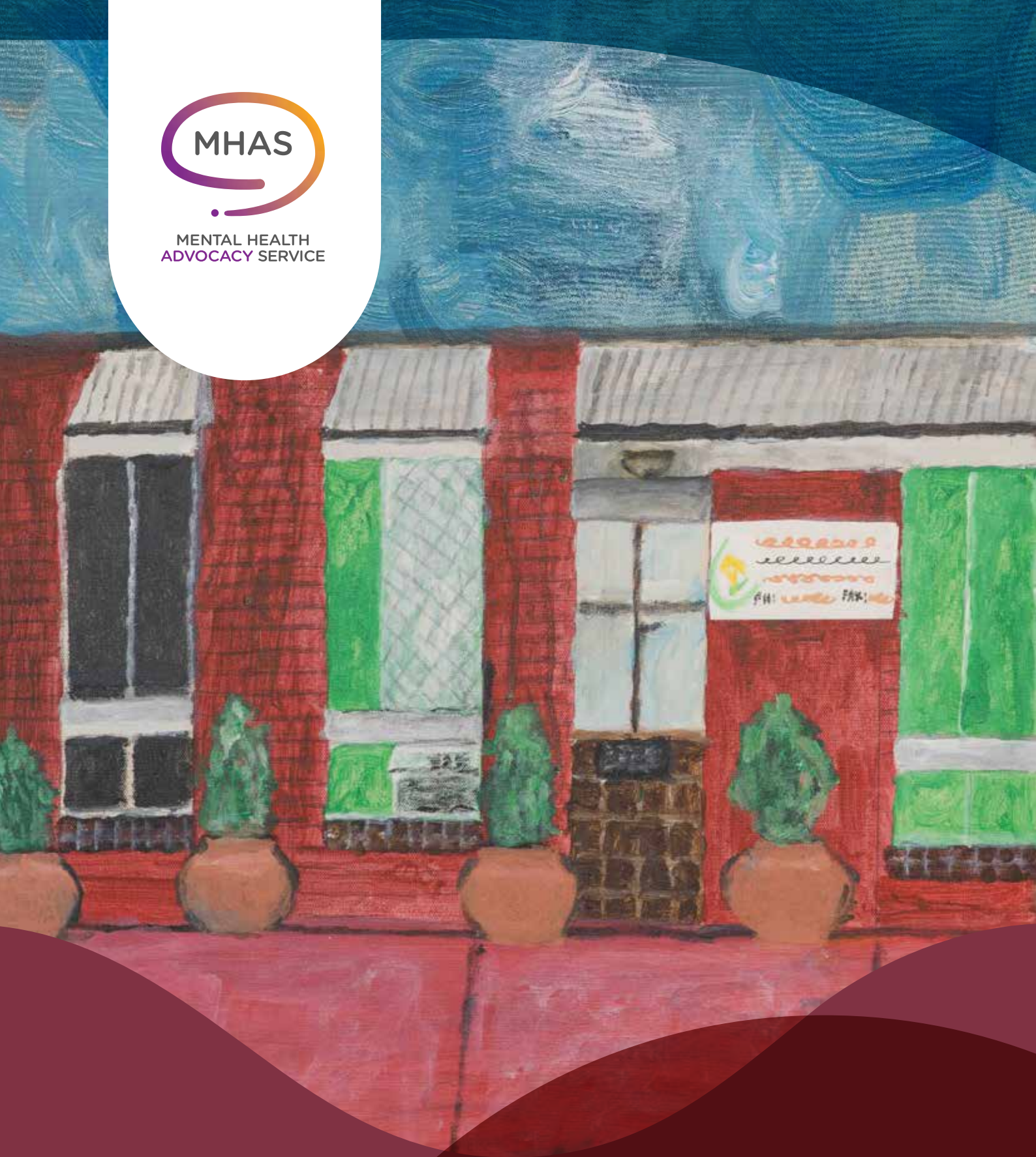
MHAS

MENTAL HEALTH
ADVOCACY SERVICE



2022-2023

Annual Report

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

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

Hon Amber-Jade Sanderson 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 2023.

As well as recording the operations of Mental Health Advocacy Service for the 2022-23 year, the annual report reflects on a range of issues that continue to affect consumers of mental health services in Western Australia.

Dr Sarah Pollock
CHIEF MENTAL HEALTH ADVOCATE

September 2023

The artwork used on the front cover of the annual report is called ‘Salisbury Home’. It has been reproduced with the permission of the artist, Mr Mervyn Harper.


Meagan Harper
2020

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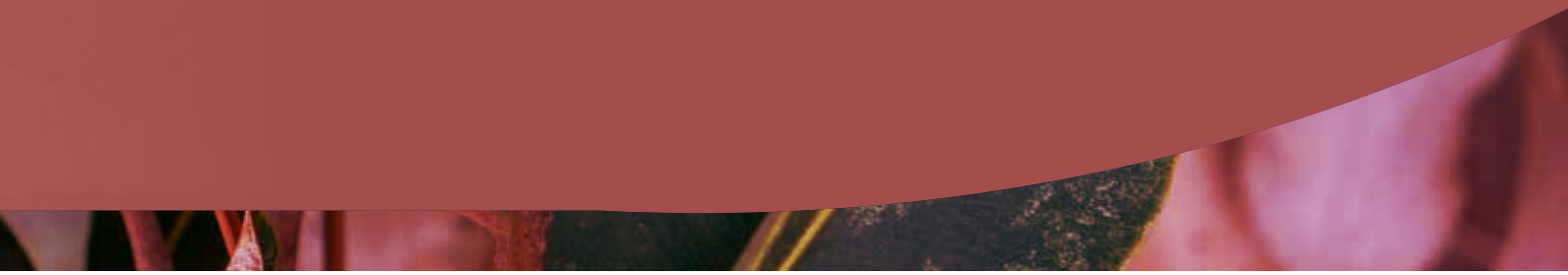


Chief Advocate's foreward

Welcome to the eighth annual report for the Mental Health Advocacy Service (MHAS). In Western Australia, every person who is identified under the *Mental Health Act 2014* (the Act) has the right to an Advocate whose job is to help them understand and access their rights. Advocates amplify consumers' voices so their needs and preferences can be heard and met. They respond to complaints and breaches of the Act, and conduct investigations and inquiries into systemic matters.

Whilst many people receive an adequate response from mental health services, some don't. Sometimes this is an outcome of a difficult systemic problem or a situation that requires investment of significant resources to change, but not always. Good communication, transparency, provision of comprehensive and accurate information, and compassionate treatment and care all make a huge difference to consumers' experiences. These are obligations under the Act and the Charter of Mental Health Care Principles, and the sorts of issues that Advocates deal with daily.

We are the only service with daily eyes on what happens in each mental health unit, medical ward, intensive care unit and emergency department (ED) when people are treated for mental crisis, distress and ill-health. We are the canary in the coalmine, the advance warning system, an accountability mechanism essential to the good governance of the mental health system.

This report outlines the activities of our Advocates and draws attention to systemic issues. Because our role is rights protection, much of the content in the report focuses on when things go wrong, and on actions Advocates take to remedy situations. However, we want the same things as the services we work with - effective and respectful consumer-clinician relationships, quick access to appropriate treatment, person-centred and holistic support for recovery. These are what our advocacy aims to promote and uphold.

The MHAS is one of the great strengths of the Act, and an essential pillar of the accountability systems for mental health care that can include coercive detention and treatment. However, we are facing a critical shortage of resourcing that is threatening our ability to fulfil this essential role.

Inadequate resourcing at establishment, obligatory but unfunded costs such as pay increases for Advocates and increased awareness of and demand for our services have accumulated to create an existential threat to the organisation. This is taking a toll on the health, safety and wellbeing of our staff and Advocates, and is beginning to impact the quality of services we provide. It is only the good will of staff and Advocates and their preparedness to put the consumer first that has delayed this from happening already.

I thank the Advocates, Senior Advocates and the advocacy support staff at MHAS for this.

Dr Sarah Pollock
CHIEF MENTAL HEALTH ADVOCATE

Executive summary

In 2022-23, MHAS experienced a noticeable increase in demand for advocacy services with service provision now exceeding that of pre-COVID 19 levels in 2019-20.

Compared to 2021-22, the number of involuntary orders increased by 10.8%, the number of Advocate hours provided increased by 20.1%, and the number of consumers supported by MHAS increased by 13.5%. In addition, the number of serious issues reported to Advocates increased by 75.4%, and the number of issues and complaints Advocates assisted consumers to resolve increased by 37.5%.

Since MHAS' inception in 2015, various unavoidable external drivers have impacted on demand for advocacy from MHAS. A system-wide increase in the demand for mental health treatment and support has led to hospital bed shortages, compounded by accommodation shortages and a delay in discharge for some. This has led to a consequent increase in Advocate workload volume and complexity. Along with the commissioning of new facilities and expansion of jurisdiction into new service types, this has created unsustainable pressure on MHAS resourcing.

Key issues that consumers raised with Advocates and which they escalated included:

- Breaches of their rights and a lack of trauma-informed approaches in the application of restrictive practices (seclusions and restraints).
- Sexual safety on facilities.
- Delays whilst waiting in an ED for examination or admission.
- Delayed discharge due to a lack of the right combination of accommodation and support in the community, despite being well enough to leave.
- Impacts on their health, safety and wellbeing caused by the deterioration of conditions in facilities.
- Specific rights breaches for hostel residents.

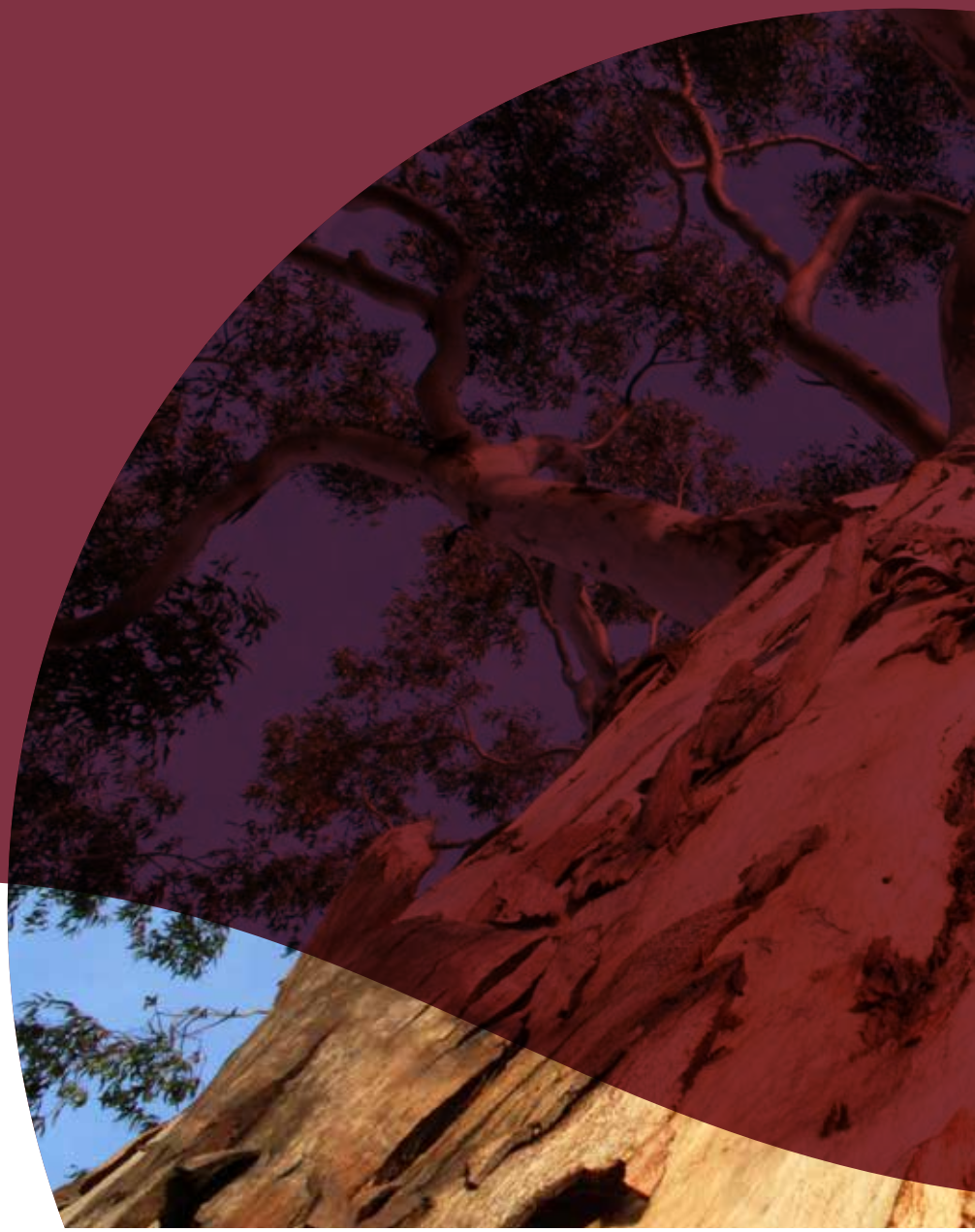
In response to concerns about conditions, MHAS undertook an inquiry into the environmental conditions of 57 mental health wards across 19 facilities in 2022-23. The inquiry identified issues relating to safety, privacy, CCTV, cleanliness, and hygiene. Whilst some actions are still to be addressed, prompt action was taken by many facilities to improve the environment for consumers.

At a time when the system is going through a period of focused development in key areas (notably, children, eating disorder services, and forensic services) having access to a well-resourced, optimally functioning advocacy service is an essential accountability mechanism for protecting and upholding consumer rights. However, Advocates must be well supported so the service can continue to offer a high quality service to consumers, and safe and sustainable working conditions to them, Senior Advocates, Chief Mental Health Advocate (Chief Advocate), and the public service staff who support them.

In 2022-23, MHAS reported an overspend of $516,557 against its approved budget of $4,294,000 (excluding funds allocated to the *Criminal Law (Mentally Impaired Accused) Act 1996* (CLMIA Act) reforms). The overspend can largely be attributed to the workforce costs associated with increased demand mentioned above. Furthermore, in 2022-23 MHAS was required to increase the Advocates' hourly rate, superannuation contributions and mileage rate without receiving any additional funds to meet these costs.

Compounding the increase in demand and insufficient budget, issues such as the urgent need to upgrade our client management system, continuous issues with phone and internet services, and significant work required to develop our corporate records storage system, continue to impact our ability to effectively support Advocates to undertake their work. Regular turnover of advocacy support staff and a heavy reliance on temporary agency staff and fixed term contracts continue to impact the retention of corporate knowledge and often requires senior staff and the Chief Advocate to undertake various administrative tasks.

MHAS is working hard to address the budget shortfall and implement strategies to rectify these issues in 2023-24.



About us

The MHAS exists to amplify the voices and protect the rights of people using, and seeking to use, mental health services.

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

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

The Act confers considerable powers on Advocates, who may do 'anything necessary or convenient' for the performance of their functions relating to advocacy for individual consumers. The powers extend to inquiring into or investigating of conditions that are impacting, or are likely to impact the health, safety or wellbeing of identified persons. The graphic to the right highlights some of the key powers and functions of MHAS Advocates.

FIGURE ONE - Functions and powers of the Chief Advocate and MHAS Advocates

- Appointed by the Minister for Mental Health and prepares an annual report to Parliament
- Engage Senior Advocates and Advocates
- Co-ordinate Advocates' activities, sets and maintains standards
- Ensure compliance with the Act
- Promote *Charter of Mental Health Care Principles*
- Escalate individual complaints for resolution and engages in systemic advocacy

- Act according to consumer's instructions
- Amplify and/or represent consumer's voice
- Support consumers to exercise their rights, including at tribunal hearings
- Inquire into and resolve consumer complaints
- Resolve issues directly with staff members
- Refer serious, unresolved and systemic matters to the Senior Advocate, who works with Chief Advocate to resolve

- Investigate conditions at mental health services that affect, or are likely to affect, consumers
- Attend wards and hostels at any time the Advocate considers appropriate
- See and speak with consumers (unless they object)
- Make inquiries about any aspect of a consumer's treatment, care and support
- View and copy the consumer's medical file and any documents (unless they object)

- Act in the child's best interests
- Have regard for the perspective of the child, their family (or guardian) and treating team
- Make sure the child's voice is heard
- Support and represent the child at tribunal hearings
- Liaise with family, guardians and the treating team to work through issues
- Inquire into and resolve consumer complaints
- Refer serious, unresolved and systemic matters to the Senior Advocate, who works with Chief Advocate to resolve

The year in review

3,919
Consumers assisted

6,874
Phone requests for contact

9,937
Issues raised by consumers

7,838
Notifications of orders

196
Letters of inquiry, concern, or complaint

278
Stakeholder meetings attended

1,048[1]
Mental Health Tribunal hearings attended

222
Further opinions requested

278
Allegations of assault or abuse received

1 Source: Advocate attendance at Mental Health Tribunal hearings is based on data provided by the Tribunal. The figure cannot be compared with the number reported in the 2021-22 annual report as this was based on Advocate reporting.

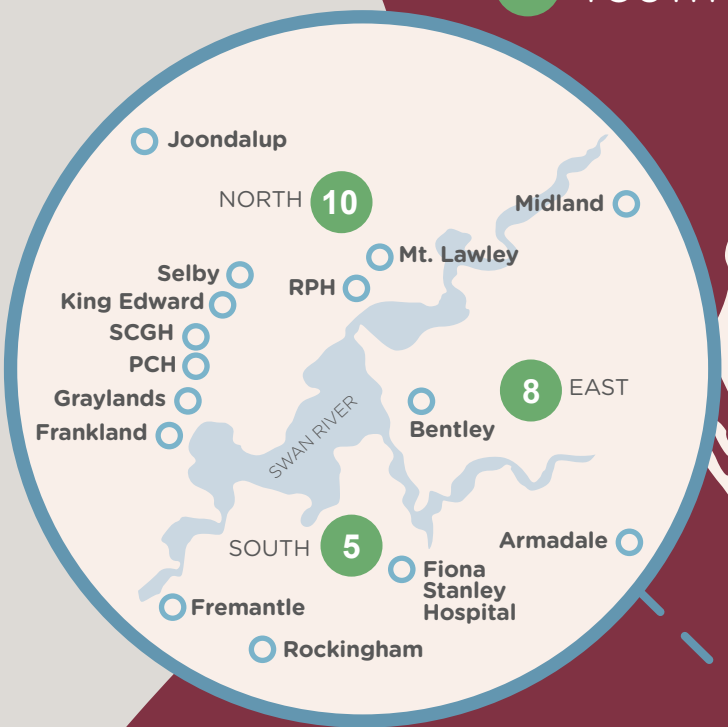
2 An authorised hospital refers to a mental health unit or ward/s where people can be detained and treated under the Act which is authorised by the Chief Psychiatrist.

Distribution of Advocates and authorised hospitals[2]

This graphic represents the numbers of Advocates working across services on 30 June 2023 and does not equate to FTE. These figures exclude the four Advocates who were unavailable for work on 30 June.

STATE-WIDE:

- 3 HOSTEL
- 0 ABORIGINAL
- 1 WEEKEND PHONES
- 9 YOUTH



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1 ALBANY

Number of active Advocates

Authorised hospitals

Advocacy service provision

Support for consumers

In 2022-23, Advocates assisted almost 4,000 consumers to help ensure they were aware of their rights and to exercise those rights, including raising almost 10,000 issues (see table one). There was a significant increase in the number of consumers assisted by Advocates – a 13.5% increase compared to the previous year and 8.7% compared to 2021-22 when MHAS assisted the highest number of consumers[3].

The increase in consumers assisted reflects similar trends in the numbers of involuntary orders and other categories of identified persons across the three years from 2020-21 to the present. It is likely the COVID-19 pandemic impacted help-seeking and service responses, creating a flattening in 2021-22 of what has otherwise been an increasing trend in all relevant figures since MHAS was established in November 2015. Informal evidence suggests the decrease or flattening of numbers over the past two years occurred because people delayed seeking help and/or services tried to treat and care for people at home.

Beyond general demand drivers such as changes in the size and composition of the Western Australian population, MHAS does not have the data linkage capability to determine other drivers of demand. Nevertheless, informal evidence from Advocates suggests that increasing complexity is a factor including increased percentage of consumers who are homeless or in unstable accommodation, increased percentage with current or recent involvement in the criminal justice system, increased percentage with comorbid problems like problematic alcohol and other drug use and/or physical health issues, and increased percentage with multiple agency involvement.

More Advocates and an intentional focus on Advocate practice is also likely to have had an impact on some figures, in particular issues and complaints (including serious issues), the numbers of voluntary children assisted, and assistance provided to hostel residents. An intentional focus to improve the consistency of coding issues and complaints is likely be in part responsible for the increases, including serious issues. However informal evidence suggests the increases cannot be explained solely by increased Advocate numbers and practice change.

Increases in the numbers relating to voluntary children and to licensed private psychiatric hostel residents has been impacted in part by greater Advocate presence at Perth Children's Hospital and a proactive approach to visiting hostels.

TABLE ONE - Identified persons assisted and issues and complaints recorded by Advocates

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Total number consumers[4]	N/A	3,132	3,141	3,427	3,605	3,454	3,919
Number of issues and complaints	6,038	6,038	7,373	5,081	8,970	7,226	9,937

[2] Numbers of consumers (or 'identified persons' as per s.348 of the Act) are based on 'contact' made by Advocates and differs from data on the number of involuntary treatment orders.

[3] The COVID-19 pandemic is likely to have been a factor in the lower numbers in 2021-22.

What their concerns were

Advocates recorded 9,937 issues and complaints in 2022-23, compared to 7,226 in 2021-22, a 37.5% increase. These are largely complaints that consumers would like Advocate assistance to resolve. Advocates must also investigate matters (even without a complaint from a consumer) where the conditions could adversely affect the health, safety, and wellbeing of any identified person.

There were increases in complaint numbers across most categories compared to 2021-22, but most specifically complaints about discharge, ground access and medication (see chart one).

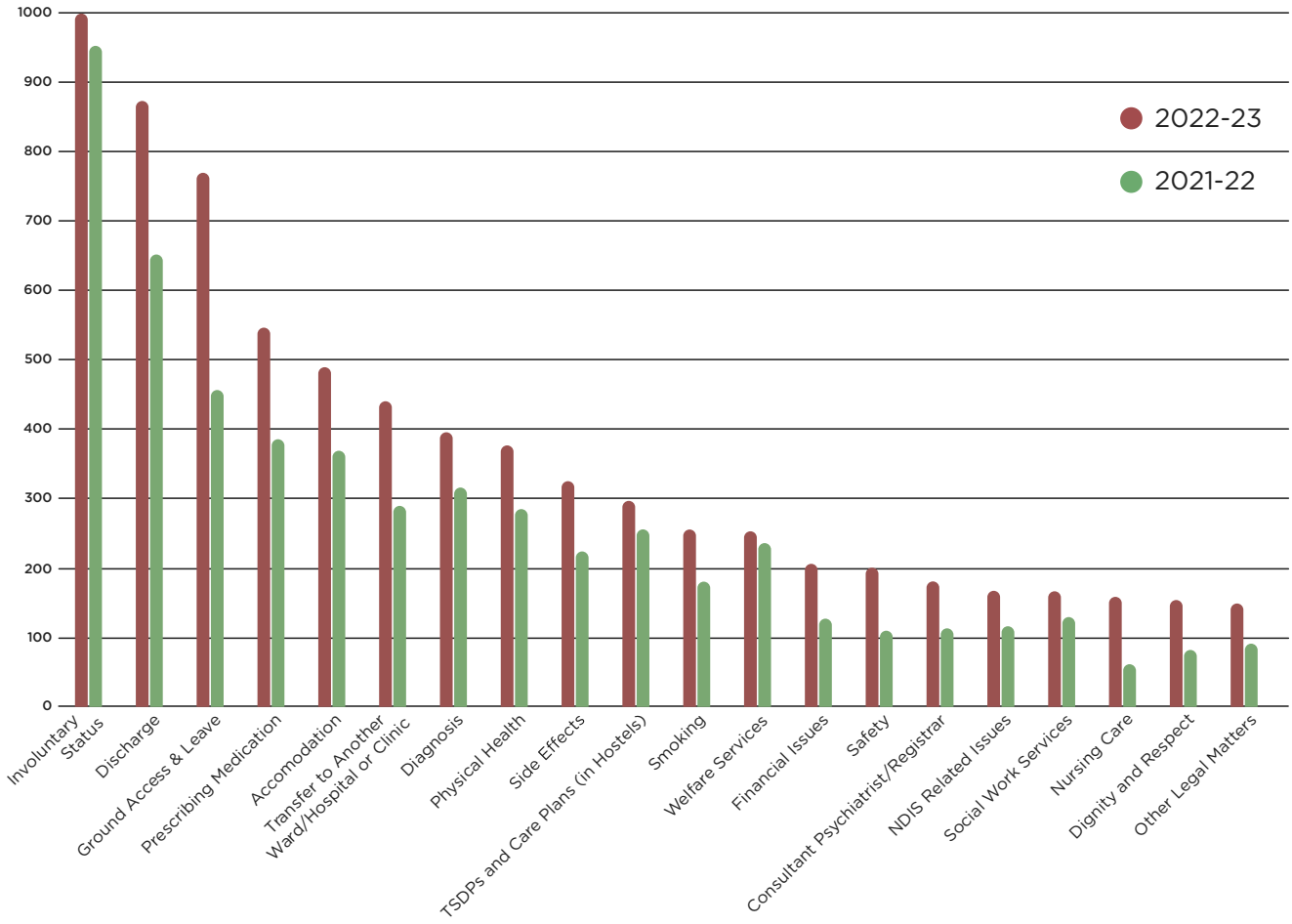
On average, there were 2.5 issues raised per consumer, equivalent to the rate in 2020-21 (noting once again the dip in issues reported in 2021-22). Some consumers do not want assistance beyond explaining their rights, and issues were recorded against 57.5% of consumers assisted, taking the number of issues and complaints per consumer to 4.4 (up from 3.9 the previous year).

The issues data includes serious issues such as allegations of assaults (physical, sexual, verbal, or financial), staff misconduct, neglect, or ill-treatment. Advocates must follow a protocol for alleged serious issues, requiring them to escalate the matter to a Senior Advocate to decide on a plan of action and who monitors the matter.

Advocates inquired into 307 allegations of serious issues in 2022-23, up from 175 allegations in 2021-22. The numbers had been relatively stable for the prior three years. Most serious issues related to misconduct allegations, wilful neglect, ill-treatment, physical abuse, or sexual safety. Data on serious issues is reliable but does not represent all the serious issues as it relies on the matter coming to the Advocate's attention.

Complaints and issues data depend on Advocates' coding and are impacted by consistency in practice between Advocates and across years. However, while the data set is large enough to consider general trends, caution is urged regarding specific complaints.

CHART ONE: Most common consumer complaints and issues in 2021-22 and 2022-23



Who we supported

Consumers on involuntary treatment orders

The number of new involuntary treatment orders for inpatients significantly increased compared to the previous year (10.8% increase; see table two and chart two) and is slightly higher than pre-COVID-19 levels in 2019-20. It is likely that this reflects a return to the pre-COVID 19 upward trend in orders.

There has been a steady increase in the number of involuntary inpatient orders made in general wards (form 6B) since 2016, with an almost three-fold increase in order numbers. In these situations, most consumers assisted by Advocates are being treated for an eating disorder. A smaller number are those being treated for physical trauma injuries. The advocacy for consumers in general hospitals is more intensive and requires more hours of input as there are commonly more issues involved and more complexity in them. Moreover, staff in general hospitals are less familiar with the requirements, responsibilities and oversight of involuntary detention and involuntary treatment, including the legal implications.

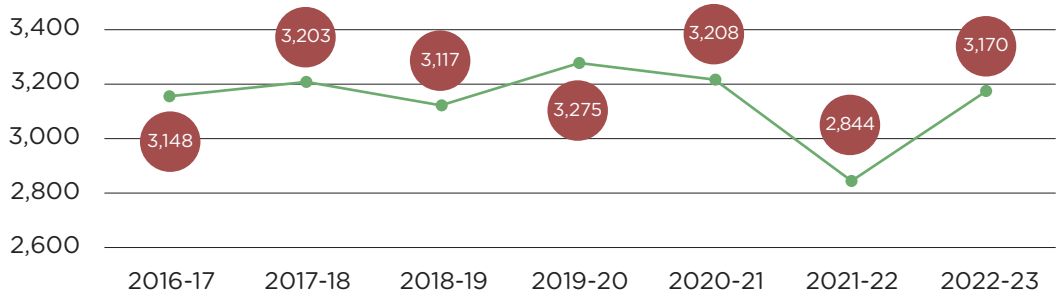
There has been a steady increase in the number of new Community Treatment Orders (CTOs) since 2016. Over the past year, the increase was significant (8.9%). There were 966 new CTOs made, compared with 884 CTOs in the two prior years. These are in addition to existing, continuing CTOs. The number of people subject to new CTOs also increased (7.6%) but at a different rate than orders, meaning there were more repeat orders per person.

MHAS does not have the data linkage capability to provide reasons for the increase in CTO numbers.

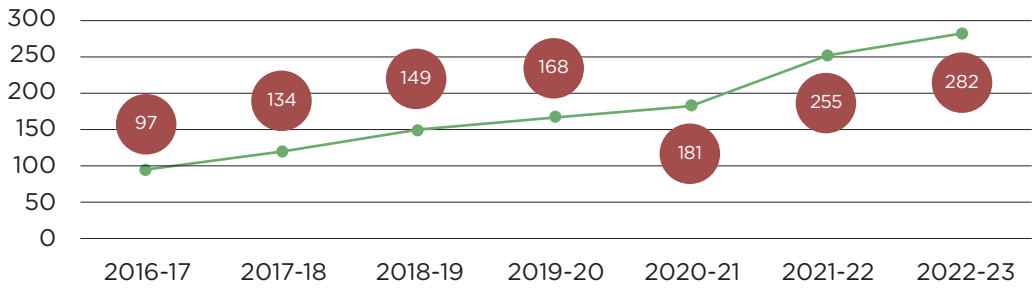
Evening sunset at Dryandra

CHART TWO: Number of involuntary orders from 2016-17 to 2022-23

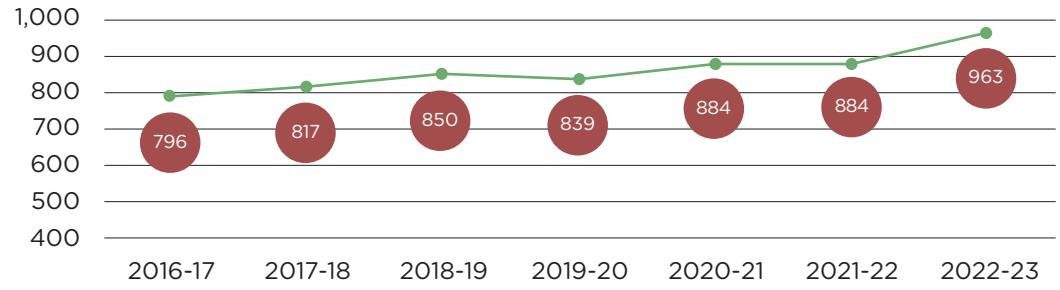
Form 6A (orders[5] made in a authorised hospital)



Form 6B (orders made on a general ward)



Form 5A (CTO)



[5] All orders are based on notifications from health services to MHAS (for adults and children) and grouped by the date the order is made. Verification of Integrated Client Management System data is ongoing and figures may be subject to change.

TABLE TWO - Number of involuntary orders[6] and number of consumers[7]

Type of Order	2016-17		2017-18		2018-19		2019-20		2020-21		2021-22		2022-23	
	Orders	Consumers	Orders	Consumers	Orders	Consumers	Orders	Consumers	Orders	Consumers	Orders	Consumers	Orders	Consumers
Inpatient treatment order in authorised hospitals - Form 6A	3,148	2,417	3,203	2,432	3,117	2,431	3,275	2,534	3,208	2,498	2,844	2,270	3,170	2,533
Inpatient treatment order in general hospitals - Form 6B	97	86	134	115	149	128	168	128	181	139	255	189	282	222
Community treatment orders - Form 5A	796	656	817	661	850	679	839	702	884	718	884	726	963	781
Total Involuntary Orders / Consumers[5]	**4,041**	**2,618**	**4,154**	**2,644**	**4,116**	**2,650**	**4,282**	**2,744**	**4,273**	**2,729**	**3,984**	**2,573**	**4,415**	**2,842**

Children

MHAS has a statutory obligation to contact children within 24 hours of an involuntary order being made and ensure they are aware of their rights under the Act. Advocates must consider the child's wishes along with the views of the parents or guardians in advocating for the best interests of the child. The added perspectives increase the complexity of advocacy for children. A fair proportion of children have several government and non-government organisations involved in their care and accommodation.

The number of children assisted on any involuntary treatment order increased in 2022-23 and has tripled in the last six years (see table three). Other than population increase, it is not clear what has driven this increase.

The trends by type of order varied:

- There was an increase in orders made in authorised hospitals for children and an overall increasing trend since 2016-17.
- The increasing trend in inpatient orders made in general hospitals for children stabilised.
- The number of CTOs for children increased. However, overall numbers are small, so caution is recommended in interpreting this information.

TABLE THREE - Number of involuntary treatment orders for children (under 18 years)

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Form 6A	37	48	53	75	80	63	86
Form 6B	14	27	28	32	42	64	61
Form 5A (CTOs)	14	13	24	28	42	37	47
Total number of Involuntary Orders	**65**	**88**	**105**	**135**	**164**	**164**	**194**

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

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

The number of children admitted voluntarily to authorised hospitals and assisted by an Advocate returned to pre-COVID-19 levels (see table four). The reduction in 2021-22 was not necessarily due to a decrease in such children treated or seeking assistance. Rather, it reflects the impact of COVID-19 on the Advocacy workforce and difficulties retaining Youth Advocates under contracts-for-service. MHAS does not receive notification of a child's admission to an authorised hospital. Therefore, the need for advocacy is dependent on Advocate availability and presence on wards.

In many instances, parents or guardians have consented to a child's admission and treatment[8]. Children are, therefore, not necessarily admitted or treated on a genuinely voluntary basis, and the Advocate plays a role in ensuring their wishes are raised in decisions about them.

On 1 January 2017 a Ministerial Direction came into effect expanding MHAS' scope in relation to classes of voluntary patients. The expanded scope included any child being treated or, seeking admission to a public hospital or authorised hospital, and children who had been assisted by an Advocate in the previous six months as a voluntary or involuntary patient. Additionally, the scope included any child who is proposed to be provided with treatment in or by a public hospital or authorised hospital. The Ministerial Direction, in combination with an increase in the number of Youth Advocates, has driven the substantial increase from voluntary children assisted over the past seven years.

TABLE FOUR - Number of voluntary children (under 18 years) assisted by an Advocate

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Voluntary children (<18 years) assisted	**15**	59	59	278	460	342[9]	462

Voluntary adult consumers

Since January 2017, MHAS has been able to continue to assist consumers in resolving 'ongoing issues' post discharge from an involuntary treatment order, as long as they remained connected to a public mental health service as a voluntary consumer (either in hospital or in the community) . The Advocate must have been assisting the consumer with the issue, have acted towards resolution, and there must be further action that can be taken to resolve the issue or complaint.

The number of voluntary adults assisted with ongoing issues (see table five) stabilised in 2022-23. Consumers are typically assisted with an ongoing issue where their order is revoked (and they are a voluntary consumer), but MHAS has yet to receive a response or a satisfactory response to a letter of complaint.

In 2022-23 MHAS received clarification from the State Solicitor's Office on the application of the Ministerial Direction 2016 to voluntary consumers with ongoing issues. The advice provided for a narrower scope than had been previously understood, limiting Advocate functions only to those people who remained patients of a public mental health service, where action had already progressed to resolve their complaint, and where there was a reasonable chance of resolution. It is likely that the limited scope has contained the increasing trend in voluntary adults assisted with ongoing issues.

[8] Under s.302 of the Act, parents/guardians may consent to admission and treatment unless it is shown that the child can apply for admission, discharge or make treatment decisions for themselves.

[9] Methodology for 2021-22 and 2022-23 data for voluntary children assisted may differ slightly from previous years: prior years' data has not been updated and is as published in previous annual reports.

[10] Advocates can also assist hostel residents, referred persons and other classes of 'identified persons' (as per s.348 of the Act) with outstanding complaints when their status changes under the Classes of Voluntary Patient Directions 2016, published in the WA Government Gazette (the Ministerial Direction).

TABLE FIVE - Seven-year trend in consumers referred for examination or assisted with ongoing issues[11]

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Referred persons assisted (adults and children)	41	238	212	303	333	302	147
Voluntary (adult) consumers assisted with ongoing issues	37	62	86	94	135	149	323

Referred persons

'Referred persons' are those who have been referred by an authorised mental health practitioner or a medical practitioner, typically in an emergency department (ED). It is a compulsory referral, and the person cannot leave the hospital until they have been examined.

MHAS is not notified when someone is placed on a referral order (form 1A) and is thus reliant on referred persons or other parties (including family and hospital staff) to request advocacy support. MHAS receives a daily centralised report (known as the 'bed report') which indicates the number of people (including children) waiting for a bed, and identifies where they are. A Youth Advocate then makes inquiries for children and young people placed on a referral order. In some situations, an inpatient bed has been identified, and the young person is waiting to be transferred. In other cases, a bed is yet to be identified. In both situations, the Youth Advocate will make contact to ensure they are aware of their rights and assist them with anything they need, issues, and complaints[12].

There was an increase in referred persons (adults and children) assisted by an Advocate in 2022-23 (see table five). However, the numbers have not returned to pre-COVID-19 levels.

Custody orders

The number of people subject to custody orders and detained in authorised hospitals increased in 2022-23 (see table six). The overall number of people subject to custody orders and the number detained for mental health treatment has increased since 2017.

The increase in the number of custody orders issued each year has not been offset by the number of people discharged from the orders since 2018-19. Therefore, the number of people on custody orders has been steadily increasing (see tables six and seven).

[11] Data is drawn from the MHAS ICMS database of notifications sent by facilities and work recorded by Advocates and extracted as of July 2023; data is subject to change. Consumers may be assisted in multiple categories during the financial year. MHAS started providing advocacy services to children and consumers with ongoing issues via a Ministerial Directive on 1 January 2017.

[12] There was a change in the MHAS recording process in 2021-22 and only instances of active advocacy is recorded in MHAS' database – the data no longer includes children where only initial inquiries are made.

[13] The data in the table was provided by MIARB in a letter from the Chairperson on 3 August 2022.

[14] Source: Mentally Impaired Accused Review Board annual reports.

[15] One mentally impaired accused person received two custody orders.

[16] In addition to the two people discharged from their custody orders during 2021-22, there were two people who were no longer subject to custody orders.

TABLE SIX - Seven-year trend in the number of custody orders as of 30 June each year[13]

Location as at 30 June	2017	2018	2019	2020	2021	2022	2023
Authorised Hospital	7	9	11	22	29	28	32
Community	19	17	18	15	10	14	13
Subject to a condition they undergo treatment for a mental illness			*15*	*12*	*7*	*10*	*10*
Not subject to conditions about treatment for a mental illness			*3*	*3*	*3*	*4*	*3*
Declared Place	2	2	3	2	3	3	3
Prison	12	10	10	11	10	10	9
TOTAL	**40**	**38**	**42**	**50**	**52**	**55**	**57**

TABLE SEVEN - Seven-year trend in the number of new and discharged custody orders[14]

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
New custody orders	4	4	8	11	6[15]	7	5
Discharged by Executive Government	3	6	4	3	4	2[16]	2

Hostel residents

MHAS reintroduced a hostel visiting program in January 2022 after progressive cuts in budget reduced the service for residents. Up to December 2021, an Advocate only responded to requests for contact from residents (or from someone on their behalf). Advocates assisted 349 hostel residents in 2022-23 compared to 261 residents in 2021-22 and 177 residents in 2020-21.

The number of issues or complaints Advocates assisted hostel residents with significantly increased in 2022-23 compared with 2021-22, from 444 issues to 1,076. While this has been driven by the proactive approach to visiting hostels, it reflects a serious concern about the vulnerability of hostel residents and their ability to access their rights.

New consumers

The number of consumers new to MHAS returned to prior years' levels (see table eight). This is probably linked to the overall increase in involuntary orders and voluntary children assisted (most of whom would be new to our service).

TABLE EIGHT - Seven-year trend in the number of consumers who have not previously accessed MHAS

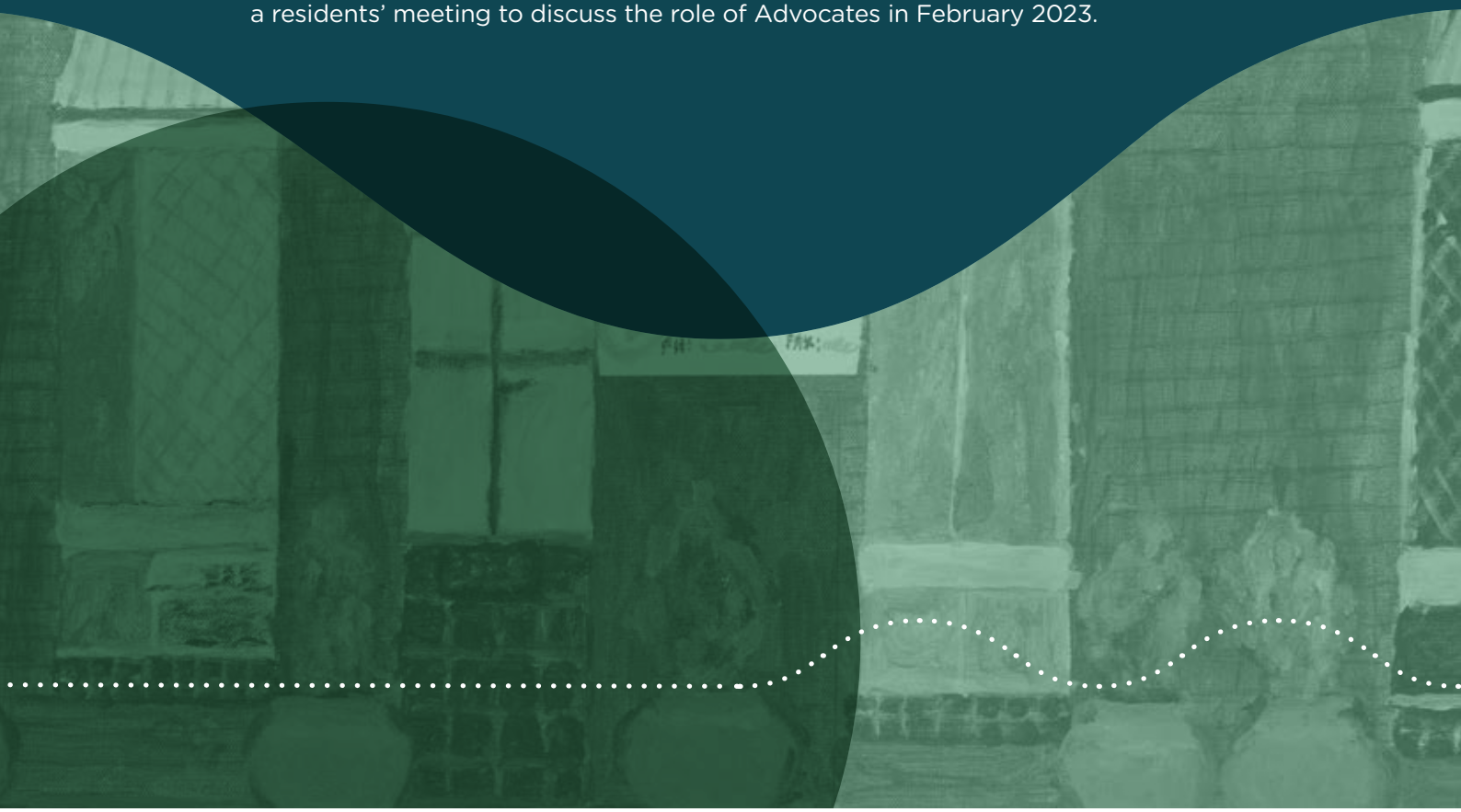
	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Consumers new to MHAS	1,629	1,560	1,566	1,798	1,876	1,526	1,844

Facilities Advocates visit

The total number of authorised mental health beds as of 30 June for each of the past four years was:

- 674 beds in 2020, of which three beds were unavailable.
- 676 beds in 2021, of which three beds were unavailable. This includes two additional beds at Graylands Hospital compared to the previous year.
- 680 beds in 2022, of which five beds were unavailable. This includes 12 new authorised beds at RPH and a reduction of eight beds at Graylands Hospital compared to the previous year.
- 686 beds in 2023, of which 13 beds were unavailable. The bed numbers as of 30 June 2023 included six additional beds at Graylands Hospital compared to the previous year. It is also noted that Dabakarn Ward at Royal Perth Hospital (authorised hospital) was closed from 18 November 2022 to 6 May 2023.

There was an overall increase in private psychiatric hostel beds licensed by the Licensing and Accreditation Regulatory Unit (LARU) of the Department of Health from 715 on 30 June 2022, to 731 on 30 June 2023. A new 20-bed licensed hostel opened in October 2022 (the Richmond Wellbeing Living Well Community Care Unit in Orelia). MHAS inquired about the status of the licence in January 2023 and made the initial visit shortly after, then attended a residents' meeting to discuss the role of Advocates in February 2023.



MHAS weekend services

MHAS operates the following weekend phone services, including over public holidays:

- Monitor messages and determine the urgency of requests. In urgent matters, the phone Advocate will contact consumers over the weekend. Otherwise, the phone Advocate will arrange for an Advocate to make contact within time periods determined by the Act or MHAS protocol.

- Contact youth mental health wards to check whether orders for children have been made, as an Advocate must make contact within 24 hours of the order being made. The Advocate also enquires about the general safety on the ward, whether any children have been referred for examination, and whether ward staff are aware of orders made in adult authorised wards, general hospitals, or regional areas.

In 2022-23, MHAS received 543 phone messages on weekends and public holidays.[17] This is a 49.6% increase on last year when 363 calls were received. In 2021-22, MHAS observed a decline in the number of messages partly due to COVID-19.

The increase in 2022-23 can largely be attributed to COVID-19 easing in the community and more individual callers who left multiple messages.

Most of the calls were received from consumers admitted to hospital, with a small number from consumers on CTOs and consumers in hostels[18]. There were also a few from consumers outside MHAS' jurisdiction who were referred to other appropriate services.

[17] Messages are checked up to Sunday lunch time (or lunchtime on a public holiday): messages left on Sunday afternoons are checked on Monday mornings.

[18] MHAS finds most hostel residents do not call for assistance, rather issues tend to get raised when Advocates are onsite.

Consumer rights and issues – children and young people

There were some encouraging signs that recent system developments are advancing the range of mental health services available to children and young people. Still, demand remains high, and the seriousness of incidents that Advocates are handling appears to be escalating. Advocates reported apparent higher levels of violence, drug addiction, more unsafe behaviours, and more children with child protection and family services (CPFS) intervention. The help these young people and their families need is not readily available. In the first half of this financial year, Advocates recorded almost as many issues as for the whole of the last year.

Across the year, the most frequently recorded issues included:

- Difficulties in accessing mental health services.
- Problems with discharge.
- Lack of appropriate accommodation options.
- Gaps in National Disability Insurance Scheme (NDIS) coverage.
- The need for advocacy for carer rights.
- System interface issues between the intersection of child protection and family services and mental health services.
- Use of restrictive practices.
- Breakdowns in communication.

Advocates recorded 68 potential serious issues regarding children. This is a substantial increase from the 38 serious issues recorded in 2021-22, although changes in Advocate practice may partly account for the rise. During the past year, practice development included an intentional focus on consistency in identifying and coding serious issues. It is likely that more serious issues were identified, coded and responded to in line with the MHAS protocol for serious issues than in previous years, thus providing better rights protection and enforcement.

The most significant number were categorised as 'other' (40) and included serious self-harm and leaving or trying to leave the ward without permission. This was followed by allegations of staff misconduct, ill-treatment, wilful neglect (21), sexual safety (4), and physical abuse (3).

Many serious problems are addressed and resolved with the facility staff and management when they occur. Some may result in a formal complaint, or an inquiry being conducted. Last year, Youth Advocates wrote ten formal complaint letters, five letters of concern, initiated nine investigations and escalated one matter to the Health and Disability Complaints Office (HaDSCO).

In addition to contacting children on involuntary orders, MHAS continued to contact those seeking admission or admitted voluntarily to mental health services to ensure they knew of their right to an Advocate. Most children are admitted and treated under parental consent, but restrictive practices are common. In the fourth quarter of the year, 11 of the 13 serious issues concerned voluntary children, indicating the importance of a proactive approach to contacting voluntary children.

Key themes in Advocates' work with children and young people

There were consistent themes in Youth Advocates' work with children and young people. These are discussed in detail below.

Difficulties in accessing mental health services

For numerous years, MHAS has reported that many children and young people experience long delays getting the help they need when they are distressed and unwell. Children and young people from regional areas, those requiring admission to a bed under the Western Australian Eating Disorder Outreach and Consultancy Service (WAEDOCS) protocol, those with complex support needs, and children aged 16 and 17 are significantly disadvantaged.

For many, a hospital ED is the gateway to getting help because supports that might have made a difference earlier do not exist, are incomplete, inaccessible or have limited eligibility criteria. MHAS monitors the daily bed report and proactively contacts EDs to determine whether there are barriers to admission. Advocacy is made available to those who request assistance.

The following case studies are typical of the issues that Advocates encountered when assisting a child or youth to access a bed, and the actions they took to resolve matters.

Despite being referred under the Act to a youth mental health unit, a 16 year old trying to get admission during acute mental health distress waited nine days in a short-stay unit attached to the ED[19]. The significant delays in accessing an admission caused the young person further distress. MHAS and the short-stay unit staff made substantial efforts to facilitate a transfer to a youth mental health unit. MHAS has since completed an inquiry into the factors that led to the delay and has supported the young person and their family in raising their concerns with the service provider. Hopefully, with the opening of the new youth unit at Joondalup Health Campus later this year, these types of delays will be avoided.

A 16 year old was admitted to a medical ward for treatment for an eating disorder. The young person was medically cleared three days later but then waited on the ward for 34 days before a bed in a mental health unit became available. During this time, two Youth Advocates provided advocacy and support to ensure the young person's rights were observed and assisted with representation at a Mental Health Tribunal hearing.

[19] Mental Health Emergency Centres and Mental Health Observation Areas (MHOA) are designated for assessment and brief treatment up to 72 hours – they are not designed for longer admissions, particularly for children and adolescents.

Delayed discharge

At the other end of admission, MHAS Advocates support some children and young people who are cleared for discharge but get stuck in the hospital because they lack suitable accommodation and support to enable them to live well in the community. This tends to impact those with complex support needs that involve multiple services, such as housing, health, mental health, disability, child protection, justice, and income support. Gaps in NDIS coverage contribute to delays in discharge to community settings. During protracted hospital stays, these children and young people are often involved in incidents that result in restraints and seclusion. Moreover, they rapidly lose functional capacity and hope.

MHAS engaged in extended advocacy on delayed discharge:

- Correspondence between the Chief Advocate and State Manager for the National Disability Insurance Agency (NDIA) (escalated by NDIA to State and Commonwealth Ministers) to express concern about delayed discharge for young people because of NDIS plan or provider failure.

- Meetings with senior officials involved in the hospital discharge program (the Long Stay Patient Program) run by the NDIA, the WA Department of Health (DoH) and the Mental Health Commission (MHC). At these meetings, the Chief Advocate put forward the view that the problem of delayed discharge was not fully understood and there was no agreement on the solutions – an issue also outlined in the Auditor General's report, *Management of Long Stay Patients in Public Hospitals* (November 2022).

- Engagement with system stakeholders to canvas the views and gain support for collaborative engagement to address delayed discharge.

- Liaison with the Mental Health Commissioner (the Commissioner) and agreement to hold a small, multi-stakeholder forum to explore the system barriers to delayed discharge, including access to clinical mental health care in the community and service and care coordination in addition to NDIS provision.

- Joint planning with the MHC for a forum later in 2023, the output of which will feed into the Steering Committee for the Long Stay Patient Program.

Services appear ill-equipped to respond to children and young people with support needs across multiple systems. Advocates frequently respond to access, safety and dignity issues related to these children and young people, often liaising with the Team Leader, Senior Advocate (Youth) and Chief Advocate to devise effective strategies.

Being treated without dignity or humanity

Safety and respect afforded to children and young people is a central focus of Advocates' work. The impact of workforce shortages, reliance on inexperienced staff, inadequate supervision, lack of trauma-informed practice, attitude and cultural concerns, and the complexity and diversity of support needs that services must respond to are all factors impacting consumers' safety and dignity.

During the year Advocates acted to remedy a range of issues:

- Rough handling and excessive force being used during a restraint, resulting in physical injury, and added distress for the child or young person.

- A lack of trauma-informed practice in both nursing care and psychiatric treatment.

- Dismissive attitudes towards family members and insufficient involvement of the child, young person, or family in treatment, support, and discharge planning.

- Allegations and observations of mistreatment, including one occasions of a child being nursed while naked.

- Perceived derogatory comments made to consumers or about them in their Mental Health Tribunal hearing.

- Vicarious trauma experienced by consumers who witness or hear incidents.

Advocacy responses vary depending on what the child and their family or young person wants and the situation. Actions include inquiring into what happened and why and establishing what changes are needed to lessen the likelihood of similar incidents. Where a consumer has been injured, the Advocate will ensure they have a physical examination, and that relevant paperwork is completed, and notifications made. At times, the consumer may want to make a complaint, or MHAS will decide to generate an inquiry if there is reason to believe that the health, safety, and wellbeing of identified persons are being or may be adversely impacted.

Treatment of children and young people with eating disorders

A large proportion of Youth Advocate time is spent working with children and young people admitted to a medical ward for the treatment of an eating disorder. Youth Advocates worked with approximately two-thirds of 18-24 year olds admitted involuntarily for the treatment of an eating disorder. The majority of these were admitted to Fiona Stanley Hospital and Royal Perth Hospital.

MHAS has built substantial expertise in working with consumers with eating disorders. Often the relationship between Advocate and consumer will last across many admissions, over many years into the consumer's adulthood. Children and young people admitted for treatment of eating disorders are frequently subject to restraints and assertive physical monitoring, such as blood tests, bladder scans, daily weighing, electrocardiograms, and one-on-one nursing. These clinical interventions can be distressing, on top of the impact of having an eating disorder.

During the year, Advocates acted to remedy a range of issues raised by children and young people being treated for eating disorders:

- Nursing staff with insufficient training and experience in working with people with eating disorders, who lack the skills to de-escalate the situation when a young person is in distress or to provide meal support.
- Distress and discomfort with aspects of care, for instance, being weighed in underwear and a hospital gown, being supervised during showers and toilet breaks, having enforced bedrest, and being confined to their room.
- High levels of distress during medical admissions, often resulting in severe self-harm.
- Medical wards that are not designed to mitigate the risks associated with a person in extreme distress.
- The frequent use of security guards and mechanical restraints to manage challenging behaviour or a young person's difficulty in following a treatment plan.
- Delays in accessing mental health admissions once medically stable due to youth mental health units' resourcing and models of care.
- Young people struggling to accept treatment being forced upon them.

In 2021-22, the state government provided an additional $31.7M to expand the provision of treatment, care and support to children and young people diagnosed with eating disorders. The funding will provide three dedicated multi-disciplinary state-wide services, co-ordination of transition from Child and Adolescent Mental Health Services (CAMHS) to the adult system and expanded community and consultation liaison services. The impact of the expanded provision is yet to be felt at a system level, although MHAS is hopeful that the coming years will see significant improvements in consumer experiences and outcomes.

Currently, eating disorder treatment options result in high levels of distress and trauma for young people. Unfortunately this can have long-lasting impacts, resulting in young people developing a fear of hospital admission and a reluctance to seek help when they need it. There are too few beds available for those who need inpatient treatment. For instance, there are four beds across the state for inpatient treatment on a mental health unit for 16 and 17 year olds with an eating disorder. This can result in long wait times to get into a bed.

MHAS continues to advocate at a service level for improved treatment and care of children and young people with eating disorders, and some positive changes have been made as a consequence:

- Upskilling staff, including specialised eating disorder training.
- Development of trauma-informed practice.
- Increasing staff resources and capacity.
- Concerted focus to reduce code-blacks and restrictive practices.

However, some children and many young people are treated on medical wards which are not specialist eating disorder services and are limited with what they can provide to this complex cohort (with some exceptions where a child or young person is admitted to a WAEDOCS bed). As a result, the recovery of children and young people is compromised, and health services are significantly impacted by the demands associated with trying to fill these gaps in service provision.

Systemic advocacy for children and young people on hospital orders

A court makes a hospital order under the *Criminal Law (Mentally Impaired Accused) Act 1996* (CLMIA Act) when there is reason to think that the person may have a mental illness for which they need treatment, and they are unable to consent to treatment.

A hospital order requires that the person is taken to and detained in an authorised hospital and examined by a psychiatrist. The person may be admitted as an involuntary patient if the examination confirms the consumer meets the criteria in the Act. Otherwise, they are transferred to a prison or detention centre. Hospital orders apply to children aged ten years and above, young people and adults.

Each child put on a hospital order that Advocates worked with had a combination of complex treatment and support needs, conflicting and multiple diagnoses, significant trauma histories and low trust in authorities. At least half were First Nations children. Once admitted to a hospital bed, Advocates continued to work with the child as they were often more easily able to establish trust, assist the consumer in engaging with their treatment and support activities, and ensure they were treated with dignity and respect and their rights upheld.

In addition to individual advocacy, the Chief Advocate lobbied for change at a system level based on MHAS' involvement with children and young people on hospital orders. The Chief Advocate highlighted the following concerns:

- Services' obligations to children on hospital orders.
- Disagreements over diagnoses, highlighting yet again the gap in capability for children with intersecting mental health and disability needs.
- Lack of clear pathways for children in detention to access an inpatient bed when required. The consequence is that decisions fall to individuals who may be impacted by negative bias, capability, risk tolerance and models of care.
- Lack of clarity between the various parties on what each can and cannot provide.
- Blocks to information sharing.
- Physical infrastructure of inpatient units.

MHAS is pleased to see a strong system response including the expanded Child and Adolescent Forensic Service which provides in-reach treatment, care and support to children at Banksia Hill Detention Centre and other initiatives to clarify the pathways for children who need admission to a mental health bed.

Consumer rights and issues - adults

Safety on wards

Recovery from mental crisis or ill-health is predicated on being and feeling safe, being treated with dignity and having one's privacy respected. Not only are these preconditions for recovery, but they are also rights. Too often Advocates reported that these rights were breached. This is reflected in the number of serious issues Advocates recorded over the year, up from 134 in 2021-22 to 206 in 2022-23. Although this figure is likely to have been impacted by practice development opportunities, Advocate and Senior Advocate feedback supports MHAS' view that the safety, dignity, and privacy of involuntary consumers is of grave concern.

The 206 serious issues comprised the following:

- 49 allegations of physical abuse.
- 24 allegations of psychological or verbal abuse.
- 35 allegations of sexual safety violations.
- 1 allegation of financial abuse.
- 69 allegations of staff misconduct, wilful neglect, or ill treatment.
- 28 incidents involving another serious issue.

Advocates received many complaints from consumers about threats to personal safety such as allegations of physical assault and mistreatment from staff. Advocates worked with services to ensure complaints were investigated and prompt action taken. Inquiries were conducted into serious incidents, with a focus on service strategies to improve consumer safety.

Allegations of assault and conflicts

Allegations of physical assault of consumers by other consumers on wards were regularly reported. In some cases, consumers reported allegations of multiple assaults during an admission. When there is an allegation of assault, an 'ethical wall' is established within MHAS to manage conflicts and ensure the voice of each consumer is heard. This comprises separate Advocates and Senior Advocates allocated to assist each consumer. When required, the Chief Advocate may become involved and is the only person to have a view of both sides of the ethical wall.

Examples of allegation included consumers being punched to the face and head, a consumer stabbed with cutlery, and a pregnant consumer hit in the stomach. In each case, Advocates took immediate action to ensure safety and trauma-informed care and assisted consumers in making complaints if they wished. Outcomes included changes to separate consumers, more frequent nursing observation, access to police reporting and investigations.

At facility and other stakeholder meetings, MHAS advocated for more accessible breakout spaces on wards and other environmental conditions that would reduce the likelihood of assaults.

At one facility, two people were assaulted on separate occasions while using the phone. They had to stand with their back to the ward to use the phone and were assaulted from behind. MHAS raised this with the service and the phone was moved to a more appropriate area of the ward.

Sexual safety

More than ten consumers made allegations to their Advocate of sexual assault during admissions. Environments that are sexually unsafe compound the distress experienced by people whose freedoms are already compromised and who, consequently, are vulnerable. In many cases these experiences are compounded by previous trauma including prior sexual assault and sexual abuse.

MHAS Advocates were also aware of reports of sexual intercourse or sexual contact between consumers, despite this being prohibited in the Office of the Chief Psychiatrist (OCP) *Sexual Safety Guidelines*. Sexual contact and sexual intercourse are prohibited in acute mental health units because of the vulnerability of consumers, difficulties establishing informed consent, and possible impacts on other consumers on the ward. In each case MHAS sent inquiry letters to ask how this happened, highlighting concerns, ensuring the facility conducted a thorough investigation, and requiring a response that would reduce the likelihood of a recurrence of the incident. In each inquiry, the service responded comprehensively.

Advocates also supported consumers to disclose allegations of sexual assault and sexual safety breaches to staff. They also supported them to exercise their rights to make reports to police when they wished to do so. A lack of bedroom and bathroom door locks continues to create safety risk in some facilities. In these cases, MHAS advocated for the privacy and protection that locks provide.

The Chief Advocate raised sexual safety, particularly impacting women, in her quarterly reports to the Minister for Mental Health throughout the year.

A person who had sexual intercourse while receiving involuntary treatment felt they had not been able to provide consent and raised this with their Advocate. An inquiry was conducted. The service provided an unreserved apology to the consumer. They also took action to improve sexual safety including exploring options for female only corridors with separate access cards and improved alerts for sexual vulnerability and staff education.

A consumer entered a shared bathroom when another consumer was showering and attempted to engage with them. It had not been possible for the consumer to lock the bathroom door because the lock had an override function which allowed anyone to enter. The service is progressing works that will allow for a locking system that can only be overridden by staff.

Gender diversity

An aspect of sexual safety is the lack of respect and sensitivity to the needs of people from the LGBTIQA+ communities, particularly those who are not cisgendered (i.e., who do not identify with the sex they were assigned at birth). Over the year, various concerns were raised with Advocates about the way people were being treated and cared for because of their gender identity or sexuality.

Under the *Charter of Mental Health Care Principles* in the Act consumers are entitled to person-centred care that is responsive to individual circumstances and that does not discriminate because of such characteristics. Advocates addressed instances of the use of incorrect personal pronouns, or the use of 'dead names' by staff when talking to consumers or documenting in the medical file[20]. Ensuring that treatment plans were changed and maintained for people in the process of transitioning was also important.

A consumer was in the process of transitioning genders and had difficulty accessing their regular hormone injection during a hospital admission. Staff told them that they would need to pay more money for the treatment to be provided in the hospital, which the consumer could not afford. Following Advocate involvement, the consumer was informed the injection could be provided for the same cost as in the community.

Safety concerns dismissed or disregarded by staff

Sometimes, consumers reported mistreatment and threats that staff attributed to their illness or believed were unsubstantiated. In each case, the Advocate asked for concerns and allegations to be treated seriously and investigated. Sometimes, the Senior Advocate needed to intervene to ensure that the consumer's concerns were heard and taken seriously. Consumers reported that they felt very distressed when they perceived their safety threatened. In such cases, MHAS advocated for measures to enable them to feel safe, regardless of the staff's assessment of the threat.

In some cases, being able to inform MHAS of their concerns and having them recorded was sufficient for consumers to feel safer on the ward.

A consumer felt unsafe and at risk of serious harm by another consumer. Staff said there was no safety concern, as the other consumer was always accompanied by two nurses. MHAS advocated for the consumer's right to feel safe, and a nurse escort was provided to them when leaving their bedroom until the consumer felt safer.

Distress was experienced by a consumer who felt they were being psychologically abused via telepathy by two other consumers. MHAS arranged for the offer of a room change away from the two consumers they were fearful of.

[20] A 'dead name' is a person's old name, the name they were called before transitioning.

Restrictive practices

Another aspect of safety relates to restrictive practices such as restraint and seclusion. In certain circumstances, the Act authorises restraint and seclusion but under strict conditions that must be complied with. The Act says the degree of force used in a restraint must be the minimum that is required in the circumstances and, while the person is restrained there must be the least possible restriction of movement consistent with their restraint. In addition, when a person is restrained they must be treated with dignity and respect.

Whilst episodes of seclusion have reduced over the years, the practice remains a feature of treatment, care and support for people placed on involuntary orders in secure wards of authorised hospitals.

Unfortunately, whilst authorised by the Act, restraints almost always result in pain and bruising for consumers, and seclusions can add to the distress they are experiencing. Although these are intended as a last resort, stressed, tired and sometimes inadequately trained staff (including security guards and nursing aids) can lead to poorly implemented restrictive practices. When this occurs, it is traumatising and distressing for everyone involved.

When a consumer is restrained or secluded, Advocates check the Act has been complied with and the forms have been completed. They assist with issues or complaints the consumer may want to raise with ward staff. Even when consumers have a complaint, some may not want the Advocate to raise it because the consumer is still detained and may fear it may delay their discharge or revocation of the involuntary order and move to treatment as a voluntary consumer.

Because of the possibility of adverse impacts from restrictive practices and the numbers of complaints that Advocates receive from consumers, this is an important area of rights protection for Advocates. In most cases, Advocates observe general compliance with consumers' rights under the Act or identify minor issues that can be remedied at a local level.

However, in 2022-23 some of the complaints consumers raised with Advocates indicate very poor practice. Where required, complaints were escalated to service management for resolution. Whilst each individual complaint was successfully resolved, in some instances recurrence of similar problems indicate systemic concerns.

Restraints

The use of restrictive practices such as restraint and seclusion in mental health wards led to widespread consumer concern about breaches of their rights and lack of trauma-informed care.

Consumers reported restraints that were rough and caused significant pain and injury. A lack of dignity and gender sensitivity were also raised with Advocates. Consumers reported not being provided with copies of restraint and seclusion forms as required by the Act. In some wards, an absence of recorded and saved CCTV footage made it impossible for allegations to be appropriately investigated.

A consumer was denied copies of their restraint forms, and the Advocate assisted the consumer in writing a complaint. The response from the service indicated that providing restraint forms was outside the service's policy. MHAS highlighted this was at odds with the Act, which requires a copy of restraint forms to be given to consumers. The policy was changed. However, MHAS has since assisted another consumer to lodge a complaint about the refusal to supply restraint forms at that service, indicating more needs to be done to change practice.

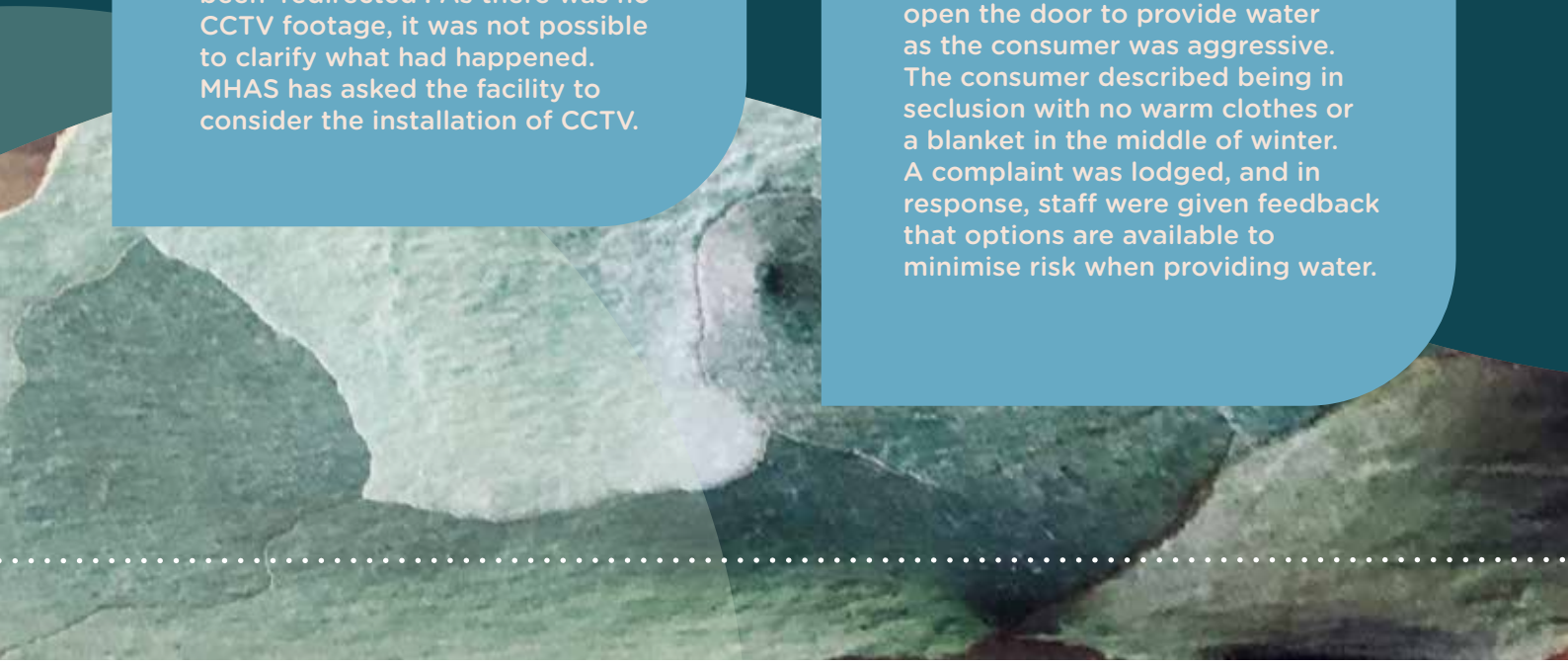
A consumer reported being marched to their room with their arm twisted behind them. They experienced pain and bruising and were left feeling unsafe and powerless. The Advocate was informed by staff that restraint had not occurred and instead, the consumer had been 'redirected'. As there was no CCTV footage, it was not possible to clarify what had happened. MHAS has asked the facility to consider the installation of CCTV.

Seclusions

Consumers reported lengthy periods of seclusion in which they variously had no access to water, toilet facilities, or warm clothes. In some cases, this resulted in the consumer having to urinate on the floor. At other times, there was no response to requests for medical attention or basic care needs. If a two-way intercom was unavailable or not used, it made it difficult for consumers to communicate with staff and added to the distress

After receiving injections and being left alone in the seclusion room, a consumer said they had difficulty breathing. They asked staff to see a doctor urgently and to use the toilet. A doctor attended hours later, and access to a toilet was not provided. They had no alternative but to urinate on the floor. The consumer was distressed and fearful they may die in the seclusion room. The Advocate assisted the consumer to lodge a complaint.

A consumer in seclusion for four hours repeatedly requested water as their medication made them thirsty. Staff said they could not open the door to provide water as the consumer was aggressive. The consumer described being in seclusion with no warm clothes or a blanket in the middle of winter. A complaint was lodged, and in response, staff were given feedback that options are available to minimise risk when providing water.



Allegations of staff misconduct, wilful neglect or ill-treatment

The final aspect of safety, dignity and privacy relates to allegations of staff misconduct, wilful neglect, or ill-treatment. The number of serious issues reported to Advocates of potential staff misconduct, wilful neglect, or ill-treatment (76) was almost double that reported in the previous year (40).

During the year, staff in a facility anonymously brought to MHAS' attention their concerns about unsafe and unhygienic conditions and the lack of respect and humanity shown towards some consumers. The problems appeared to have arisen following a service reconfiguration but were not addressed promptly or comprehensively. A MHAS Advocate inquired into the impact on consumers, and following this the Chief Advocate alerted the Chief Psychiatrist. A prompt visit was arranged, and the Chief Advocate and Chief Psychiatrist inspected the facility. The complaint from staff was substantiated, and the service agreed to rectify the majority of issues immediately. The service developed an action plan to address the remaining issues and provided a regular update of progress.

Consumers in regional Western Australia

While consumers in regional Western Australia experience many of the same issues as their counterparts admitted to metropolitan authorised hospitals, there are unique issues related to distance:

- Staffing shortages.
- Reliance on lengthy transfers.
- Equity for people on CTOs.

Staffing shortages

Regional areas continue to be disproportionately impacted by staffing shortages across many disciplines, and this has impacted the quality of care provided to some consumers. For example, psychiatrist shortages prevented the completion of Mental Health Tribunal reports, and delayed consumers' access to leave. Auxiliary staff shortages resulted in bed linen not changed and washing not done. The Advocate, and often the Senior Advocate, liaised with nursing staff and treating teams to explore options or other ways in which they can meet their obligations under the Act.

Delayed transfers

People in regional and remote areas continue to be impacted when transfers are required to the metropolitan area for specialised or intensive care. This disproportionately impacts First Nations people and youth aged 16 and 17 years. Transfers can be experienced as particularly traumatic when they become protracted because of logistical issues with transport, unavailability of staff to accompany the consumer, and a lack of beds. Delayed transfers are often associated with the use of sedation and ventilation (which itself carries risks) and restraints. These increase the distress of being taken to a hospital far away from home and family when the consumer is already unwell.

Advocates have arranged for clothing and footwear for consumers transferred from a warm climate to a colder environment, food on the journey, and for family members to be supported to travel to the metropolitan area with their loved ones. However, a system in crisis is not serving people who live in remote locations well.

Equitable treatment for consumers on CTOs

Over the year, MHAS advocated for three people on a CTO who were taken to an authorised hospital against their wishes because they had refused the medication often in a slow-release injection (a requirement of their CTO). In each case, the consumer did not want the injection because of the unwanted effects of the medication, and instead wanted to be given the skills and tools to self-care during periods of declining mental health. Each consumer complained that the community mental health service had not assisted them to build self-care skills, merely offering 'the jab' and therefore increasing consumers' distrust in the mental health system.

This issue was also raised with the Chief Advocate by a psychiatrist working in regional WA. The psychiatrist was concerned about the practice of taking people who breached the treatment conditions of their CTO to an authorised hospital for forced treatment - with the risks of lengthy transfer as outlined above.

The Office of the Chief Psychiatrist's *Clinicians' Practice Guide to the Mental Health Act 2014* (5.10) confirms that the compliance process for a CTO should not be made so difficult or impractical that the consumer is bound to fail, thus exacerbating feelings of dissatisfaction with the service they receive. Moreover, if suitable arrangements cannot be made for the care and treatment of the person in the community, the psychiatrist can revoke the CTO.

MHAS notes the paucity of services and difficulties of access to supports for people living in remote communities. The issue has been raised in routine facility meetings, and MHAS intends to continue to advocate for approaches that do not discriminate against people because they live remotely.

Consumer rights and issues - older adults

For the past two years, MHAS has reported on the experiences of older adults involuntarily admitted to authorised hospitals, and the impact of bed and staffing shortages on this group of vulnerable consumers.

Older adults receiving involuntary treatment are disproportionately affected by a lack of communication and involvement in treatment decisions affecting them, concerns that their physical health conditions are not being addressed, and a lack of privacy and dignity in treatment. Advocates reported multiple examples this year where older adults could not access their rights or when their treatment, care and support did not match the standards set by the Charter of Mental Health Care Principles.

In addition to the rights of involuntarily admitted older adults, MHAS continues to raise the needs of those admitted voluntarily. This cohort is currently not categorised as 'identified persons' and have no right to an Advocate. Yet may have been admitted by family or a public guardian to a locked ward where their rights are curtailed. This has been a long-standing concern for MHAS.

The current and former Chief Advocates have been raising their concerns about voluntary older adults with the MHC since 2016. First raised in 2016 as part of the Ministerial Direction sought in that year, it was not included but was highlighted for a second stage direction once it was clear how the first stage was operating. In 2021, the Mental Health Commissioner committed to progressing the matter through a workshop process. However, COVID-19 priorities impacted this process. During 2022-23 the Chief Advocate sought updates from the MHC in December, February, and June. The MHC commenced a process to look at advocacy needs for a range of cohorts and agreed that advocacy for voluntary older adults on locked wards remained a priority that needed to be addressed outside of the wider process.

To date, progress remains slow, and MHAS' advocacy is ongoing.

Access to older adult beds and staffing shortages

There were insufficient older adult beds across the state to meet demand, resulting in lengthy delays in accessing inpatient treatment. Some older adults had to wait weeks in MHOAs, EDs or medical wards for a mental health bed. This is an ongoing issue with a clear negative impact on older adults.

In December 2021 MHAS was informed that a lack of older adult psychiatrists had led to a temporary reduction in the number of beds (from 8 to 4) in the Older Adult Mental Health Hospital in the Home service. The beds resumed in February 2022 but were suspended once again in June 2022. MHAS welcomed the reinstatement all eight beds in September 2022, but notes the shortage of older adult psychiatrists continues.

An older adult had been waiting in a short-stay area of an ED for 14 days and was facing a further two-week wait before they could be transferred to an older adult bed. The family were concerned about the adverse impact of this lengthy wait on the consumer's mental health. The Advocate liaised with the consumer and the health service and arranged for a transfer to an adult ward.

Issues on the wards

Lack of respect and privacy for dignity

Older adults often raise concerns with their Advocate about lack of privacy and respect for their dignity in their treatment. Doors were sometimes left open when older adults were being assisted with personal care such as toileting, showering or changing so they could be seen by others. Older adult consumers voiced their fear that other consumers would enter these private spaces. Some older adults reported they were 'talked down to', their views were not taken seriously, or their private information was discussed within others' hearing. Advocates raised these concerns and facilitated treatment and care changes to better protect consumer dignity and privacy.

An older adult said that staff would come in and stare for lengthy periods while they were in the shower at night, violating their privacy. The consumer also complained that a psychiatrist had discussed their symptoms where others could overhear leaving them feeling belittled. MHAS wrote a letter of complaint on behalf of the consumer, and the concerns were resolved with an apology and agreement that staff would knock on the door before shower safety checks and leave promptly and that future discussions involving diagnosis would only be held in a private room.

Physical health care

Many older adults were concerned that services did not adequately recognise or address their physical health conditions. This is an ongoing issue for older adults, as many have co-occurring needs and conditions. Advocates raised these concerns and the rights of consumers to have their physical health needs assessed and addressed, resulting in changes to treatment and response times.

An older adult had concerns about their physical health, particularly the need for an operation, which had been delayed. The Advocate liaised with staff and brought the scheduled operation date significantly forward.

Communication and access to interpreters

Lack of effective communication by health services is an ongoing issue affecting older adults. An older adult's ability to understand information and express their views and preferences can be negatively affected by hearing impairments, language spoken, culture and cognitive issues. There were many instances where consumers did not understand or contribute to their treatment plan, as interpreters and other communication supports were not regularly used.

An Advocate assisted an older adult with very limited English who had not had an interpreter for nursing care or psychiatric review since being made involuntary two weeks prior. This caused considerable distress, and after advocacy by MHAS, an interpreter was arranged for clinical reviews.

Impact of positive ward environments

Some older adult wards had positive environmental features that were appreciated by consumers and assisted their recovery. These included rooms with attractive or pleasant views and large windows allowing exposure to natural light. Personalised boards in some bedrooms with helpful details such as the date and the name of the allocated nurse helped to orientate consumers and assisted their engagement with daily activities.

Courtyards with gardens containing multiple flowers in bloom also assisted in creating a home-like and welcoming environment. The images on this page show what can be done. The older adult unit at St John of God Midland has a small internal courtyard with attractive flower beds and different seating areas. The older adult unit at St John of God Mt Lawley has maximised the view over the Derbarl Yerrigan by using a clear wall with laser beam technology along the top of the walls as a safety measure.

St John of God Hospital Midland – internal courtyard on older adult unit

St John of God Hospital Mount Lawley – courtyard on older adult unit

St John of God Hospital Mount Lawley – view from courtyard

Rights and issues - people in the criminal justice system

MHAS Advocates can assist people in the criminal justice system in certain situations[21]. These include:

- A person placed on a hospital order by a court which requires the person to be taken to and detained at an authorised hospital for examination by a psychiatrist, so they can determine whether an involuntary treatment order needs to be made.
- When a person is unfit to stand trial or found not guilty due to 'unsoundness of mind' and the Mentally Impaired Accused Review Board (MIARB) determines that they need to be detained at an authorised hospital for treatment.
- A person placed on a custody order and they are released on the order of the Governor subject to a condition that they undergo treatment for a mental illness.

Advocates may also assist prisoners referred for examination by a psychiatrist or admitted to an authorised hospital under an involuntary treatment order. In practice, this is almost exclusively prisoners detained for inpatient treatment at the state's facility for forensic consumers, the Frankland Centre (FC).

[21] For details see s348 of the Act, definition of 'identified persons'.

Access to inpatient assessment and treatment for prisoners

In April 2023 Minister Sanderson announced $219M for the first stage of the Graylands Reconfiguration and Forensic Taskforce project. The funding will provide for at least 53 additional forensic beds, including a five-bed unit for children and young people. This was an important announcement and an essential investment in WA's response to people requiring specialist forensic mental health care. MHAS is confident that it will alleviate many of the impacts of the critical shortages described in the following section.

The FC offers 30 secure beds for acute mental health treatment and care. Additionally, four 'open' forensic beds are in a shared ward on the Graylands Hospital (GH) site, totalling 34 forensic beds for the state. Because the four open beds are in a shared ward, they are only available to male consumers.

There is now a critical shortage of beds at the FC, with the result that prisoners who need specialist inpatient mental health care and treatment cannot get it or are required to wait for a long time in prison before a bed becomes available. The situation for female prisoners who need an acute bed and women on a custody order who cannot be moved to an open ward is dire.

Almost all of the 34 beds at, or managed by, the FC were occupied by people subject to custody orders in 2022-23. Since 2017, the number of people on custody orders and detained to the FC has increased steadily from seven to 32 (as of June 2023). Over the same period, the number of new involuntary treatment orders made at the FC has fallen from 169 in 2016-17 to 33 in 2022-23.

MHAS understands that for much of the past year at least nine people have been waiting in prison on most days for a specialist inpatient mental health bed. MHAS knows at least one prisoner who has waited more than three months for admission. In most cases, prisoners waiting for a bed are held in isolation and only assessed and treated if they agree. By the time they get into a mental health bed, they are often very unwell, require more intensive treatment, and take longer to become well again.

Similarly, the number of people on hospital orders admitted to the FC has diminished from 110 in 2017 to three in 2022-23. With no inpatient beds available, people on hospital orders are being diverted to prison. In-reach psychiatric services must be negotiated by the prison mental health staff for examinations, and the only treatment they receive is what they accept voluntarily. Moreover, despite having the right to an Advocate, in practical terms, they cannot access this. In a few cases, a prisoner may be admitted to a 'civil' bed in another authorised hospital, but MHAS is unaware of this happening in the past year.

The critical shortage of forensic beds was foreseen and predicted. The Inspector of Custodial Services reported[22] five years ago that the FC had 'nowhere near enough beds to meet demand' and that the problem had reached 'such alarming levels that a solution is needed'. MHAS has been raising for several years, including in past annual reports, that the FC was nearing capacity due to people detained indefinitely on custody orders. The Chief Advocate has consistently raised this issue over the past year in multiple forums, including with the Minister for Mental Health, the Mental Health Commissioner, the Executive Director of Mental Health for North Metropolitan Health Service (NMHS) and through the Graylands Reconfiguration and Forensic Taskforce (GRAFT) Clinical Advisory Group (CAG).

[22] Inspector of Custodial Services (2018) Prisoner Access to Secure Mental Health Treatment.

Issues raised and advocacy responses

Many of the issues that consumers in the forensic system raise with their Advocates are like those raised by consumers in authorised hospitals (treatment, safety, the environment they are detained in). Likewise, Advocates take actions to remedy the situation. However, some issues relate to the person's status as a forensic consumer.

Proposed closure of duplexes used by families of consumers at Frankland

Two duplexes were available for families visiting consumers admitted to FC and the Hospital Extended Care Service (HECS) at GH. A review of the facilities by NMHS identified the need for structural changes and refurbishment to address disability access and upgrade the facilities. It was proposed to close both duplexes. In November 2022, the Chief Advocate wrote to the NMHS Chief Executive about the predictable impact on consumers and families if the duplexes were to be closed. MHAS pointed out that closure would especially disadvantage regional and First Nations consumers. In response, NMHS advised MHAS that the duplexes were part of the GRAFT planning and business cases, but that one duplex would be refurbished in 2023 while awaiting the outcome of the business cases. Although the refurbished duplex was not suitable for people with disability access needs, MHAS was informed that people would be advised of alternatives.

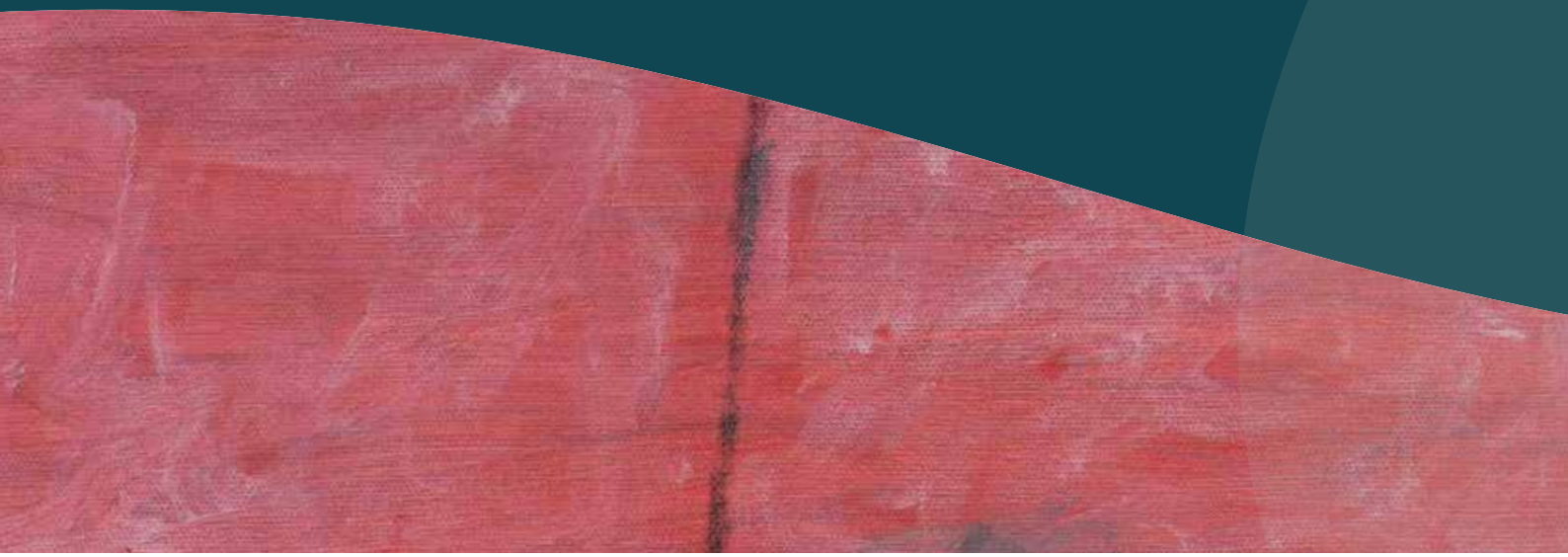
Access for women to forensic inpatient care

MHAS has been raising their concern about the lack of access to forensic beds for women at the FC since the ward closures at GH and consequent loss of beds in 2018. In addition to the need for an equitable response, MHAS is mindful of the safety of female consumers on largely male wards. The Chief Advocate continued to raise the matter at facility meetings, with the NMHS executive, through her role on the GRAFT CAG throughout the year and directly with the GRAFT steering committee.

MHAS has been assured that the specific needs of women will be managed operationally in stage one of the redevelopment of forensic services. MHAS also eagerly awaits the anticipated funding for female-specific beds.

Until that time and based on experience to date, MHAS remains concerned that an operational solution alone will be insufficient. MHAS continues to advocate for specific provision for women, as well as sufficient provision of beds in a step-down pathway for all forensic consumers. The current allocation of four step-down beds in one ward at GH, which can only be used by men, is inadequate.

MHAS is also concerned that there is an appropriate and safe response for gender diverse consumers and will advocate for this as the services are developed.



Development of a new model of care for forensic inpatient services

MHAS played a key role in ensuring that forensic consumers had a say in developing the new model of care endorsed by GRAFT. Working with a representative from the MHC, an Advocate supported consumers on each of the FC wards to have their say about how forensic services could meet their needs.

This feedback from consumers was highlighted by MHAS when NMHS announced the re-alignment of Smith Ward at GH to a forensic ward including 'low-secure forensic beds for women'. The new arrangements will allow for some consumers on custody orders who are ready to transition to a low-acuity forensic setting to have their place of custody changed from FC to GH. Although this should somewhat alleviate the pressure for forensic beds, MHAS is mindful of the potential impact on civil consumers currently admitted to Smith Ward. MHAS was assured that NDIS has positively impacted consumers' discharge.

The arrangements will be put in place in the first quarter of 2023-24, with a net increase of 11 beds for forensic consumers, bringing the total to 45 forensic beds. The Chief Advocate is involved in ongoing discussions with the Executive Director of Mental Health at NMHS and will monitor general and specific demand for and access to forensic beds.

Advocacy for *Hearing Voices*, a valued program

The *Hearing Voices Network WA* program, run by lived-experience facilitators, has operated at the FC and GH for many years. In April 2023, consumers raised concerns with Advocates because they had been told the groups would not continue despite getting much value from the program. Consumers told Advocates:

- 'The group has taught me how to manage the voices so that they don't overwhelm me.'
- 'I learnt new strategies to keep the voices down, so they don't drown the 'good' voices.'
- 'I understand that the voices are not always real, and I can push them away.'

MHAS learned that *Hearing Voices* had not met the criteria for services included in the newly awarded contracts in the MHC's recommissioning of group support services. Although accepting the outcome of the MHC process, MHAS has a duty to respond to the concerns raised by consumers about the cessation of the program.

In April 2023 MHAS wrote to the MHC expressing concern about the cessation of the program and asking whether continued provision of a similar in-reach program by a suitably experienced provider was possible. The MHC responded stating that they had extended the service agreement with the *Healing Voices* provider for a period to enable consumers to transition or exit from the program. MHAS understands that the provider is aiming to continue delivery under the Commonwealth Psychosocial Support Program.

MHAS also raised the issue with NMHS, advocating for ongoing funding for the program and highlighting the impact of the loss of the program on the recovery and wellbeing of consumers.

Reform of the Criminal Law (Mentally Impaired Accused) Act 1996

For the first time, MHAS will offer advocacy services to people with mental impairment who have been accused of a crime and may be unfit to stand trial. This section outlines MHAS' implementation work and key advocacy concerns.

MHAS was funded for a 0.8FTE project manager during 2022-23 to plan for the implementation of new legislation that will replace the CLMIA Act. Delays in drafting the legislation continued in the first part of the year, impacting timelines and preparation activities. Eventually, Parliament passed the *Criminal Law (Mental Impairment) Act 2023* (CLMI Act), and it received Royal Assent in April 2023. Dates for the commencement of the CLMI Act are yet to be confirmed.

For the first time, people accused of a crime and whose fitness to plead is raised, will have the right to an Advocate. The CLMI Act provides for notifications to the Chief Advocate at various stages, and there are statutory timeframes for Advocates to contact consumers, for example, when a matter is adjourned in court to assess fitness to stand trial and when a custody order or community supervision order is made. Statutory advocacy will be available to 'unfit accused' persons while their fitness to stand trial is assessed and when a person is found unfit but with the possibility that they may become fit. Advocacy will be available to all 'supervised persons' including consumers:

- On custody orders in prison.
- Residing in the community on leave of absence orders or community supervision orders without conditions to undergo mental health treatment.

These complement the existing rights to statutory advocacy under the Act for consumers on custody orders who must be detained in an authorised hospital or released on condition they undergo treatment for mental illness.

The preparatory work for the new legislation included the development of a service model for advocacy, implementation plans for MHAS, and comment on the project management framework coordinated through a multi-agency Program Board. MHAS was represented on the Program Board and Implementation Steering Committee for the reforms. MHAS representatives also participated in two working groups regarding the CLMIA reforms the Department of Justice convened.

MHAS raised queries about specific rights introduced in the CLMI Act, including that a supervised person may appear before the Mental Impairment Review Tribunal (s.165 of the CLMI Act; unless the Tribunal considers it is not safe or practicable) and at court hearings to extend orders (S.125; although the court may direct them to appear by audio or video link). MHAS has been assured that courts can accommodate in-person attendances. MHAS continues to raise attendance at Mental Impairment Review Tribunal (MIRT) hearings as important in ensuring supervised persons have the best opportunity to understand proceedings and participate in their hearings.

To the same end, MHAS has strongly advocated introducing a program for communication partners (refer to s.21 of the CLMI Act). Communication partners help communicate and explain court matters and the Mental Impairment Review Tribunal. MHAS has been advised that the Department of Justice are discussing options internally and will reach out to relevant agencies once a position has been established.

The paucity of data available on the operation of the existing CLMIA Act has impeded planning activities and highlights the need for the

identification of key performance indicators, the collection of data and reporting on the operation of the new CLMI Act to ensure the fundamental reforms, including the introduction of limiting terms are achieved. MHAS continues to query the collection and monitoring of program-level data by the multiple agencies involved in providing services to unfit accused and supervised persons. Currently, this is not part of the implementation project at a program level (although individual agencies may be considering information technology, communication and data needs created by introducing the CLMI Act). Agreement has been reached to survey the data currently collected by agencies and their data needs.

MHAS has also raised concerns about existing mentally impaired accused persons who were acquitted of manslaughter or murder on account of 'unsoundness of mind' and whose limiting term will be the duration of their life (unless a life term would be unjust, and they are unlikely to be a threat to the safety of the community). MHAS is keen to ensure adequate planning and resources are available for those consumers likely to be detained until they die. Similarly, MHAS is eager to ensure that the introduction of limiting terms in the CLMI Act is resourced so that potentially indefinite extensions of custody or community supervision orders are minimised.

MHAS will continue to advocate for adequate resourcing so that other changes introduced through the reforms are realised, that unfit accused persons can become fit where possible, and that people subject to custody orders and community supervision orders can access timely supports to enable them to transition to release.

The rights of First Nations consumers

The Act provides specific and additional rights for First Nations consumers that go some way to recognising the unique ways in which they conceptualise 'mental health', often referred to in terms of 'social and emotional wellbeing'. Sections 50, 81 and 189 of the Act seek to involve significant members of a consumer's community, including Elders, cultural healers, or Aboriginal or Torres Strait Islander mental health workers, but this is only to the extent that it is possible. These are important rights, but significant ongoing, and unmet resourcing and procedures continue to impede First Nations peoples' access to these rights.

Although aware of a small number of service specific instances of good practice, either because of advocacy or strong service leadership (or both), MHAS does not see general compliance with these requirements. There continues to be little evidence of the necessary investment in change that would provide a culturally secure, legally compliant response to First Nations people's needs when being treated, or at risk of being treated, under the Act.

On country activity at Dryandra – Elders, Traditional Custodians and Curtin University staff around the campfire

Kaatadjiny Waalbraniny Danjoo (Learning to Heal Together) project

As reported last year, MHAS and the OCP are working with Noongar Elders and younger community members on the Kaatadjiny Waalbraniny Danjoo project. This will develop and implement an accountability framework in each organisation and is the basis for MHAS and OCP to drive systemic change. The work is facilitated by members of the Looking Forward team from Curtin University.

Activities this year included:

- Storying sessions with the Elders, community members and the Curtin team at Kaarta Ga'rup (Kings Park) and Star Swamp Reserve. Most MHAS staff and Advocates took part, sharing their story and listening to others, and through this, starting the work of building relationships and connection to each other and to country.
- A two-day on country event held in the Dryandra State Forest, attended by 20 staff and Advocates from MHAS, as well as several of their family members.
- A co-design process with Elders and community members to develop an action plan to increase organisational accountability to community. The plan identified key gaps in current practices, and suggested actions to amend these.

Some outcomes from this approach are already evident in MHAS' individual advocacy, as the following section illustrates. MHAS appreciates the collaboration with the OCP and holds that this is an important element of being able to drive systemic change.

Individual advocacy with First Nations consumers

At the end of one of the co-design workshops an Advocate with many years' experience working with First Nations consumers made the following observation about the impact of the project:

> **For the first time in many years of working with First Nations people I no longer feel alone. I have raised issues but have not been able to address them because neither MHAS nor the mental health services have had the connections with Aboriginal community-controlled organisations and with community that we need to really help consumers. We need to talk more to organisations like Derbarl Yerrigan, Yorgum, and the Aboriginal Legal Service, establish connections and relationships so that when we call – or ask a registrar to call – they know who we are. If MHAS has got these relationships, then we can provide the link to the service and so staff can make connections and provide an effective and culturally appropriate response to the consumer. This is starting now.**

The impacts of the Kaatadjiny Waalbraniny Danjoo project can be seen in the growing confidence with which Advocates and staff across MHAS approach their work with First Nations consumers:

> **Letters of support for two families of Aboriginal children from remote communities was sent to Perth for inpatient treatment to assist them in accessing the Patient Assisted Transport scheme.**
>
> **The successful advocacy for smoking ceremonies in a facility where a First Nations consumer had told the Advocate about a bad feeling or spirit in a specific room. In another facility, the staff organised a smoking ceremony as part of a ward re-arrangement.**

As well as a strengthening response in Advocate practices, MHAS' concern about the shortfall between what the Charter of Mental Health Care Principles make available and what happens daily has also been heightened. Advocates have reported the following themes in the issues that First Nations consumers raise with them:

- A widespread lack of understanding of First Nations people's rights under the Act and, at times, a lack of commitment to or interest in meeting those rights.
- Access to Aboriginal Mental Health Workers and Aboriginal Liaison Officers in many facilities is a problem. Advocates encounter vacant positions, insufficient numbers of staff, lack of choice of gender, and at times, conflicting interests because of family and community connections. Senior Advocates monitor staffing issues and regularly raise these at facility meetings.
- Ward design that makes it impossible to meet cultural protocols regarding space and movement when there is more than one admitted First Nations consumer.

Access to interpreters

The Act includes the right to communications in a language, form of communication and terms that a consumer is likely to understand, using an interpreter if necessary and practicable. Advocates have assisted several First Nations consumers whose first language is not English and who required an interpreter to participate in discussions with their treating team and Mental Health Tribunal hearings.

Tribunal hearings for at least two consumers were adjourned because of the unavailability of interpreters. In these cases, limited qualified interpreters were available in the languages spoken. Advocates raised and continue to raise the need for interpreters with the Tribunal and treating teams to help ensure consumers can comprehend the complex concepts and express themselves. However, the problems continue with the general paucity of interpreters in various languages and the lack of commitment and flexibility in the sector to coordinate this service.

Inquiry into First Nations people's rights

In 2019-20, MHAS conducted an inquiry into the rights of First Nations people under the Act[23]. The inquiry found that the Act is not being complied with, and overall, First Nations consumers are not consistently being offered their rights. While some initial progress has been made towards fulfilling the promise of the Act, and there are some positive examples of collaboration, there is still a long way to go before all First Nations people being assessed, examined, and treated have access to the rights offered by the Act.

The report contains 15 recommendations all supported, or supported in principle, in a joint response to the preliminary report from the Director General of the Department of Health, the five health service providers, and the then Acting Mental Health Commissioner.

Since then, MHAS has reported annually on the slow rate of progress towards addressing the recommendations.

The Chief Advocate raised the lack of progress with the MHC in February 2023. In June she wrote to the Director General of the Department of Health. MHAS received a response in the same month which confirmed that an Aboriginal consultant had been appointed to support the project, and the first quarterly progress report had been provided to the Mental Health Executive Committee. MHAS received a copy of the progress report shortly after the end of the annual reporting period and will continue to monitor progress and raise concerns with the relevant agencies.

[23] *The Inquiry into Services for Aboriginal and Torres Strait Islander People and Compliance with the Mental Health Act 2014* is on the MHAS website at mhas.wa.gov.au.

Other consumer rights

Mental Health Tribunal hearings

Mental Health Tribunal hearings are one of the fundamental rights of consumers subject to an involuntary order under the Act. Involuntary orders provide the authority for a psychiatrist to detain and treat a person against their will, including compelling them to attend a community mental health service in the community if on a CTO. These are profound restrictions on a person's freedom and rights and requires strong protections.

The Mental Health Tribunal is responsible for ensuring the authority granted to psychiatrists by the Act is appropriately exercised. It provides a process that should afford natural justice so that parties, including the consumer, have the right to be made aware of, and respond to, information used by the Tribunal when it makes a decision about them. The importance of hearings for individuals and the mental health system cannot be understated, particularly in WA, where only one psychiatrist's decision is needed to make a person involuntary.

Advocate representation at Mental Health Tribunal hearings has been 40% or higher of conducted hearings since 2019-20 (see table nine). MHAS considers every consumer should have the opportunity for representation, whether by an Advocate or a lawyer. Advocates can assist consumers in accessing legal services, including from the Mental Health Law Centre, whose funding includes free representation at hearings.

A lawyer or an Advocate represented a consumer at 51% of hearings (including 1% of hearings at which both a lawyer and Advocate attended[24]). Advocate attendance rates do not necessarily reflect MHAS' use of resources as Advocates also assist consumers in preparing for hearings that do not proceed. Assistance may include confirming an interpreter is being arranged for the hearing, following up about medical reports and ensuring the treating team has discussed the report with the consumer. In 2022-23, a significantly greater proportion/number of hearings listed were not conducted: 395 more than in the past year. Another way to put it is there were more hearings listed in 2022-23, but fewer hearings were conducted compared to 2021-22. This may account for the apparent reduction in attendance by Advocates and lawyers.

During the year, Advocates raised concerns about hearings being adjourned due to delays in psychiatrists' reports for the Tribunal or a treating psychiatrist or treating team member being unavailable to attend the hearing.

Earlier in the financial year, there were widespread delays in scheduling initial and periodic hearings outside the timeframes required by the Act (and there were also longer than usual wait times for requested hearings). Overall, there was an improvement in the number of face-to-face hearings held by the Tribunal in the metropolitan area (as opposed to hearings conducted through audiovisual means). When a hearing is not conducted face-to-face, this can create a barrier to consumer participation. This has been a major issue for consumers for several years.

[24] Where requested by a consumer, MHAS Advocates may jointly attend hearings along with a lawyer where the consumer is in a regional area, where a lawyer is attending by audio-visual means, or in other situations with the approval of a Senior Advocate.

TABLE NINE - Seven-year trend in representation at Tribunal hearings[25]

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Number of hearings listed	3,320	3,446	3,618	4,253	4,007	3,908	4,118
Number of hearings conducted	2,103	2,247	2,320	2,627	2,659	2,742	2,557
Percentage of hearings attended by MHAS	35%	34%	36%	40%	40%	43.5%	41.0%[26]
Percentage of hearings attended by the MHLC	8%	9%	9%	8%	11%	10%	9%

Further Opinions

Consumers have the right to request a Further Opinion (FO) and often report a good outcome, even if their involuntary status continues. There may be changes to their medication or access to leave, which can assist with a sense of empowerment and confidence in the treatment they are given without their consent or agreement.

Since the DoH mandatory operational directive on the right to a FO was rescinded in June 2021, the number of FOs requested through an Advocate has dropped. The number was relatively stable when the directive was in force, averaging 273 opinions per year. However, numbers dropped to 177 in 2021-22 but have increased again to 222 opinions in 2022-23. A consumer can request a FO directly. Therefore, the data does not equate to the total number of requests made.

Despite the increase in FOs, MHAS remains concerned that this important consumer right is being eroded.

During the past year, MHAS has had discussions with the Chief Psychiatrist and the Office of the Minister for Mental Health, exploring options for the effective provision of a FO service. MHAS has expressed a preference for the reinstatement of the operational directive with a memorandum of understanding (MOU) between the DoH and Health Service Providers (HSP). The directive could reinstate the template for written opinions and timeframes to arrange the opinions and outline the data required to enable reporting. An MOU could help address financial barriers to providing external opinions and provide a dedicated funding mechanism linked to the MHC's service agreements.

[25] Source: Data is based on information from Mental Health Tribunal annual reports, with the exception of 2022-23, which was supplied directly from the Tribunal. Note that MHAS published statistics on Advocate attendance in 2021-22 based on reports from Advocates, which are not comparable.

[26] The Mental Health Tribunal that both a MHAS Advocate and MHLC lawyer attended 1.0% of hearings in 2022-23.

Treatment, support and discharge plans

Person-centred care is a central theme of the Act and *Charter of Mental Health Care Principles*. The Treatment, Support and Discharge Plan (TSDP) is a key practical mechanism for this. The Act requires that a TSDP governs all treatment, care and support and that the consumer and their personal support person are involved in the preparation and review of the TSDP. It must be reviewed regularly, and the consumer and their personal support person must be given a copy.

In 2017, MHAS conducted an inquiry into compliance with the provisions for TSDPs and found that most mental health services were not complying fully with the Act. Sadly, little seems to have changed in the six years since the inquiry. Based on issues raised by consumers and Advocates' observations of their files, there are system-wide issues:

- A lack of consumer and personal support person involvement.
- Incomplete plans or plans that have not been updated.
- Plans that contain predominantly clinical information and do not respond holistically to consumers' needs.
- Plans that are not recovery-oriented and are written in exclusively clinical language.

Although Advocates reported some good examples, these tended to be the exception and often depended on the presence of a senior member of staff, who drove improved practice for a brief period until they moved elsewhere, at which point practice deteriorated again. MHAS contends that some of the problems with delayed and failed discharges for children and adults could have been addressed through better joint care planning, involving not only the consumer and their support people but community agencies, including NDIS and other non-government providers.

The MHC provided additional funding to MHAS to address the advocacy needs of long-stay consumers whose discharge had been delayed because of a lack of the right combination of accommodation and support in the community. The project, which is ongoing, explored the barriers to discharge to improve the effectiveness of advocacy for long-stay consumers. Initial findings from an audit of 22 plans in one facility demonstrate significant opportunities for improvement in TSDP practice:

- 86% of NDIS plans showed evidence of consumer involvement.
- 36% of TSDPs showed evidence of consumer involvement.
- 9% of TSDPs aligned with the consumer's NDIS plan.
- 45% of TSDPs demonstrated partial alignment between TSDP and NDIS plan.
- 41% of TSDPs did not show evidence of any alignment with the NDIS plan[27].
- None of the consumers' TSDPs showed evidence of shared care planning from NDIS providers (including positive behaviour support specialists).

MHAS acknowledges that the implementation of TSDPs has been hindered by the delay in providing a standardised form on the Psychiatric Service Online Information System (PSOLIS). However, this does not account for the observed lack of embedded person-centred shared care planning practices.

The Chief Advocate raised her concerns about these practice gaps with the Mental Health Commissioner in July 2022. Following this, she met with the Chief Medical Officer - Mental Health and the Deputy Chief Psychiatrist to discuss options for addressing the gaps. A community of practice has been considered but has yet to be developed and delivered. The Chief Advocate has also flagged the issue in her quarterly report to the Minister for Mental Health and through her involvement with the *Statutory Review of the Mental Health Act 2014* steering committee. In June, she wrote to the MHC and the DoH Mental Health Unit about the need for training in shared care planning and asked which agency was responsible for developing and funding any such training. MHAS hopes this matter will receive the attention it requires through the anticipated MHA Compliance Steering Group to be convened jointly by the MHC and OCP in 2023-24. The Chief Advocate has been invited to be a member of this steering group and attended the inaugural meeting in July 2023.

[27] MHAS could not establish alignment in 5% of cases because the NDIS plan was unavailable at the time of audit.

Responses to consumer complaints

Advocate functions include inquiring into and seeking to resolve complaints raised by consumers. They do this in various ways, including raising the issue with ward staff, helping the consumer write their own letter of complaint and writing a letter of complaint from MHAS.

During the past year, MHAS experienced variability in the quality of responses to complaint letters. Last year, MHAS Advocates, Senior Advocates and the Chief Advocate wrote 64 complaint letters. Of the responses to these:

- Six were deemed unsatisfactory by the consumer, but they did not want to take further action.
- Four were raised at meetings, and improvements sought for future letters.
- In four cases, consumers chose to escalate their complaint to HaDSCO.

Fourteen per cent (or one in seven responses) fell below a standard acceptable to consumers. Unsatisfactory responses included:

- Failure to offer an apology when one had been sought or did not offer solutions sought by the consumer.
- Discounting the consumer's version of events without providing a credible or evidenced alternate version.
- Being based on a disputed understanding of the Act.
- Blaming the consumer for what had happened to them.
- Not being written in recovery-focused language or demeaned or dehumanised the consumer.

Senior Advocates have worked with mental health service and consumer liaison staff to improve complaint handling and responses. MHAS is pleased with the investment in improving complaint handling and responses and has seen many good results:

- Ensuring timely responses.
- Greater use of trauma-informed, recovery-oriented language in letters.
- Respectful and dignified ways of presenting differing views of the facts.

MHAS will continue to focus on the quality of responses in the coming year as a key accountability mechanism and consumer right.

Licensed private psychiatric hostels

In 2021-22, the MHC provided MHAS with additional funding to commence a program of work - the *Enhanced Hostels' Visiting Program (EHVP)* - to facilitate better access to advocacy for people living in licensed private psychiatric hostels. The funding was extended for a second year, supporting a part-time Senior Advocate to oversee the EHVP, prepare quarterly progress reports, supervise the team of hostel Advocates, and manage complex and serious issues. Regular hostel visits commenced in January 2022 and have continued since.

The EHVP has revealed the precarity of residents' rights and the extent to which the Charter of Mental Health Care Principles and LARU Standards are breached on a regular basis. In relation to the Principles, those least complied with are:

- Principle 1 - Attitude towards people experiencing mental illness: Advocates frequently observe disrespectful encounters between residents and hostel staff.
- Principle 3 - Person-centred approach: Advocates encounter policies and procedures applied inflexibility and without considering residents' needs, and insufficient participation by residents in the planning and delivery of support for their recovery journeys.
- Principle 4 - Delivery of treatment, care and support: Advocates report that many residents do not feel safe in what is supposed to be their home. Trauma informed care is not provided at many sites, nor are timely responses to some immediate resident needs.

Principles 8 (co-occurring needs), 9 (factors influencing mental health and wellbeing) and 10 (privacy and confidentiality) are poorly complied with. These principles are difficult to monitor and regulate, but the gaps are frequently encountered by Advocates who spend time in facilities and by listening attentively and respectfully to residents.

Through its advocacy, MHAS was able to address many issues as they arose but is also aware that without constant vigilance, conditions and practices can, and do, slip. This results in a lack of compliance with standards and other obligations.

MHAS is concerned that residents in some hostels are reluctant to raise issues or to ask Advocates to assist because they fear reprisals. Most commonly, consumers report being fearful of losing their accommodation. Some hostels do not have a phone for residents' use or phones are in a staff area where there is no privacy. Many residents do not have their own phone, and this impedes a person's ability to contact MHAS when they need to.

MHAS considers there is an urgent need to review the hostel program and replace the older, congregate hostels or to put in place arrangements to ensure the safety of residents, and to facilitate their access to their rights. The current funding and governance arrangements not only present a significant risk to people's rights, but a risk to government, as funder and regulator of the program. This situation is acknowledged by the Minister for Mental Health and the Mental Health Commissioner, and there are plans underway for reform of the hostel sector in the medium-term.

MHAS acknowledges the difficulty this situation presents, and notes that both MHC and the Licensing and Regulatory Unit (LARU) are taking actions to ensure the safety and quality of services provided to licensed private psychiatric hostels via the supported accommodation program. The loss of multiple hostels in a short space of time carries with it the real risk of people becoming homeless or in inappropriate accommodation and left without vital supports. Replacement of housing stock, refurbishment of dilapidated buildings, and development of workforce capabilities are expensive and take time. Short-and medium-term actions and contingencies are required to enhance people's quality of life, protect their rights, and protect government against the risks that hostels present.

The Enhanced Hostel Visiting Program

MHAS has a team of three Advocates who work solely in metropolitan hostels. At times, they are assisted by Youth Advocates in the hostel for young people and general Advocates in the hostels in Bunbury, Busselton, and Albany. They are supported by a three-day-per-week Senior Advocate. The EHVP provides structure to MHAS' hostel work, focuses on residents' rights and includes regular reporting against targets which facilitates a focus on policy and risk mitigation through the Psychiatric Hostels Agencies Committee (the combined oversight agencies' body).

The EHVP has three objectives:

1. Make connections and build trust and rapport with hostel residents.

2. Check on and raise hostel conditions that may impact on residents' health, safety and/or wellbeing.

3. Implement regular visits to hostels, with more frequent visits where Advocates are concerned that conditions could adversely impact residents' health, safety or wellbeing.

All hostels, except for Geraldton, were visited during the year. Advocates met with 95% of residents, assisted 310 people with 1,076 issues raised. Accommodation, physical health, financial issues, NDIS-related issues, and issues with administration orders accounted for over half of all issues. Most issues were addressed and resolved at a hostel level. Residents have been assisted to write complaint letters about matters impacting them. Advocates have written emails and letters to hostel management, addressing broader systemic issues raised by individual residents. There were 33 serious issues recorded. Ten were allegations relating to sexual safety. Seven were allegations of misconduct, wilful neglect, or ill-treatment. Seven were allegations of psychological or verbal abuse. Five were allegations of physical abuse. Two were allegations of financial abuse and two were categorised as 'other'.

In addition to issues raised by individual residents, Advocates also independently identified, recorded and addressed 132 issues with the hostel, its services or management. Most of these issues came from three hostels. The most common facility issues concerned the building or environment, temperature, cleanliness and hygiene, and food and beverages. Most issues were resolved through correspondence and meetings with facility management. Although the hostels where residents are most at risk tend to be the larger, congregate living facilities, the EHVP has demonstrated that even in the more contemporary and generously funded facilities, there are significant issues impacting (or that could impact) residents that need to be addressed.

There has also been an increase in the requests for contact received by phone to MHAS. Over the year, MHAS received 381 requests for an Advocate to contact a resident from 122 individual consumers. Advocates report this increase reflects increased confidence to call MHAS for assistance.

Examples of outcomes from Advocate intervention on the top five issues raised include:

Accommodation

- Advocated successfully for a resident to move to a hostel where they could cook and be more independent. The resident is now looking for work, with support from the Advocate.
- Supported a resident to move from transitional hostel accommodation to a hostel which provides a full recovery program and where the resident feels safe.
- Presented a resident's views and legal rights in a multidisciplinary meeting to assist in gaining clinic and hostel management support for their move to Supported Independent Living.
- Advocated for case managers/key workers to assist several residents to apply for private accommodation.

Physical health

- Negotiated $5 physiotherapist consultations (with a GP Care Plan) for a resident with back problems.
- Ensured continence products were provided for a resident who was concerned about urinary incontinence.
- Requested for hostel staff to arrange GP appointments for residents reporting physical health issues.
- Addressed reports from residents that hostel staff minimised their physical health issues.
- Advocated for one resident to get dental care. Following this visit, all residents in that hostel are being canvassed for a referral to the local public dental clinic.

Financial matters

- Negotiated access to all historical financial statements for a resident. They were then able to make choices about how to manage their money.
- Assisted various residents to access funds from the Public Trustee, including increased weekly amounts of funding. The Advocate was successful where previous attempts made by the resident and staff had been unsuccessful.
- Advocated for resident's medication to be paid for by the Public Trustee instead of by their brother (Guardian).
- Organised a bank card to be sent to a resident so they could access funds independently.

NDIS issues

- A resident received an extra day of supports and an additional support worker following advocacy.
- A resident was given the opportunity to explore the NDIS as an option although they decided against this.
- Advocacy to support residents to apply for access to NDIS earlier in their stay at hostels.

Medication

- A resident had their medications reviewed and reduced, which was what they wanted, following an Advocate request for review.
- A resident was not happy with their medication and sought Advocate support to access the review. The review led to a change in medication and the resident reported an improvement in their mental health.
- Following investigation, the Advocate was able to assure a resident that a form they were requested to sign did not allow staff to give them injections against their will.

The impact of advocacy, before and after - the replacement of damaged furniture

New furniture at Mimidi Park Inpatient Unit, Rockingham Hospital

Access to advocacy in hospital

Hostel residents have the right to an Advocate when admitted to hospital. This includes those admitted as voluntary patients. Presentation and admission to hospital remain a significant eviction risk for residents. Hostels may demonstrate a reluctance to take a resident back upon discharge because their support needs may have increased. A resident's support needs may exceed what hostel management feel they are resourced to provide.

In July 2022, MHAS commenced an inquiry into what happened to a hostel resident who had been urged by hostel staff to attend ED following a suicide attempt and who was evicted whilst attending the ED. After initial attempts to prevent the eviction failed, the Chief Advocate wrote to the hostel management and the HSP involved. Difficulties in obtaining adequate responses from each party hampered the timely resolution of the inquiry. Given the systemic nature of the issues under investigation and the lack of complete resolution, the Chief Advocate is making a report with recommendations on enhanced oversight and safeguards for residents seeking hospital assistance.

Having an Advocate assist a hostel resident in hospital can be vital to ensuring proper follow-up, identification of other supports needed and even a change in accommodation provider if requested by the consumer.

The Advocate assisted a hostel resident who had presented to ED multiple times for falls and trips over a period of time. At each presentation, the resident had their wounds dressed and was sent home without further examination to assess the cause of the repeated falls. The Advocate and the resident's guardian worked together to ensure that the resident was admitted, and extensive investigations were undertaken. Once admitted, it was determined the resident had extensive internal injuries from previous falls and required further treatment.

Whilst admitted to a medical ward, a resident asked their Advocate to attend their neurology and psychiatry meetings. The resident said they did not feel heard or understood at the appointments. With the Advocate's assistance, the resident was able to access ongoing psychiatric care and case management from the community mental health service (who had previously refused to treat the resident).

Environmental inquiry

An Inquiry into the environmental conditions of mental health wards was completed in March 2023. In 2022, MHAS sent each authorised hospital a closed-circuit television (CCTV) survey. The findings from that survey were incorporated into the feedback provided to facilities as part of the environmental inquiry.

The basis for the inquiry comprised a checklist that Advocates used to inspect each facility. They also sought input from current consumers on the environmental issues that made a difference (positive or negative) to them. Consumers offer unique insight into environmental issues on wards that at times are not picked up by routine hospital maintenance schedules and OCP inspections. Moreover, the MHAS Environmental Inquiry prioritises the issues that matter to the consumers.

Inspections of wards were conducted in all authorised hospitals across the state, as well as in MHOAs and the Mental Health Emergency Centre. Licensed psychiatric hostels were not included in the inquiry. As with most MHAS inquiries, it set out to identify conditions that adversely affected or may adversely affect the health, safety, or wellbeing of identified persons. A key focus was understanding the impact on consumers, as explained in their own words, many of whom were involuntarily detained for weeks or longer.

Advocates inspected 57 wards at 19 mental health facilities. Over a thousand (1027) environmental issues of concern and 58 CCTV issues were identified. A report with feedback about the issues identified was provided to each of the facilities inspected, seeking a response. The Health Service Provider Chief Executives were sent a copy of all facility reports within their jurisdiction.

Issues identified in the inquiry

There is a high degree of alignment with the issues consumers regularly raise with Advocates and those covered elsewhere in this report. This indicates the impact the environment has on consumer health, safety, and sense of dignity and humanity.

Based on what consumers told Advocates about the ward conditions, significant concerns were found to be widespread across facilities.

- **Safety:** Some potentially dangerous or high-risk conditions and practices that could compromise consumer safety were identified. Some wards used plastic bags as bin liners, presenting an asphyxiation risk to vulnerable consumers. Other examples included common areas that were frequently locked, reducing available breakout spaces, and no locks or broken locks on bedroom doors in mixed-gender wards.

- **Privacy:** A lack of protection around consumer privacy and dignity was evident. In some cases, consumers were visible while showering or using the toilet because of broken ensuite and bedroom curtains which had not been replaced. Bed pans or cardboard urinals were provided for use in some seclusion rooms.

- **Cleanliness and hygiene:** Inspections showed many communal areas that were unclean, with torn furniture, damaged walls, cracked lino and stained carpets. Unhygienic conditions in bathrooms were evident, including apparent mould and vermin. Some toilets did not adequately flush. Many courtyards had damaged furniture and rubbish, with insufficient seating and shelter.

- **Bedrooms:** Very hard or torn mattresses were of concern. Some bed frames did not accommodate people taller or larger than average, leading to consumers sleeping on the floor or having disturbed sleep. Uneven heating and cooling concerned consumers, and some rooms had poor access to natural light.

- **CCTV:** There was a lack of recorded CCTV footage in communal areas. Consequently, incidents and risks to consumers in volatile situations were not able to be readily monitored. Footage could not be accessed or used in investigations of incidents. In several facilities, there was no visible signage available inside the wards to alert consumers to the use of CCTV on the ward. In some instances, consumers could see live CCTV streaming on monitors in nursing stations in communal areas.

Outcomes of the inquiry

MHAS received written responses from six of the 19 mental health facilities by 30 June 2023. The inquiry findings were discussed at facility meetings. Facility responses have been almost unanimously positive. MHAS will follow up to collect responses from the remaining facilities (some of whom have delayed sending individual responses while they collect and collate responses across the HSP).

Feedback also showed positive features of ward environments that consumers welcomed and valued. These included wards with Aboriginal artwork and colourful furnishings, the presence of aquariums, exercise equipment, and gazebos and flowers in courtyards. Independent access to hot and cold drinks and common areas with natural light also improved consumer experiences on mental health wards.

Action has already been taken by some facilities to improve the environment for consumers, and significant progress noted for some issues:

- A bariatric mattress and a new bed were supplied to a larger-than-average person who could not sleep on the single mattress previously provided. Before this, the consumer had been in the ward for several months with inadequate bedding and said their sleep had been impacted as a result.
- One hundred and sixteen new mattresses are now being supplied across several mental health wards.
- Babies were sleeping in cots with a gap between the mattress and cot wall at a Mother and Baby Unit. Towels had been rolled up and placed at the cot wall to avoid the baby falling into the gap. On investigation, it was found that the mattresses had been placed upside down as they were worn, thus creating the gap. These mattresses are being replaced.
- Locks for shared bathrooms are to be replaced with privacy locks across three wards of one facility, and doors will be replaced to meet anti-ligature and privacy requirements.
- A privacy screen sticker has been placed on bedroom windows overlooking a ward courtyard. Previously, people in the courtyard could see into these bedrooms, compromising consumer privacy. Some courtyards are undergoing refurbishment, and new flowers have been planted in gardens.
- Plastic bags have been removed from wards where they were previously identified.
- OCP Sexual Safety Guidelines posters and MHAS posters and pamphlets have been placed in many wards following the inquiry.

Next steps

In November 2023, Advocates plan to revisit and reinspect all authorised mental health facilities. MHAS will then report on how many issues have been resolved completely, partially or remain outstanding.

MHAS appreciates the responses already received to the Inquiry and looks forward to working collaboratively with HSPs and facilities to achieve improvements in the physical environment to the benefit of all consumers.

Connecting with country at Dryandra

Resourcing, data, and disclosures

Budget and expenditure

In 2022-23, the total allocated budget for MHAS was $4,490,000 which comprised:

- $3,898,000 under direct control of the Chief Advocate for statutory advocacy services.
- $396,000 (8.8% of the total budget covering the cost of corporate services provided by the MHC).
- $196,000 for planning and policy development activities to prepare for implementation of the Criminal Law Mentally Impaired (CLMI) Bill.

The $196,000 allocated to MHAS in 2022-23 for the implementation of the reform of the CLMIA Act was provided by the Department of Justice. MHAS incurred costs of $166,733 relating to this work.

Excluding the $196,000 allocated for the reform of the CLMIA Act, the allocated budget for MHAS statutory advocacy services and corporate support services from the MHC was $4,294,000 in 2022-23. MHAS worked to the best of its ability to operate within this budget. However, due to several factors, expenditure in 2022-23 was $4,810,557, which was $516,557 (or 12.0%) over budget.

Various unavoidable external drivers have impacted on MHAS' costs. System-wide increases in demand for mental health treatment and support have led to hospital bed and accommodation shortages. Delays in admissions result in more acute, intensive, and complex support needs. There has been a consequent increase in Advocate workload volume and complexity. Additionally, the requirement to increase Advocate's hourly rate of pay, superannuation contributions and mileage rates without receiving any additional funding to meet these costs has contributed to the overspend.

TABLE TEN - MHAS allocated budget and expenditure 2017-18 to 2022-23[28]

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Expenditure	$2,702,375	$2,651,988	$2,724,443	$3,017,802	$3,095,685	$4,129,100	$4,810,557
Budget	$2,654,000	$2,627,000	$2,668,000	$2,719,000	$2,858,000	$4,060,000	$4,294,000

[28] This excludes funding provided for the Criminal Law (Mental Impairment) Bill implementation.

TABLE ELEVEN - Actual cost of resources received free of charge in 2022-23

Agency	Resources received free of charge	Amount
Mental Health Commission	Corporate support services	$429,183
State Solicitor's Office	Legal services	$29,048
Department of Finance	Leasing services	$13,145
TOTAL		**$471,376**

The cost of advocacy services, including payments to the Chief Advocate, Senior Advocates, Team Leaders and Advocates comprised 66.5% of MHAS expenditure in 2022-23. Employment costs for advocacy support service staff (including agency staff and payroll support for Advocates) comprised a further 15.7% of the total expenditure. Other goods and services accounted for 8.9% of MHAS expenditure. This included costs such as to Advocate training, building lease, telephone, printing, and fleet vehicle expenses. The remainder of MHAS costs (8.9%) were contributed to corporate support services provided by the MHC.

Remuneration

Advocates (including the Chief Advocate, Senior Advocates and Team Leaders) are entitled to remuneration as determined by the Minister for Mental Health. The Chief Advocate's remuneration is determined by the Minster, on the recommendation of the Public Sector Commissioner.

The Advocates, Team Leaders and Senior Advocates are paid an hourly rate plus superannuation and mileage. Advocates are engaged on a contract for services and have no entitlement to paid leave. Advocates supply their own vehicle and mobile phone, while laptops are provided to maintain security of information.

In 2018, The Minster for Mental Health approved annual pay increases for Advocates in line with Public Sector staff. However, MHAS has not been funded to meet these obligatory increases. In 2022-23, the hourly rates of pay increased as follows:

- Senior Mental Health Advocate increased from $62.60 to $64.60
- Team Leaders increased from $57.60 to $59.60
- Advocates increased from $52.60 to $54.60

Resourcing

Recruitment and induction of new Advocates

As per the Act, Advocates are engaged on a contract-for-services for a period not exceeding three years, which can be renewed by mutual agreement. Whilst engaged on a contract, Advocates can declare themselves unavailable for work for a fixed period or resign from the position. Upon resignation, Advocates' contracts are terminated. The Chief Advocate can also terminate an Advocate's contract in the case of mental or physical incapacity, incompetence, neglect of duty or misconduct.

During 2022-23, nine Advocates resigned, or their contracts were not renewed, and twelve new Advocates were engaged. Throughout the year, there were four Advocates who were not available for extended periods. One Senior Advocate resigned during the year and two new Senior Advocates commenced.

In 2022-23, The Minster for Mental Health approved the creation of dedicated Advocate Team Leader positions. The Team Leaders support the Senior Advocates with some of their day-to-day coordination of Advocates, allowing the Senior Advocates more time to focus on statutory functions, such as inquiries, investigations and serious issues. Three part-time (15 hours per week) Team Leader positions have been established on a trial basis for twelve months to December 2023. The Team Leaders were appointed from within the existing Advocate pool and undertake Advocate work.

As of 30 June 2023, the Advocacy service comprised:

- The Chief Mental Health Advocate.
- 4 Senior Advocates, including one part-time (15 hours per week) Senior Advocate overseeing advocacy to psychiatric hostel residents.
- 3 part-time Team Leaders.
- 46 Advocates (including one person in a combined Hostel Senior/Advocate role and three people in combined Team Leader/ Advocate roles). This comprised:
    - 23 general Advocates operating in the Perth metropolitan area.
    - 6 Advocates operating in regional Western Australia (Broome, Kalgoorlie, Bunbury and Albany).
    - 1 Advocate providing a weekend phone service.
    - 9 Youth Advocates.
    - 3 Advocates working in hostels.
    - 4 Advocates on contracts but unavailable.
- 10 public servant advocacy support staff (8.1 FTE) including the Principal Project Manager (CLMI) reform.

In 2022-23, the total number of Advocate hours undertaken was 37,959, representing a 20.1% increase compared to the 31,601 Advocate hours undertaken in 2021-22.

The increase can largely be attributed to the 10.8% increase in involuntary orders, the 75.4% increase in the number of serious issues reported to Advocates, and the 37.5% increase in the number of issues and complaints Advocates assisted consumers to resolve in 2022-23. Additionally, in 2022-23 MHAS significantly increased advocacy services to people living in psychiatric hostels through the funding provided by the MHC for the enhanced psychiatric hostel program.

Most Advocates are engaged on zero hours contracts without guaranteed hours or leave entitlements. Advocates continue to cite employment conditions and laborious payroll processes as a major disincentive and issue impacting attraction and retention of Advocates.

In 2022-23, MHAS commenced a review of its Advocate Payment and Availability Protocol. The review examined the basis for payments, the mechanisms by which those payments are justified and made, and the efficiency and ease of application of the protocol. An important aspect of the review was to provide for a measurable sense that the recording, checking, approval and disbursement of payments is easier, less burdensome, and just in terms of delivered services and payment while continuing to meet government accounting requirements. The work is ongoing and will be completed in the first half of the 2023-24 financial year.

New Advocates complete an intensive five-day in-house induction, participate in observation days at mental health facilities and complete the MHC's clinicians' e-learning module. Additionally, new Advocates are mentored by experienced Advocates for several weeks where they participate in a variety of key advocacy tasks including attending tribunal hearings. Once new Advocates have completed their training and are assessed as competent, they work alone with consumers under the general guidance of their Senior Advocate.

Advocate training and development

The Chief Advocate is committed to improving Advocate safety and retention by focusing on improving Advocate support.

In 2022-23, 38 Advocates attended a workshop on managing vicarious trauma. The workshop focused on exploring the impact of vicarious trauma and identifying steps to develop resilience and self-care strategies. The workshop was well received by those who attended.

Advocates also attended a two-day workshop focused on Advocate development and best practice. This workshop included topics such as boundaries, serious issues, record keeping as well as a presentation from the OCP on compliance issues that Advocates frequently encounter.

Advocates participated in a monthly meeting called the 'Kookaburra Call', where the Chief Advocate provided important information to Advocates and staff and sought input on practice and organisational matters. Additionally, Advocates attended regular team meetings and participated in practice focused sessions, including peer reflective practice and guided practice development.

Advocacy support service staff

Public Service Officers are appointed to assist the Chief Advocate to perform functions under the Act. The advocacy support service comprises a small team that undertakes a variety of policy, executive support, data management, system support, administration support and consumer liaison functions. The number of full time equivalent (FTE) advocacy services staff has increased to 7.3 FTE, not including the 0.8 FTE CLMI Principal Project Manager[29].

MHAS continues to experience regular turnover of advocacy services staff. In 2022-23, MHAS has heavily relied on temporary agency staff and fixed term contracts to fill positions. This has impeded the ability to maintain corporate knowledge, impacted critical business systems and resulted in a significant reduction in the quantity and quality of support provided. Over the past year, an increasing number of administrative tasks were routinely performed by senior staff, including the Chief Advocate. The current level of support staff does not align with the needs of the organisation, impacting on multiple functions not being performed to the required standard or within the expected timeframes.

In 2022-23, MHAS commenced the process of engaging a consultant to undertake a functional review of its staffing needs and organisational structure, in consideration of the additional workload through the CLMI Act.

[29] In 2022-23, MHAS received 12 months funding for a 0.8 FTE Principal Project Manager to prepare for the CLMI Act reforms.

MHAS strategy plan

During 2022-23, MHAS finalised the development of its five-year Strategy Plan 2022-2027. Advocates and advocacy support staff provided input into the development of the plan through a series of surveys and workshops.

Quarterly reporting

In 2022-23, MHAS refined its quarterly reporting process where the Chief and Senior Advocates prepare a report detailing the various activities undertaken by each team during the quarter. The reports are presented to the MHAS leadership team and a summary of these reports is then provided to the Minister for Mental Health and the Mental Health Commissioner for their information, and as the basis for system advocacy. In 2023-24, MHAS also plans to provide HSP chief executives with the summary reports.

Integrated Client Management System upgrade and migration

The Integrated Client Management System (ICMS) used by MHAS is a 2013 Microsoft Dynamics customer relationship management software which requires an urgent and essential upgrade. The software has not been supported since 2019, creating major security risks and significantly hampering system maintenance and functionality.

Data quality is of increasing concern and report production capability is limited and resource intensive. On average, report production often exceeds 60 hours per month to produce a limited range of reports. The limited reporting capability and dubious quality impacts both our ability to monitor performance and limits our capacity to understand systemic issues. MHAS is not currently able to report with confidence on the extent to which key consumer rights are being upheld.

Migration of the ICMS system to a cloud-based platform was initially delayed due to technical issues. However, the project could not resume in 2022-23 due to MHAS resourcing issues. This work is planned to recommence in 2023-24 as a priority to ensure a functional system is in place when MHAS commences providing advocacy through the CLMI Act.

MHAS will also investigate the inclusion of a payroll function into ICMS to automate the Advocate pay claims process. MHAS currently utilises a resource intensive manual process which places a significant burden on Advocates and on average, requires around 18 hours of administrative time each fortnight. Work to implement the automation of the payroll process can be undertaken once the ICMS migration has been completed.

MHAS phone system upgrade

An upgrade to the phone system was initiated to facilitate timely contact between Advocates and consumers. The project was planned to be implemented over multiple stages. The first stage was the introduction of a contemporary Voice Over Internet Protocol (VOIP) phone system. There continues to be ongoing technical and functional issues with the VOIP system. As a result, the other stages have been placed on hold until the issues are fully resolved. MHAS has been working with the MHC, internet provider and phone provider throughout 2022-23 to investigate the possible cause of these issues, which are yet to be resolved.

The existing MHAS office phone system relies on an office-based liaison officer to either transfer calls to Advocates' personal mobile phones or to take a message for Advocates. This creates inefficiency and potentially requires the consumer to tell their story multiple times. Stage two of the upgrade aims to resolve some of the inefficiency issues through the implementation of a system that enables communication directly between Advocates and consumers, removing MHAS staff members as conduits.

During 2022-23, MHAS commenced work to implement a mobile phone-based application which allows Advocates to make VOIP calls to consumers from their mobile phone without identifying their mobile phone number. Further work is underway to identify a solution where Advocates can securely send text messages to consumers from their personal mobile phones while not disclosing their personal phone numbers.

Records management

In accordance with section 19 of the State Records Act 2000, MHAS maintains a record keeping plan which governs the management of its records. The plan required MHAS to finalise its record-keeping procedures manual and classification system, which was completed in 2018. In February 2022, the State Record's Office wrote to the Chief Advocate to remind MHAS of the requirement to review the record keeping plan within five years of being approved. This review is due by 10 August 2023.

In 2022-23, MHAS upgraded the classification system within its electronic document and record keeping system (HP TRIM). The upgrade established a basic framework which still requires significant development. While some training was provided to staff, the lack of files in which to save records has significantly impacted MHAS' ability to capture records in a timely manner. MHAS plans to further develop the filing structure and provide staff with ongoing training and support in 2023-24.

Disclosures

Electoral Act requirements

As required under the *Electoral Act 1907*, section 175ZE (1), section 175ZE (1), MHAS recorded $4,054 in expenditure related to the designated organisation types between 1 July 2022 and 30 June 2023, which is broken down as follows:

- Advertising agencies: Bigwig Advertising Pty Ltd $4,054 (graphic design of the annual report and strategy plan)
- Media advertising organisations - nil.
- Market research organisations - nil.
- Polling organisations - nil.
- Direct mail organisations - nil

Quality assurance

MHAS is committed to continuous quality improvement in our service delivery, and we welcome both informal and formal feedback regarding our operations.

Complaints

In 2022-23, MHAS received seven complaints about our service, each of which was handled according to the MHAS complaints protocol. Six complaints have been resolved, and one remains in process. The Complaints, Feedback and Compliments Protocol is published on the MHAS website. Six complaints relate to advocacy services and one complaint relate to advocacy support services.

MHAS breaches of the Act

The Act requires Advocates to contact consumers within seven days of an involuntary treatment order being made for an adult, and within 24 hours of an order being made for a child. Consumers were contacted by an Advocate within the statutory timeframes for 94.6% of involuntary treatment orders. This is a decrease in the proportion of consumers contacted in statutory timeframes compared to 2021-22, when 96.4% of consumers were contacted.

The most common reason for a breach was due to the order being revoked or a subsequent order made within that timeframe (67.8% of all breaches). In addition, 13.5% of breaches (down from 30.3% in 2021-22) were due to orders being revoked within two days. Revocations within a few days of an order being made are a concern. They raise questions about whether an alternate form (3C) should have been used to enable further examination by a psychiatrist, with the possible outcome of avoiding the need for an involuntary order.

Contact was achieved within statutory timeframes for 91.8% of children (178 out of 194 orders). This is a reduction from the previous year, when 96.3% of children were contacted on time (158 out of 164 orders). Eleven out of the sixteen breaches occurred where orders were either revoked within 24 hours, or where the HSP did not notify MHAS within two hours (as agreed), or within 24 hours of the order being made.

Ministerial directions

The Minister for Mental Health may issue written directions to the Chief Advocate about general policy to be followed by the Chief Advocate, and the Chief Advocate may request the Minister issue directions (under s354 of the Act). During 2022-23, no directions were issued, nor did the Chief Advocate request directions.

Similarly, the Minister for Mental Health may request the Chief Advocate report on the provision of care by a mental health service or ensure that a service is visited (see s355 of the Act). There were no directions issued during 2022-23.

Committees, submissions, and presentations

The Chief Advocate, or nominated proxy, was a member on seven committees during 2022-23, as set out in the appendix.

The Chief Advocate and Senior Advocates regularly give presentations to facility staff and other stakeholders on the role of MHAS and consumer rights. The presentations are an important means of helping to protect consumers' rights and improving understanding of the role of MHAS.

Over the year, MHAS delivered presentations to staff in ten facilities and made three presentations to psychiatric trainees.

MHAS was able to increase the number of presentations it undertook, compared to previous years when COVID-19 limited the ability for this to occur. This has been particularly important due to the turnover of staff in the mental health workforce and the loss of corporate knowledge.

Appendix 1: Committees, forums and submissions

Continuing committees

1. Private Hostel Agencies Committee (oversight agencies' committee)
2. Accountability Agencies Collaborative Forum
3. Mental Health Act 2014 Statutory Review Steering Group - MHC
4. Criminal Law Mental Impairment Reform, Implementation Steering Committee - Department of Justice
5. Optional Protocol on the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment Advisory Group - Ombudsman Western Australia
6. Reducing Structural Stigma and Discrimination Technical Advisory Group - National Mental Health Commission
7. Graylands Reconfiguration and Forensic Taskforce, Clinical Advisory Group - MHC

New committees in 2022-23

Nil

Submissions, forums and consultations

1. Health Navigators Pilot Program Co-Design - Department of Health - workshop - August 2022
2. Model of Care for Admission and Inpatient Treatment for People with Eating Disorders - Fiona Stanley Hospital - submission - August 2022
3. Chief Psychiatrist's Review of Mental Health Act 2014 s.303 Segregation of Children from Adult Inpatients - Office of Chief Psychiatrist - submission - September 2022
4. Statutory Review of the Mental Health Act 2014 - MHC - workshops (14) - August and September 2022
5. Infants, Children and Adolescents (ICA) aged 0-18 years - Ministerial Taskforce - MHC -workshops (17) - September to November 2022
6. Model of Care - State Forensic Mental Health Service – consultation - January 2023
7. Treatment Support and Discharge Plans - WA Justice Association – consultation - May 2023
8. Aftercare Model in WA - Telethon Kids - consultation - May 2023
9. CLMI Youth Model of Service - Department of Justice - consultation - May 2023
10. H2H Kids Hub Sector Professionals Engagement - MHC -workshop - May 2023
11. WA Branch Autumn Symposium - Australian College of Mental Health Nurses - May 2023
12. Working with Families Framework - Child and Adolescent Mental Health Service - working group - May and June 2023
13. Child Safe Organisation Campaign - Department of Communities - workshop - June 2023
14. Reforming WA Disability Legislation - Department of Communities - submission - June 2023

Presentations and education sessions for third parties

1. Consumer Rights and Role of MHAS - presentations to mental health services (10) - August 2022 to May 2023

2. Enhancing Access to Rights for Older Adults - Mental Health Leads Sub Committee - MHC - June 2022

3. Using the Act and Charter for Positive Consumer Experiences in Emergency Departments - Scientific Emergency Medicine WA Conference 2022 - Australasian College for Emergency Medicine - October 2022

4. MHAS Strategy and Key System Issues - Mental Health Tribunal Members Forum - November 2022

5. Mental Health and Related Legislation and Reports: Stage 1 Lecture - Postgraduate Training, Gascoyne House - Graylands Hospital - February 2023

6. Compliance with the Mental Health Act: Youth and Residents of Psychiatric Hostels - Postgraduate Training in Psychiatry Lecture Series - North Metropolitan Health Service - April 2023

7. Introduction to MHAS - Regional Psychiatry Trainees of Western Australia Country Health Services - WACHS - April 2023

Glossary of acronyms

CAG	Clinical Advisory Group
CCTV	Closed-Circuit Television
CPFS	Child Protection and Family Services
CTO	Community Treatment Order, also called a form 5A
CLMI Act	*Criminal Law (Mental Impairment) Act 2023*
CLMIA Act	*Criminal Law (Mentally Impaired Accused) Act 1996*
DoH	Department of Health
ED	Emergency department
EHVP	Enhanced Hostel Visiting Program
FC	Frankland Centre
FO	Further Opinion
FTE	Full time equivalent
GH	Graylands Hospital
GRAFT	Graylands Reconfiguration and Forensic Taskforce
HaDSCO	Health and Disability Services Complaints Office
HECS	Hospital Extended Care Service
HSP	Health Service Provider
ICMS	Integrated Client Management System
LGBTIQA+	Lesbian, gay, bisexual, transgender, intersex, queer/ questioning, asexual, plus
LARU	Licensing and Accreditation Regulatory Unit, Department of Health
MOU	Memorandum of Understanding
MHAS	Mental Health Advocacy Service
MHC	Mental Health Commission
MHLC	Mental Health Law Centre
MHOA	Mental Health Observation Area
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NMHS	North Metropolitan Health Service
OCP	Office of the Chief Psychiatrist
PSOLIS	Psychiatric Services Online Information System
THE ACT	*Mental Health Act 2014*
TSDP	Treatment, Support and Discharge Plan
VOIP	Voice Over Internet Protocol
WAEDOCS	Western Australian Eating Disorder Outreach and Consultation Service

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