutory timeframes following 95.6% of all involuntary orders in 2020-21. This is slightly higher than the previous year when 94.9% of consumers were contacted within the statutory period. Advocates will still seek to contact a consumer after the seven-day timeframe (or 24 hours for children) if the consumer is still subject to an order.

Although all children were contacted by an Advocate following an involuntary order being made, this was not achieved within the statutory 24-hour timeframe for 12.8% of orders (or 21 out of 164 orders). This is an increase from 10.3% the previous year. The reason for the majority of the breaches (76.2%) were a result of the Health Service Provider not notifying MHAS within two hours (as agreed by health services and in many the cases the order was not received within 24 hours either).

MHAS counts as breaches even those cases where the order is revoked within seven days (or 24 hours) and the Advocate had not made contact. These accounted for 66.0% of breaches (or 121 involuntary orders) in 2020-21. It raises questions especially when orders are revoked within a couple of days of being made whether the time should have been extended to enable further examination by a psychiatrist (ie using a Form 3C). The number of breaches

represents only the consumers who have not been contacted by an Advocate within the statutory timeframe and there are many more consumers whose order is revoked within days of the order being made but were promptly contacted by an Advocate. MHAS considers this trend requires investigation to try to clarify what is happening however MHAS has had to curtail its inquiry and investigations as required under the Act due to inadequate funding for several years.

## Ministerial directions

The Minister for Mental Health may issue written directions to the Chief Advocate about the general policy to be followed by the Chief Advocate, and the Chief Advocate may request the Minister issue directions (under s354 of the Act). During 2020-21 no such directions were issued, nor did the Chief Advocate request directions.

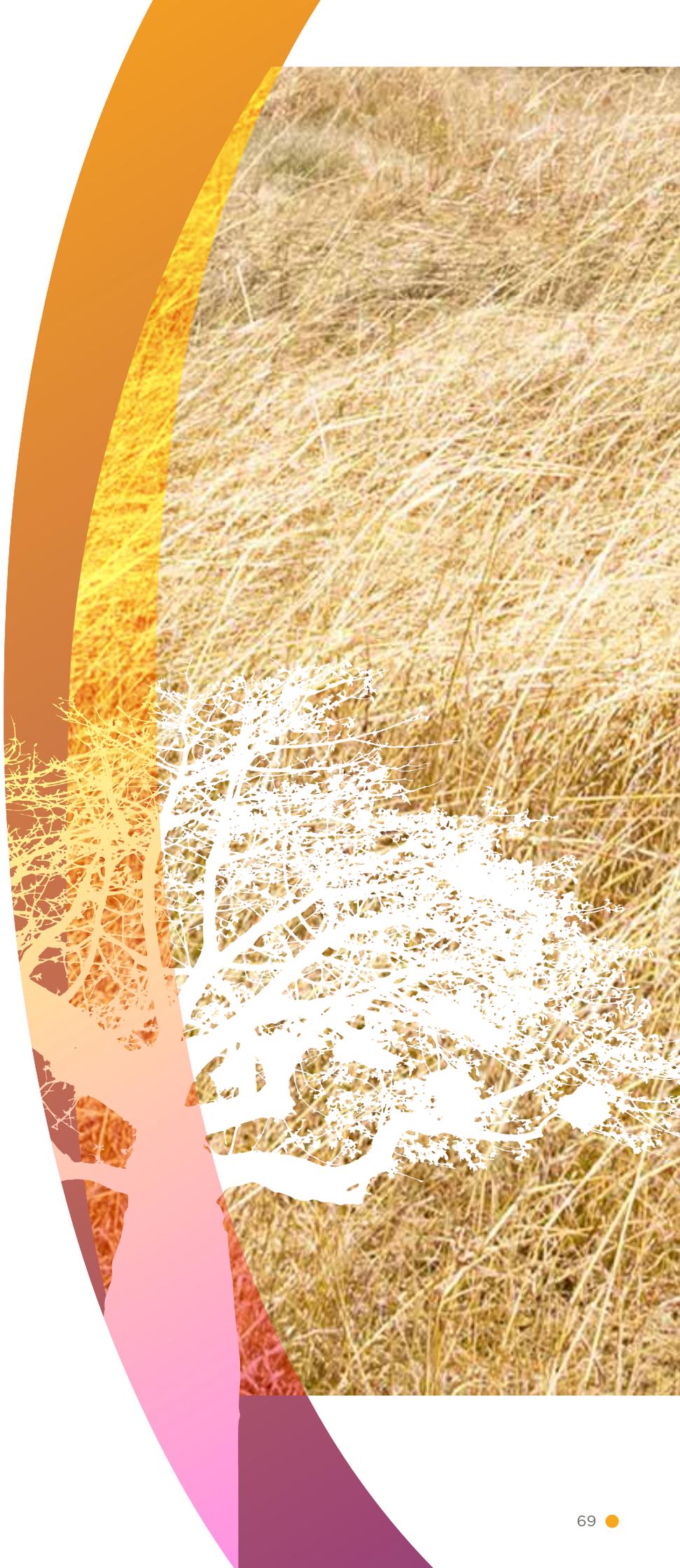
Similarly, the Minister for Mental Health may request the Chief Advocate report on the provision of care by a mental health service or ensure that a service is visited (see s355 of the Act). There were no such directions issued during 2020-21.

## Committees, submissions and presentations

The Chief Advocate, or her proxy, was a member on 15 committees and took part in 14 consultations or provided written submissions during 2020-21, as set out in appendix 3.

Presentations are also given by the Chief Advocate and Senior Advocates to facility staff and other stakeholders on the role of MHAS and consumer rights. The presentations

are an important educational tool which help protect consumers' rights and improve understanding of the role of MHAS. This work was curtailed due to lack of funding with the number of presentations falling from 35 in 2018-19, to 18 and 21 in the past two years. A lot more work could be done in this area to promote the Charter of Mental Health Care Principles and educate mental health staff. A list of presentations given is provided in appendix 4.





# Appendices

## Appendix 1: Involuntary treatment orders

TABLE SIX - Number of involuntary orders<sup>44</sup> and number of consumers<sup>45</sup>

Type of Order	1 July 2016 - 30 June 2017		1 July 2017 - 30 June 2018		1 July 2018 - 30 June 2019		1 July 2019 - 30 June 2020		1 July 2020 - 30 June 2021	
	Orders	Consumers								
Inpatient treatment orders in authorised hospitals - Form 6A	3,148	2,417	3,203	2,432	3,117	2,431	3,275	2,534	3,208	2,498
Inpatient treatment orders in general hospitals - Form 6B	97	86	134	115	149	128	168	128	181	139
Community Treatment Orders - Form 5A	796	656	817	661	850	679	839	702	884	718
<b>Total Involuntary Orders / Consumers</b>	<b>4,041</b>	<b>2,618</b>	<b>4,154</b>	<b>2,644</b>	<b>4,116</b>	<b>2,650</b>	<b>4,282</b>	<b>2,744</b>	<b>4,273</b>	<b>2,729</b>

<sup>44</sup> All orders are based on notifications from health services to MHAS (for adults and children) and grouped by the date the order is made. Verification of ICMS data is ongoing and figures may be subject to change.

<sup>45</sup> Some people were subject to more than one order during the period but are only counted once against each form type (in the number of consumers columns).

## Appendix 2: Location of mentally impaired accused persons

The table represents the location of a mentally impaired accused persons as at the 30 June each year. This may differ from the Place of Custody Order where the person is on a Conditional Release Order. As at 30 June 2021 there were 36 people whose Place of Custody was an authorised hospital, however seven were on a Conditional Release Order in the community.

**TABLE SEVEN - Location of mentally impaired persons as at 30 June each year<sup>46</sup>**

Location as at 30 June	2018	2019	2020	2021
Authorised Hospital	9	11	22	29
Community	17	18	15	10
• Subject to a condition they undergo treatment for a mental illness		15	12	7
• Not subject to conditions about treatment for a mental illness		3	3	3
Declared Place	2	3	2	3
Prison	10	10	11	10
<b>TOTAL</b>	<b>38</b>	<b>42</b>	<b>50<sup>47</sup></b>	<b>52</b>

<sup>46</sup> The data in the table below was provided by MIARB on 22 July 2021.

<sup>47</sup> Two orders were for the same person so there were 49 people on 50 Custody Orders.

## Appendix 3: Committees and submissions

### Continuing Committees

1. Private Hostel Agencies Committee (oversight agencies' committee)
2. Accountability Agencies Collaborative Forum
3. Hostel Closure Strategy Steering Committee - Department of Health, Licensing and Accreditation Regulatory Unit
4. Mental Health Network Executive Advisory Group - Mental Health Commission
5. Treatment Support and Discharge Planning and Clinical Review of Care Implementation Working Party - Armadale Hospital, East Metropolitan Health Service
6. Co-Leadership Safety and Quality Mental Health Steering Group - Mental Health Commission
7. Smoke Free Working Group - Fiona Stanley Fremantle Hospital Group, South Metropolitan Health Service
8. Inter-Agency Expert Advisory Group - Mental Health Commission

### New Committees in 2020-21

1. St Jude's East Street Lodge and Cottage Closure Operational Clinical Team - East Metropolitan Health Service
2. Criminal Law Mental Impairment Project Officer Group - Department of Justice
3. Criminal Law Mental Impairment Reform Implementation Steering Committee - Mental Health Commission
4. Private Psychiatric Hostels Improvement Program - Mental Health Commission
5. Targeted Review [Hostel name] - Office of the Chief Psychiatrist
6. Mental Health Act 2014 Statutory Review Steering Group - Mental Health Commission

### COVID-19 Committee

- Mental Health / AOD Interim Reference Group - COVID-19 Response and Recovery - Mental Health Commission

## Submissions, forums and consultations

1. MHAS Report on Cases for the Chief Psychiatrist's Targeted Review into the treatment of Ms Kate Savage by Child and Adolescent Mental Health Services - September 2020
2. Feedback on Services for Young People - Young People's Priority Framework - November 2020
3. Patient Journey Initiative, Kimberley Mental Health and Drug Service - September 2020
4. Emergency Medicine Mental Health Roundtable, Western Australia - November 2020
5. Mental Health in the ED - Nowhere Else to Go Webinar - September 2020
6. COVID-19 Congregate Living Outbreak Response Plan - August and September 2020
7. State Health Incident Coordination Centre, COVID-19 Mental Health Hostel Outbreak Response Desktop Exercise - October 2020
8. Mental Health and Other Drugs Forum - Implementing the Sustainable Health Review - October 2020
9. Review of the WA Health Smoke Free Policy and associated guidelines - January 2021
10. Submission to the Department of Justice on the Implementation of the Criminal Law (Mental Impairment) Reforms - January 2021
11. Submissions to Mental Health Commission, Consultation on *Community Services Request for Independent individual advocacy services for mental health and/or alcohol and other drug consumers, their families and carers in Western Australia* - January 2021
12. Response to Mental Health Commission Consultation on *Mental Health and AOD Accommodation Vacancy System* - February 2021
13. Submission to the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with a Disability* - February 2021
14. South West Inpatient Admissions to Mental Health Service, Bunbury Hospital - May 2021

## Appendix 4: MHAS presentations

1. Role of MHAS including in EDs and the general hospital, and Treatment, Support and Discharge Plans - Fremantle Hospital registrars - August 2020
2. Role of MHAS - Graylands Hospital new registrars - August 2020
3. Role of MHAS including in EDs and the general hospital, and Treatment, Support and Discharge Plans - Rockingham Hospital registrars - August 2020
4. Role of MHAS and in particular focus on MHAS presence in ED's and the general hospital, and Treatment, Support and Discharge Plans - Midland nursing staff and caregivers - November 2020
5. Role of MHAS and in particular focus on MHAS presence in ED's and the general hospital, and Treatment, Support and Discharge Plans - Midland registrars and consultants - November 2020
6. Treatment Support and Discharge Plans - Mental Health Matters 2 - November 2020
7. Treatment Support and Discharge Plans - Mental Health Matters 2 Panel - December 2020
8. Statutory review of the Mental Health Act 2014 - Mental Health Advisory Council - February 2021
9. Role of MHAS - Fremantle Hospital registrars - February 2021
10. Role of MHAS - Rockingham Hospital registrars - February 2021
11. Role of MHAS - Midland Hospital caregivers - February 2021
12. Role of MHAS - HaDSCO, Mental Health Tribunal, Equal Opportunity Commission, Ombudsman WA, Commissioner for Children and Young People WA, Office of the Inspector Custodial Services and Office of the Information Commissioner - February 2021
13. Role of MHAS - Graylands Hospital new registrars and interns - February 2021
14. Role of MHAS - St Barth's Arnott Villas staff and residents - April 2021
15. Role of MHAS - St Jude's Hostel staff and residents - April 2021
16. Role of MHAS - Sir Charles Gairdner Hospital new registrars - April 2021
17. Role of MHAS - St Barts Sunflower Villas residents' meeting - May 2021
18. Role of MHAS - Roshana Group staff and residents (Burswood, Honey Brook and BP Luxury hostels) - April and May 2021
19. Role of MHAS - Richmond Wellbeing, Bunbury Hostel - June 2021 Role of MHAS - Richmond Wellbeing, Busselton Hostel - June 2021



# Glossary

## Acronyms and Terms

<b>Act</b>	<i>Mental Health Act 2014</i>
<b>Advocate</b>	Mental Health Advocate
<b>CAMHS</b>	Child and Adolescent Mental Health Service
<b>Chief Advocate</b>	Chief Mental Health Advocate
<b>CPFS</b>	A division of the Department of Communities, known as Child Protection and Family Support
<b>CLMIA Act</b>	<i>Criminal Law (Mentally Impaired Accused) Act 1996</i>
<b>Consumer</b>	An 'identified person' as defined by s348 of the Act who can be assisted by an Advocate, but excluding hostel residents
<b>CTO</b>	Community treatment order, also called a Form 5A
<b>Disability services</b>	A division of the Department of Communities
<b>DJC</b>	Disability Justice Centre
<b>ED</b>	Emergency department
<b>Form 1A</b>	Referral order for a compulsory examination by a psychiatrist who decides whether the person should be made involuntary and put on a Form 5A, 6A or 6B
<b>Form 5A</b>	Community treatment order, and a type of involuntary treatment order
<b>Form 6A</b>	Involuntary inpatient treatment order made in an authorised hospital (by a psychiatrist), and a type of involuntary order
<b>Form 6B</b>	Involuntary inpatient treatment order made in a general hospital (by a psychiatrist), and a type of involuntary treatment order
<b>HiTH</b>	Hospital in The Home
<b>Hostel</b>	Private psychiatric hostel as defined in the Act
<b>HSP</b>	Health Service Provider, comprising (each of or collectively) East Metropolitan Health Service, North Metropolitan Health Service, South Metropolitan Health Service, Child and Adolescent Health Service and WA Country Health Service



<b>ICMS</b>	MHAS' database termed Integrated Case Management System
<b>Involuntary treatment orders</b>	Collectively include community treatment orders (Form 5As), involuntary inpatient treatment orders on an authorised mental health ward (Form 6As) and involuntary inpatient treatment orders on a general medical ward (Form 6Bs).
<b>MHAS</b>	Mental Health Advocacy Service
<b>Minister</b>	Minister for Mental Health
<b>NDIS</b>	National Disability Insurance Scheme
<b>NGO</b>	Non-government organisation
<b>PCH</b>	Perth Children's Hospital
<b>PSOLIS</b>	Psychiatric Services Online Information System
<b>TSD Plan</b>	Treatment, support and discharge plan
<b>WA</b>	Western Australia
<b>YPECN</b>	Young People with Exceptional and Complex Needs Program



MENTAL HEALTH  
ADVOCACY SERVICE

**Unit 6, 18 Harvest Tce, West Perth WA 6005**

Post (*no stamp required*):  
Reply Paid 84455 West Perth 6005

(08) 6234 6300 or 1800 999 057 **T**

(08) 9226 3977 **F**

contactus@mhas.wa.gov.au **E**

**mhas.wa.gov.au**