

Annual Report

2018-2019



MENTAL HEALTH ADVOCACY SERVICE

Hon Roger Cook MLA

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 2019.

As well as recording the operations of the Advocacy Service for the 2018-19 year, the Annual Report reflects on a number and range of issues that continue to affect consumers of mental health services in Western Australia.

A handwritten signature in black ink, appearing to read 'D. Colvin', with a long horizontal stroke extending to the right.

Debora Colvin

CHIEF MENTAL HEALTH ADVOCATE

September 2019

The artwork on the front cover and throughout the Annual Report is by WGQ. This artwork has been reproduced with the artist's kind permission.





“ The Advocate has been a great support for me throughout my time in hospital.

When I was first admitted, I was very angry – I just wanted to be discharged – and they explained my rights and helped me go through the procedures to try to get out.

Then I calmed down and realised I was really not well, and the Advocate helped me deal with the staff and work out what needed to happen next.

After that, I was okay handling things on my own, but the Advocate was still there to speak with. They regularly visited or called me to check if everything was fine or if they could do anything to help. I think they were also just giving me the chance to talk.

It can be very lonely in hospital. My family didn't really understand what I was going through. Other patients have their own issues. And the staff do their best, but I always felt they were forcing me to stay here and I couldn't trust them. The Advocate understood me, and understood the system. And I could trust them.

And I wasn't alone. ”

— *Jay*



CONTENTS

- 1 EXECUTIVE SUMMARY
- 2 ABOUT US
- 5 THE YEAR IN REVIEW
- 6 Gaps in care
- 16 Cultural and gender diversity
- 20 Safety
- 25 Mental Health Tribunal reviews
- 28 Basic rights and person-centred care
- 33 Hostels
- 35 HOW WE WORK
- 35 Involuntary orders
- 38 Budget and resourcing
- 42 Quality assurance
- 44 Ministerial directions
- 44 Committees, submissions and presentations
- 45 Records management
- 46 APPENDICES
- 51 GLOSSARY OF ACRONYMS AND TERMS



FOREWORD BY THE CHIEF ADVOCATE

This is the fourth annual report on the activities of Mental Health Advocates submitted to the Minister for Mental Health since 30 November 2015, when the *Mental Health Act 2014* came into force. The style has changed this year, which we hope will make it more readable while still drawing attention to the work of the Advocates and issues in the system.

The report outlines the activities of the Mental Health Advocacy Service and includes real consumer stories, data, and information about several major inquiries. I think the report reflects the issues and hurdles for mental health consumers, while also showing the enormous amount of work at an individual and systemic level carried out during the year. If there is a theme to this year's report, it is about fragmentation and lack of integration of care.

There is so much more that could be done, but our resources are limited. I cannot emphasise enough how the services could not be provided without the hard work, professionalism and passion - as well as a considerable deal of goodwill - from the Mental Health Advocates, the Senior Advocates and Advocacy Services staff working in the office.

Data in the report is from the Advocacy Service's database (ICMS), unless otherwise stated. It is based on notifications by health services as at 8 July 2019. The verification of data is ongoing, so figures may be subject to change.

Debora Colvin
CHIEF MENTAL HEALTH ADVOCATE

Executive Summary

In 2018-19, Mental Health Advocates reported:

- 16- and 17-year-olds falling through the gap between child and adult services, and being failed by a system which doesn't deliver continuity of care or appropriate post-discharge support
- consumers with eating disorders experiencing fragmented care, and lacking the support of a state-wide specialist eating disorder service
- prisoners unable to access mental health services
- people with serious behavioural issues turned away from hospitals
- people with intellectual or developmental disabilities inappropriately placed in mental health units
- people left in emergency departments for days waiting for beds, while others were stuck on hospital wards due to lack of community supported accommodation
- Aboriginal people over 50% more likely to be placed on involuntary orders than the broader population
- wards with dirty, unsafe and dangerous conditions.

Addressing these issues, the Advocacy Service:

- provided advocacy under the *Mental Health Act 2014* to 3,117 people, including 93 children
- represented people in 838 Mental Health Tribunal hearings
- undertook major inquiries into sex and gender issues in hostels; Aboriginal services; and environmental conditions on wards
- saw the Chief Advocate or her proxy sit on 13 committees, draft or take part in 22 submissions and consultations, and give 35 presentations to health service staff, consumers and carers.



About Us

The Mental Health Advocacy Service assists all patients on involuntary treatment orders, as well psychiatric hostel residents, people referred for psychiatric assessment, people subject to custody orders and required to undergo treatment, and some voluntary patients.

Its functions and powers are set down in Part 20 of the *Mental Health Act 2014* (the Act), which requires the Chief Mental Health Advocate to ensure advocacy services are delivered to the above groups of people – who are 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, and Mental Health Advocates must contact all adults within seven days of them being made involuntary, and all children within 24 hours. Advocates also make contact at the request of consumers or others acting on their behalf. Involuntary treatment orders comprise community treatment orders (CTOs) (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).

The Advocates’ functions include ensuring consumers are aware of their involuntary status, and their rights under the Act, and assisting consumers in protecting and exercising those rights. Advocates also seek to resolve complaints by consumers, facilitate their access to other services, and assist them in Mental Health Tribunal and State Administrative Tribunal hearings.

The Act confers considerable powers on Advocates, who may do 'anything necessary or convenient' for the performance of their functions. These include the powers to:

- investigate conditions at mental health services which do, or may, adversely affect consumers
- attend wards and hostels any time the Advocate considers appropriate
- see and speak with consumers, unless consumers object
- make inquiries about any stage of a consumer's time in the mental health system, with staff required to assist (and subject to penalties if they fail to assist)
- view and copy a consumer's medical file and any other documents about them, unless the consumer objects.

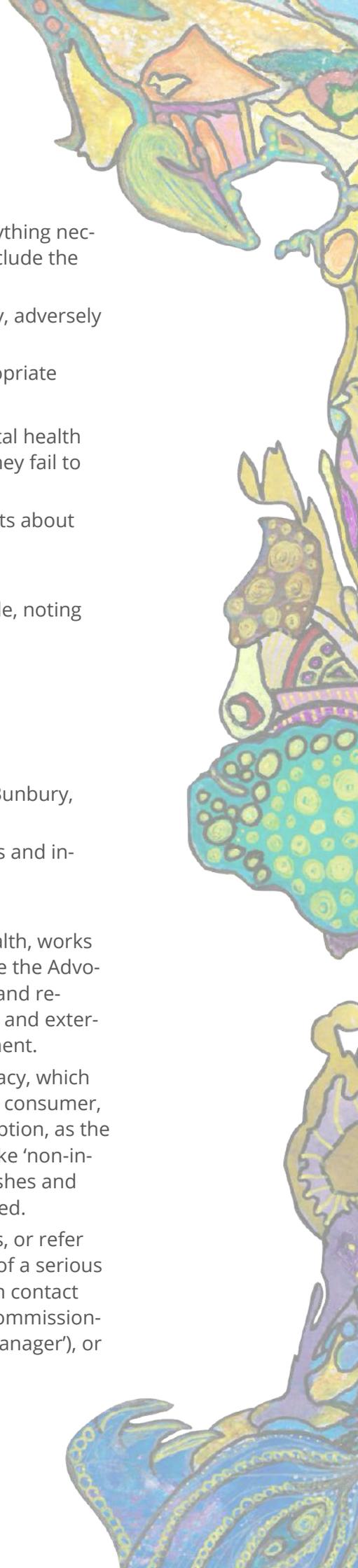
At 30 June 2019, the Advocacy Service comprised the following people, noting most Advocates do not work full-time hours:

- the Chief Advocate
- two Senior Advocates
- four Youth Advocates
- three Aboriginal Advocates
- 33 Advocates (24 in metropolitan Perth, as well as Advocates in Bunbury, Albany, Kalgoorlie and Broome), and
- eight Advocacy Services Officers (6.0FTE), who are public servants and include a Manager.

The Chief Advocate, who is appointed by the Minister for Mental Health, works with the Senior Advocates and Advocacy Services Officers to coordinate the Advocates' responses to notifications received from mental health services and requests for contact, as well as setting protocols, delivering both internal and external training, ensuring compliance with the Act and reporting to Parliament.

Advocates deliver pure advocacy, also called representational advocacy, which means they serve as a mouthpiece for the consumer, are partial to the consumer, and act according to the wishes of the consumer. Children are an exception, as the Act requires best-interests advocacy for them. Advocates may undertake 'non-instructed advocacy' in cases where a consumer cannot express their wishes and where the Advocate is concerned the consumer's rights may be infringed.

Advocates may attempt to resolve issues directly with staff members, or refer matters to the Chief Advocate if they cannot be resolved or if they are of a serious or systemic nature. The Chief Advocate and Senior Advocates may then contact management of the facility, the Chief Psychiatrist, the Mental Health Commissioner, the Director General of the Department of Health (as the 'system manager'), or the Minister to seek resolution.

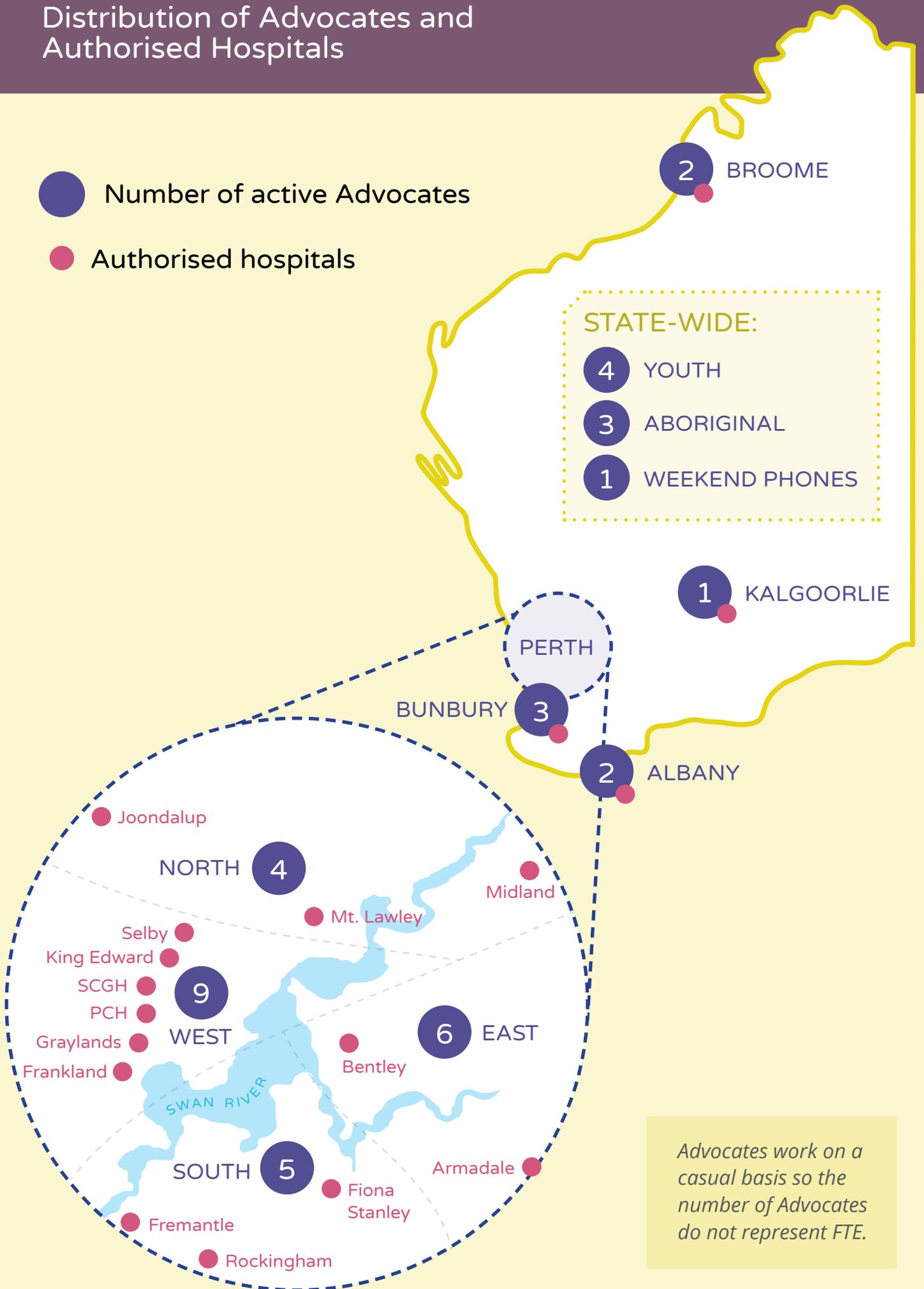


Distribution of Advocates and Authorised Hospitals

- Number of active Advocates
- Authorised hospitals

STATE-WIDE:

- 4 YOUTH
- 3 ABORIGINAL
- 1 WEEKEND PHONES



Advocates work on a casual basis so the number of Advocates do not represent FTE.

The year in review



provided services to **3,117** consumers, including 93 children



received **5,906** phone requests for contact



attended **835** Mental Health Tribunal hearings



launched **3** major inquiries



responded to **7,542** notifications of orders



2018-19 expenditure **\$3,000,826**



requested **282** further opinions



received **130** allegations of assault or abuse

Gaps in care

Principle 4 of the Charter of Mental Health Care Principles in the Act says:

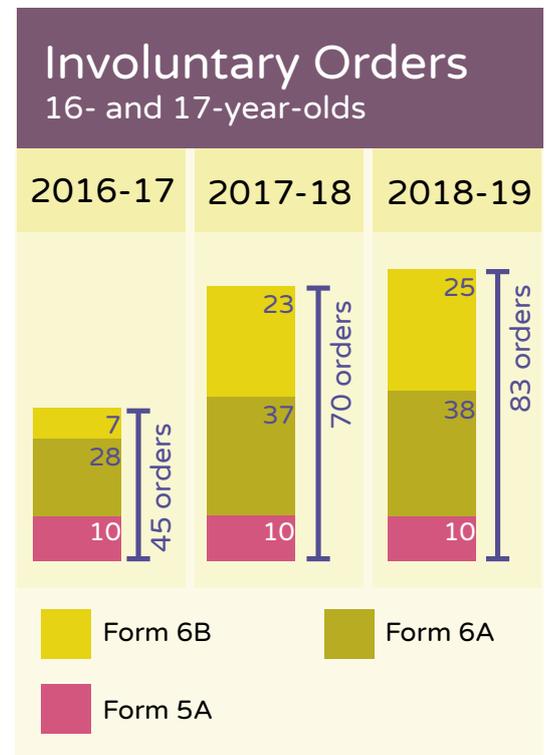
A mental health service must be easily accessible and safe and provide people experiencing mental illness with timely treatment, care and support of high quality based on contemporary best practice to promote recovery in the least restrictive manner that is consistent with their needs.

The following is a list of gaps in care raised with or by the Advocacy Service.

16- and 17-year-olds

There is no single health service responsible for 16- and 17-year-olds, which means they get moved around the metropolitan area and between health service providers (HSPs), and there is no planning co-ordination for this group. The Youth Advocates reported a lack of continuity of care and poor service provision. From a prevention perspective, and noting that many mental illnesses emerge at these ages, it is a gap in care with long-term implications.

Nearly 20% of people detained in 2018-19 were under 25 years old. Of these, 65 were children (aged 13 to 17) on 105 involuntary orders – 79% of those orders were for 16- and 17-year-olds. The number of children made involuntary has significantly increased in recent years, particularly in relation to children detained on an involuntary inpatient order (forms 6A and 6B).



Children aged 16 and 17 are not accepted as inpatients by the Child and Adolescent Health Service (CAHS) and can only be admitted to one of the two youth wards (which take people up to age 24) - the East Metropolitan Youth Unit and the Fiona Stanley Hospital Youth Unit, which are managed by different HSPs. There are usually wait-lists for beds in these wards, which often means long wait times in emergency departments (EDs) likely managed by a different HSP. It also means families and friends must travel long distances to visit, and discharge is to CAHS community services - in one episode of care they may be treated by three different mental health services.

Perth Children’s Hospital (PCH) is required to accept 16-year-olds where it is developmentally appropriate, but the Advocacy Service has not been able to get a definition of what this means, and attempts on behalf of consumers waiting in EDs and their psychiatrists to get admission have failed.

“ I am a teenager and have been in care for much of my life. It has been tough, and I have had traumatic experiences in care. My last care arrangements broke down and this has caused me a lot of distress and uncertainty. Since then, I have really struggled.

I’ve spent most of the past few months as a patient in different mental health facilities. During that time, I’ve had quite a few restraints and been in seclusion and that’s been distressing for me.

I am still stuck in the system because there is nowhere for me to go. My Advocate has supported me at many big meetings with youth mental health services and child protection, who are trying to work out what to do. There have been so many meetings! I try and contribute but it’s hard to focus and remember everything everyone is saying.

It is upsetting being in hospital for so long and not knowing where I will go.

My Advocate has walked by my side and advocated for a placement that will keep me safe and help me recover. My treatment team is working hard to support the right placement for me too. I want to be well. If I have a home and support, I have hope for the future.

It’s just taking so long to get there. ”

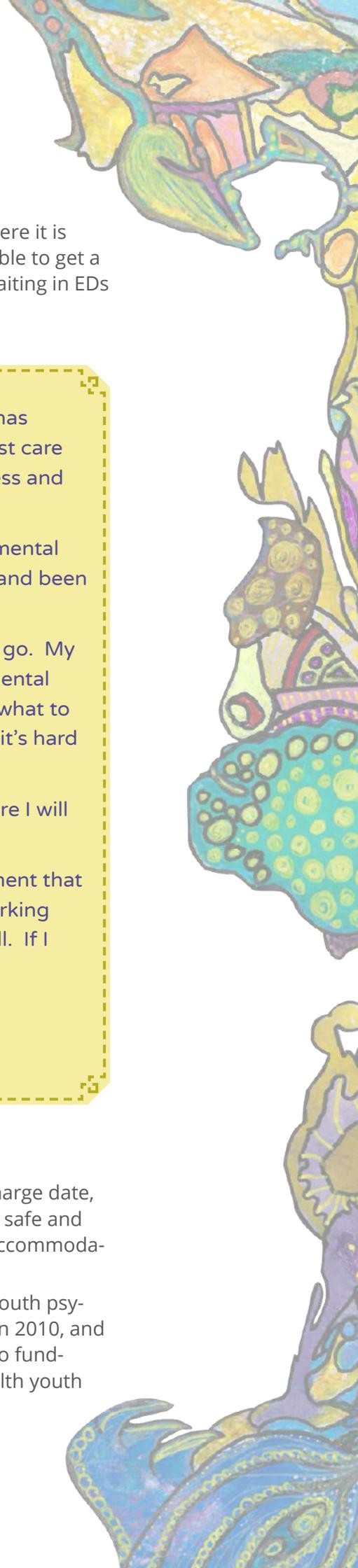
— Terry

Supported accommodation services for youth

Following on from the above gap in responsibility for 16- and 17-year-olds, and perhaps because of that gap, acute inpatient facilities are accommodating youth consumers for long periods,

beyond their expected discharge date, due to the lack of adequate, safe and therapeutically supported accommodation in the community.

Western Australia’s only youth psychiatric hostel was opened in 2010, and since then there has been no funding of additional mental health youth



hostel beds. In 2018-19, forty-three¹ 18-to-24-year-olds faced prolonged hospitalisation due to accommodation issues. They were all excluded from 'step-up/step-down' supported transitional accommodation services as they did not meet the admission criteria of having a discharge address.

One such consumer was admitted to a youth unit for 110 days due to lack of suitable accommodation in the community.

Prolonged Hospitalisation due to Accommodation Issues¹

No. of Children
(<18 years)

8

No. of Youth
(18 to 24 years)

43

In addition, eight children aged under 16 experienced prolonged hospital admissions and barriers to discharge due to accommodation issues. In all cases, the child had complex needs requiring intensive home-based support. In one case, a child remained in an acute youth mental health unit for more than three months while waiting for accommodation. The delays in this case were due to applications for funding, tendering contracts, establishing the accommodation, and recruiting and training staff to provide care.

¹ This data is limited to those consumers assisted by an Advocate, and may not reflect the total number of children and youth whose admission was prolonged due to a lack of accommodation.

Eating disorders

The Advocacy Service assisted 61 consumers treated for eating disorders on involuntary inpatient treatment orders (form 6Bs). There was a 53.6% increase in form 6B orders from the previous year, and consumers with eating disorders accounted for 47.6% of the total in 2018-19.

The issues raised for, and by, these consumers were around the fragmentation of care and variability in treatment expertise. This was most likely compounded by the lack of a state-wide specialised eating disorder service, which could potentially integrate services and care.

There is a particular gap for 16- and 17-year-olds since PCH opened because these children are no longer admitted to a specialist children's hospital. Sixteen children² aged 16 and 17 were treated for eating disorders across seven different hospitals. Care for these children can be further fragmented, as treatment occurs across health services under different management structures:

- inpatient medical care is managed by adult services
- inpatient mental health care is managed by youth services
- outpatient mental health care is managed by either the Eating Disorder Program at PCH or other community youth services.

For those aged 18 and over, access to outpatient care was also piecemeal, as there are no clear clinical pathways for treatment in the community. Most

² These numbers do not include voluntary children, who can also receive advocacy services.

specialist community services are in the private sector, but public adult community mental health services absorb the management of CTOs, despite not being specialist eating disorder service providers.

Emergency department wait times

“ My daughter and I have been going around in circles with the mental health system for several years, desperately trying to get help for her condition which has now become chronic because, I believe, there wasn't enough done by both inpatient and community services in the early stages.

One of the biggest ongoing issues we have had has been accessing a mental health bed when she is in crisis and unsafe.

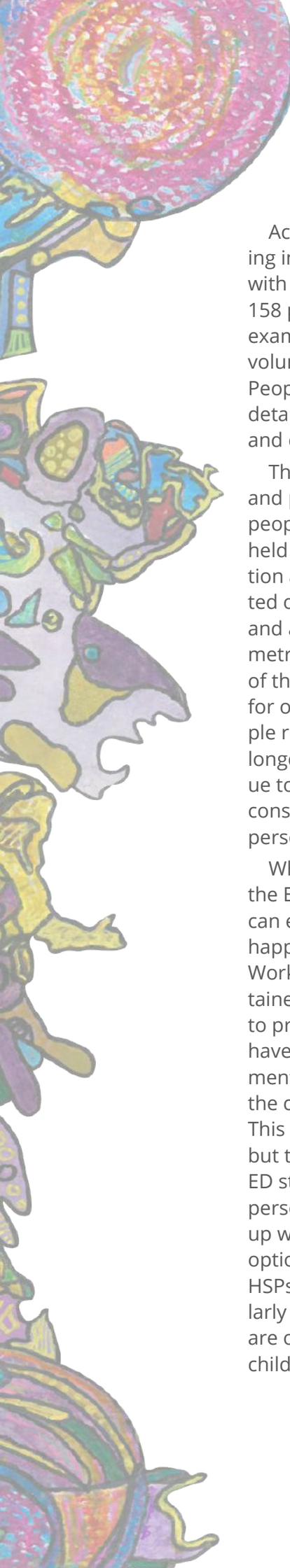
On multiple occasions over the years, she has presented to the ED with thoughts of self-harm and suicide, only to be made to feel like staff are not taking her seriously and are fobbing her off. This has resulted in her often leaving the ED, and either overdosing or inflicting significant self-harm injuries on herself.

On other occasions, she has been formally discharged from the ED while still in crisis, despite my expressed concerns, and even after she has already self-harmed. Hospital staff clean her up and suture her wounds, only to tell her that there are no beds available and that she needs to wait at home for a bed, and that a member of the community team will follow her up. The last time this happened she went home and self-harmed to the point that she required ambulance assistance. I don't understand how hospitals can discharge a patient to home when they are still unsafe.

Every now and then she will be taken seriously and detained under the Mental Health Act, but I have found this often depends on what hospital she has presented to or which staff member she is being seen by. However, on these occasions, due to the lack of beds, she has often had to wait in the ED for up to five days for a transfer, further adding to her distress and deterioration in her mental health.

I feel like the mental health system has totally failed my daughter. ”

— *Mel*



Access to care, and long delays waiting in EDs continued to be major issues, with Advocates providing services to 158 people on referral orders awaiting examination by a psychiatrist, as well as voluntary children seeking admission. People on referral orders are usually detained on the ED or a locked ward and cannot leave.

The Advocacy Service was aware of and provided services to, a number of people, including children, who were held in EDs or mental health observation areas for days before being admitted or released. The Act allows referral and associated detention orders in metropolitan hospitals for a maximum of three days, with extensions provided for only in regional areas, but multiple referral/detention orders covering longer periods were being (and continue to be) made. The Advocacy Service considers this to be a breach of the person's rights under the Act.

Where a person is being detained in the ED for lengthy periods, Advocates can ensure they understand what is happening and what rights they have. Working with the person being detained, the Advocate explores options to present to ED clinicians. Advocates have a good understanding of the mental health system and often know the consumers, so are trusted by them. This can be a comfort to the person, but the Advocate also assists the busy ED staff in better understanding the person's needs and wishes, in coming up with alternative and less restrictive options, and sometimes in assisting the HSPs to prioritise admissions - particularly with 16- and 17-year-olds, as there are only two youth wards where these children can be admitted.

The Chief Advocate continued to raise the issue of delays and breach of rights in EDs with the chief executives of the five HSPs, the Director General of the Department of Health (DOH), the Mental Health Commissioner (Commissioner), the Chief Psychiatrist, the Minister and in her submissions on the new draft patient bed flow management policy³. The final version of that policy agreed to by the HSPs contains a number of improvements over the previous bed flow policy. This includes giving decision-making authority to the Statewide Mental Health Medical Director when there are not enough beds, including consumers in the forensic unit who are no longer prisoners (known as civil patients), clear processes for repatriation of consumers (when a person is admitted to a hospital a long way from home) and admitting people with no fixed address. People in prison needing hospital admission, however, are not covered by the policy ([see page 13, People in Prison](#)).

The new policy also provides for matters to be escalated when a patient has been waiting for 10 hours or longer, and the Minister announced during the year that he wanted to be advised every time a person was waiting in an ED for over 24 hours.

Lack of community services and fewer hostel beds

The lack of alternative services in the community, including supported accommodation and poor integration of

³ Mental Health Bed Access, Capacity and Escalation Statewide Policy, June 2019, <https://www.chiefpsychiatrist.wa.gov.au>

services generally, are major reasons why people continue to use EDs to get help and why there is so much pressure on inpatient beds.

An extra 20 beds at Fremantle Hospital, as announced by the Minister, will relieve some of the pressure in South Metropolitan Health Service EDs but consumers and carers continue to ask why there isn't somewhere else they can go for help when becoming unwell, while others, who are stuck on hospital wards, ask why there is nowhere for them to go.

Inpatient snapshot surveys by the Advocacy Service in previous years have shown the bottleneck over and again. The Mental Health Commission (MHC) conducted such a survey in April this year and the results of that will hopefully be used to prioritise action and provide business cases to Government ([see page 13](#)).

The number of psychiatric hostel⁴ beds fell during the year to 723 (from 832 beds two years earlier). Most of the drop in bed numbers was from Franciscan House, a 75-bed hostel which closed in December 2017. In 2018-19, however, another 25-bed hostel (Woodville House), which had been recently renovated and took some people from Franciscan House when it closed, changed from a psychiatric hostel to an aged care facility. It is understood more funding is available for aged care (from the Commonwealth Government).

Some of the Franciscan House residents were moved to more

⁴ Defined as "private premises in which three or more persons who are socially dependent because of mental illness, and are not members of the family of the proprietor of the premises, reside and are treated or cared for".

Number of Psychiatric Hostel Beds



independent accommodation (also funded by the MHC) than a hostel, and some were moved to aged care facilities.

The MHC is also conducting an evaluation of its purchased publicly-funded non-admitted mental health services, which may assist in understanding referral pathways between community services delivered by the HSPs and services provided by non-government organisations.

Step-up/step-down facilities

The step-up/step-down facilities (two in the metropolitan area, one in Albany and others planned) are the only new supported accommodation initiatives announced. They are short-stay (28 days), do not take anyone without an address or who needs a higher level of care, and rarely take a person under 18 years of age. The current model operates primarily as a 'step-up' to hospitalisation, based on information provided by the MHC in July/August 2018 that it is rare for a person to be discharged from a hospital bed into a step-up/step-down facility.

The Chief Advocate raised the need for sub-acute facilities without such restrictions, and for an evaluation of the current step-up/step-down model, with the Minister and Commissioner.

The MHC advised it was planning an evaluation which would analyse service utilisation before and after admission. The Chief Advocate welcomed this initiative because, while the step-up/step-down beds cost about a third of a hospital bed, they are relatively

expensive and there is no evidence that the people using the service would otherwise have ended up in a hospital bed. However, it is known that people are stuck in hospital beds, delaying their recovery because there is nowhere for them to go, and others are effectively discharged into homelessness, only to find themselves back in EDs and hospital wards a short time later. It may be better to prioritise the limited funding elsewhere.

People said to have ‘behavioural issues’ being denied care

Kim was put on involuntary orders four times in three months. On each occasion Kim did not want to be discharged. Kim wanted to stay in hospital and get long-term treatment, and went through several EDs between the involuntary hospital admissions - they attempted suicide on one occasion, and committed some minor offences on another.

Following each admission, Kim was discharged to a lodging house charging \$80 a night or \$210 rent a week for a single bedroom and access to shared kitchen, laundry and bathroom facilities. After paying \$420 rent for two weeks, Kim’s Newstart allowance of about \$500 leaves little or nothing for food and the other necessities of life.

One psychiatrist said Kim had a ‘behavioural personality disorder’, indicating it was not a mental illness. A psychiatrist providing a further opinion said Kim had a mental illness and needed to be kept in hospital to develop a proper discharge plan for community support, and to be released on a Community Treatment Order which would ensure mental health care and treatment in the community. This never happened.

It is clear Kim does not have the skills, capacity or resilience to manage in the community without care or support to help them continue to deal with their mental health condition. Each time Kim is sent to a lodging house, rather than supported accommodation, the whole cycle starts again. There is no mention in the brief periods when Kim is in hospital of getting NDIS support or the more appropriate disability support pension.

In August 2018, the Chief Advocate briefed the Minister and raised concerns with him, the Commissioner and a number of the HSP chief executives about the increasing number of cases where health services were refusing to admit people said to have behavioural, rather than mental health issues. In some cases, family members feared for their own safety and refused to take the person home. In other cases, the person and their family would go from health service to health service seeking help.

Staff attitudes to people with a personality disorder were also raised, with examples of staff telling patients they were 'just trying to get attention'. The Chief Advocate called for an independent inquiry across all HSPs to review how they were responding to cases where the person was said to have behavioural issues or challenging behaviours, with a view to determining best practice care and conducting a gap analysis.

Acute hospital wards used for respite care

The use of mental health acute wards as a provider of last resort for people with an intellectual or developmental disability is impacting availability of mental health beds. The Chief Advocate briefed both the Minister for Mental Health and the Minister for Disability Services with several case studies. Discussions with the chief executives of the HSPs indicated the issue goes beyond mental health wards. There is no transitional accommodation available and it is increasingly difficult to get non-government organisations to

provide services where the person has challenging behaviours, so they are taken to EDs, put on wards and it takes months for them to be discharged because there is nowhere for them to go.

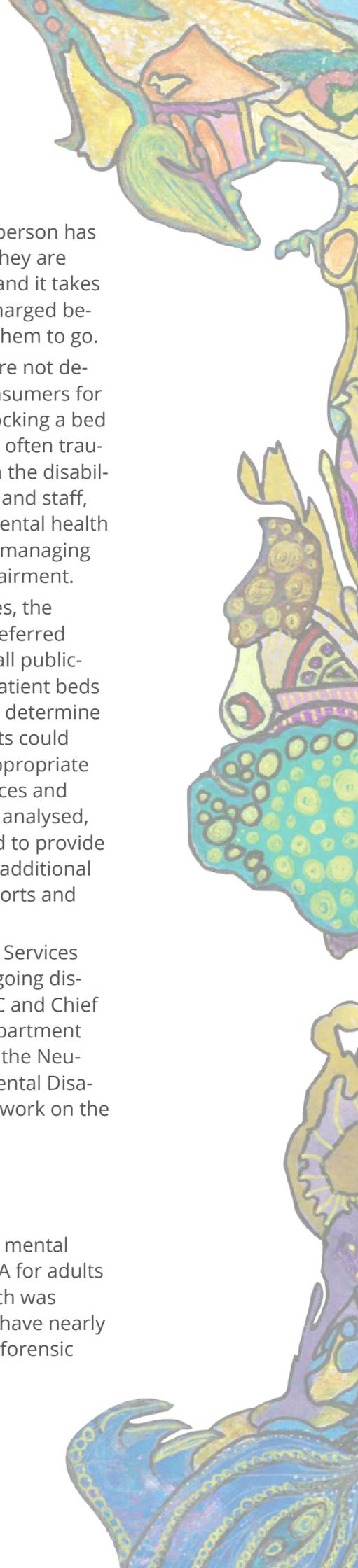
Acute inpatient facilities are not designed to accommodate consumers for long periods. Apart from blocking a bed for others, the experience is often traumatising for the person with the disability, as well as other patients and staff, who are trained for acute mental health episodes, not necessarily in managing people with intellectual impairment.

In response to these issues, the Minister for Mental Health referred to the 'snap-shot' survey of all publicly-funded mental health inpatient beds by the MHC ([see page 11](#)) to determine what proportion of inpatients could be discharged should the appropriate community bed-based services and supports be available. Once analysed, the survey data is to be used to provide information on the types of additional community bed-based supports and services required.

The Minister for Disability Services also replied, referring to ongoing discussions with the DOH, MHC and Chief Psychiatrist, and said his department had recently consulted with the Neuropsychiatry and Developmental Disability Mental Health Sub Network on the issue.

People in prison

There is only one forensic mental health inpatient facility in WA for adults – the Frankland Centre, which was opened in 1993. It does not have nearly enough beds, and no youth forensic facility.



Advocacy during the year for consumers in prisons included the following:

- Working with HSPs and Corrective Services regarding the admission and care of children from the Banksia Hill Detention Centre. This included:
 - ⊙ continued work with clinicians on a pathways project (began the previous year)
 - ⊙ facilitating a way to reduce the number of custodial officers on the two youth wards when children from Banksia Hill Detention Centre were admitted. Up to four custodial officers from the detention centre had been on the wards at one time. Apart from the negative impact of the presence of guards on a ward, there were misunderstandings about their role and powers, which led to friction with ward staff. Detention centre staff have duties under their legislation but agreed that a risk assessment of the (locked) wards could lead to a decision not to have so many custodial officers on the ward, and possibly none. The two HSPs responsible for the youth wards agreed that detention centre staff would conduct a risk assessment of the wards, and protocols would be negotiated.
- Continuing to raise the issue of prisoners waiting for a bed at the Frankland Centre. At times, there were up to 10 prisoners waiting for a bed, which also meant that the referral order (form 1A), which the Act says can only last three days, was being repeated over and again, requiring repeated

assessments by clinicians and completion of forms. The Chief Advocate argued for prisoners to be included as part of the patient flow management policy. While prisoners were not included in that policy, it did include provisions to escalate and prioritise the movement of civil consumers⁵ out of Frankland Centre in order to free up beds for prisoners. Provisions in the policy regarding people of no fixed address will also assist in getting civil patients, who still need hospital care, moved out of the Frankland Centre.

- The Chief Advocate welcoming a report, by the Office of the Inspector of Custodial Services (OICS) on *Prisoner Access to Mental Health Treatment*. It found that 61% of referrals for mental health assessment under the Act (form 1A) did not result in placement at the Frankland Centre and most lapsed. Recommendations were made to free up Frankland Centre beds, including diverting non-serious offenders to mental health services other than the Frankland Centre. The Chief Advocate's response to the report stated:

'It is clear that people in prison are not getting anywhere near the level of care available for people in the community and, in principle, I support these recommendations. However the mental health system cannot currently cope with an influx of people from prison without

⁵ Consumers who had served their time in prison or been released from remand.

an increase in inpatient beds (or other mental health services). Diverting prisoners to other authorised hospitals will impact negatively on other people in the community seeking hospital admission and may not increase access for people in prison in any event.'

- Continuing to raise issues around the closure of eight open beds, which compromised the ability to move civil and custody order patients (under the *Criminal Law Mentally Impaired Accused Act 1996* (CLMIA Act)) out of the Frankland Centre, and the recovery of those consumers. It also resulted in a reduction in the number of available rehabilitation beds, as several custody order patients were moved into Murchison Ward at Graylands Hospital. The issue was raised with the Minister, the Commissioner, and North Metropolitan Health Service, and Advocates continue to seek better services and less restriction for these consumers.
- Raising issues of safety for women in the Frankland Centre ([see page 22, Lack of Safety for Women](#)).

The State Government's pre-election commitment to reform the CLMIA Act was to address procedural fairness in terms of a right of review about release and provide greater options for Courts in sentencing mentally impaired accused persons. Legislative changes are strongly supported, and long overdue. However, this will need to consider the demand for access to forensic inpatient treatment, given the difficulty prisoners currently face in receiving treatment for mental illness.

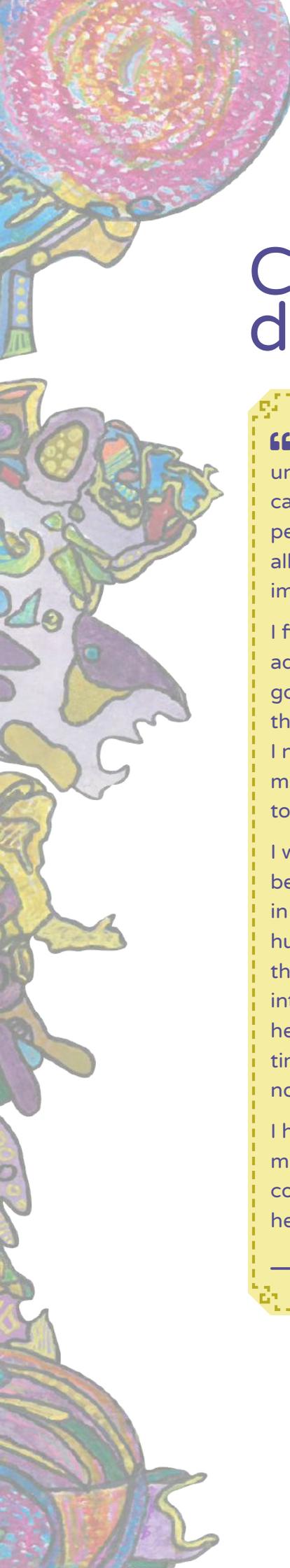
NDIS

While many of the consumers supported by Advocates have complex and/or chronic mental health conditions, NDIS support is low. The Advocacy Service took part in the Hostel Recovery Support project - jointly funded by the MHC and National Disability Insurance Agency - which aimed to encourage and support psychiatric hostel residents through the NDIS application process. The project focussed on residents in those hostels where the MHC funding was comparatively low and recovery support was minimal. The Advocacy Service understands it was considered that NDIS should be available for a very high percentage of these hostel residents due to their permanent psychosocial disability.

Despite the enormous support given as part of the project, in May 2019, a year after the project began, only 30 of the 80 applications sent for eligibility testing had been returned – and some were rejected, while others required more information.

It is difficult to see how people with psychosocial disability who do not get this level of support will be able to navigate the NDIS process.





Cultural and gender diversity

“ I arrived in Australia when I was five years of age. I did well at school until I reached the age of 14. This is when I started smoking cigarettes, cannabis and drinking alcohol. I stole items from a shop and scared some people. I was in trouble with the police and had to go to Children’s Court, all of which I did not fully understand as I had an undiagnosed intellectual impairment and did not speak very much English.

I first came into contact with the mental health system when I was admitted to a youth unit at the age of 17. I told everyone I wanted to go home. I ran away three times before being discharged home. I took the medication given to me in hospital but when I was at home neither I nor my family fully understood what was happening to me. I took the medication until it ran out and then I did not take any. I found it very hard to tell people what I was thinking. I am shy around people I do not know.

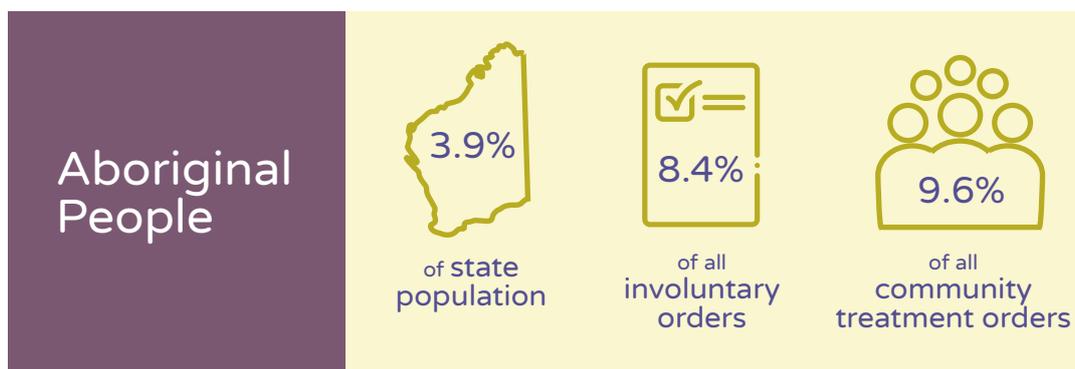
I was also admitted to an adult mental health ward. I was all alone because they moved all the adults from the ward. I did not like being in hospital and tried to get out many times, sometimes inadvertently hurting people. I bounced back several times to the adult ward. During these times my family tried to understand my mental health issues and intellectual disability. They are proud people and find it hard to accept help from outside our community of people from the same country. Over time we received a lot of help from different government agencies and non-government organisations.

I have been out of hospital since June 2018. I have been taking medication regularly. My family and I have accepted the help from my community workers, who have taken the time to get to know me and are helping me achieve my goals of playing sport and finding employment. ”

— *Alex*

The Act requires culturally appropriate services be offered to Aboriginal and Torres Strait Islander people, and the Charter of Mental Health Care Principles (to which mental health services must have regard) states that services must recognise and be sensitive and responsive to diverse individual circumstances including gender, sexuality and cultural and spiritual beliefs.

Over-representation of Aboriginal people made involuntary



The number of Aboriginal people⁶ detained under the Act is considerably higher than the proportion of Aboriginal people estimated to be living in WA (3.9%⁷). In 2018-19, 175 Aboriginal people were detained on 350 involuntary orders, comprising 8.4% of all involuntary treatment orders. Aboriginal people were subject to 9.6% of CTOs (form 5As), which may reflect the proportion of Aboriginal people living in rural and regional areas, where the number of CTOs is higher overall.

Apart from providing advocacy services to Aboriginal consumers and beginning an inquiry into Aboriginal services ([see page 18](#)), during the year the Advocacy Service:

- provided submissions at request to the Department of Premier and Cabinet regarding the 42 recommendations from the Coronial Inquest into the 13 Deaths of Children and Young Persons in the Kimberley Region and the former Education and Health Standing Committee’s *Learnings from the Message Stick: The Report of the Inquiry into Aboriginal Youth Suicide in Remote Areas*
- engaged two additional Aboriginal Advocates
- successfully raised issues in Mental Health Tribunal hearings about the application of the Act and the need for relevant cultural considerations to be taken into account by the treating team.

⁶ Based on notifications to the Advocacy Service, and identification and reporting by Advocates that an individual identifies as Aboriginal or Torres Strait Islander. The number of Aboriginal and Torres Strait Islander consumers is likely to be an under-representation.

⁷ 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>

» Inquiry into services for Aboriginal and Torres Strait Islander people

The MHC Post Implementation Review of the Act, published in March 2018, recommended that the Advocacy Service conduct an inquiry into, and prepare a report on, services available to assist in the assessment, examination and treatment of Aboriginal and Torres Strait Islander people, in accordance with the requirements of the Act. Those rights include being assessed, examined and treated in collaboration with Aboriginal or Torres Strait Islander mental health workers and significant members of the person's community, including elders and traditional healers.

A survey of all mental health services where involuntary orders are made or supervised was conducted from May to June 2019 asking questions including:

- the number of Aboriginal mental health workers and where they worked
- the number of Aboriginal and Torres Strait Islander people who had a significant member of their community involved in their care
- policies or procedures for:
 - ⦿ identifying a consumer as Aboriginal or Torres Strait Islander
 - ⦿ involving and collaborating with an Aboriginal and Torres Strait Islander mental health worker and the patient and/or carer/ personal support person
 - ⦿ involving and collaborating with a significant member of the person's community
- training of other staff.

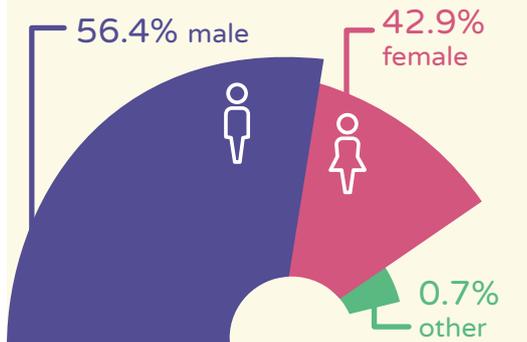
The results are being collated at the time of this report, while follow-up inquiries and interviews take place.



Gender diversity

Due to changes in practice by Advocates, the number of people who were subject to involuntary orders and identified to an Advocate as other than the traditional male or female (also known as cisgender⁸) increased this year, though this is probably still an under-representation of gender diversity on wards.

Number of Orders by Gender



In addition to the changes in Advocate practices, training on gender diversity by Living Proud LGBTI Community Services of WA was held in December to further educate Advocates on the issues and potential referral agencies, as well as gender-neutral language practice.

See also the [page 33](#) and the [Report on an Inquiry into the Rights of Psychiatric Hostel Residents to Sexual Expression, Sexual Safety and Gender Diversity](#).

⁸ A person whose sense of personal identity and gender corresponds with their birth sex.

Other cultural issues

Under Advocacy Service protocols, Advocates are required to offer an interpreter to anyone for whom English is not their first language. Not every such person wants an interpreter and the interpreter is there for the Advocate to communicate with the consumer - the treating team is expected to organise its own interpreter. Interpreters were arranged for 15 people during the year for 12 different languages (Persian, Tigrinya, Arabic, Russian, Burmese, Polish, Indonesian, Cantonese, Mandarin, Thai, Amharic and Hokkien).

In one case, following Advocate support in making a complaint, the mental health service acknowledged failures to meet requirements under the Act including:

- not providing copies of the consumer's referral and involuntary treatment forms
- not adequately providing an explanation of their rights in a clear and easily understood manner
- not offering the use of an interpreter when they were referred for assessment
- detaining them and not advising them of their right to an Advocate.





Safety

“ I was admitted to the locked ward following a suicide attempt. I was trying to sleep, having taken sedating medications, when a male patient burst into my bedroom screaming verbal abuse at me, including profanities and threats to kill.

He pushed me. I felt intimidated and terrified. I experienced abuse in my childhood and I found the whole thing re-traumatising.

I didn't feel enough was done by staff to control the situation and support me. I asked if my bedroom door could be locked and was told that this was not possible. I did not feel safe.

The following day I approached an Advocate and told them what had happened. They listened to me, spoke to staff and arranged for me to move rooms so that I was able to have my door locked. This helped me to feel safer.

They also helped me to lodge a written complaint about my experiences, whereby I asked for locks to be available on all bedroom doors as standard. Following my complaint, this is being considered and I also received an apology.

I want to do whatever I can to make sure that the same thing does not happen to anyone else. ”

— *Pat*

Right to feel safe on a ward or in a hostel

Advocates dealt with 130 assault and abuse allegations from consumers or residents across 18 hospitals and community mental health services, and five psychiatric hostels.

Advocates are required to advise a Senior Advocate and follow through on every allegation made to them by a consumer to ensure it is properly investigated by the relevant mental health service. This includes asking for CCTV footage to be retained and viewed - in one case, ward staff denied the allegations put by the consumer until shown the CCTV footage.

Even if the allegation is found to be unsubstantiated, the person was distressed and it may indicate other problems in the ward or hostel. In many cases, the consumers did not want to make formal complaints, but Advocates follow up with the treating team to ensure an investigation occurs and/or to consider potential systemic issues.

The assault and abuse allegations comprised:

- 29 allegations of staff misconduct, wilful neglect or ill treatment
- 18 allegations of sexual assault and abuse by staff
- 51 allegations of physical assault by another consumer
- 20 allegations of sexual assault by another consumer, including harassment
- 10 allegations of verbal abuse by another consumer
- two allegations of financial abuse by family members

Allegations against staff

Of the 47 allegations about staff, 18 resulted in formal inquiries by the Advocacy Service. Two of these allegations were substantiated, nine were found to be unsubstantiated and seven were pending.

Allegations of assaults by other consumers

Forty-four consumers made 51 allegations of physical assault by another consumer. Of those, 39 consumers were in hospital and five were in hostels but there were clusters of complaints in one hospital and one hostel, which the



Advocacy Service is continuing to follow up. Allegations may reflect a lack of safety in the wards and hostels, which are meant to be places of safety.

Consumers did not want to make a complaint to the health service regarding 20 of the allegations, but this does not necessarily mean that the assault did not happen. Seven allegations were addressed through six formal inquiries or complaints by the Advocacy Service raising safety issues. In relation to the remaining 24 allegations, Advocates worked with the consumers based on their wishes and concerns, including advocating for access to further medical examinations and transfers to another ward away from the alleged perpetrator of the assault.

There were 20 allegations about sexual assault or harassment by another patient or hostel resident. Four of these resulted in formal inquiries by the Advocacy Service; five consumers did not want Advocates to take any further action, and 11 were followed up informally by Advocates.

Financial abuse

Two allegations were about financial abuse by family members. Advocates followed up with each of these consumers, who reported they were pleased with the support provided by their mental health service and did not want further action by the Advocate.

“ I was brought to hospital because I was scared of people trying to kill me. Then, the first night, I couldn’t sleep because of other patients screaming and shouting, and nurses shouting. And someone tried to open my door. I was terrified.

Since then, I’ve seen patients attack other patients, and hit staff, and security guards carting patients away.

I know they are very sick and need help, but I just don’t feel safe around them. I stay in my room most of the time. I know I’m lucky to be here, because these rooms have locks on the doors, but in some mental hospitals they don’t have locks.

I don’t know what the solution is. But feeling unsafe all the time hasn’t helped me. How are you supposed to get better when you are scared? ”

— *Jamie*

Lack of safety for women

The Frankland Centre is the state’s only forensic inpatient facility, admitting people from prisons, people referred by the Courts for examination by a psychiatrist⁹ (called Hospital Orders) and people on custody orders (where the Mentally Impaired Accused Review Board has determined the place of custody as the Frankland Centre). With 30

beds, there are often only two or three female consumers, and sometimes only one. Female consumers have told Advocates how intimidated and vulnerable they felt on the ward, with one describing the admission as a traumatising experience. The only solution offered is that they be put on a nursing special, which means they are intrusively followed by a staff member at all times. As recently recommended by Coroner Sarah Linton¹⁰, a subacute mental health unit at Bandyup Women’s Prison and

⁹ Occasionally a person subject to a Hospital Order made by the Courts is assessed in another authorised hospital ward.

¹⁰ https://coronersCourt.wa.gov.au/_files/inquest-2019/Nicol%20finding.pdf

a 'female only' secure forensic mental health unit are urgently needed, rather than sending women to the male-dominated Frankland Centre.

The Advocacy service raised these issues during the year with the Commissioner and the HSP responsible for the Frankland Centre, North Metropolitan Health Service (NMHS). The Commissioner replied that *'without further*

funding the current circumstances in regards to the placement of female patients in the Frankland Centre alongside male patients is likely to remain unchanged.'

The letter went on to say that the MHC did not receive funding for capital projects, and infrastructure (such as building a new unit) was the responsibility of the Department of Health as system manager.



» Safety issues in Kalgoorlie Hospital

From September to November 2018, the Advocacy Service conducted an inquiry which focussed on the safety of patients in Kalgoorlie Hospital, and children in regional hospitals generally. This followed a suicide and a serious incident involving two young people at Kalgoorlie Hospital, ongoing concerns about delays in access to specialist child and youth inpatient services in all regional areas, and the safety of patients at Kalgoorlie Hospital generally when they required transfer to another hospital during times of risk.

The Advocacy Service's inquiry concluded that Kalgoorlie Hospital was not a safe place for such patients. It had greater challenges in maintaining a safe environment compared to authorised hospitals in



the metropolitan area and other regional authorised hospitals. This was particularly true in relation to children, young people, and those who were at risk of absconding and self-harm.

The report noted that this could not be addressed by the hospital or WA Country Health Service (WACHS) alone - it required a collaborative approach from other parties, including specialised youth services in the metropolitan area and patient transport services such as the Royal Flying Doctor Service (RFDS). More funding was also needed.

Eleven recommendations were made to multiple parties. The report was given to the Minister and the relevant HSPs, including WACHS, as well as the Director-General of the DOH, the Commissioner, the Chief Psychiatrist and the RFDS.

The reaction to the report was swift and fairly decisive, with WACHS noting that other reviews concurrent to the Advocacy Service report had showed significant concordance with the findings of the Advocacy Service:

- immediate changes were made to the mental health ward, though more permanent and more aesthetic changes were still to be made
- more specialist mental health staff were engaged
- \$3.8m extra funding was provided by the MHC for 12 more full-time staff
- mandatory mental health and suicide prevention training was initiated
- long-term planning for a new mental health unit was initiated
- the mental health patient flow policy was eventually agreed between the HSPs, with recognition of the issues for patients in regional hospitals like Kalgoorlie
- planning commenced for a Mental Health Emergency Telehealth Service to provide 24/7 specialist mental health assessment and care for all rural and regional patients
- the RFDS issued an operational circular about assessment of priority of patients, making clear that staff are to take into account the patient's clinical condition but also the risk of an adverse event if transfer is delayed, and the resources available at the referring location.

Mental Health Tribunal reviews

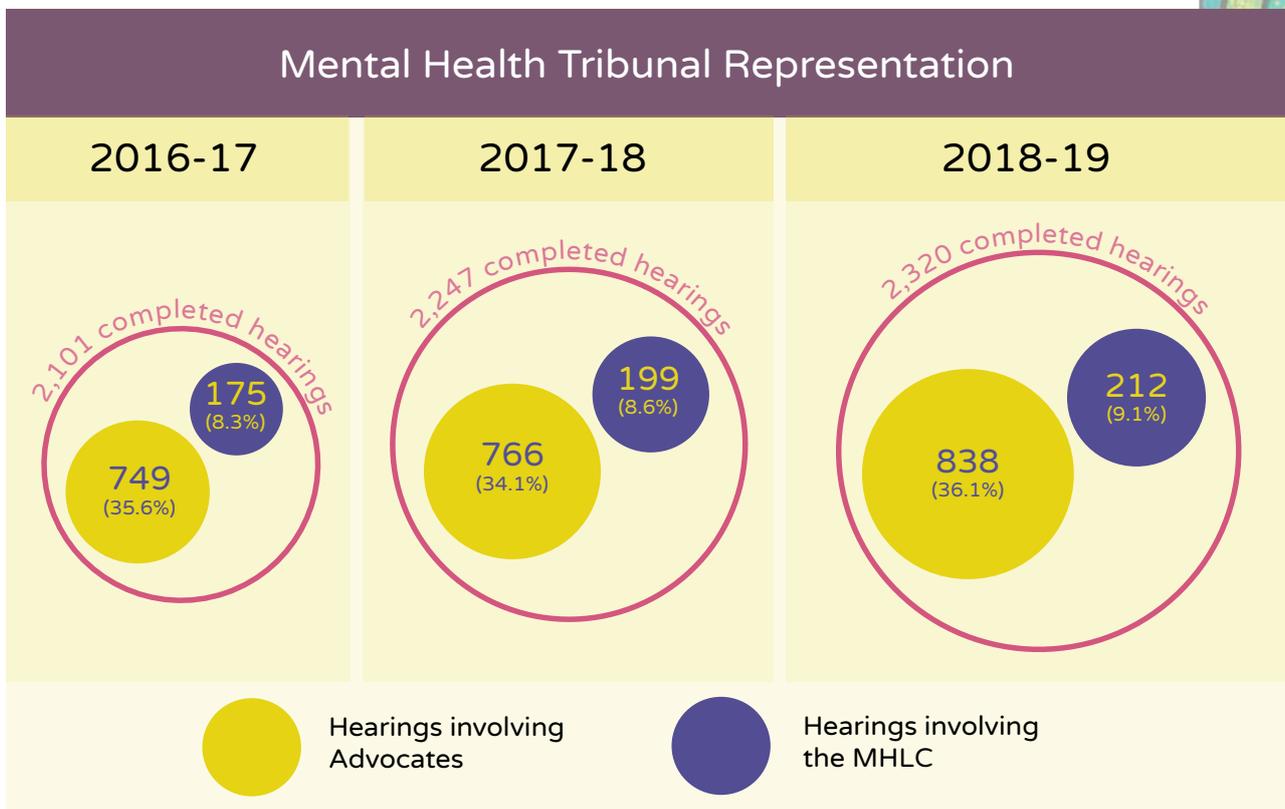
The data and why the Tribunal is so important

The Advocacy Service would like to see representation in close to 100% of hearings by the Mental Health Tribunal, subject to the consumer's wishes in each case. Tribunal hearings are a fundamental mechanism to protect people's rights when they are detained under the Act as, apart from the psychiatrist, it is the only party which can make the consumer voluntary and release them from detention on a ward.

A psychiatrist, lawyer and community member form the Tribunal and can question and over-ride decisions by the psychiatrist - this happened in 84 hearings where the involuntary order was revoked (3.6%), and in 12 hearings (0.5%) where the inpatient order was changed to a Community Treatment Order (CTO) (form 5A) so the person could go home

Advocates represented people in 838¹¹ of Tribunal hearings in 2018-19.

¹¹ Data was provided by the Mental Health Tribunal on 18 July 2019 and may be subject to change.



This was an increase of 72 hearings (or 9.4%) over the previous year and accounted for 36.1% of all Mental Health Tribunal hearings. Lawyers from the Mental Health Law Centre (MHLC) represented people in 212 hearings (9.1%). Overall, people had representation by either Advocates or MHLC lawyers at 45.3% of hearings.

A guardian (appointed under the *Guardianship and Administration Act 1990* and often from the office of the Public Advocate) attended 1.5% of hearings; a family member was present at 19% of hearings; and a friend or carer at 6.6% of hearings, reinforcing the need for an Advocate or lawyer to be supporting the person in hearings.

How advocacy can help – testing capacity

The five essential criteria for an involuntary treatment order include that a person lacks capacity to make a treatment decision, and that there is no less restrictive alternative.

Sam acknowledged that they had a mental illness requiring treatment; they had been using a medication (S) but it had ceased to be effective and so they stopped using it. The psychiatrist was now prescribing another medication (SV) but wanted Sam to be detained for another two weeks.

Sam was not a significant risk other than when untreated, as their record clearly showed. The Advocate submitted that Sam could be treated in a less restrictive environment and had capacity to make treatment decisions so could not be detained under the Act. When asked in the Tribunal hearing by the Advocate how they could be trusted to take SV when they had stopped taking S, Sam spoke cogently, telling the Tribunal members that they had known for years that they had a mental illness and understood they probably needed to take medication for the rest of their life. Sam said they wouldn't stop taking the new medication as they knew it worked for them, while the old medication had not. They described how they had, of their own volition, asked the nurses to stop giving them another medication for a physical health complaint because they were no longer suffering the pain that necessitated that drug being prescribed. The doctor told the Tribunal that the main argument against deemed capacity was that Sam did not acknowledge that they needed to be treated in hospital. The Advocate objected that s18 of the Act did not mention the location of treatment at all.

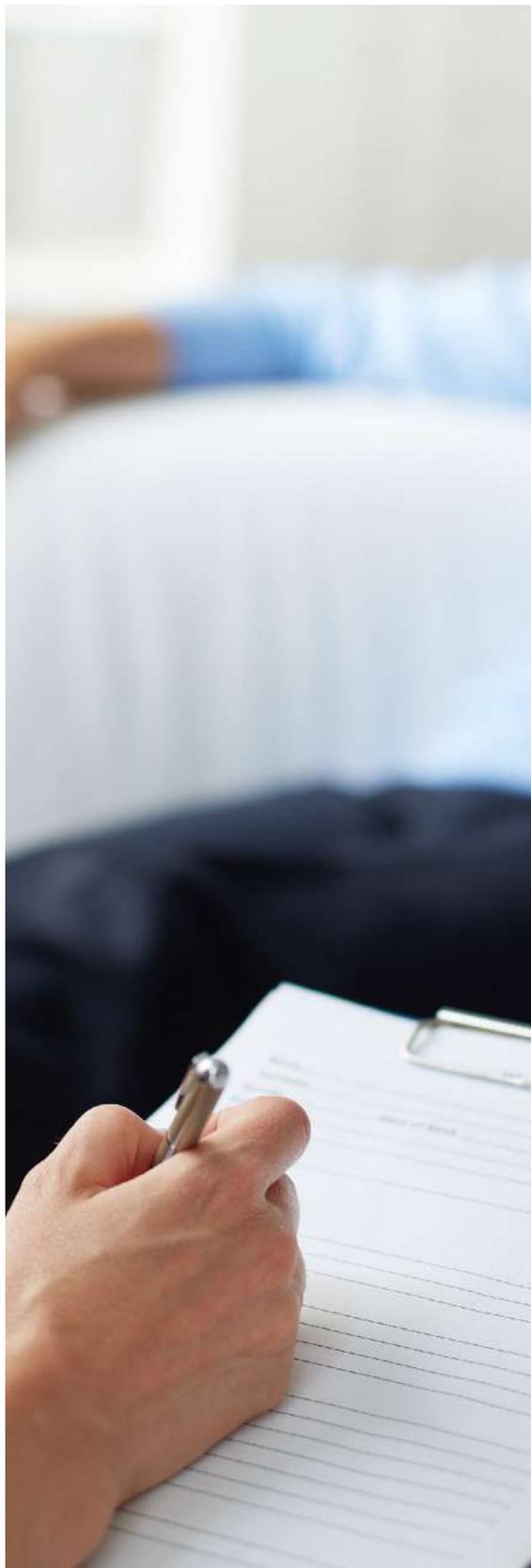
The Tribunal revoked Sam's involuntary order.

Doctors failing to turn up, and poor quality medical reports

Psychiatrists attended only 59% of hearings, and psychiatric registrars attended 34% of hearings (either with a psychiatrist or alone) according to Tribunal data¹². This continues to be a major concern to the Advocacy Service, along with late and poor quality medical reports. In some cases, the hearing had to be adjourned as a result, which means the person continued to be detained in the interim. Other issues include inconsistency between Tribunals in their approach. This leads to a serious risk of hearings not being procedurally fair, and a lack of natural justice as a result.

The President of the Tribunal has been very active this year, producing standard orders for Tribunal members, a medical report template for completion by doctors, and application forms for hearings. The new medical report template provided by the Tribunal draws attention to the need for a treatment, support and discharge plan, supporting the long-standing campaign by the Advocacy Service to get compliance by psychiatrists and mental health services with this requirement of the Act ([see page 29, *Treatment, support and discharge plans*](#)). The changes brought in by the Tribunal President are therefore very welcome and it is hoped there will be an improvement for consumers in the consistency and procedural fairness of the reviews.

¹² Data was provided by the Mental Health Tribunal on 18 July 2019 and may be subject to change.



Basic rights and person-centred care

Principles 1, 2, 3, 4, and 5 of the Charter of Mental Health Care Principles, to which all mental health services and staff must have regard, require person-centred care, recovery-focused attitudes, patient involvement in their care, and for people to be treated with dignity and respect.

“ After being made involuntary, my doctor and I ended up having a discussion about what the plan was for my admission and I was later given a document called a treatment, support and discharge plan. Even though I didn’t agree with some of the things on the plan, I signed the document because I thought I had to because I was an involuntary patient. I later spoke to my Advocate and they told me that I didn’t need to sign the plan if I didn’t agree with it.

My Advocate spoke to my doctor and explained the points in the plan that I didn’t agree with, and organised for my family and me to meet with my treating team to discuss the plan. At that meeting, I was able to have the plan changed to more fully reflect my recovery goals, and then for the remainder of my admission, my treatment team met my family and me regularly and my plan was updated to reflect those conversations.

When I was ultimately discharged home, I was discharged with a clear treatment, support and discharge plan that was created in consultation with not just me, but also with my family and community team. My plan included a clear pathway back into hospital which was designed to encourage me to seek help voluntarily as soon as I start to struggle with my mental health. It also included my recovery goals, including a plan to return to study. This has been great because my case manager has been able to support me with these goals.

Since that admission, I have needed a couple of short hospital stays. But because my plan is in place and there is a copy of it on file in the Emergency Department to make ED staff aware of what my treatment and support should be in various circumstances, I know I can seek help voluntarily and get the help I need straight away. ”

— *Chris*



Treatment, support and discharge plans

The key under the Act to achieving person-centred care is compliance with requirements for a treatment, support and discharge plan (TSD Plan), specifically that:

- all care and treatment must be governed by a TSD Plan
- the consumer must have input to the TSD Plan
- the consumer must be given a copy of the TSD Plan
- relevant personal support persons must also be involved and given a copy of the TSD Plan.

Compliance with the Act remains elusive, as Advocates, the Senior Advocates and Chief Advocate continue to

educate and persuade mental health services and psychiatrists on consumer rights.

The first application for a compliance order from the Mental Health Tribunal for a TSD Plan was made this year. Under the Act, there is a serious consequence for the psychiatrist or mental health service when a compliance order is made because they must be named in the Tribunal's annual report tabled in Parliament. This application to the Tribunal was made after attempts over a long period of time to get the mental health service to comply with the Act. Following the application, but before the hearing, a very good TSD Plan, with consumer and personal support person input, was developed, so the hearing did not go ahead.

The Tribunal, which has the power to make recommendations and compliance orders in relation to TSD Plans, has been supportive. The new medical report template provided by the Tribunal draws attention to the need for a TSD Plan, and some Tribunal members have been active in raising the issue and recommendations in hearings with treating psychiatrists. In one case, the psychiatrist started to outline the treatment plan. The Advocate interrupted to ask whether the consumer had been provided with a written copy (as required by the Act and for the purposes of procedural fairness in the hearing). Both the psychiatrist and the case manager acknowledged there was no plan other than the one that had been completed while the consumer was an inpatient nine months earlier. The Act requires regular review of the TSD Plan.

The Chief Advocate also gave a presentation on TSD Plans to the carer and consumer group Mental Health Matters 2 (MHM2). It can be much easier for a consumer to get their rights heard where they have family support to engage with the treating team and insist on a TSD Plan that complies with the Act. This presentation led to MHM2 successfully seeking funding to draft resources about TSD Plan rights.

» Conditions on wards inquiry

The physical conditions on a ward can make a big difference to a consumer's recovery, particularly when they are being detained on a ward for weeks, as are many of the consumers supported by the Advocacy Service. From May to June 2019, 27 Advocates undertook inspections of 54 mental health wards across all 18 authorised hospitals in Western Australia to consider the physical environment and conditions in wards from a consumer and carer perspective.

Positive practices included wards where visually welcoming strategies were used, engaging activities were readily available, consumer privacy was respected and the physical environment clean and well-maintained. Examples included colourful murals on common area walls, aquariums, provision of gardening, music and pet therapy activities, and exercise equipment. Private en-suite rooms promoted privacy and reduced safety risks - one ward had an LGBTIQ-identified toilet.

However, inspections revealed significant privacy, safety and hygiene concerns across a significant number of mental health wards:

- shared bedrooms, designed for single occupancy, with beds centimetres apart
- bedroom door privacy screens not present or semi-transparent



Advocates preparing for the conditions on wards inquiry.

- external windows with curtains hanging off rails, blinds held together with a bulldog clip or missing, and newspapers over a window for privacy
- seclusion rooms with no toilet, or a toilet that remained locked and consumers having to use cardboard urinals in full view of staff monitoring the seclusion
- broken or no locks on doors to shared toilets and shower cubicles
- no intercoms in seclusion rooms, creating risks in medical emergencies
- various ligature risks in bathrooms, and due to exposed beams or metal grating of undercover outside areas, and plastic bags used as bin liners presenting an asphyxiation risk for consumers with suicidal ideation
- no lockable storage for consumers' personal possessions and risk of theft

- cleanliness and hygiene issues such as blood stains on a mattress; blood stains on seclusion room doors; stained carpet; faeces on a toilet seat and the corridor outside the bathroom door; broken toilet seat and toilet flushes not working; dirty air vents and inadequate ventilation, and mould in bathrooms; poor drainage in en-suites, seeping into bedrooms; used sanitary products in an open bin of a laundry room; stained sanitary bin; spiders in the corner of a seclusion room; ants in bedrooms and bathrooms; dirty bed ensembles, and mattresses ripped in the centre without mattress protectors
- mattresses that didn't fit the bedframe, with some too wide and hanging off the bedframe and some too small
- uneven heating and cooling of rooms; worn and dirty furniture; insufficient hot water from bathroom taps and low water pressure; threadbare carpet in places; peeling paint and chipped walls
- common areas such as gyms, Courtyards, occupational therapy rooms and quiet rooms frequently locked at some facilities; dirty and depressing Courtyards; and not enough seating for consumers in communal area, despite the facility being relatively new.

The Advocacy Service has provided written feedback to all the facilities inspected, including requesting information about how they will address the issues identified by Advocates, and will be following this up in the 2019-20 financial year.

Involving carers and personal support persons

Based on data given to the Advocacy Service, family and personal support persons are not routinely being notified of events such as when a referral for examination and an involuntary treatment order are made, as required by the Act. The notification is to be given as soon as practicable after the event occurs, and reasonable efforts must be made to contact the person. The Chief Advocate must be given the details of the person notified and if no one has been contacted, the Chief Advocate is to be given the reasons why.

The Advocacy Service is automatically notified through the mental health service database (PSOLIS). Based on that data, some hospitals are notifying family, carers, etc multiple times but most hospitals are not notifying anyone in the majority of cases. This could be data entry error, but the HSPs and DOH have been unable to explain the reasons or clarify the position. The Advocacy Service continues to seek answers.

Hostels

Advocacy services for residents

Psychiatric hostels house some of the most vulnerable and marginalised people in our society, and are often long-term homes for residents. Advocates provided services to 218 hostel residents during the year. There were 266 issues noted by Advocates relating to care of residents in hostels, five of which relate to serious issues in two hostels and continue to be followed up.

Evictions

Advocates regularly act on behalf of residents under threat of eviction. There are so few options for hostel

residents, and the hostel is often their home. In one case, the person had been living there for many years. Hostel management argued it could no longer handle the resident's needs, but the Advocate countered that the resident's needs had not changed, and that it was the staff who had changed and needed more training.

In another hostel, changes in practice led to numerous residents fearing eviction because hostel management said they were not engaging with the hostel's recovery program. It was pointed out that the programs were not suitable for all residents and needed to be more person-centred. After meetings and correspondence, the hostel's management agreed to change its approach.

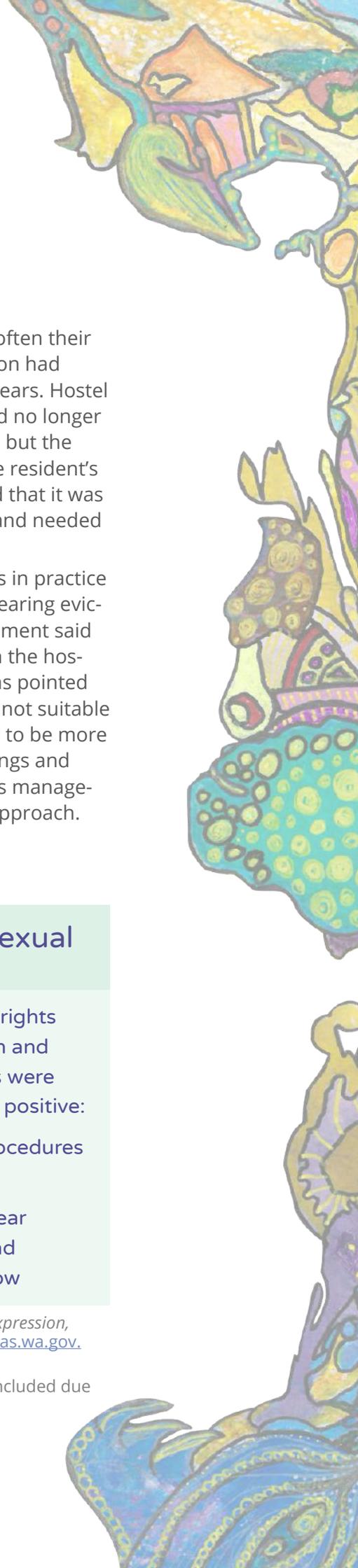
» Inquiry into rights to sexual expression, sexual safety and gender diversity

A major project during the year was an inquiry¹³ to promote the rights of psychiatric hostel residents to sexual safety, sexual expression and gender sensitivity, conducted in 21 of 33 hostels¹⁴. The findings were concerning but the responses of hostel management have been positive:

- six hostels did not have any policies, guidelines or written procedures on sexual safety
- 15 hostels had policies on sexual safety, but only nine had clear policies, procedures or information covering the reporting and investigation of unwanted sexual behaviour. This included how

13 The report on *Inquiry into the Rights of Psychiatric Hostel Residents to Sexual Expression, Sexual Safety and Gender Diversity*, June 2019, is available on the website <https://mhas.wa.gov.au/>.

14 Regional hostels and smaller, more independent-living, facilities were not included due to the Advocacy Service resource issues.





residents could make a complaint or get help, or to guide staff when an allegation was made against a staff member

- nine hostels had a policy or guidelines about sexual expression and gender sensitivity
- eight hostels required residents to share bedrooms, and three of those did not meet other basic requirements, such as locks on bedroom and bathroom doors, and single-gender bathrooms.

There were mixed processes around identifying and supporting people with a history of sexual trauma, and very little training offered to staff on how to handle and respond to a sexual safety incident. Residents' knowledge of what to do in the case of sexual abuse or inappropriate behaviour was largely limited to saying they would talk to staff, compounded by so few hostels having policies or giving information to residents.

In the absence of written policies that are made known to residents, residents are less likely to complain about safety issues or abuse, and issues are more likely to be handled in a way that compromises the well-being of, and natural justice for, residents. This also heightens the risk of inconsistency in the delivery of care and handling of complaints.

The response to the inquiry by the majority of hostel managements was positive. Some hostels responded with action plans and strategies being developed to address the identified gaps, while others indicated they would review their policies and practices. One of the hostel licensees has since reported that their review and rewriting of policies around the issue has resulted in a change in culture among staff - previously there had been a mistaken belief that people with mental health issues did not have the capacity to engage in sexual relations and needed to be 'protected' from doing so. The hostel conceded that a previous incident resulting in staff calling the police and the eviction of a male resident was a prime example of ill-conceived notions.

A benefit of the inquiry was to make Advocates more accessible to hostel residents who can be too fearful, or not know who, to ask for help.

The report, which was sent to the Minister, will be discussed by the Psychiatric Hostels Agency Committee, comprising the Advocacy Service, the MHC, the DOH's Licensing and Accreditation Regulatory Unit, the Office of the Chief Psychiatrist (OCP) and a representative of the HSPs.

How we work

Involuntary orders

The total number of involuntary treatment orders (form 5A, 6A and 6B orders) in Western Australia increased slightly (1.9%) over the past three years, but there were variations in age groups, gender and types of orders.

- the number of orders for females aged 25 to 64 years decreased 8.3%
- the number of orders for older adults decreased 9.2%.

Community treatment orders (Form 5As)

The number of community treatment orders has steadily increased over the past three years (up 6.8%) and is largely accounted for by a 76.9% increase in orders for male youth (aged 18 to 24 years), while there has been a steady decrease in orders for older adults (65 years and older).

Inpatient treatment orders in an authorised hospital (Form 6As)

The total number of form 6As has decreased slightly (1.0%) across three years in Western Australia, however:

- the number of orders for consumers under 18 years has increased 39.5%

Inpatient treatment orders in a general hospital (Form 6Bs)

An involuntary treatment order can be made in a general hospital due to the consumer's physical medical needs. Although the number of orders is relatively low (149 in 2018-19), the figure has significantly increased each year (up 53.6% in the past three years). The increase is due largely to more form 6Bs being made for young females (aged under 25 years).

Overall three times as many form 6Bs orders were made for female consumers as compared to males, whereas more form 5A and 6A orders were generally made for males (with the exception of orders for older adults).

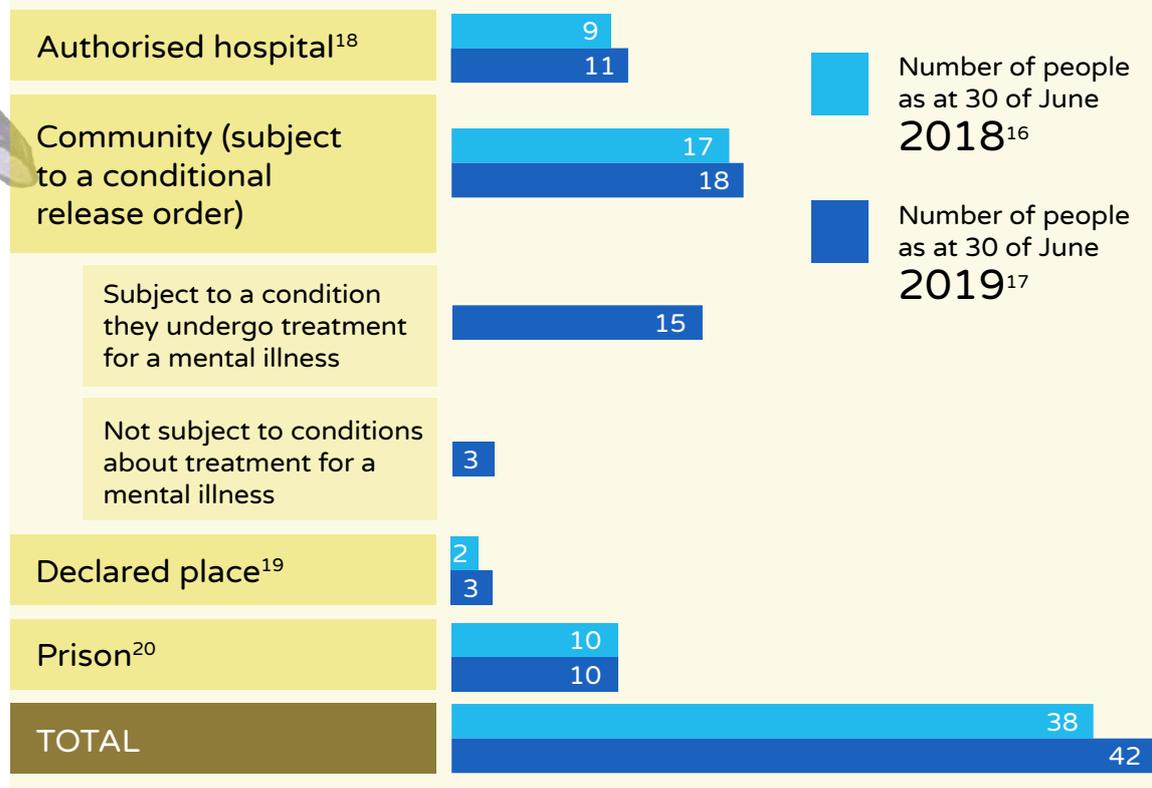
Custody orders

During 2018-19 there were eight¹⁵ new custody orders made by the Courts in Western Australia. In Western

¹⁵ Data in this section was provided by the Mentally Impaired Accused Review Board.

Australia, Courts can make a custody order where a person accused of a crime is found unfit to stand trial (unable to understand the charge, the requirement to plead, the purpose of the trial, etc) or is found to have been of unsound mind. The Mentally Impaired Accused Review Board made orders that seven people subject to custody orders were to be detained at an authorised hospital during 2018-19 (who are required to be contacted by an Advocate). Of these people, two had recently been put on a custody order by the Court. Five people on custody orders who were detained at an authorised hospital were no longer required to be detained in hospital during 2018-19.

Mentally Impaired Accused Persons



16 Source: Mentally Impaired Accused Review Board Annual Report 2017/18.

17 Source: Mentally Impaired Accused Review Board email of 1 August 2019. The data is based on 'Place of Custody Orders' made by the Board from 1 July 2018 to 30 June 2019.

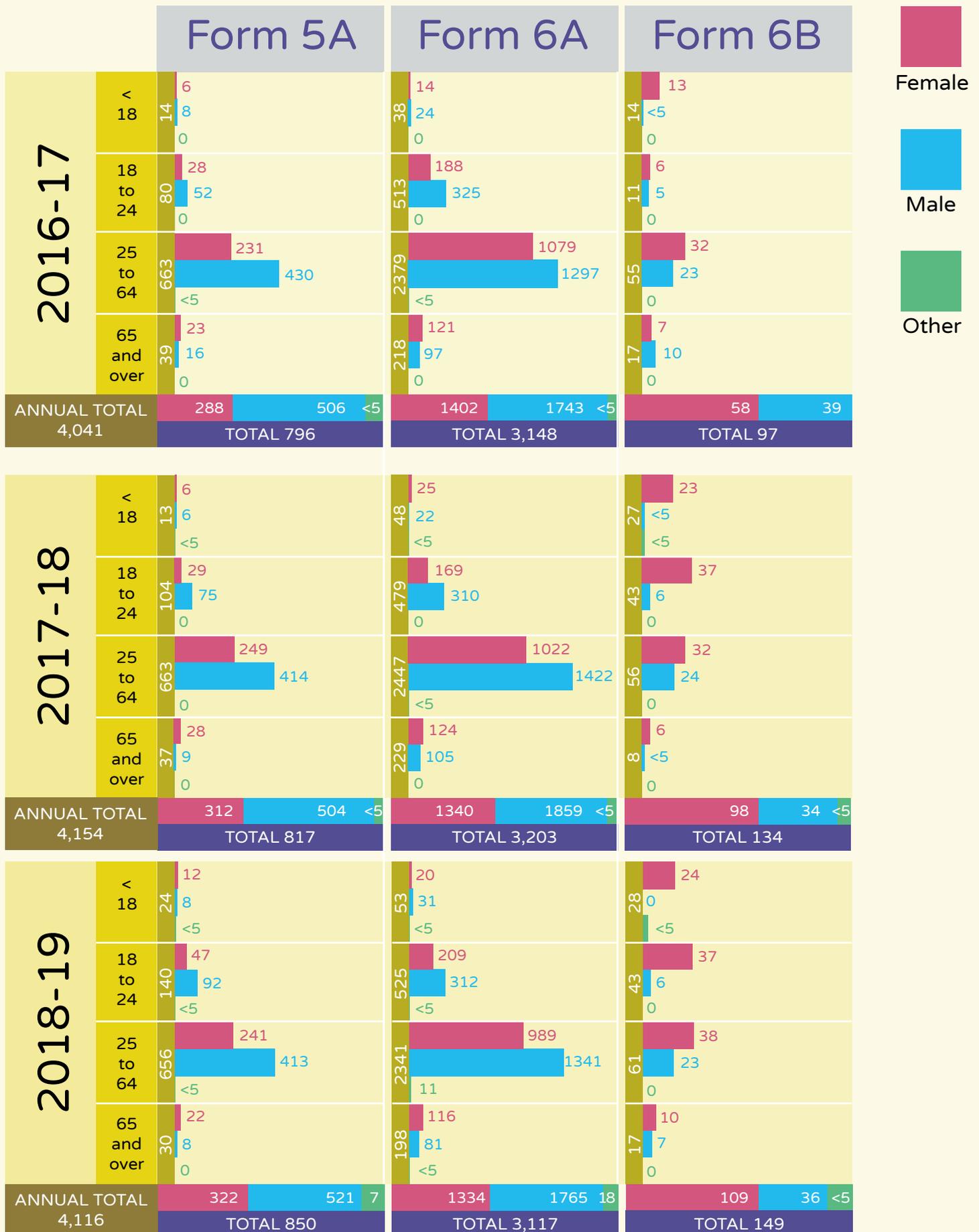
18 MIA persons who are inpatients in authorised hospitals may be participating in a leave of absence from the hospital.

19 MIA persons may be detained at a "Declared Place" if the reason for the person's disability is not predominantly due to mental illness.

20 MIA persons may be participating in a leave of absence from prison.

Number of Involuntary Treatment Orders

by age group and gender from 2016-17 to 2018-19



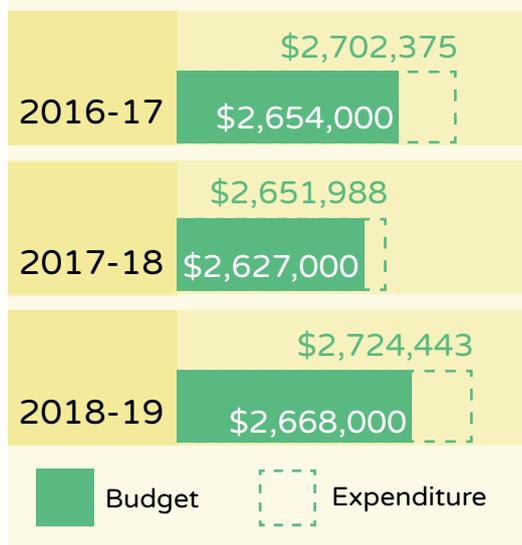
Budget and resourcing

2018-19 expenditure

In 2018-19 the Advocacy Service's total allocated budget was \$3.02 million, which comprised:

- \$2.668 million under direct control of the Chief Advocate for service delivery
- \$352,000 to cover the cost of services said to be provided 'free of charge' by the Mental Health Commission.²¹

The Advocacy Service's Allocated Budget for Its Service Delivery



²¹ Services include payroll and human resources support for staff, processing invoices and some financial services and IT support, some of which is provided by Health Support Services. The amount allocated in the budget for the "free services" is based on the Advocacy Service paying a proportion of the cost of the Mental Health Commission's corporate, audit and executive salaries as estimated by the Mental Health Commission.

The Advocacy Service aims to work within the budget allocated for service delivery (ie \$2.668 million), however expenditure was \$2,724,443, which was \$56,443, or 2.1%, over budget²². The Advocacy Service has had 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 the Advocacy Service is not able to completely fulfil its statutory responsibilities, particularly systemic inquiries and investigations.

In January 2018 the Advocacy Service implemented 19 cost-saving measures to try to remain within budget, and in August 2018 a functional review of support services was completed by an external consultant to identify how support services could better meet operational needs. The functional review resulted in changes to workflows, abolition of a level 5 public service position and creation of a level 4 position, which have improved efficiency and effectiveness.

In early 2018-19 two of the cost-cutting initiatives were partially rolled back, based on Advocate feedback that there were significant adverse impacts to consumers: a limited version of a weekend phone service was reinstated,

²² The cost of services received free of charge in 2018-19, as advised by the Mental Health Commission, was \$276,383 (or \$75,102 under budget). The Advocacy Service was therefore under budget by \$18,659 when the services provided free of charge were taken into account (noting that the allocated budget is not under the control of the Advocacy Service).

and a change in procedures for attendance at Tribunal hearings provided consumers with greater choice about representation.

The impact of inadequate funding principally affects consumers, as the Advocacy Service must be more economical with its services, however this also places greater pressure on those who work for the Advocacy Service who are repeatedly compromised in the services that can be provided.

The cost of Advocates, including the Chief Advocate, comprised 66.2% of the expenditure. The remaining costs were for Advocacy Services Officers' salaries and on-costs, building lease, travel, training and other goods and services.

2019-20 budget

The 2019-20 budget for service delivery (ie excluding the cost of services received free of charge from the Mental Health Commission) is \$2.71 million, which is less than the Advocacy Service's expenditure the previous year. An annual pay rise for Advocates and staff will further restrict the Advocacy Service's ability to remain within its 2019-20 budget, and impact on services.

Advocate remuneration

Advocates (including the Chief Advocate and Senior Advocates) are entitled to remuneration as determined by the Minister.

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 was in-line with the salary increases under the Public Service and Government Officers General Agreement and resulted in:

- Senior Advocates' rate increasing from \$60.00 to \$60.66 per hour
- Advocates' rate increasing from \$50.00 to \$50.65 per hour.

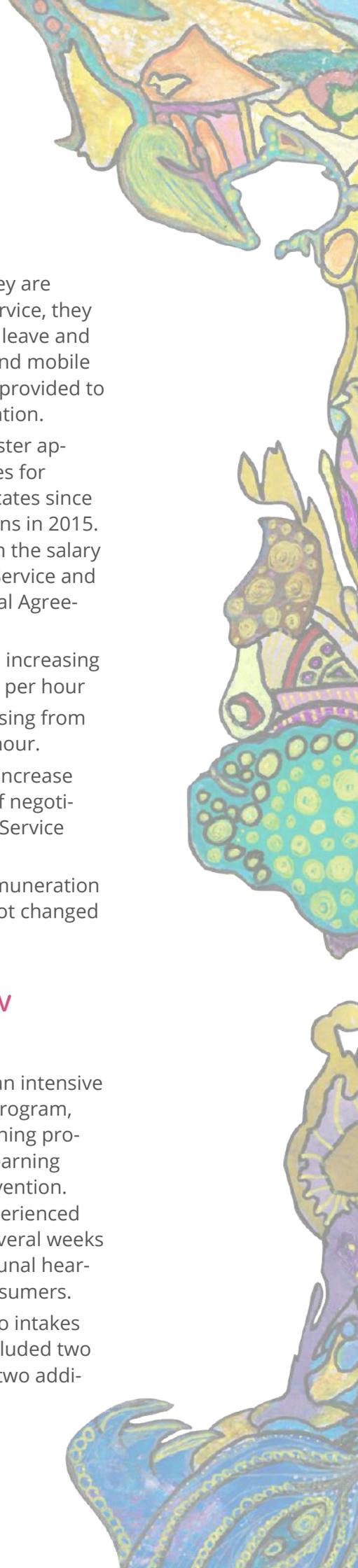
As at 30 June 2019, a pay increase was pending the outcome of negotiations of an updated Public Service Agreement.

As at 30 June 2019 the remuneration of the Chief Advocate had not changed since November 2015.

Induction of new Advocates

New Advocates undergo an intensive four-day in-house training program, complete a four-hour e-learning program on the Act, and an e-learning program on aggression prevention. New Advocates observe experienced Advocates in the field for several weeks and attend at least one Tribunal hearing before working with consumers.

In 2018-19, there were two intakes of new Advocates, which included two more Youth Advocates and two additional Aboriginal Advocates.



Advocate training and development

In previous years, Advocates attended half- and full-day training and development sessions on a quarterly basis in Perth. Due to budget constraints, only one half-day meeting was held in 2018-19, with regional Advocates attending by video-link.

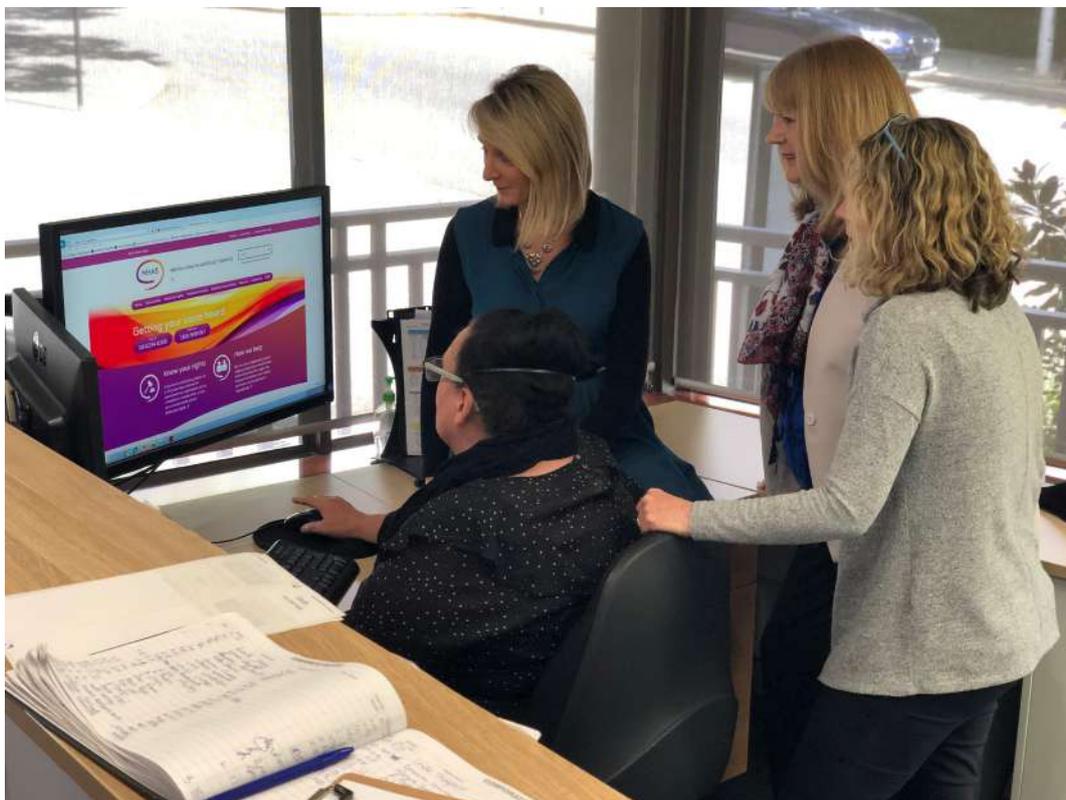
The financial situation also meant that monthly team meetings, used for training and discussion of issues specific to individual teams, were reduced to every second month last year (2017-18). As Advocates largely work in isolation from their colleagues, this frequency of meetings was untenable in terms of agency communications, consistency of practices and Advocates' job satisfaction, and so three additional meetings were scheduled in 2019. Regional Advocates, some of whom have virtually no face-to-face contact with colleagues (or occasional face-to-face contact with one colleague) have been particularly adversely affected by the Advocacy Service's financial situation.

Three joint 90-minute training sessions were also organised to be held on team meeting days (with regional Advocates attending by video-link).

The Chief Advocate, or her proxy, attended external forums and seminars during the year and information from those sessions is shared with Advocates through internal training, meetings and, increasingly, through emails.

A weekly email newsletter by the Chief Advocate is also used to raise issues and keep Advocates in touch with developments.

[Appendix 3](#) provides a list of the training events.



Advocacy Services staff

The Chief Advocate must be provided with Advocacy Services Officers to assist them to perform her functions under the Act. While the full-time equivalent complement of staff remained unchanged from the previous year, a level 5 position was abolished and a new level 4 position was created, as recommended by a functional review. This reflected changes in the Advocacy Service's operational needs and resulted in cost savings for the agency.

Electoral Act requirements

As required under the *Electoral Act 1907*, section 175ZE(1), the Advocacy Service recorded \$8,573 in expenditure related to the designated organisation types between 1 July 2018 and 30 June 2019, which is broken down as follows:

- Advertising agencies: \$4,390 Whistling Moose Graphics
- Media advertising organisations: \$1,130 Ethical Jobs; \$780 Seek; and \$2,273 Initiative
- Market research organisations: nil
- Polling organisations: nil
- Direct mail organisations: nil.

Quality assurance

The Advocacy Service is committed to continuous quality improvement in its service delivery and welcomes feedback of an informal and formal nature regarding its operations. In its 2018-19 budget submission, the Advocacy Service applied for \$25,000 funding to have an external party conduct an evaluation. The funding was not granted.

Complaints

The Advocacy Service received 13 complaints about its service during 2018-19, which were handled according to its complaints protocol (a copy of the protocol is available on the [Advocacy Service website](#)):

- six complaints were made by HSP staff
- four complaints were made by consumers
- three complaints were made by other parties (a guardian, a nominated person and a service provider).

Nine complaints were resolved informally and four complaints were made formal. Seven complaints were dismissed as unsubstantiated and, of these, five were found to be a misunderstanding of the role of the Advocacy Service. An apology was made on six occasions, although in some instances the outcome of the investigation found a misunderstanding between the parties and/or part of the complaint was substantiated.

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. Advocates contacted 93.6% of consumers within statutory timeframes in 2018-19. Advocates will still seek to contact a consumer even if it is after the seven day timeframe (or 24 hours for children) if they are still subject to an order, and, when this is taken into account, the Advocacy Service contacted 94.7% of consumers subject to an involuntary order.

The Advocacy Service counts as breaches even those cases where the order is revoked and the person is made voluntary within the seven day period. These accounted for 46.2% of breaches in 2018-19.

The rate of notification to the Advocacy Service by HSPs improved when the DOH started providing the Advocacy Service with notifications of involuntary and other orders directly through its PSOLIS database. Although the number of breaches due to the Advocacy Service not being notified within seven days (or 24 hours for children) has decreased, this may be due to the Advocacy Service's practice of Advocates seeking to speak with consumers recently made subject to involuntary orders (and not yet appearing on the database) when they are on wards.

Although all children were contacted by an Advocate following an involuntary order being made, this was not achieved within the statutory 24 hour timeframe in 13 cases. This was due to the notification not being received within two hours, as agreed by health services, and in most cases it was not received within 24 hours.

Reason for Breach	2016-17	2017-18	2018-19
Inpatient Treatment Orders			
<input checked="" type="checkbox"/> Order not received within 7 days	10	13	9
<input checked="" type="checkbox"/> Order received within 7 days and			
Order revoked within 7 days	168	134	121
Contact made after 7 days	20	26	32
Subsequent order made within 7 days (and consumer not contacted beforehand)	6	7	5
Consumer not contacted	36	13	15
Community Treatment Orders (CTO)			
<input checked="" type="checkbox"/> Order not received within 7 days	23	15	11
<input checked="" type="checkbox"/> Order received within 7 days and			
Order revoked within 7 days		2	1
No address available and unable to contact by phone	4	2	1
Letter was returned and unable to contact by phone	22	26	20
 Orders for children	12	16	13
 Advocacy Service administration error	7	5	26
 Other	1	6	8
TOTAL BREACHES	309	265	262

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 section 354 of the Act. During 2018-19 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 particular mental health service or ensure that a particular service is visited (see section 355 of the Act). There were no such directions issued during 2018-19.

Committees, submissions and presentations



The Chief Advocate, or her proxy, was a member of 13 committees and took part in 22 consultations or provided written submissions during 2018-19, as set out in [Appendix 1](#). The Chief Advocate was also asked to give evidence at a public hearing by the Joint Standing Committee of the Commissioner for Children and Young People, which was conducting an inquiry into the monitoring and enforcing of child safe standards.

Presentations are also given by the Chief Advocate, or her proxy, to facility staff and other stakeholders on the role of the Advocacy Service and consumer rights. The presentations are an important educational tool which help protect consumers' rights and improve understanding of the role of the Advocacy Service. A list of the 35 presentations given is provided in [Appendix 2](#).

Records management

In accordance with section 19 of the *State Records Act 2000*, the Advocacy Service 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 the Advocacy Service 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.

An evaluation of the Advocacy Service's record-keeping plan is scheduled for 2023, in accordance with the State Records Commission Standard 2, Principle 6.





Appendix 1: Committees and submissions

Continuing committees:

1. Private Hostel Agencies Committee
2. National Visitor and Advocacy Bodies Group
3. Accountability Agencies Review Working Group
4. Hostel Recovery Support Project
5. OCP - Sexual Safety of Mental Health Consumers - Standards and Guidelines Reference Group
6. Joint Advocacy Agencies

New committees in 2018-19:

7. Franciscan House Evaluation Reference Group
8. Co-Leadership Safety and Quality Mental Health Steering Group
9. Forensic Youth Mental Health - Mapping of Pathways
10. Mental Health Network Executive Advisory Group
11. PCH - Review of the Mental Health Patient Journey
12. Independent Oversight of Child Related Services Working Group
13. Child and Adolescent Mental Health Services Eating Disorder Review Steering Group

Submissions, forums and consultations:

1. Consultations by the Department of Communities on the *Action Plan for At Risk Youth Project* – July 2018
2. Submissions on draft *Chief Psychiatrist's standards for authorised hospitals under the Mental Health Act 2014* – August 2018
3. Response to discussion paper *An office for advocacy and accountability in Aboriginal affairs in Western Australia* – September 2018
4. Emergency Department Summit hosted by the Australasian College for Emergency Medicine in Melbourne – October 2018
5. National Review of Community Visitor Schemes for the NDIS, Perth consultation – October 2018

6. Submissions on the draft *Western Australian Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-1015* – October 2018
7. NDIS Systemic Advocacy for People with Disabilities briefing, October 2018
8. Human Rights Commission consultation on the *Optional Protocol to the Convention against Torture and Cruel, Inhuman and Degrading Treatment (OPCAT), in Perth* – November 2018
9. Review of South Australian Community Visitors arising from the ICAC Report on the Oakden Facility - February 2019
10. Feedback on the draft *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 Update 2018* – February 2019.
11. Mental Health Network Open Day Forum – February 2019
12. Consultation with the Mental Health Commission on proposed amendments to the Mental Health Act 2014 – February 2019
13. Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse - Duty of Institutions Recommendations – March 2019
14. Office of the Auditor General, interview for its performance audit into *Services for People with Mental Health Issues* – March 2019
15. State Government's response to the recommendations of the Coroner's Inquest into 13 youth suicides in the Kimberley– comments on recommendations requested by the Department of Premier and Cabinet - February 2019
16. Mental Health Clinical Governance Review – consultation with Dr Martin Chapman and Professor Bryant Stokes – February to May 2019
17. Department of Justice, consultation on proposal for mental health unit at Casuarina Prison as part of the planned Alcohol and Other Drugs Unit - March 2019
18. Public hearing with the Joint Standing Committee on the Commissioner for Children and Young People - March 2019
19. Submissions on draft *Mental Health Bed Access, Capacity and Escalation Statewide Policy* - May 2019
20. Submissions on draft *Notifiable Incidents Psychiatric Hostels Policy 2019* - May 2019
21. Submission on the draft Criminal Law Mental Impairment Bill, Department of Justice – October 2018 and June 2019
22. Curtin University Honours Research Project: *Advocacy training needs for professional advocates* – June 2019.



Appendix 2: Advocacy Service presentations

1. Honeybrook Lodge psychiatric hostel staff, Senior Advocate, July 2018
2. SJOG Midland Hospital staff, Senior Advocate, July 2018
3. Broome Community Mental Health Service staff, Advocate, July 2018
4. WACHS Mental Health Executive Advisory Group, Chief Advocate, July 2018
5. Armadale Hospital staff, Senior Advocate, July 2018
6. Burswood Care psychiatric hostel staff, Senior Advocate, July 2018
7. BP Luxury Care, psychiatric hostel staff, Senior Advocate, July 2018
8. Rockingham Hospital, new medical staff, Senior Advocate, August 2018
9. Fremantle Hospital, new medical staff, Senior Advocate, August 2018
10. Fremantle Hospital, mental health service staff, Senior Advocate, September 2018
11. Graylands Hospital, social work and welfare officers, Advocate, October 2018
12. Fremantle Hospital, mental health service staff, Senior Advocate, November 2018
13. Department for Communities, District Directors, Youth Advocate, November 2018
14. Armadale Hospital, mental health service staff, Senior Advocate, November 2018
15. Individual Disability Advocacy Service Forum 2018, *'Advocacy: Future Perspectives'*, Chief Advocate, November 2018
16. Department for Communities, District Directors, Youth Advocate, December 2018
17. Fremantle Hospital, staff on ward 4.1 and 5.1, Senior Advocate, December 2018
18. Fremantle Hospital, staff on ward 4.2 and 4.3, Senior Advocate, December 2018
19. Sir Charles Gairdner Hospital (SCGH) Medical Executive Committee, Chief Advocate, December 2018
20. Honeybrook Lodge psychiatric hostel staff, Senior Advocate, February 2019
21. Royal Flying Doctor Service, Chief Advocate, February 2019
22. SCGH Emergency Department clinicians, Chief Advocate, February 2019
23. SCGH Patient Flow Unit, Chief Advocate, February 2019
24. Fremantle Hospital, new medical staff, Senior Advocate, February 2019
25. Rockingham Hospital, new medical staff, Senior Advocate, February 2019

- 26.** Bentley Hospital staff, Senior Advocate, February 2019
- 27.** Mental Health Matters 2, consumers and carers, presentation on Treatment, Support and Discharge Plan rights under the Mental Health Act 2014, Chief Advocate, February 2019
- 28.** SCGH Nursing Executive Committee, Chief Advocate, March 2019
- 29.** Bentley Hospital staff, Senior Advocate, March 2019
- 30.** Fiona Stanley Fremantle Hospitals Group, mental health service staff, Senior Advocate, March 2019
- 31.** Road to Recovery radio interview, *Advocacy and Complaints in the Community Sector*, Chief Advocate, April 2019
- 32.** Health Complaints Commissioners' meeting, *Role of MHAS*, Chief Advocate, May 2019
- 33.** Kalgoorlie Mental Health Unit and Community Mental Health Team staff and consumers, Senior Advocate, June 2019
- 34.** Broome Mental Health Unit staff, Senior Advocate, June 2019
- 35.** Wheatbelt Community Mental Health teams (Northam, Merredin, Gin Gin), Senior Advocate, June 2019



Appendix 3: Training, seminars and conferences

1. Symposium by NMHS led by Professor Killaspy, *Pathways through a connected system, rehabilitation and recovery for people with complex mental health needs*, 1 and 2 October 2018, Chief and Senior Advocates
2. Launch of the *Foundational Engagement Resource* by Mental Health Matters 2, 25 October 2018, Chief Advocate
3. Eating Disorders Sub-network Planning Workshop, 8 October 2018, Youth Advocate
4. Advocate training day December 2018 :
5. *Understanding Sex and Gender Diversity* by Sandra Norman from Living Proud
6. *Smoking Cessation and Nicotine Dependence in Mental Health Care Settings* by Dr Matthew Coleman
7. Amended MHAS Serious Issue Protocol by Chief and Senior Advocates
8. Advocate training session, February 2019: Dr Lisa Miller, WAEDOCS, and Shannon Calvert, Lived Experience Advocate, on Eating Disorders
9. Public Interest Disclosure Session, Crime and Corruption Commission, February 2019, Manager
10. Advocate training session, March 2019: Karen Whitney, President of the Mental Health Tribunal, on the new Tribunal application forms and capacity under section 25 of the Act
11. Advocate training workshop in preparation for Conditions in Wards Inquiry, May 2019
12. Health Consumers Council *Patient Experience Day* focussing on the Aboriginal Patient Experience of the WA Health system, April 2019, attended by two Advocates working on the MHAS *Inquiry into Services for Aboriginal and Torres Strait Islander people and Compliance with the Mental Health Act 2014*.

Glossary of Acronyms and Terms

Act	Mental Health Act 2014
Advocacy Service	Mental Health Advocacy Service
Advocate	Mental Health Advocate
CAHS	Child and Adolescent Health Service
Chief Advocate	Chief Mental Health Advocate
CLMIA Act	<i>Criminal Law (Mentally Impaired Accused) Act 1996</i>
Consumer	An 'identified person' as defined by s348 of the Act who can be assisted by an Advocate, but excluding hostel residents (unless the resident is in hospital under the Act)
CTO	Community treatment order, also called a form 5A
DOH	Department of Health
ED	Emergency department
EMHS	East Metropolitan Health Service
EMYU	East Metropolitan Youth Unit
FSH YU	Fiona Stanley Hospital Youth Unit
Form 5A	Community treatment order, and a type of involuntary treatment order
Form 6A	Involuntary inpatient treatment order made in an authorised hospital, and a type of involuntary treatment order
Form 6B	Involuntary inpatient treatment order made in a general hospital (by a psychiatrist), and a type of involuntary treatment order
Hostel	Private psychiatric hostel as defined in the Act
HSP	Health Service Provider – comprising each of or collectively EMHS, NMHS, SMHS, CAHS and WACHS
Involuntary treatment orders	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).
LARU	DOH Licensing and Accreditation Regulatory Unit
MHC	Mental Health Commission
MHLC	Mental Health Law Centre

MHM2	Mental Health Matters 2, consumer and carer group
Minister	Minister for Mental Health
NDIS	National Disability Insurance Scheme
NMHS	North Metropolitan Health Service
OCP	Office of the Chief Psychiatrist
OICS	Office of the Inspector of Custodial Services
PSOLIS	Psychiatric Services Online Information System, a DOH database of clinical information of people in the public mental health system which records the status of people under the Act
SAT	State Administrative Tribunal
SCGH	Sir Charles Gairdner Hospital
SJOG	St John of God
SMHS	South Metropolitan Health Service
Tribunal	Mental Health Tribunal
TSD Plan	Treatment, support and discharge plan
WACHS	WA Country Health Service



Unit 6, 18 Harvest Tce, West Perth WA 6005
Post (no stamp required): Reply Paid 84455 West Perth 6005

T: (08) 6234 6300 or 1800 999 057

F: (08) 9226 3977

E: contactus@mhas.wa.gov.au

W: www.mhas.wa.gov.au

