MHAS

MENTAL HEALTH
ADVOCACY SERVICE

2024-2025

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 or living 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.

A note on terminology

Throughout this report, the term First Nations is used inclusively to refer to both Aboriginal and Torres Strait Islander Peoples in recognition of Aboriginal and Torres Strait Islander Peoples as the original inhabitants of Australia.

Several specific terms are used throughout this report to describe different groups of people accessing assistance from the Mental Health Advocacy Service:

- Consumer – a person as defined by section 348 of the *Mental Health Act 2014*, who is eligible for advocacy services. This excludes residents of private licensed psychiatric hostels.
- Identified person – an unfit accused or supervised person within the criminal justice system who can access advocacy services under the *Criminal Law (Mental Impairment) Act 2023*.
- Resident – a person residing in a private licensed psychiatric hostel, or at the Bennett Brook Disability Justice Centre.

When referring to the totality of people we work with, we use the term 'identified person/s' to indicate the group of people who are in legislative scope to engage with our services.

Thank you

The artwork used on the front cover of the annual report has been reproduced with the permission of the artist, **Samantha Johnston**.

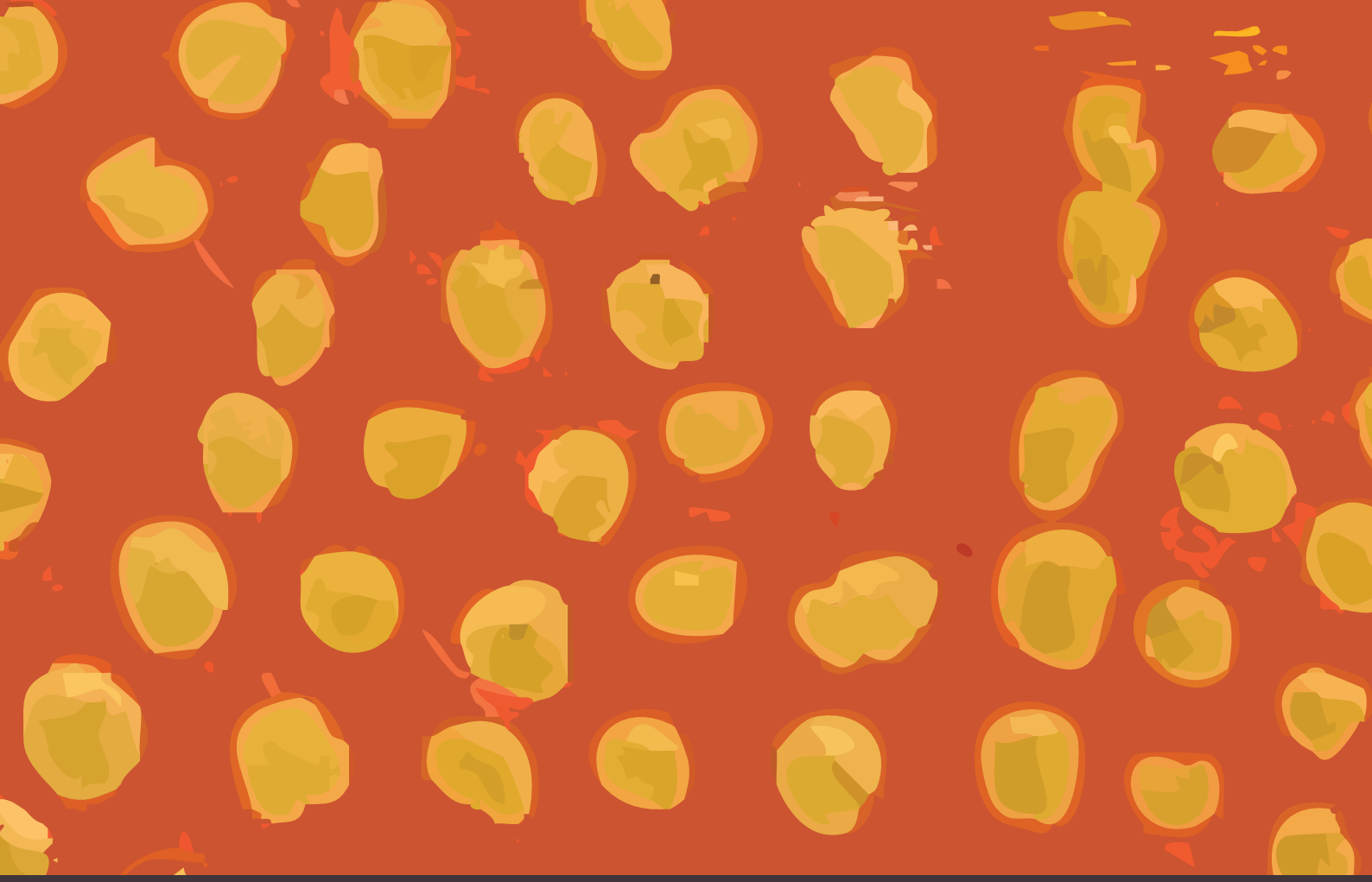
About the Artist

Samantha Johnston is a Yanyuwa woman from Vanderlin Island, which is part of the Sir Edward Pellew archipelago islands in the Northern Territory and is the traditional lands of the Walu people.

Samantha uses canvas and re-purposes discarded items to create works of art and takes inspiration from the natural world, relationships, and life experiences.

About the Artwork

The painting symbolises the catastrophic impacts of global warming on the solar system. The image depicts a yellow centre circle that represents the sun exploding and has four outer planets that have lost their internal heat and become cold from the event.



Hon Meredith Hammat MLA
MINISTER FOR HEALTH AND MENTAL HEALTH

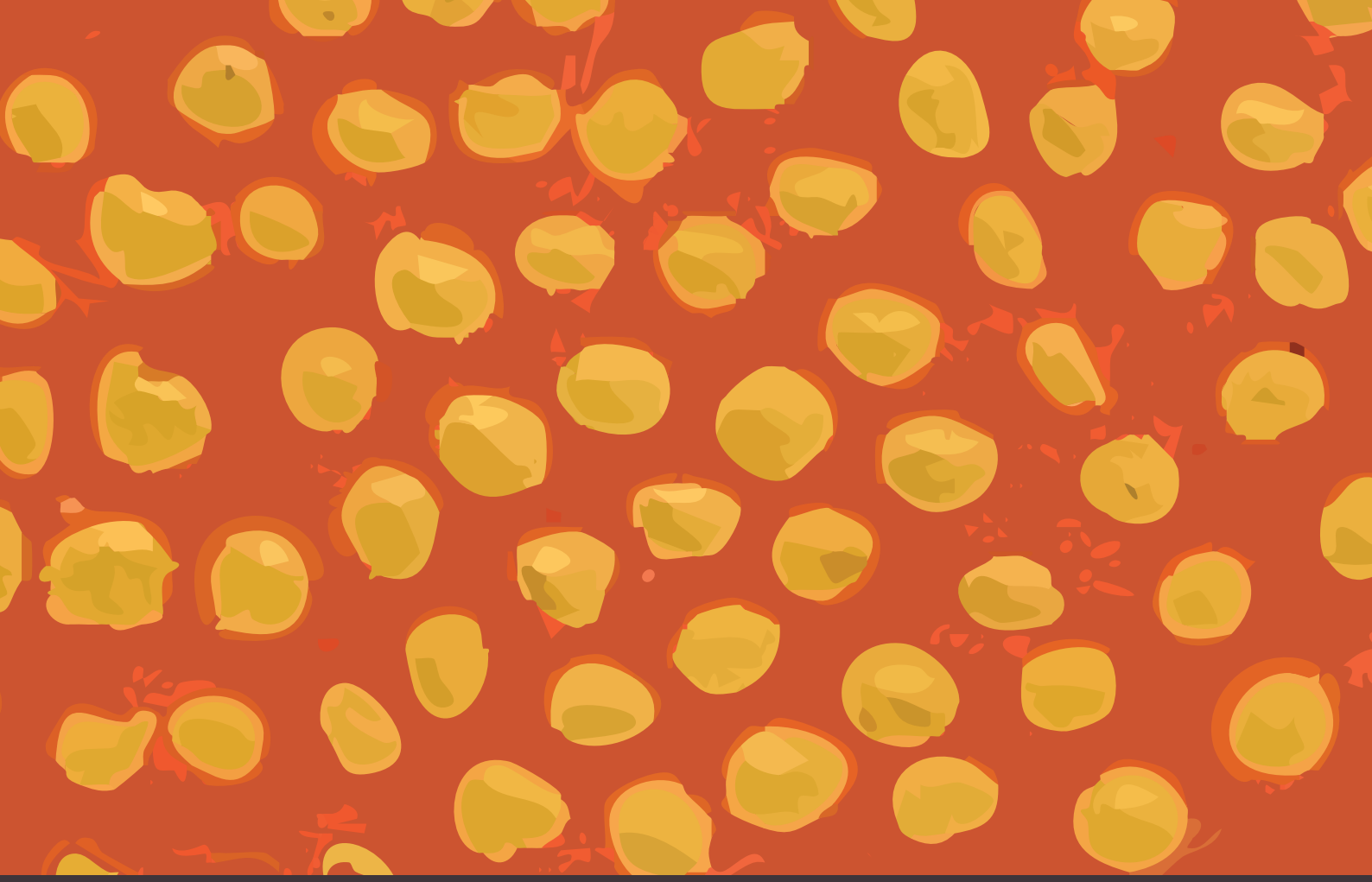
In accordance with sections 377 and 378 of the *Mental Health Act 2014*, I submit for your information and presentation to Parliament the Annual Report of the Chief Mental Health Advocate for the financial year ending 30 June 2025.

As well as recording the operations of the Mental Health Advocacy Service for the 2024-25 year, the report reflects on a range of issues that continue to affect consumers of mental health services in Western Australia.

Dr Tony Buti MLA
ATTORNEY GENERAL

In accordance with section 140(2) of the *Criminal Law (Mental Impairment) Act 2023*, I submit for your information and presentation to Parliament the Annual Report of the Chief Mental Health Advocate for the financial year ending 30 June 2025.

The report reflects on the service delivered by the Mental Health Advocacy Service to identified persons since the *Criminal Law (Mental Impairment) Act 2023* came into effect on 1 September 2024. The report also identifies issues arising from our advocacy and the experience of identified persons with mental impairment in the justice system in Western Australia.



Hon Hannah Beazley MLA
MINISTER FOR LOCAL GOVERNMENT; DISABILITY SERVICES; VOLUNTEERING; YOUTH; GASCOYNE

In accordance with section 56(3) of the *Declared Places (Mental Impairment) Act 2015*, I submit for your information and presentation to Parliament the Annual Report of the Chief Mental Health Advocate for the financial year ending 30 June 2025.

The report records the activities of the Mental Health Advocates who provided services to residents of the Bennett Brook Disability Justice Centre, a declared place, during the 2024-25 year.

Dr Sarah Pollock
CHIEF MENTAL HEALTH ADVOCATE

September 2025

Contents

Chief Advocate's foreword

In the middle of 2024, the Mental Health Advocacy Service was a quite different organisation to the one it is now. Much has changed in the space of twelve months. We have a new service for people with mental impairment who have been accused of a crime. To serve them, Advocates are now working in courts and prisons across Western Australia as well as mental health services and the Disability Justice Centre. We have a bigger public service team to support our service delivery. We have moved to fit-for-purpose offices with enough space and technology that facilitates engagement with Advocates and stakeholders across the state. And to top it off, we implemented a new client management system, the Hub, offering enhanced integration across business systems.

Amongst these changes some things are constant. Our focus on people's rights and what is fair and reasonable, our values, our commitment to amplifying the voices of people we work with are unwavering. However, the extent and speed of change have come at a cost. It has at times been difficult for people to find the energy and good will to remain committed, but they did.

I thank our Advocates, the liaison team, the legal and governance team and the business support and policy and performance teams for their dedication and hard work.

For the first time, this report brings together our work across all three service streams, mental health, criminal law (mental impairment) and disability justice. Across three streams safety, dignity and respect stood out as areas where our presence had most impact. We have seen some excellent outcomes from our advocacy across the service.

This report stands as testament to the value of statutory advocacy. As you read this report, imagine a mental health system where people can be detained and treated against their

Dr Sarah Pollock
CHIEF MENTAL
HEALTH ADVOCATE

will, or a criminal justice system where people with mental impairment have no-one to help them with complex legal processes and the alienating experience of incarceration.

Advocacy work is humanising and relational. When we work relationally the voices of people who are often not heard are centred and as a result interactions are safer, focused and more efficient. We work to build and maintain productive relationships with staff in facilities where people are detained or receive services so our advocacy contributes to creating outcomes that people value.

I thank those staff, their managers and executive for our frank exchange and the times they continued to listen when our discrete perspectives did not initially overlap.

Most of the adverse experiences that are reported here have come about because services themselves are stretched and dealing with social and environmental complexities they were not designed to accommodate. Many of the problems are not easy to solve, but there are opportunities for improvement. In some cases, simple actions would have made a significant difference. This report offers a unique view of what it means to be in receipt of involuntary treatment or incarcerated with impaired understanding and communication. Inspiration to do things differently can come from seeing things from a different view.

We have been guided in our work to strengthen our relational practice by Elders Aunty Cheryl Phillips and Aunty Sandra and Uncle Peter Wilkes. I thank you for your wisdom, grace and generosity and look forward to continuing our walk together.

Executive summary

The 2024-25 financial year was a period of significant growth and transformation for the Mental Health Advocacy Service, marked by a substantial increase in demand, a successful expansion of its legislative mandate, and a restructuring to better support its workforce and service delivery.

Our core function of providing advocacy to people in the mental health and justice systems continued to grow. The number of people assisted rose by 11.2 per cent with 4,561 people supported, compared to 4,102 in the 2023-24 financial year. The number of issues and complaints recorded by Advocates increased by 13.7 per cent compared to the previous year. This highlights the escalating complexity of mental health care needs and the growing demand for statutory advocacy services. In response to this demand, the total number of Advocate hours undertaken increased by 16 per cent to 45,453 hours.

This year was defined by three major strategic developments. On 1 September 2024, the Mental Health Advocacy Service successfully launched its new *Criminal Law (Mental Impairment) Act 2023* service to extend our advocacy services to people with mental impairment in the criminal justice system. In its first ten months, Advocates responded to 391 statutory notifications and 507 direct requests for contact, assisting a total of 145 unique identified persons. Advocates also worked in new environments, including courts, prisons, and community settings, to advocate for procedural fairness, access to legal representation, and culturally safe support.

We also underwent a comprehensive organisational restructure, which was implemented in March 2025, to create a more resilient and sustainable structure that supports our expanding obligations.

Finally, we relocated to a new, fit-for-purpose office in April 2025 to accommodate our expanding workforce of more than 60 Advocates and 16 public service officers and staff.

In 2024–25, demand for advocacy under the *Mental Health Act* continued to rise. Across all services, systemic themes of access, dignity, safety, and cultural respect emerged consistently, with particular concern for First Nations people, children, and those with complex support needs. The new *Criminal Law (Mental Impairment) Act* service commenced strongly, with identified persons supported

in courts, prisons, and community settings across WA, including children for the first time. Numbers of residents at the Bennett Brook Disability Justice Centre stayed low, and we remain concerned about the under-utilisation of this excellent service.

The year was not without its challenges. Unmanageable workloads, frequent exposure to vicarious trauma for Advocates, and the impact on the workforce of so many significant changes in such a short space of time were all challenges that needed both managing, and the investment of time and resources.

Financially, the Mental Health Advocacy Service ended the year within budget for the first time since 2010. The initial budget was $7.73M, which, after receiving an additional $1.1M for the new office fit-out and $404,000 additional funding for the enhanced hostels visiting program, increased to a total of $9.31M. The total expenditure for the year was $9.25M.

While this is a positive financial outcome, it was influenced by delays in deploying the new organisational structure and shortages in the Advocate workforce, which placed unavoidable workload pressures on existing staff. The increase in demand for advocacy and the completion of the new organisational structure recruitment is expected to impose an increase in budget spend in the upcoming year.

We remain committed to ensuring that the voices of the people we serve are heard, respected, and central to decisions that affect their lives.

> I will always remember you as the one person that made a lasting difference in my life.
>
> **CONSUMER**

The Mental Health Advocacy Service 2024-25

The Mental Health Advocacy Service (MHAS) is an independent statutory body that amplifies the voices and protects the rights of people using, and seeking to use, mental health services, and people with mental impairment in the criminal justice system.

Our Purpose

People need to be and feel safe, and to be heard so they can live well and thrive. We believe people should be able to access their rights, including the right to be represented by an Advocate. We exist to amplify the voices and protect the rights of people in the mental health system whose liberty and self-determination have been impacted, and those with mental impairment in the criminal justice system. We draw on their voices to advocate for better services and systems.

Our Vision

Each person is treated with dignity and respect regardless of their legal status.

Our Values

Tenacity
Led by the consumer
Integrity
Engagement without judgement
Commitment to making a difference

Our Legislative Foundation

The MHAS operates under several key pieces of legislation that define who we serve and inform how we deliver advocacy:

- *Mental Health Act 2014 (MH Act):* confers considerable powers on Mental Health Advocates (Advocates), who may do 'anything necessary or convenient' for the performance of their functions relating to advocacy for people on involuntary treatment orders, those referred for psychiatric examination, people on hospital orders, psychiatric hostel residents and some people who are voluntary patients including children.
- *Declared Places (Mental Impairment) Act 2015 (DP Act):* establishes the MHAS' statutory obligations in relation to residents of the Bennett Brook Disability Justice Centre (DJC).
- *Criminal Law (Mental Impairment) Act 2023 (CLMI Act):* from 1 September 2024, extends our mandate to include people for whom fitness to stand trial has been raised, those who have been found unfit and supervised people under a custody order (CO) or community supervision order (CSO).

What we do

The people we advocate for are often among the most vulnerable in the community. Our independence from mental health, criminal justice and correctional services is central to building trust with the people we assist and to providing effective advocacy on their behalf.

In delivering individual advocacy, Advocates help people to:

- Be and feel heard.
- Understand and access their rights.
- Participate in decisions about their treatment, care and support.
- Participate in tribunal hearings and legal proceedings.
- Resolve complaints and raise concerns about matters affecting their health, safety or wellbeing.
- Access culturally safe and inclusive services.

In addition to individual advocacy, the MHAS identifies and addresses systemic issues across the mental health and criminal justice systems that are impacting the rights, health, safety and wellbeing of identified persons. This dual focus helps address people's immediate needs, while also influencing long-term policy and service improvements.

Our impact in 2024-25

4,561
People we supported[1]

5,250
Involuntary treatment orders[2]

43
Education sessions on consumer rights and the role of the MHAS

1,286
Mental Health Tribunal hearings attended[3]

12,064
Issues raised by identified persons

393
Serious issues

82
Complaint letters

42
Inquiry letters

47 min/h
Liaison Officers spent taking calls from people seeking help

[1] Based on individuals falling under an Identified Person category for the MH Act, CLMI Act and DP Act with at least one consumer related task completed by the MHAS between 1 July 2024 and 30 June 2025.

[2] Involuntary treatment orders include ITOs made in authorised hospital and general hospitals, and CTOs.

[3] Data provided by the MHT for financial year 2024-25.

What was new in 2024-25

2024-25 was a year of change at the MHAS. In September we launched our new CLMI Act service. In March we implemented a new organisational structure to better support our advocacy service delivery. And in April we moved to new, fit-for-purpose, offices.

Launch of the Criminal Law Mental Impairment Act Service

On 1 September 2024, the MHAS began providing advocacy under the new CLMI Act. This significant reform replaced outdated legislation and created fairer processes for people with mental impairment who are accused of crimes and whom fitness to stand trial has been raised, those who have been found unfit and supervised people on a CO or CSO. The reforms also mean that the MHAS now works with people whose mental impairment is related to intellectual or other cognitive disability, including acquired brain injury or dementia as well as those whose mental impairment is related to mental illness.

Work to develop the MHAS CLMI service commenced in 2021 and included collaboration with other stakeholders across the criminal justice, mental health and disability sectors. As time progressed, the work increased in volume and intensity, and the focus shifted from ensuring the wider system was ready, to ensuring the MHAS had what it needed in place to start providing a service on 1 September 2024

During July and August of the 2024-25 financial year, the CLMI project team that had commenced in 2023-24 completed the remaining work required to support the launch of the new service. This included the recruitment and training of a team of CLMI Advocates, the development of resources including brochures, posters, letter templates and information to provide to identified persons and other stakeholders, the finalisation of protocols and guidelines to govern Advocate practice, and the implementation of our new client management system, the Hub.

The CLMI reforms mean that more people will receive advocacy, access procedural fairness, and have greater opportunities for rehabilitation and community reintegration. Demand for advocacy is expected to grow, and the MHAS will continue to work closely with government and non-government partners to ensure the reforms achieve their intended impact.

See the CLMI Act Service section of this report for further details about the CLMI service.

Organisational restructure

In 2023-24, in response to the service expansion brought about by the CLMI Act reforms and amendments to the *Work Health and Safety Act 2020* (WHS Act), the MHAS commissioned a two-stage functional review of the organisation. The new organisational structure was endorsed in March 2025 and implementation commenced thereafter.

The restructure encompassed both the advocacy service and advocacy support service arms of the MHAS. It set out to assess the organisation's capacity and performance considering the MHAS' expanding obligations, new working environments (i.e. prisons and courts), and increasing demand for service. It created a structure to support the delivery of high-quality services to identified persons while meeting statutory obligations and maintaining a robust and proactive approach to work health and safety.

The review of the advocacy support service found that the MHAS needed expansion and diversification of the roles required to effectively support service delivery. Without these additional positions, the MHAS would struggle to meet its statutory obligations safely and sustainably, especially given the expansion required for the new service under the CLMI Act.

Some of the recommendations from the review of the advocacy support service were funded and implemented during 2023-24 (the Deputy Chief Mental Health Advocate [Deputy Chief Advocate], and a part-time, fixed term General Counsel). The MHAS received funding for additional positions in its 2024-25 budget to support the implementation of the CLMI Act service including:

- Manager, Consumer Services and Business Systems
- Manager, Policy and Performance
- Senior Business Analyst
- Senior Consumer Liaison Officer
- Consumer Liaison Officer
- Executive Assistant

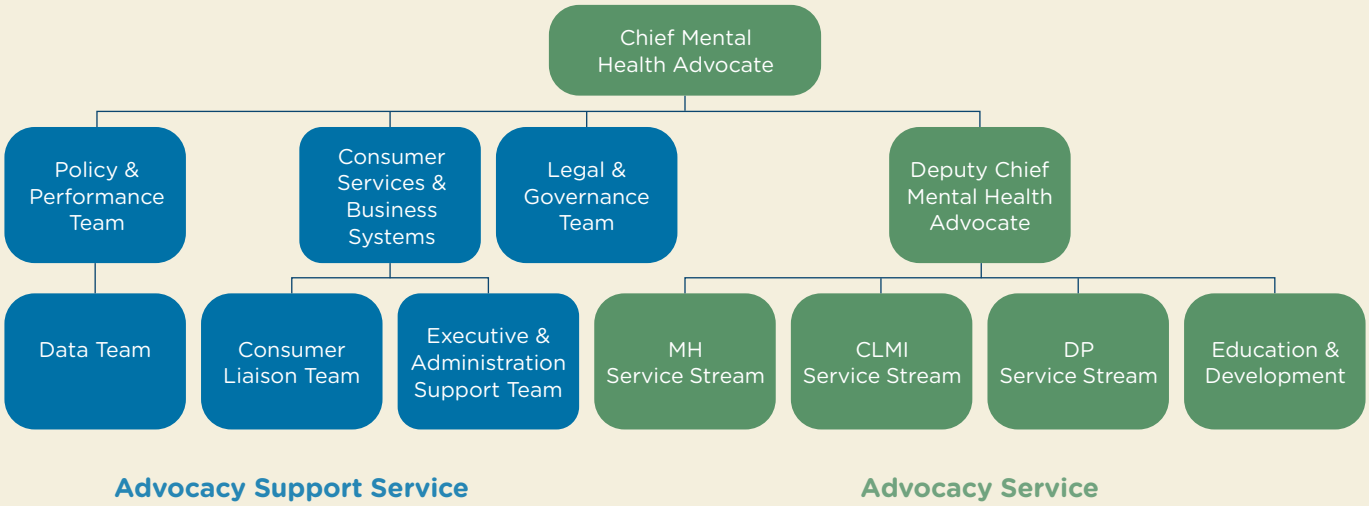
The recruitment for these public service positions commenced in the 2024-25 financial year and will be concluded early in 2025-26.

The review of the advocacy service noted issues related to unmanageable workloads, frequent exposure to vicarious trauma, and insufficient management support available for a dispersed workforce working in isolated conditions.

Review recommended a greater investment in line supervision, and that Advocates be arranged into smaller teams, to create sustainable workloads for each Senior Mental Health Advocate (Senior Advocate). It also recommended Team Leaders, trialled in 2023-24, be introduced into the new structure to provide more facility-level support for Advocates, and to assist Senior Advocates with serious and complex matters. A Senior Advocate role was created to oversee education and development for the MHAS workforce, and to manage the MHAS' considerable contribution to education and professional development for partners in the mental health and criminal justice systems.

The advocacy service now comprises four teams aligned to Health Service Provider (HSP) jurisdictions, delivering advocacy to consumers under the MH Act (four Senior Advocates and five Team Leaders), and two CLMI Act teams, including the DJC, led by two Senior Advocates. Team Leaders were recruited in 2024-25 for commencement in July 2025.

FIGURE ONE - Organisational Structure

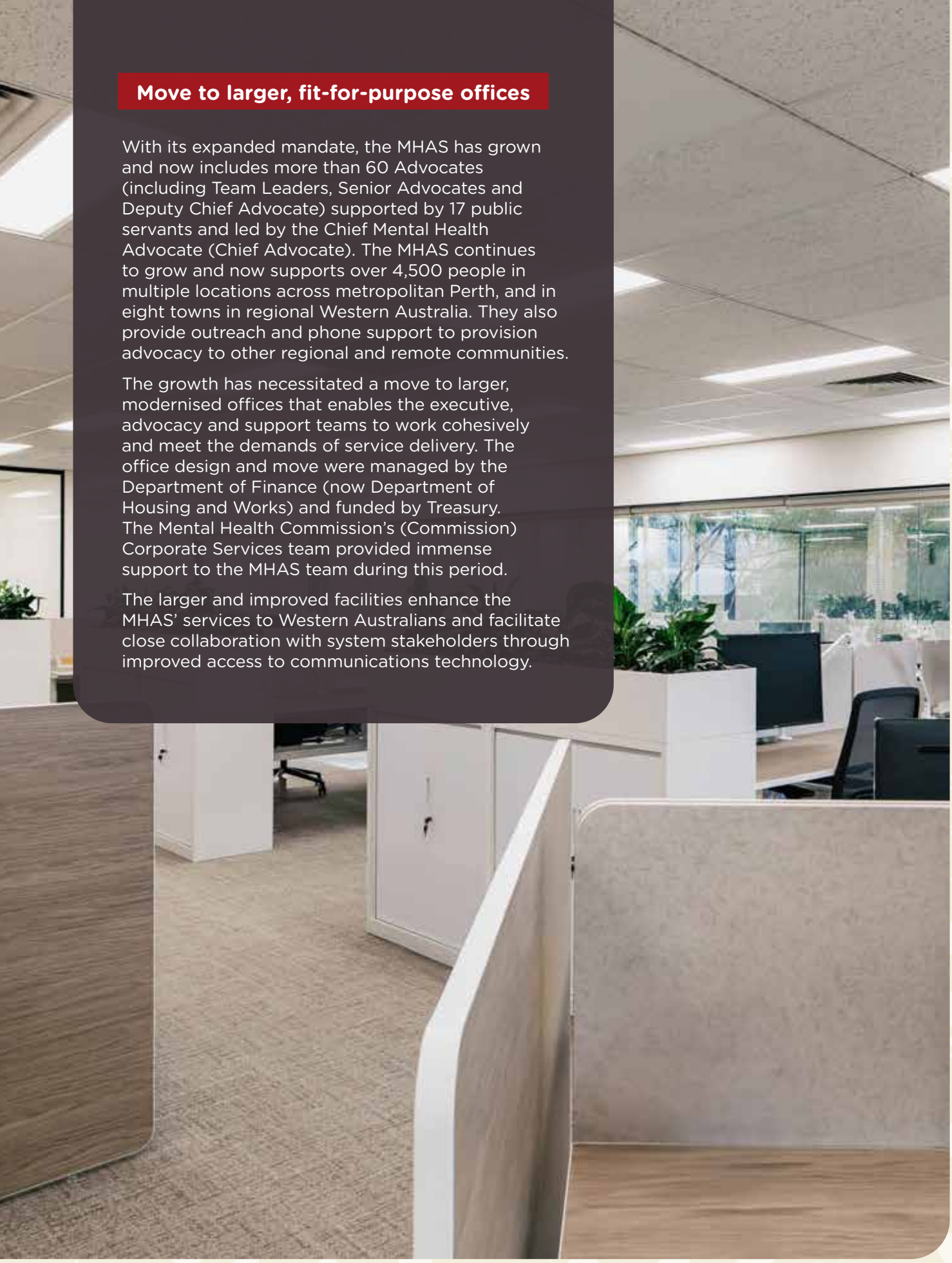


Move to larger, fit-for-purpose offices

With its expanded mandate, the MHAS has grown and now includes more than 60 Advocates (including Team Leaders, Senior Advocates and Deputy Chief Advocate) supported by 17 public servants and led by the Chief Mental Health Advocate (Chief Advocate). The MHAS continues to grow and now supports over 4,500 people in multiple locations across metropolitan Perth, and in eight towns in regional Western Australia. They also provide outreach and phone support to provision advocacy to other regional and remote communities.

The growth has necessitated a move to larger, modernised offices that enables the executive, advocacy and support teams to work cohesively and meet the demands of service delivery. The office design and move were managed by the Department of Finance (now Department of Housing and Works) and funded by Treasury. The Mental Health Commission's (Commission) Corporate Services team provided immense support to the MHAS team during this period.

The larger and improved facilities enhance the MHAS' services to Western Australians and facilitate close collaboration with system stakeholders through improved access to communications technology.



SPH Architecture and Interiors (for the Architectural Fitout Design)
Photographer: Nicholas Putrasia

Inclusive employment and workforce culture

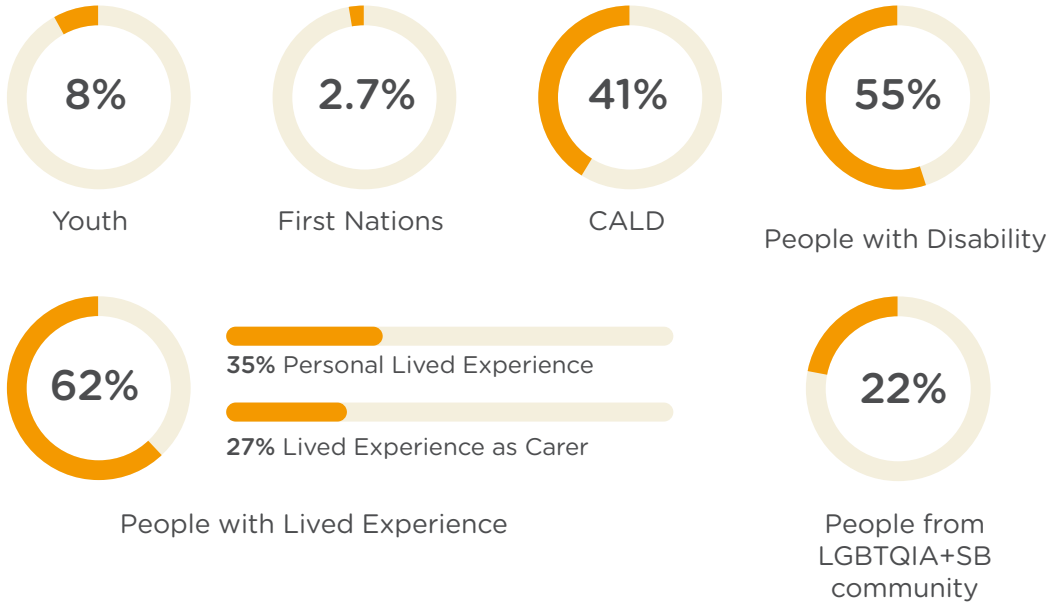
The MHAS values diversity and inclusion and is committed to building a workforce that reflects the communities we serve. We believe that this has a direct effect on our service delivery and how we support the people we work with.

In 2024-25, the MHAS Leadership Team identified workforce diversity as a priority area within its Operational Plan. To establish a baseline understanding of the current workforce profile, an internal diversity survey was conducted. A total of 37 self-reported responses were received, representing approximately 40 per cent of the MHAS workforce. The survey sought to capture workforce diversity across several key areas: Youth[4], First Nations, Culturally and Linguistically Diverse (CALD)[5] backgrounds, Lived Experience[6], Disability[7] and LGBTQIA+SB[8] identities.

The outcomes revealed a relatively high level of diversity, especially in areas of CALD, Lived Experience and Disability.

Having this diversity at the MHAS promotes a culture of inclusivity, thoughtfulness and respect, and better reflects the communities we work with. It fosters a safe environment to express thoughts and share different perspectives, in turn enhancing our capabilities in supporting and engaging with identified persons, their families and communities.

FIGURE TWO – MHAS workforce diversity



4 Younger than 24 years old.

5 As per the definition provided in the Western Australian Multicultural Policy Framework, CALD applies to groups and individuals who differ according to religion, language, and ethnicity, and whose ancestry is other than Aboriginal or Torres Strait Islander, Anglo-Saxon or Anglo-Celtic (i.e. In a broad sense, CALD relates to people who are not Aboriginal or Torres Strait Islanders and whose ancestry/heritage is from places other than England, Scotland, Ireland, or Wales.)

6 As per the Western Australian Lived Experience (Peer) Workforces Framework 2015-2024, Lived Experience describes an individual who has had a personal lifechanging experience of mental health, alcohol and other drug challenges and or suicidal crisis (including thoughts, feelings or actions) or a family member or significant other who has or is caring for or about someone with these experiences or who has been bereaved by suicide.

7 A disability may be visible or hidden, permanent or temporary, and includes physical, sensory, intellectual, psychosocial, or neurological conditions. This includes chronic illness, mental health conditions, and lived experience of disability.

8 LGBTQIA+SB refers to people who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, other diverse sexualities and gender identities, Sistagirls and Brotherboys.

Kaatadjiny Waalbraniny Danjoo Project

Our First Nations engagement strategy remains central to the identity and values of the MHAS, reflected in our continued commitment to the Kaatadjiny Waalbraniny Danjoo (KWD) Project. With the relationship now well established between Elders, younger community members and MHAS leadership and workers, in 2024-25 we commenced a program of engagement. During this year the Elders have led the first day of our induction program for new Advocates and participated in our annual training event. Commencing early in the coming financial year, each team at the MHAS will take part in a yarning circle with Elders and younger community members to explore the theme of 'two cultures, one place', where First Nations culture and workplace culture meet in the diverse settings in which the MHAS operates.

These events have been designed collaboratively to create meaningful opportunities for MHAS workers to engage with the Elders and younger community members and build confidence and competence in working with First Nations people in diverse settings.

Lived and Living Experience

The MHAS values the contributions of people with Lived and Living Experience, recognising the invaluable insights they bring to advocacy. For many years, we have incorporated Lived and Living Experience consultants into our recruitment processes, including participation as panel members. In 2024-25, Lived and Living Experience consultants participated in four recruitment panels. Their involvement provided meaningful perspectives and highly valuable insights into the decision-making. Moving forward, we are committed to expanding this approach by more fully integrating Lived and Living Experience into the way we do things.

> **Your expertise and insights were incredibly valuable and have greatly enriched our understanding of the MHAS.**
>
> CLINICIAN

> [Advocate] has such a calming nature, and her trauma centred approach and persona made me feel at ease and I knew the moment I met her everything was going to work out and be okay.
>
> **RESIDENT**

Children and young people

As well as our dedicated youth advocacy team who provide specialist advocacy for children and young people, and intentional recruitment of younger people as Advocates, for the first time, the MHAS collaborated with the McCusker Centre for Citizenship at the University of Western Australia to offer internship opportunities to young students.

We had two successful internships completed during Winter semester in Communications and Web Projects.

Interpreter services

We recognise the importance of supporting consumers, identified persons and residents in ways that best meet their individual needs. To this end, the MHAS actively utilises interpreter services to ensure effective communication for individuals accessing advocacy or support from Consumer Liaison Officers (CLO).

In 2024-25, the MHAS contracted interpretation services at a cost of $30,000, enabling us to support consumers across a wide range of language groups through professional interpreters.

Sector wide engagement

The MHAS engages with a broad range of partners to ensure that people can access their rights at every level of the mental health and criminal justice systems. We work closely with the Commission to escalate systemic issues and advocate for the right resources in the right places at the right time. Our ongoing collaboration with the Mental Health Tribunal (MHT) supports the delivery of fair and effective hearings. In addition, our constructive working relationships with the Office of the Chief Psychiatrist (OCP) and HSPs help ensure that consumer voices are represented within clinical governance processes and service improvement initiatives.

This year we have focused on establishing and building relationships with key agencies in the criminal justice system, including courts, prisons, Adult Community Corrections (ACC), Department of Justice (DoJ) and wider Corrective Services, as well as community organisations who support prisoners post-release and people on CSOs.

Community partnerships are equally vital to our work. The MHAS collaborates with organisations such as Consumers of Mental Health (WA), Ruah Legal Services, Legal Aid, the Aboriginal Legal Service, and other non-government organisations to provide integrated advocacy and coordinated support for consumers.

Additionally, we actively contribute to system improvements and reform through participation in a range of committees and working groups, engagement in forums and consultations, and the preparation of submissions for reviews of legislation, policies, and standards. We also deliver presentations and education sessions to a broad range of stakeholders. Our activities for 2024-25 are listed at the end of this report.

Enabling advocacy: people, services and systems

The MHAS is defined by the advocacy it provides directly to identified persons. In 2024-25, our scope expanded with the introduction of the CLMI service, but our commitment to protecting people's rights remains unchanged.

The advocacy service

In 2024-25, the total number of Advocate hours undertaken was 45,453, representing a 16 per cent increase compared to the 39,175 Advocate hours undertaken in 2023-24. This figure includes the hours undertaken by Advocates across the three MHAS service streams, including the new CLMI service. It does not include the hours worked by the Chief Advocate, Deputy Chief Advocate, Senior Advocates or Team Leaders.

As at 30 Jun 2025, the advocacy service comprised:

- The Chief Advocate
- Deputy Chief Advocate
- Seven Senior Advocates
- Five Team Leaders
- 38 Advocates, comprising:
  - 33 Advocates available for work
  - 5 Advocates on contract but unavailable.

Of the 33 Advocates available for work, two were based in Albany, one in Broome, two in Bunbury and one in Kalgoorlie. Due to ongoing challenges in recruiting in Broome and Kalgoorlie, much of our advocacy support in those locations was completed via phone, email and video link during the reporting period.

Advocates often work across multiple locations and in some cases, across more than one portfolio. As at June 30 2025, 10 Advocates were delivering CLMI services, six Advocates were delivering specialist services to children and to youth aged 18-24 years, five Advocates were delivering advocacy services to hostel residents, three Advocates were delivering advocacy services to consumers in the South Metropolitan Health Service catchment area, eight to consumers in the East Metropolitan catchment area, ten to consumers in the North Metropolitan catchment area, and seven to consumers located in regional and remote Western Australia.

FIGURE THREE – Locations where Advocates delivered advocacy services in 2024-25

Recruitment of new Advocates

As per the MH Act, Part 20, Advocates are engaged on a contract for service for a period not exceeding three years. At the end of this period, contracts can be renewed based on mutual agreement.

While engaged on the contract, Advocates may declare themselves unavailable for a specific time as per their need or they can resign. Once they resign, the Advocate's contract is terminated, and should they wish to re-engage with the MHAS, they need to go through a new recruitment process.

The Chief Advocate may also terminate an Advocate's contract in the case of incompetence, neglect of duty, misdemeanour, misconduct, or mental or physical incapacity.

In 2024-25, six Advocates resigned (a 40% decrease compared to 2023-24) and 11 new Advocates were engaged.

Work health and safety

When it was established in November 2015, the MHAS had no legal obligations to Advocates (as contract for services workers) for their health and safety at work. However, reforms to legislation in the new WHS Act created obligations on the MHAS for its Advocate workforce, how they work with the many varied stakeholders, and within the variety of workplaces. The role of Advocates exposes them primarily to psychosocial risks, but also physical risks associated with vehicle use and working within acute hospital areas, the community, courts and prisons. This past year, the MHAS has sought legal and other specialist advice to identify the gaps in our approach to work health and safety management and practices and developed a plan to address these issues.

The MHAS is working with relevant stakeholders to understand our shared obligations and develop ongoing consultation. In 2024-25, we undertook a questionnaire of our workforce to understand the risks and the impact of these risks upon workers. A work health and safety Project Manager was engaged to help develop a plan and implement the required changes. They will commence this work on 1 July 2025.

Advocates' training, development and support

Induction

New Advocates complete a comprehensive induction program covering their role and responsibilities under the various legislation, service delivery and advocacy practice, and managing the impact of the work on self. In 2024–25, four induction programs were held (two Advocate inductions, one Senior Advocate induction, and one Team Leader induction). Training was delivered through classroom sessions, completion of the Commission's clinician e-learning module, in-field observations, mentoring, and supervision.

Peer Reflective Practice

Advocates often work in challenging and emotionally distressing situations, including responding to disclosures of abuse, supporting individuals in crisis, and participating in inquiries into serious incidents or deaths. These experiences highlight the intensity of the role and the need for strong Advocate wellbeing supports.

To address this, the MHAS engaged Converge International to deliver Peer Reflective Practice sessions for Advocates, Senior Advocates, and Team Leaders. These sessions provide a safe space for reflection, support, and guidance. In 2024-25, forty-one sessions were held, with plans to expand the program in 2025-26.

> The impact of having [Advocate] attend meetings in person, walk alongside me, and advocate face-to-face cannot be overstated.
>
> CONSUMER

Communication

Regular communication between the advocacy and advocacy support service team is essential, particularly with our workforce spread across Western Australia. The MHAS holds regular all-staff virtual meetings, facilitates in-person and virtual team meetings, and shares a written e-newsletter to keep staff informed and connected.

Training and Professional Development

The MHAS also runs an annual two-day training event and provides ongoing learning opportunities throughout the year. Training materials and resources are accessible to the advocacy and advocacy support service team via our internal SharePoint site.

Advocacy support service

The advocacy support service supports the Chief Advocate in fulfilling statutory functions under the various legislation, providing critical systems, administrative, and performance support, as well as maintaining consumer service delivery systems.

As at 30 June 2025, the MHAS had 11.1 full-time equivalent (FTE) public service staff working across both the Mental Health service and CLMI service (including DP Act service). Some of these positions are fixed-term and due to end in 2025-26, creating a risk to service sustainability as the MHAS continues to expand. A strong advocacy support service base will be essential to meet growing and increasingly complex operational demands delivered in high-risk settings.

While the employing authority for public service officers is the Commission, the team is operationally independent and is guided by the Chief Advocate, and in accordance with the strategy and business needs of the MHAS.

Public service staff access training through the Commission's learning platform (PD-Hub) and occasional face-to-face sessions. They are also supported by the Commission's People and Culture team. However, the unique nature of the MHAS' work requires tailored training and development, which has not yet been fully implemented. For example, the consumer liaison team need hybrid training programs that address both administrative responsibilities and direct consumer engagement, including handling complex or distressing calls.

In early 2025, CLOs began participating in the Peer Reflective Sessions, and the MHAS is working to extend training days to include all staff as part of its broader commitment to workforce development and wellbeing.

Consumer liaison team

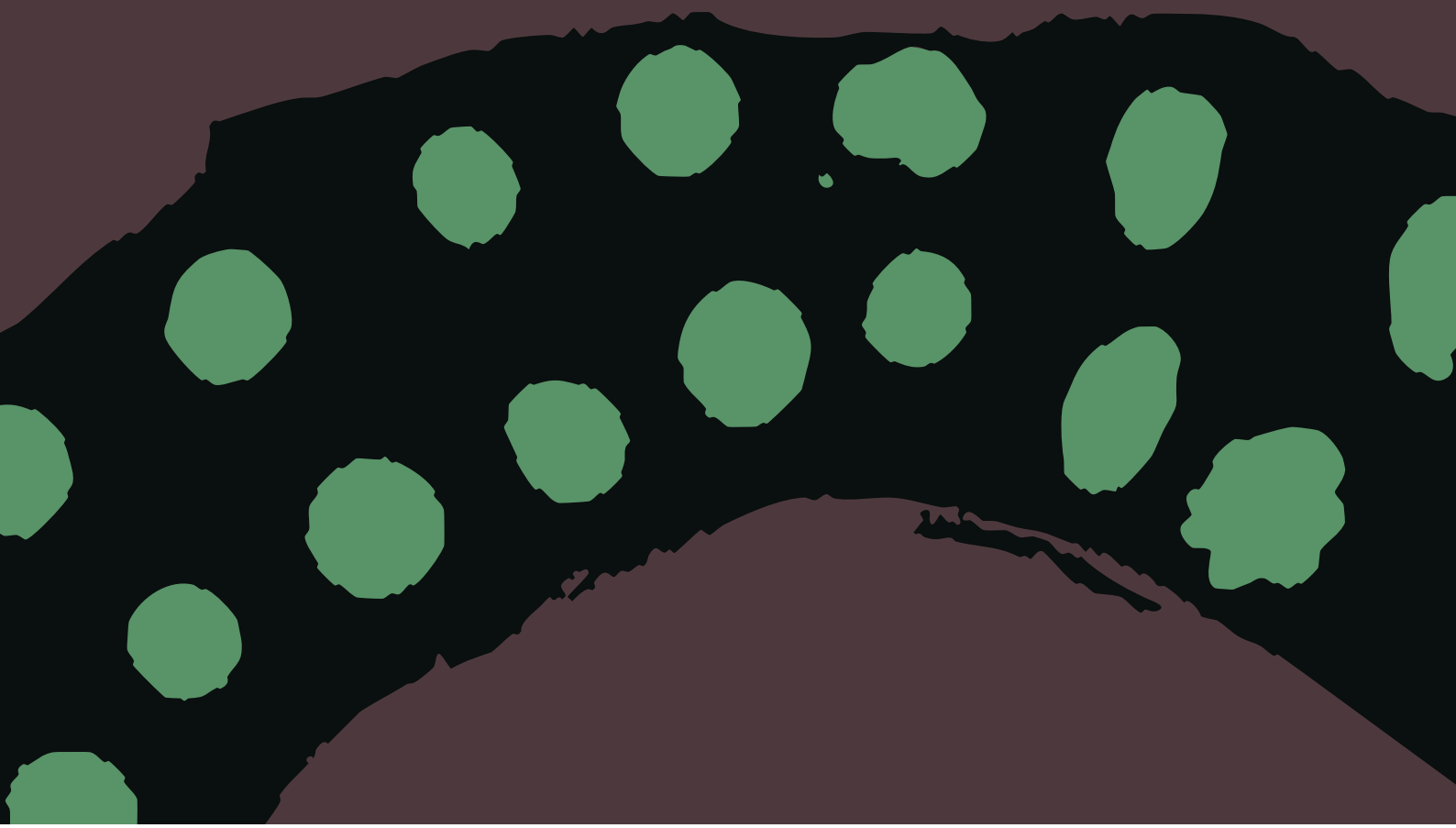
Often serving as the first point of contact for consumers and the public, the consumer liaison team delivers responsive support to callers, handling enquiries with empathy and professionalism. They maintain accurate records within our client management system, the Hub, and efficiently coordinate statutory processes such as notifications. By promptly allocating cases to Advocates, they provide a vital foundation for the timely and effective delivery of advocacy services.

To improve reporting on consumer liaison team service delivery, the MHAS requested call data from the phone provider in late 2024-25. While early data is not yet representative, initial findings show about 70 per cent of incoming calls are answered. Of those, 86 per cent are answered within 15 seconds and the remaining within 30 seconds.

This analysis is expected to highlight trends, such as peak call volumes on Mondays, and help identify efficiencies and areas for improvement to better support the consumer liaison team and consumers.

The Hub

During 2023-24, the MHAS upgraded its client management system, now known as the Hub, to Microsoft Dynamics 365 Cloud, enhancing security, usability, and supporting new CLMI services. In 2024-25, the system was tailored to improve business needs and engagement, with a fixed-term Senior Project Officer appointed to oversee CLMI requirements. At the end of the financial year, Hub management transferred to the newly established data team who are now responsible for system management, embedding it within the MHAS' wider data governance and reporting environment.



Mental Health Act Service

The MHAS has been providing advocacy to people being treated, or at risk of being treated forcibly under the MH Act since November 2015. The Chief Advocate is required by Part 20 of the MH Act to ensure that advocacy services are provided to certain classes of people, with a view to ensuring their rights are protected.

These are mainly people being treated involuntarily and against their will, including those on community treatment orders (CTO), but also people referred for psychiatric assessment, some voluntary patients, and psychiatric hostel residents. The MH Act obliges services to notify the Chief Advocate when someone is placed on an involuntary treatment order, and an Advocate must contact them within timeframes set out in the legislation.

Thereafter, Advocates engage with the consumer, identify issues they may have with the service they are receiving, including their treatment, and work to resolve the issues. Advocates work hard to ensure the consumer's voice is heard and their needs and preferences are considered in decisions that impact them.

Advocates can also assist consumers raise complaints or raise them on their behalf, assist them to access legal services, and work with treating teams to help them access other services. Advocates may also inquire into and investigate conditions of mental health services that adversely impact, or may adversely impact the health, safety and wellbeing of any identified person. Staff are obliged to respond and assist Advocates in their inquiries and investigations.

The MH Act provides broad powers of access to people, places, and records to assist Advocates in their functions. Advocates must escalate unresolved issues to the Chief Advocate who has additional powers that can be brought to bear on systemic and intractable concerns.

This section quantifies the general work of the Advocates.

Who we worked with and the issues they raised

Demand for the MHAS increased again this year, continuing a consistent upward trend since our work began in 2015. In 2024-25, Advocates assisted 4,393 consumers, marking a 7.1 per cent increase from the previous year and a 22 per cent increase over the past five years (see table one). Such consistent growth highlights the escalating systemic challenges within mental health care and the growing demand for services.

TABLE ONE – Number of identified persons assisted, and issues recorded by Advocates

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	Change
Number identified persons	3,132	3,141	3,427	3,605	3,454	3,919	4,102	4,393[9]	▲ 7.1%
Number of issues and complaints recorded by Advocates[10]	7,373	5,081	8,970	7,581	7,226	9,937	10,610	11,689	▲ 10.2%

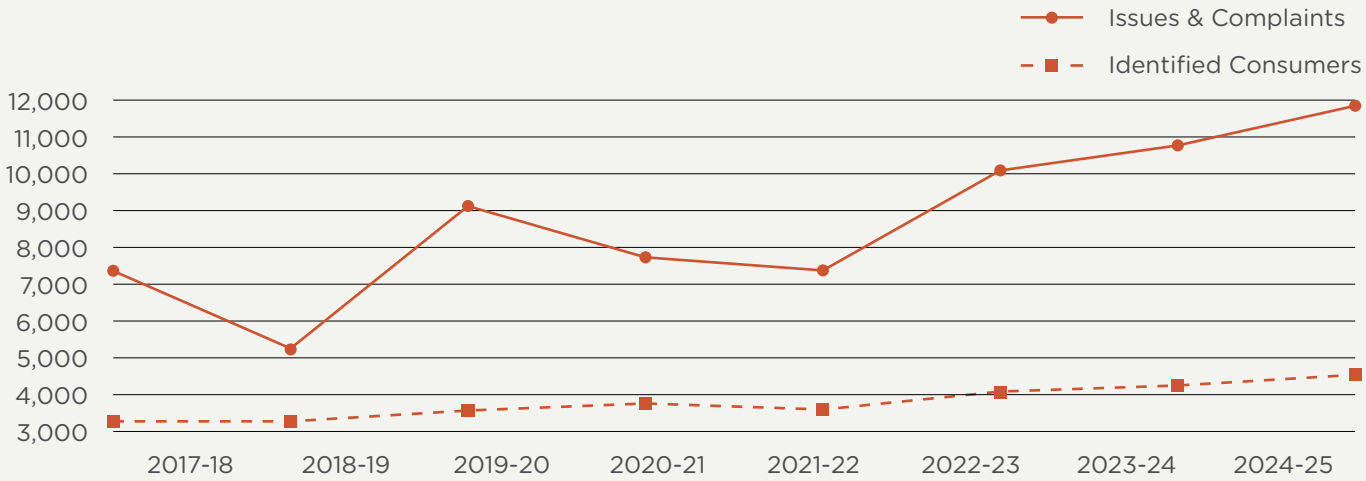
9 Figures for 2024-25 include consumers assisted on custody orders up until the commencement of the MHAS' work under the CLMI Act on 1 Sept 2024. Any consumers assisted on custody orders (or any other category of CLMI Act identified person) after 1 September 2024 are not counted in this total but are reflected in the figures reported in the CLMI Act section of this annual report.

10 These totals are for issues and complaints raised on a consumer's behalf and do not include general issues raised regarding facilities that were not related to a specific consumer.

In 2024-25, Advocates recorded 11,689 issues and complaints, a 10.2 per cent increase from the previous year. The ratio of issues per consumer rose from 2.59 to 2.66, requiring each Advocate to devote more time to meeting the needs of each consumer, and indicating a trend towards greater complexity and more multifaceted advocacy needs.

Overall, the MHAS has experienced real growth in demand for advocacy, both in the number of consumers assisted and the number of issues and complaints handled per consumer (see chart one).

CHART ONE – Growth in number of identified persons assisted, relative to issues recorded[11]



[11] Data is drawn from Table One - Number of identified persons assisted, and issues recorded by Advocates.

The issues consumers faced

Consumer issues and complaints provide critical insight into the lived experiences of individuals navigating the mental health system. The data from 2024-25 reveals significant increases in several categories. It also shows the emergence of new issues affecting consumers, particularly in relation to both accessing necessary services and supports, and concerns about the quality of those (see chart two).

It should be noted that the complaints and issues data recorded by the MHAS relies on individual recording of interactions with consumers and may be affected by variations in practice between Advocates and over time. However, the data set is large. Many of the trends observed during this period are significant and confidently point to an increased demand for, and reliance on, advocacy.

The biggest increase in consumer issues was related to complaints about medical reports, which increased from 45 to 117 reported incidents (up 160%). This category did not rate at all in the top categories in 2023-24, and so while the number of complaints may not appear significant, the overall increase is of concern. Advocates have reflected that most of the concerns raised relate to delays in receiving medical reports for MHT hearings. Medical reports should be provided to the consumer by their treating team at least three days before the hearing is scheduled to allow time for the consumer to review the report and seek advice. The lack of timeliness in providing the report impacts the consumer's ability to respond and prepare submissions, and therefore impacts procedural fairness, which is a fundamental legal right.

Concerningly, notable increases were observed in the number of complaints related to conflicts experienced by consumers during episodes of care (up 43.9%), general safety (up 34.7%), and dignity and respect concerns (up 40%). Safety, dignity and respect are fundamental to the wellbeing of consumers during their mental health journey and should be central to the care provided. This year's reporting raises concerns that consumers are increasingly experiencing challenges in these critical areas.

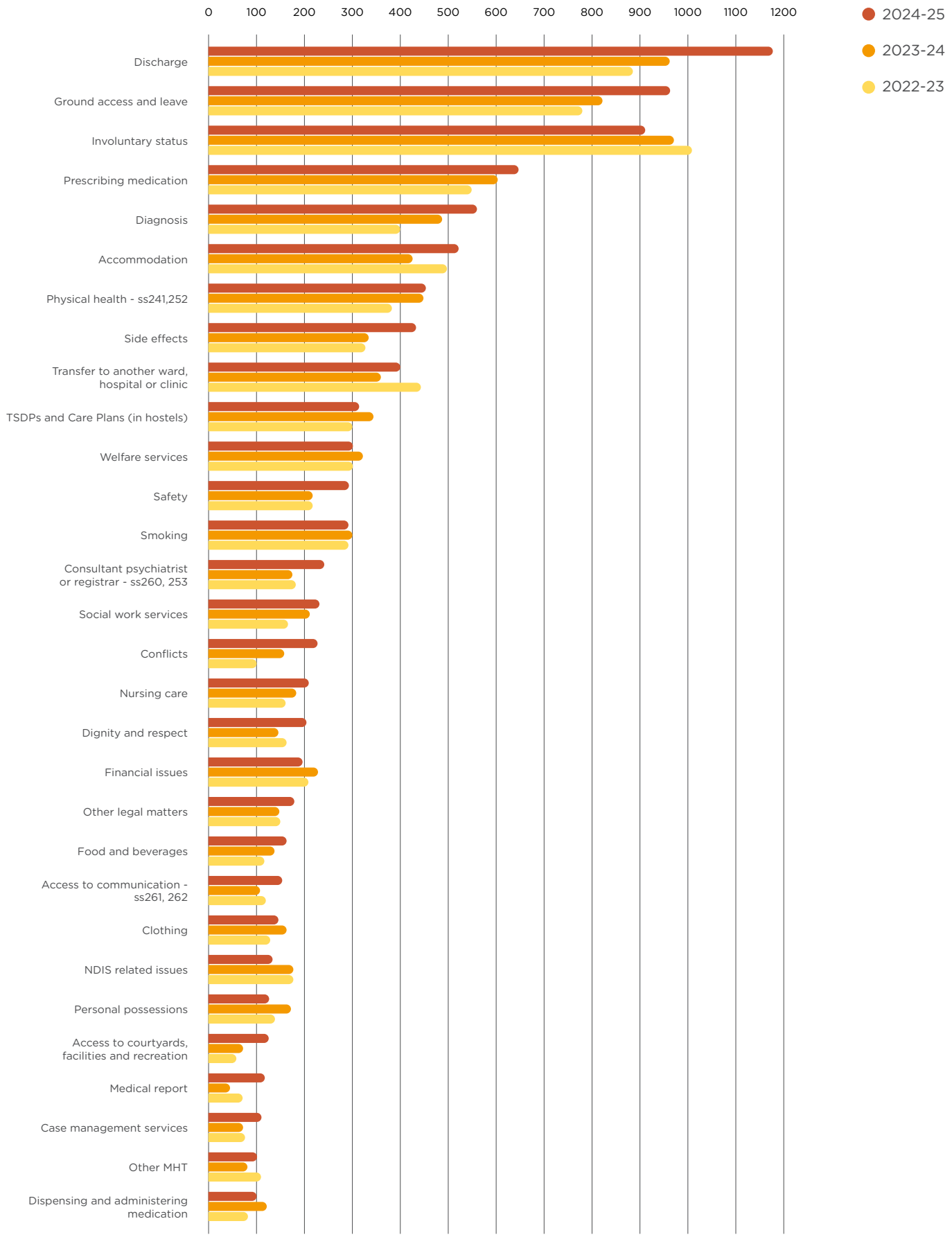
Other categories that saw significant increases in reporting this year include access to courtyards, facilities, and recreation and/or exercise (up 73.6%); complaints relating to consultant psychiatrists or registrars (up 37.9%); and concerns about side effects from medication (up 29.5%). The top five reported areas from last year (discharge, ground access and leave, involuntary status, prescribing medication, and diagnosis) again featured as the most frequently recorded issues, albeit with some reduction in reports concerning involuntary status.

In 2024-25, the issues data showed an increase of incidents that the MHAS reports as 'serious issues'[12]. These incidents include consumer allegations of potential staff misconduct, wilful neglect or ill-treatment, suicidality, sexual safety, and all forms of assault. Advocates must escalate all such allegations through to a Senior Advocate, who will develop a plan of action that prioritises prompt action to ensure consumers feel safe and are safe, and that appropriate action and response is initiated by services or individuals involved. Serious issues are treated as allegations, and the Advocates' role is to ensure that consumers are safe and that the service has responded appropriately to the matter, including any necessary investigation or referral to external agencies to confirm, dispute or overturn the allegations.

Advocates responded to 393 serious issues for this financial year, an increase from 343 in 2023-24, or 14.5 per cent. Most of these allegations related to potential misconduct, wilful neglect or ill treatment, followed by suicidality, and then sexual safety issues. Serious issues reported by children 0-17 years declined to 28 this year (from 45 in 2023-24) but increased for young people 18-24 years to 79 (from 51). While the reduction in reported serious issues for children is somewhat reassuring, this is influenced in part by a shortage of Advocate cover in child and youth facilities for much of the year, thereby reducing the number of opportunities for children (and their families) to report serious matters.

[12] 'Serious issues' in the MHAS reporting system include allegations of assaults (physical, sexual, verbal, or financial), staff misconduct, wilful neglect, or ill-treatment, and suicidality. Once identified these allegations require a specific response, involving escalation to a Senior Advocate to decide on a plan of action and who monitors the matter.

CHART TWO - Most common consumer complaints and issues 2022-23 to 2024-25



Consumers on involuntary treatment orders

The mental health system has experienced a consistent upward trend in the number of involuntary treatment orders issued since the MHAS commenced operations in November 2015. Over the last eight reporting periods, the total number of involuntary orders increased from 4,154 in 2017-18 to 5,250 in 2024-25, representing a cumulative growth of approximately 26.4 per cent.

TABLE TWO - Number of involuntary orders and consumers under the MH Act

Type of Order	2017-18		2018-19		2019-20		2020-21		2021-22		2022-23		2023-24		2024-25		Change
	Orders	Persons	Orders	Persons	Orders	Persons	Orders	Persons	Orders	Persons	Orders	Persons	Orders	Persons	Orders	Persons	Orders
Inpatient treatment orders in authorised hospitals - Form 6A	3,203	2,432	3,117	2,431	3,275	2,534	3,208	2,498	2,844	2,270	3,170	2,533	3,333	2,675	3,693	2,962	▲ 10.8%
Inpatient treatment orders in general hospitals - Form 6B	134	115	149	128	168	128	181	139	255	189	282	222	331	258	369	280	▲ 11.5%
Community treatment orders - Form 5A	817	661	850	679	839	702	884	718	884	726	963	781	1,005	808	1,188	934	▲ 18.2%
Total Involuntary Orders/Consumers	**4,154**	**2,644**	**4,116**	**2,650**	**4,282**	**2,744**	**4,273**	**2,729**	**3,984**	**2,573**	**4,415**	**2,842**	**4,660**	**3,024**	**5,250**	**3,339**	▲ 12.4%

In the past year, there was a 12.4 per cent increase in the number of involuntary treatment orders. Similarly, the number of individual consumers subject to those orders also increased substantially. As a result, there was a significant increase in demand for initial contact by the MHAS, and for ongoing advocacy services.

The number of inpatient treatment orders (ITOs) made in authorised hospitals (Form 6A) increased compared to the last financial year from 3,203 to 3,693, a notable rise of 10.8 per cent.

The number of individual consumers subject to these orders also increased by 10.7 per cent compared to the previous year.

The number of ITOs made in general hospitals (Form 6B) also rose this year, with an 11.5 per cent increase. Since 2017-18, these orders have shown the highest relative growth, increasing by 175 per cent, perhaps highlighting the demand for mental health treatment provided on medical wards. Perhaps most notably, 157 of the 369 Form 6B orders this year, representing 42.5 per cent, related to children (under 18 years) or youth aged 18-24.

As reflected in last years' annual report, much of the growth in the use of the Form 6B is associated with involuntary treatment for people diagnosed with eating disorders or disordered eating. This is particularly the case with children and youth, reflecting the national trend which shows that 27 per cent of diagnosed eating disorders are for those aged 10-19 years[13]. In such cases, Advocates typically work closely with the consumer, their family and/or support person, and the treating team to address what are often difficult and complex issues. The advocacy required can become more challenging because it often requires Advocates to liaise with nursing and clinical staff who have limited experience in mental health and/or the treatment and care of people diagnosed with eating disorders. Additionally, they are often less familiar with the legal requirements and responsibilities related to involuntary treatment. With the use of Form 6B in general hospitals continuing to trend upwards, additional training for staff on their obligations under the MH Act may be of value.

Another emerging trend is the use of a Form 6B following a referral order (Form 1A) by community and inpatient specialist eating disorder programs which require the consumer to attend the emergency department (ED) to facilitate examination by a psychiatrist. These specialist programs typically only provide voluntary treatment, so when a consumer becomes less engaged in their treatment, and subsequently becomes physically compromised, they may be referred to the ED and ultimately placed on a Form 6B to enable assertive (i.e. forcible) treatment. This could account for some of the data trends we have observed this year. The MHAS will continue to monitor this in 2025-26.

Consumers can also be subject to involuntary treatment orders while based in the community. CTOs grew steadily, with an 18.2 per cent increase in the use of Form 5As compared to the previous year, reaching 1,188 orders. The increase in community-based models such as Hospital in the Home may account for some of this increase, as clinicians have greater access to less restrictive options for providing treatment and support.

As a reflection of the higher number of orders, there has also been a significant rise in unique consumers being treated under a CTO, namely 934 individuals, an increase of nearly 16 per cent. Advocate experience suggests that, again, consumers receiving involuntary inpatient treatment for an eating disorder, are increasingly likely to discharged on a CTO, and that this may also account for some of the growth in CTOs.

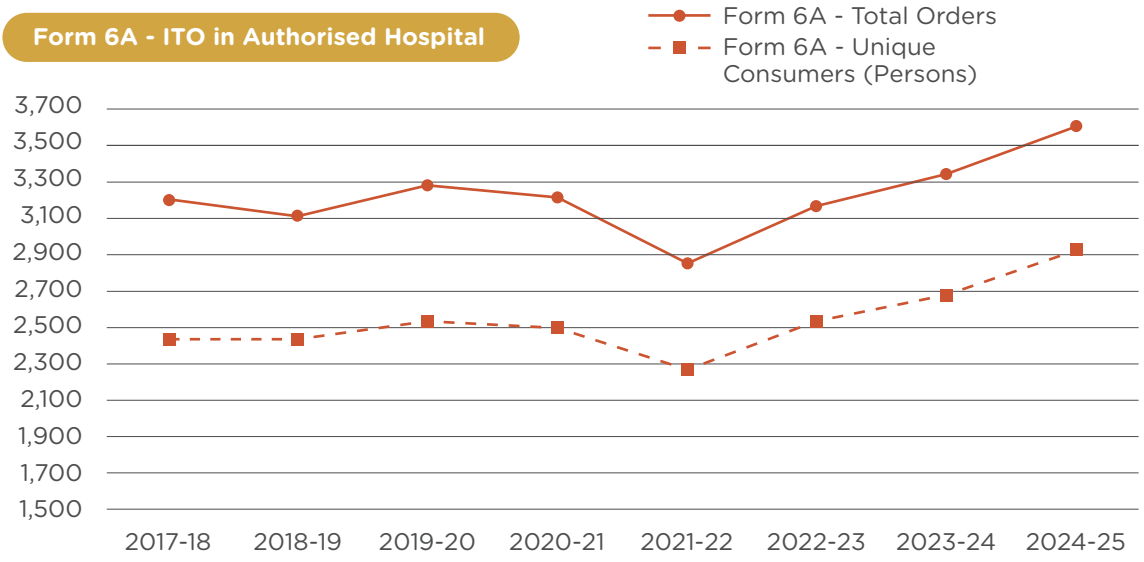
The sustained growth in involuntary treatment orders, particularly in community settings, underscores the increasing demand for mental health services and the need to ensure that resources are being directed towards the right services in the right places. It may support the view that the current arrangements, which remain heavily hospital-centric, are imbalanced and there is a lack of support in sub-acute and non-acute services in the community. These might prevent escalation and need for acute and involuntary treatments, and assist people continue to recover and remain well following an admission.

The data should be used to support systemic forward planning for services, including the need to rebalance the system through expanded infrastructure, enhanced workforce capacity, and improved coordination across inpatient and community-based services, including new service types and investment in supports in the community.

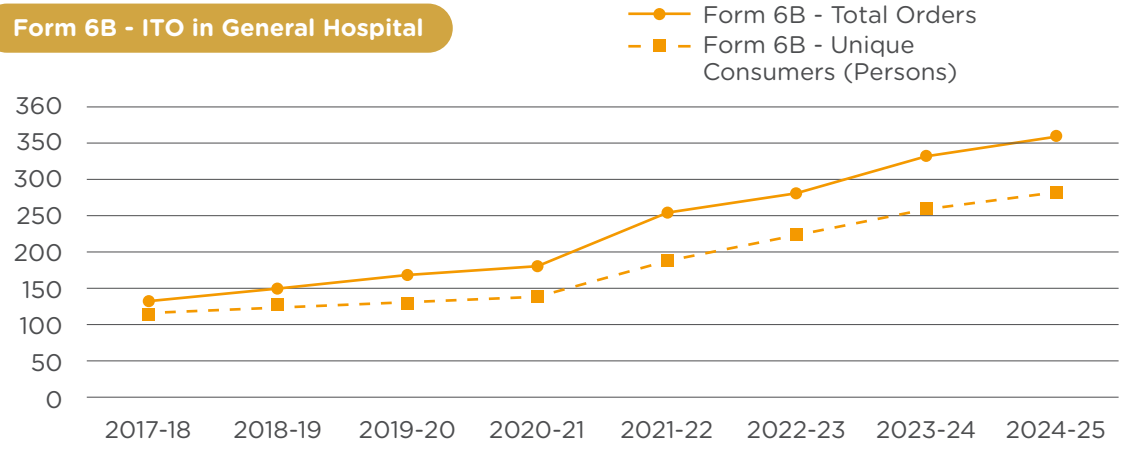
[13] Deloitte Access Economics (2024). Paying the Price, Second Edition: The economic and social impact of eating disorders in Australia. Report commissioned for Butterfly Foundation. Sydney: Butterfly Foundation. https://butterfly.org.au/wp-content/uploads/2024/02/Paying-the-Price_Second-Edition_2024_FINAL.pdf

CHART THREE: Number of involuntary orders and unique consumers from 2017-18 to 2024-25

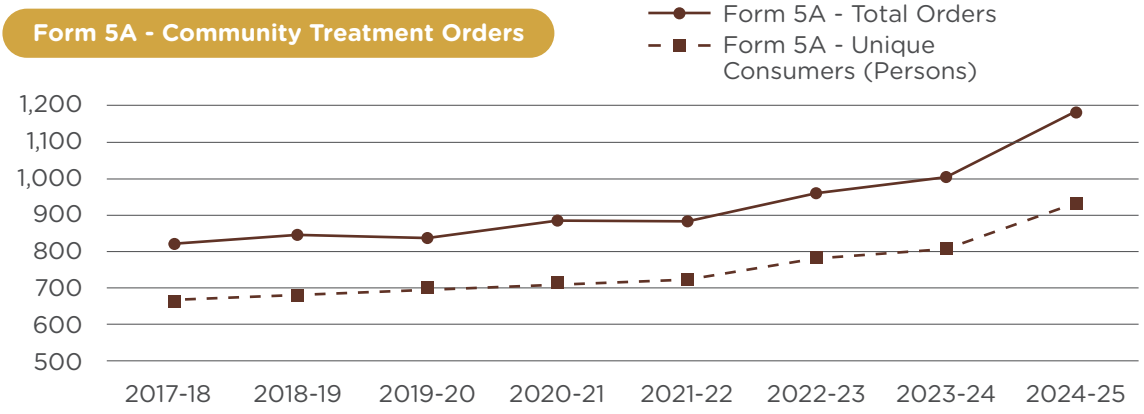
Form 6A - ITO in Authorised Hospital



Form 6B - ITO in General Hospital



Form 5A - Community Treatment Orders



Children aged 0 to 17 years

Under the MH Act, the MHAS has a statutory obligation to contact any child aged 0–17 years within 24 hours of an involuntary treatment order being issued. The priority of this contact is to help the child understand their rights under the MH Act, including the right to be heard, to participate in decisions about their care, and to have their views considered. However, like anyone performing a function under the MH Act in relation to a child, Advocates are required to have regard to what is in the child's best interest.

This means that Advocates working with children must balance multiple perspectives including the child's wishes, the views of the parent or guardian, and those of the treating team. As many children also have external agencies involved in their care, these views must also be considered. Because of the broad consultation that must occur, and the often-competing views of the various parties involved, advocacy for children is often more time-consuming and resource intensive compared to that for adults.

MHAS Weekend Phone Services

The weekend phone service was established to ensure the MHAS meets statutory obligations to contact children within 24 hours of an involuntary treatment order being issued, and as a mechanism to respond to urgent requests for contact on weekends. The phone service operates every weekend, including public holidays. The Advocate who manages the weekend phones:

- Contacts child and youth mental health wards to check whether involuntary treatment orders for children have been made, including asking staff if they are aware of any that may have been made in adult authorised wards, general hospitals or regional hospitals.
- In the case of new involuntary treatment orders for children, the weekend phone Advocate will either complete the initial contact with the child via phone or arrange for a Youth Advocate to visit in-person (metropolitan area only).
- Monitors voicemail messages and determines the urgency of requests. In urgent matters, the weekend phone Advocate will contact the consumer over the weekend. For non-urgent matters, the weekend phone Advocate will arrange for an Advocate to make contact within time periods determined by the legislation or MHAS protocol.

During 2024-25, there were 40 ITOs for children that required initial contact to be made on the weekend by the phone Advocate or the rostered 'on-call' Youth Advocate. This represents 22 per cent of ITOs made for children in 2024-25.

In late 2024-25, an on-call payment was introduced for Youth Advocates who were rostered to be 'on-call' on weekends should an in-person visit be required for a child who had been made involuntary. This payment helps ensure Advocates are now being adequately compensated for their readiness to work at short notice over the weekend.

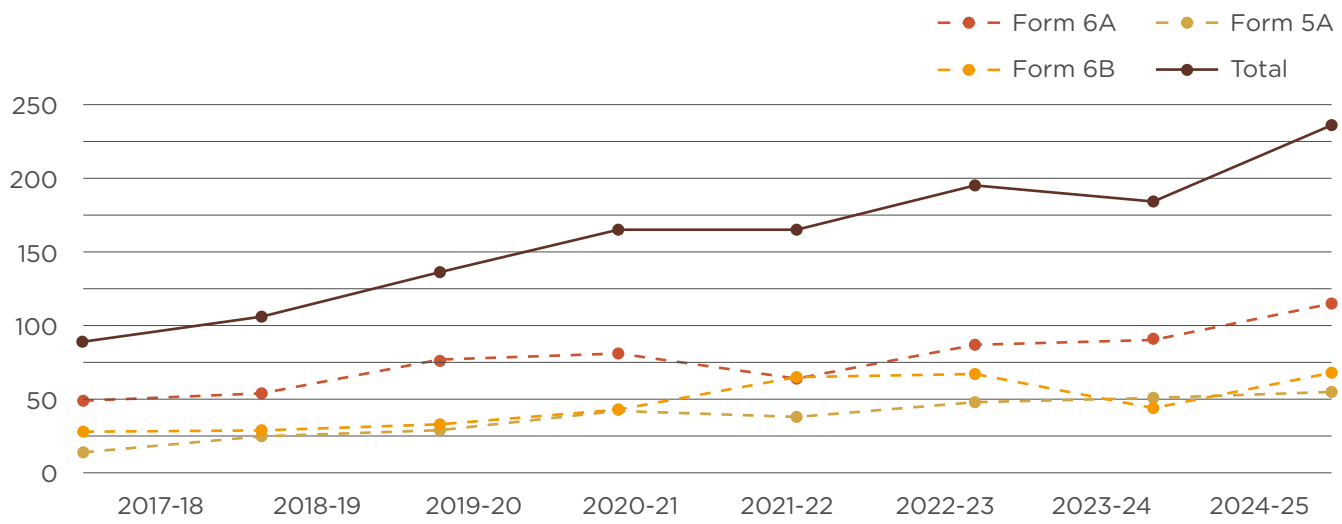
In 2024–25, there was a significant increase in the number of children treated under all categories of involuntary treatment orders, rising to 235 cases, a 28.4 per cent increase from the previous year. The ITOs made in authorised hospitals (Form 6A) increased significantly from 90 to 114 orders, an increase of nearly 27 per cent. But the most notable growth occurred in ITOs made in general hospitals (Form 6B), which increased by 55.8 per cent. This was a reversal from last year, when a significant decline was seen against historical trends.

The reasons behind this correction are unclear, but the experience of Advocates suggests it is likely related to the treatment of eating disorders. Last year's data suggested an increase in the use of community-based treatment options following the government's investment in specialist eating disorder services. However, with the involvement of specialist services comes early identification and intervention when children and young people's physical and mental health become compromised. And as noted earlier in this section, Advocates have observed a growing number of children and young people linked to these services being put on Form 6B orders in the past year, primarily to facilitate refeeding and other necessary medical interventions.

TABLE THREE - Number of involuntary treatment orders for children (0-17 years)

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	Change
Inpatient treatment orders in authorised hospitals – Form 6A	48	53	75	80	63	86	90	114	▲ 26.7%
Inpatient treatment orders in general hospitals – Form 6B	27	28	32	42	64	61	43	67	▲ 55.8%
Community treatment orders – Form 5A	13	24	28	42	37	47	50	54	▲ 8.0%
Total Involuntary Orders	**88**	**105**	**135**	**164**	**164**	**194**	**183**	**235**	▲ 28.4%

CHART FOUR - Growth in involuntary treatment orders for children (0-17 years)[14]



Compared with its obligations under the MH Act to adult consumers, the MHAS has an expanded jurisdiction regarding child consumers due to a Ministerial Direction that came into effect on 1 January 2017, expanding the MHAS' scope in relation to classes of voluntary patients. In addition to children subject to involuntary orders, the MHAS also provides advocacy to children seeking admission to public or authorised hospitals (voluntary patients); children who have been assisted by an Advocate in the previous six months, and children proposed to receive treatment in or by a public or authorised hospital.

Children whose parents or guardians have consented to their treatment (under s.302 of MH Act) are considered voluntary, even if the child has declined the treatment.

While involuntary treatment orders for children have increased in the past year, the MHAS has recorded an 8.7 per cent decrease in advocacy assistance for voluntary children. We believe this decrease was likely influenced by reduced Advocate availability due to Youth Advocate shortages for much of the past is a factor in this decrease, whereby there were, fewer opportunities for voluntary children and their families to engage with an Advocate, rather than a true decline in demand.

TABLE FOUR - Number of voluntary children assisted by an Advocate

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	Change
Voluntary children (<18 years assisted	59	59	278	460	342	462[15]	390[16]	356	▼ 8.7%

14 Data is drawn from Table Three - Number of involuntary treatment orders for children (0-17 years).

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

16 Data is drawn from the MHAS ICMS database of notifications sent by facilities and work recorded by Advocates and extracted as at July 2024; data is subject to change. Consumers may be assisted in multiple categories during financial year. MHAS started providing advocacy services to children and voluntary consumers with ongoing issues via a Ministerial Directive on 1 January 2017.

This decline also builds upon a similar drop in children who were assisted by an Advocate in 2023-24 which is also consistent with data provided by the Department of Health (DoH) regarding the number of children admitted voluntarily to authorised mental health wards in 2024[17]. The 2024 calendar year data[18] provided by DoH, notes that 485 children were admitted voluntarily, representing a 9.5 per cent decrease from 536 in 2023. A factor influencing the reduction in voluntary admissions is the increased supports being provided to children and their families in the community via initiatives such as the Child and Adolescent Mental Health Service's (CAMHS) Crisis Connect and the roll-out of the CAMHS Acute Care Response Teams who are able to provide short-term support in community settings. The MHAS views these initiatives to be positive developments.

Despite these developments, the issues and complaints raised with Advocates regarding children (1022 issues were raised in 2024-25) indicate they continue to face unique challenges within the mental health system, including understanding and being able to access their rights and options, communication barriers with clinicians and staff, timely access to age and developmentally appropriate facilities, and a range of issues relating to safety, dignity and culturally appropriate care. They also expose a lack of services equipped to deal specifically with young people with complex needs, including a lack of supported accommodation options. Given this, the value of having the support of an Advocate during a child's episode of care cannot be understated.

On that note, as previously mentioned, the MHAS faced a period of resourcing challenges in 2024-25 that impacted on service delivery. For a large part of the year, the Youth team operated with only half the required number of Advocates. A full complement is around 7 FTE to be able to deliver specialist youth advocacy services across the state. Although efforts were made to increase Youth Advocate numbers during the first half of the year, retention proved difficult for various reasons, and coverage did not improve. Encouragingly, a recruitment round in the fourth quarter resulted in three new Advocates (3.0 FTE) being engaged for the Youth team, to commence in July 2025. In addition, a 1.0 FTE Team Leader position has been filled to provide additional support and practice development to the Youth team, with the goal of improving Advocate retention and sustaining service capacity and quality.

17 Data supplied by DoH, Mental Health, Information and System Performance Directorate | Purchasing & System Performance, on 12 August 2025.

18 The DoH voluntary child admission data refers to the 2024 calendar year rather than the 2024-25 financial year.

Voluntary consumers with ongoing issues

Consumers tell us that continuity of treatment, care and supports, and being able to access rights are important to them as they navigate the mental health system. Since January 2017, Advocates have been permitted to continue to work with consumers to resolve outstanding issues as the consumer transitions from involuntary to voluntary status. This continued service can occur provided the consumer remains connected to their public mental health provider as a voluntary patient, whether that is in hospital or the community[19]. Advocates can then continue to assist consumers to resolve any ongoing issues where work towards resolution is already underway and there is a likelihood of resolution being reached.

The MHAS recorded a small decline of 1.5 per cent in voluntary consumers assisted with ongoing issues this financial year (see table five).

Unfortunately, when consumers are discharged completely from public mental health services, the MHAS loses the ability to be able to support the consumer through a resolution of their issue or complaint. This recognised problem will be addressed when recommendations from the Statutory Review of the MH Act are implemented in the future.

Referred persons

'Referred persons' are those who have been referred by a medical practitioner or authorised mental health practitioner for a compulsory psychiatric examination (Form 1A). This examination most often occurs in hospital, and the person is not allowed to leave the hospital or place of examination until they have been examined.

As is the case with voluntary child consumers, there is no process in place for the MHAS to be automatically notified when someone is placed on a Form 1A. This means that referred persons may not be notified of their right to an Advocate, therefore missing out on vital support and information about their rights at this often-distressing time. Access to an Advocate often relies on consumers being aware of the MHAS from previous experience, or a member of staff advising them and/or contacting the MHAS to advise the service that someone is on a Form 1A. It should be noted that anyone with a sufficient interest in the consumer, including hospital or other medical staff, may request Advocate contact on the consumer's behalf. Two simple ways to improve referred persons' access to advocacy would be if staff ensured that consumers are informed of their right to an Advocate, and secondly if they offered to contact the MHAS on behalf of the person.

Table five shows that the MHAS provided service to an increased number of referred persons in 2024-25. There were 20 additional referrals this past year, representing an increase of just over six per cent.

[19] 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 - Consumers referred for examination and those assisted with ongoing issues

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	Change
Referred persons assisted (adults and children)	238	212	303	333	302	323	320	340	▲ 6.3%
Voluntary (adult) consumers assisted with ongoing issues	62	86	94	135	149	147	135	133	▼ 1.5%

Licensed private psychiatric hostels residents

The number of licensed private psychiatric hostel beds in Western Australia fluctuates from time to time for a few reasons, including maintenance and staffing. Data supplied by the DoH Licensing and Accreditation Regulatory Unit (LARU) at various points during the financial year has varied slightly; however, around 680 licensed beds across all hostels have been available throughout most of 2024-25.

The number of individual hostel residents assisted by Advocates increased from 391 in 2023-24 to 418 in 2024-25. This support involved the completion of 3,440 consumer contact tasks and represented assistance to just over 60 per cent of all licensed hostel beds.

> [Advocate] also explains clearly about the rights as residents of psychiatric hostel and I was beginning to feel comfortable in telling the truth about my situation.
>
> **CONSUMER**

FIGURE FOUR – The five most common issues raised by hostel residents

Advocates raised a total of 1,454 issues on behalf of hostel residents, with the five most common being:

There were 78 serious issues raised by hostel residents, including 13 related to suicidality[20] of residents. The average time it took Advocates working in hostels to resolve a serious issue to satisfactory completion was 45 days.

Living conditions in hostels remain an important issue for residents and are a cause for much support provided by the MHAS. Advocates raised 83 issues related to hostel facilities in general, with the three most common categories being related to food and beverages, resident safety, and accommodation cleanliness and hygiene.

[20] Suicidality, as defined by the MHAS' Serious Issue Protocol, is when a consumer expresses a clear intention to kill themselves, either planned or impulsive. It includes when a consumer carries out actions with the intention of dying or when a consumer dies by suicide.

Consumers new to MHAS

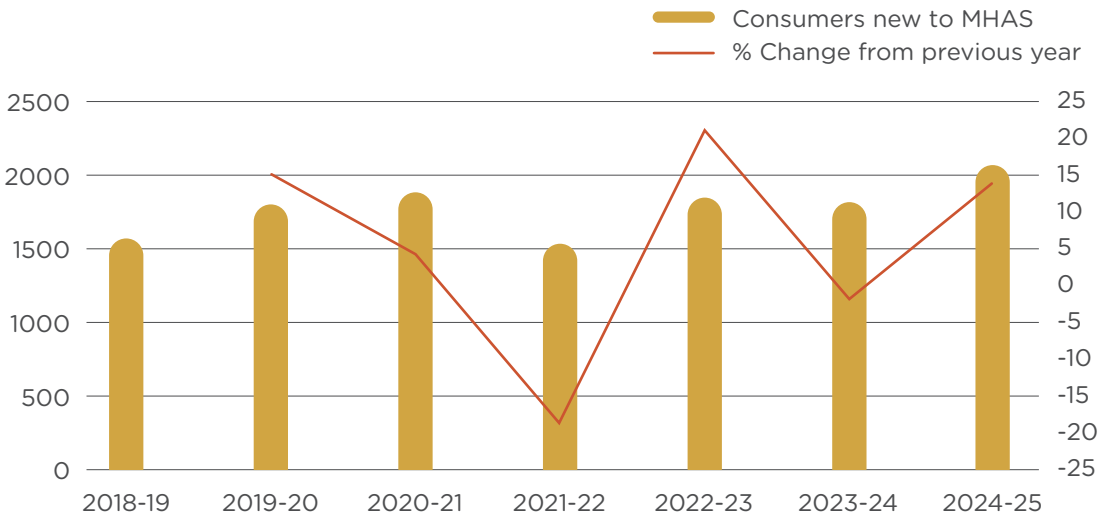
The MHAS provided advocacy services to 2,059 new consumers in 2024-25, representing a 13.9 per cent increase. Some of this growth is likely attributed to the expanded jurisdiction of the service to provide support under the CLMI Act. Table six reflects the trend change in new consumers experienced over the past seven reporting years. It shows a rebound in the number of new consumers this year following last years' decline.

TABLE SIX - Number of consumers new to MHAS

	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	Change
Consumers new to MHAS	1,566	1,798	1,876	1,526	1,844	1,808	2,059[21]	▲ 13.9%

Consumers new to the MHAS represented 47 per cent of all consumers provided support in 2024-25. Over the years since the MHAS commenced services, this figure has fluctuated between 44 per cent to 52 per cent, so remains within this band. The fact that consumers continue to use the MHAS when re-engaging with mental health services reflects positively on the quality and impact of the advocacy services provided.

CHART FIVE - Percentage change in numbers of new consumers each financial year[22]



[21] For 2024-25, new consumers could be identified under the MH Act or CLMI Act, both Acts at the same time, or each interchangeably over the financial year. The total for 2024-25 is based on new consumers added to the MHAS' Hub who were identified under the MH Act as at the 30 June 2025.

[22] Data is drawn from Table Six - Number of consumers new to MHAS.

> When I explained about the quality of food that was served at [private licensed psychiatric hostel], [within] a few months there was a sufficient change in the food being served as better quality.
>
> **RESIDENT**

Numbers of authorised mental health beds attended

The number of beds available within the system fluctuates over the course of the year. The DoH maintains records of total beds in the system overall, and the number that become unavailable for various reasons such as staffing shortages, refurbishment or maintenance works (see table seven).

TABLE SEVEN - Total authorised mental health beds, availability and percentage unavailable

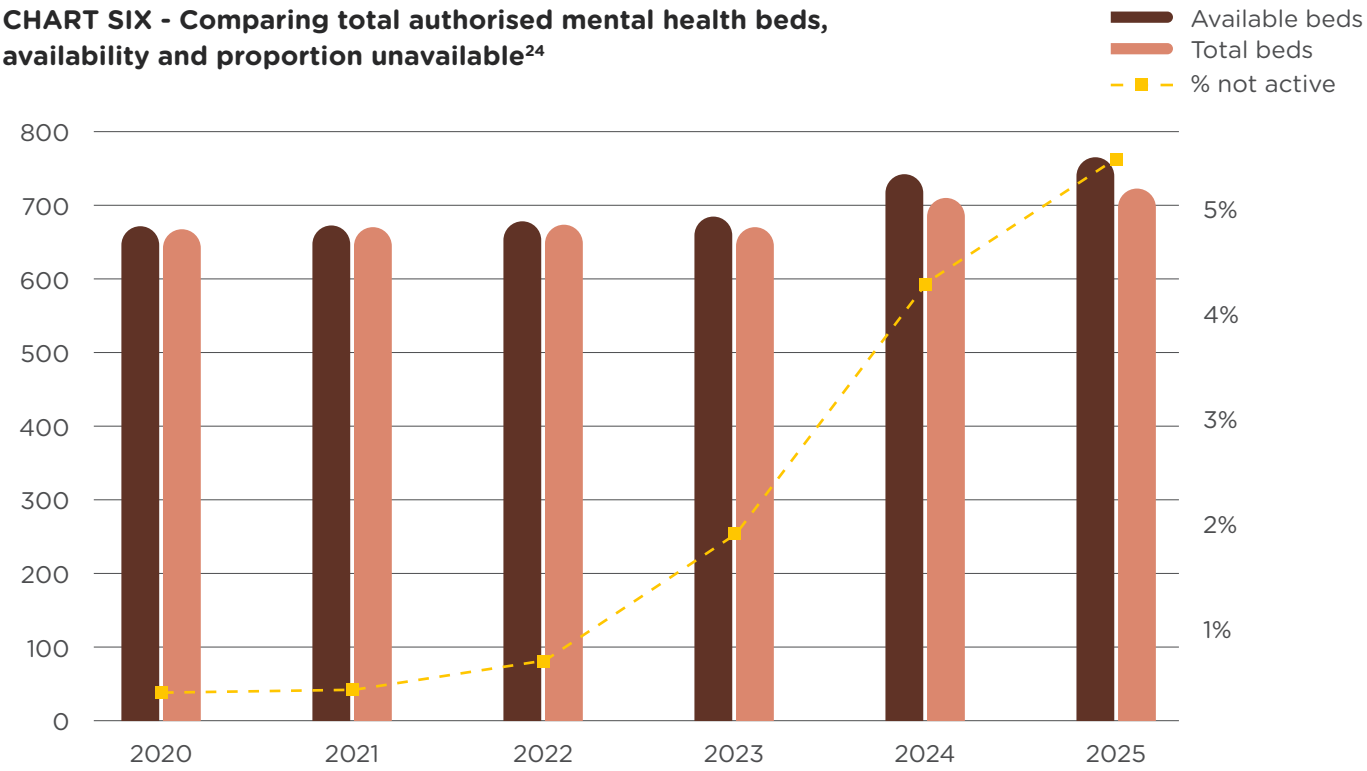
Bed numbers as at 30 June	Total beds	Available beds	Inactive beds	Inactive beds[23]
2020	674	671	3	0.4%
2021	676	673	3	0.4%
2022	680	675	5	0.7%
2023	686	673	13	1.9%
2024	745	713	32	4.3%
2025	769	727	42	5.5%

[23] Rounded to nearest 0.1%.

As was the case last year, the MHAS is again concerned that the trend of increasing unavailability of beds has continued. While acknowledging the significant mental health infrastructure work undertaken across the state during 2024-25, such as anti-ligature works, new builds, and remediation, all of which the MHAS supports, we note the impact on the system, and on specific groups of consumers who have been required to seek services outside their catchment area.

The average daily total of beds available in the 2024-25 financial year has increased to 773, with 725 available and 49 inactive. Historically, the MHAS has used a snapshot of beds available on 30 June of each year to assess fluctuations over time. Data indicates that while the overall number of actual beds in the system has increased over the past six years, the percentage of beds unavailable for use has also increased. Chart six emphasises the steep growth in bed unavailability since 2022.

CHART SIX - Comparing total authorised mental health beds, availability and proportion unavailable[24]



[24] Data is drawn from Table Seven - Total authorised mental health beds, availability and percentage unavailable.

Mental Health Tribunal hearings

Access to independent review by the MHT is an important right of consumers subject to an involuntary treatment order under the MH Act. The MHAS works closely and collaboratively with the MHT to improve consumer experience and outcomes. In 2024–25, Advocates attended 1,286 of the 3,223, or 39.9 per cent, of the MHT hearings held, supporting consumers to express their views and exercise their right to procedural fairness during the hearings. Chart seven represents Advocate work in supporting consumers at MHT hearings over the last five reporting-year periods.[25]

TABLE EIGHT – Representation at Tribunal hearings[26]

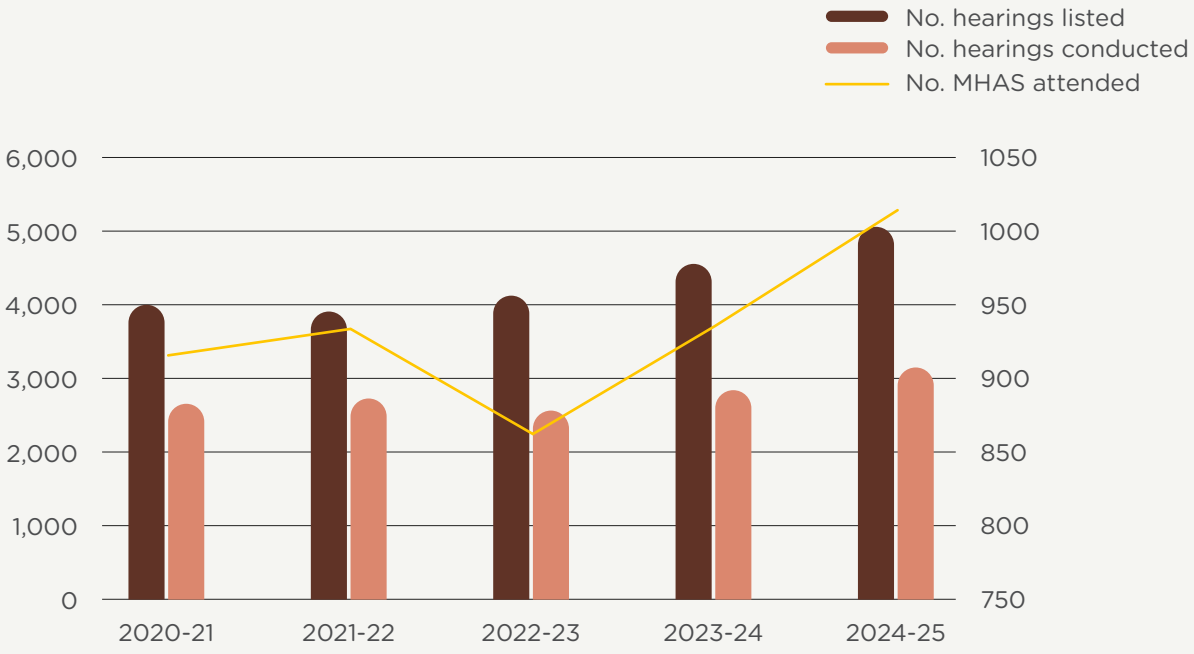
	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Number of hearings listed	3,446	3,618	4,253	4,007	3,908	4,118	4,550	5,056
Number of hearings conducted	2,247	2,320	2,627	2,659	2,742	2,557	2,841	3,223
MHAS hearing attendance (based on MHAS Hub data)[27]	693	692	906	916	934	862	935	1,013
MHAS hearing attendance (based on MHT data)	-	-	-	-	-	-	1,188	1,286
%	34.0%	36.0%	40.0%	40.0%	43.5%	41.0%	41.8%	39.9%
Number of hearings attended by the MHLC	-	-	-	-	-	-	252	338
%	9.0%	9.0%	8.0%	11.0%	10.0%	9.0%	8.9%	10.5%

25 Data is based on information published in the MHT's annual reports.

26 Data is based on information published in the MHT's annual reports from 2017 onwards with the exception of Advocate attendance figures, which are based on MHAS data.

27 Advocate attendance at MHT hearings is based on data recorded by Advocates and is historically lower than the numbers recorded by the MHT, which are printed in the row below.

CHART SEVEN: Percentage of Advocate representation at Tribunal hearings



Themes and trends in Advocates' work with mental health consumers

This section reflects on the problems and complaints consumers raised with their Advocates when they were receiving services or seeking help for their mental health and distress. In many cases the Advocate was able to resolve the issue at the ward level. Sometimes the issue needed to be escalated to the Senior Advocate for liaison with service management. Issues that were difficult to resolve or those that had serious implications for all consumers may have been the subject of an inquiry and/or were raised with service executive by the Chief Advocate or the Deputy Chief Advocate.

> In my 34 years of engaging with the mental health system, I have never felt truly heard—until now.
>
> **CONSUMER**

Common themes arising across all services from trying to resolve issues

There are common themes that arise from the issues presented in this section. The MHAS recommends that services and their administering agencies consider these when prioritising service improvement initiatives.

- Issues are interlinked. Inability to access the right services in a timely way creates safety issues for the individual and for other people using or delivering the service. Service access, adequacy of resourcing, and safety are linked.
- Respect and dignity are safety issues. Lack of respect and dignity lie at the heart of many issues that consumers raise and Advocates encounter. When treatment and care lacks respect for the individual or is delivered in a way that is inhumane, the environment becomes unsafe for everyone.
- Facility conditions, cleanliness and maintenance have a significant impact on people's sense of how much they matter (including staff). Dilapidated and poorly cleaned and maintained facilities convey a strong negative message to consumers about the importance and priority placed on their care.
- Many of the issues that consumers raise with Advocates appear to be obvious injustices of one sort or another, and yet remain unaddressed until they are raised by the Advocate. It is not clear why staff do not act to remediate when they can (presumably) see that something is wrong. Gaining a better understanding of this apparent behaviour would offer services a pathway to making their offerings safer and more acceptable for consumers.
- Frequently, it takes repeated effort and escalation to get an issue addressed, including relatively simple matters that do not require large additional resources or complex planning. The quality and timeliness of responses to issues demonstrates a lack of respect for the consumer.
- Consumers do not always want Advocates to raise concerns about physical and sexual safety because they are concerned this will lessen their chances of speedy discharge. This contributes to the normalisation of aggression and violence in ward settings.
- Knowledge of and compliance with MH Act requirements remain a concern, and there are inadequate system measures to identify and address breaches and monitor compliance. Many of the examples in this section reflect a poor understanding of the MH Act and are indicative of likely breaches of the legislation and the Charter of Mental Health Care Principles (the Charter).

Systemic issues arising from Advocates' work

This section provides a high-level overview of systemic issues arising from the general work of Advocates. The issues are grouped thematically and account for the issues consumers faced as they tried to access their rights while receiving services or seeking help for their mental ill-health and distress. The themes reflect frequently encountered issues across multiple facilities. Unless otherwise noted, all comprise inpatient wards in public hospitals. Where a theme relates to a particular cohort of consumers or service type, this is noted.

In many cases the Advocate was able to resolve the issue at the ward level. Sometimes the issue needed to be escalated to the Senior Advocate for liaison with service management. Issues that were difficult to resolve or those that had serious implications for all consumers may have been the subject of an inquiry and/or were raised with service executive by the Chief Advocate or the Deputy Chief Advocate.

> **We don't know where we'd be without [Advocate], she is incredible – kind, neutral and caring.**
>
> **FAMILY MEMBER**

Access to inpatient mental health services

Access to appropriate and timely services is a central principle of mental health care in Western Australia, including inpatient services. Access is impacted by the type of bed required, bed availability by type within the local catchment, specialised requirements relating to treatment and/or care, and whether transport is required.

The most difficult access issues related to specific cohorts of consumers. Children aged 16 and 17 years, consumers with high intensity care needs in the Kimberley and Pilbara, and prisoners are most impacted by bed availability. Children and adults with complex support needs, and First Nations consumers are most impacted by the availability of specialised supports.

Despite the increase in bed numbers for youth aged 16-24 years provided by the opening of the Joondalup Health Campus (JHC) youth unit, it remains difficult for 16- and 17-year-old children to access timely inpatient care. The JHC youth unit is not fully operational and difficulties with access remain for children with high acuity presentations and intensive treatment and care needs. In-catchment children have been referred to other youth units placing a strain on those services. It is not clear when the JHC youth beds will be fully operational.

Access for consumers with high intensity needs living in the Kimberley and Pilbara improved following the re-opening of the high dependency unit in the mental health unit at Broome Hospital. Although fewer people needed transfer to Perth those who live in remote communities still required transfer away from home and family to access inpatient treatment. This situation would be improved by a mental health inpatient unit at Port Hedland.

Access to forensic mental health beds at the Frankland Centre remains a challenge. Although expansion of forensic beds is planned via the Graylands Reconfiguration and Forensic Project, a date for the first tranche of new beds has not been provided. At the time of reporting, on any given day there were around 20 prisoners awaiting a bed at the Frankland Centre. Whilst waiting, prisoners are held in infrastructure that is has not been designed for the management of severely mentally unwell people, with limited access to staff with skills in mental health care.

First Nations consumers have additional provisions under the MH Act designed to protect their cultural rights, however these are not met consistently or reliably. First Nations consumers have reported not feeling welcome in wards that reflect little recognition of their culture, having difficulties accessing Aboriginal Liaison Officers, or only being able to access their rights under the MH Act with the assistance of an Advocate. Opportunities exist to improve the system by considering how resources can be obtained for designated First Nations staff positions, having mechanisms in place to promote First Nations staff retention, providing mental health training for First Nations staff, and ensuring that non-First Nations staff can access training on cultural safety and working with First Nations colleagues.

Noting the work that some services have undertaken to provide good treatment and care to people with complex support needs, there are neither specialised services nor models of care specifically designed for this cohort. People with complex support needs often need longer stays in purpose-designed facilities, and access to specific supports including accommodation supports, delivered by an appropriately skilled workforce.

Conditions in inpatient mental health services

The human and built environments in inpatient mental health services contribute to consumers' experiences of care and impact their recovery.

Consumers raised issues that related to the impact of staffing shortages on the quality of the care they received. Shortages were reported across all parts of the mental health workforce. Shortages in nursing teams led to gaps in basic care. In the allied health workforce, they led to gaps in access to activities, and delays in referrals and assessments. Shortages of psychiatrists led to delays in access to timely or in-person reviews.

The issues consumers raised with Advocates related to the poor quality of facilities and the impact on their wellbeing. Although Advocates were able to resolve simple issues at ward level, those that required significant expenditure tended to be difficult to resolve, requiring escalation and persistent advocacy, sometimes over months and years.

The condition of built environments also impacted the quality and experience of care. Lack of cleanliness of bathrooms, bedrooms, common and outdoor areas were all raised with Advocates at multiple facilities. Enhanced cleaning schedules, repairs to equipment and remediation work were solutions implemented by services following advocacy. In some cases, it was not possible to resolve issues because extensive structural or system remediation was required. In these instances, advocacy focused on ensuring consumers remained comfortable and safe despite the conditions.

In some facilities, consumers complained about the impact on their wellbeing and recovery of a lack of access to outdoor spaces and exercise because courtyards were being repaired, or were dirty, not shaded or inclement, or had blind spots and there were insufficient staff to take them outside. Other complaints related to the availability or state of repair of exercise equipment. Supplementary activities were not always provided, generally because of a lack of allied health staffing.

Consumer safety in facilities

Safety is a fundamental requirement for mental health service delivery, and to support recovery. Complaints about general safety increased by 34.7 per cent compared to 2023-24. Two dimensions of safety arose in the issues that consumers raised with Advocates during the past year: practices relating to the restraint and seclusion of consumers, and bodily safety including sexual and physical safety.

There are strict requirements for the conduct of restraints and seclusions. Consumers reported the traumatic impact of these events, the pain and distress they experienced, the loss of dignity feelings of disrespect and dehumanisation. Because of the propensity for adverse experiences, conducting these practices as they are supposed to be done is of paramount importance. Advocates responded to practices that were not compliant with requirements, for instances prolonged restraints without bathroom access, missing or incomplete restraint paperwork, and failure to complete or document post-seclusion reviews. The use of security guards without clinical direction was an issue of concern. The predominance of male security guards is a problem, with some female consumers reporting that they felt sexually violated by the way they were handled during a restraint by a male guard.

Education, practice development, policy review and occasionally individual remedial action were included amongst the responses of services when MHAS raised restraint and seclusion issues with them.

Mixed gender wards are a feature of inpatient mental health services across Australia, and Western Australia is no different. The implementation of the Chief Psychiatrist's Standard on Sexual Safety came into effect in July 2024 and has improved the understanding and visibility of sexual safety issues in inpatient mental health services. Most consumers who raised sexual safety issues with their Advocate were female, pointing to the specific adverse impact of mixed wards on women. Advocates also investigated serious sexual safety allegations made by a small number of male consumers and worked with services to ensure they were treated equitably. Issues that Advocates investigated included allegations of harassment or assault, privacy and security (for instance, ability to lock bedrooms).

Inpatient mental health services generally responded promptly and effectively when Advocates raised sexual safety issues. However, work remains to improve practice against the Chief Psychiatrist's Standard in private licensed psychiatric hostels. Although some have effective measures in place to mitigate risks and to respond to incidents and allegations, others do not. In several of the incidents that Advocates investigated poor understandings of sexual safety and inadequate responses were apparent.

Physical safety is influenced by factors such as ward layout, duress and CCTV systems, adequate numbers of appropriately trained and well-supported staff, and models of care that engage consumers in accessible recovery programs. As well as addressing issues and allegations brought to them by individual consumers, Advocates investigated the presence of such measures and how well they were working to keep the ward and all the people in it safe.

Last year, as with previous years, assaults and allegations of assault occurred regularly on wards. Advocates responded by investigating to ensure that policies were followed, paperwork was completed, and that consumers were able to exercise their right to report matters to police and were supported to do so where required.

Unfortunately, consumers did not always want Advocates to raise concerns about physical and sexual safety because they were concerned this would lessen their chances of speedy discharge. This lack of preparedness to report incidents and concerns contributes to the normalisation of aggression and violence in ward settings.

Dignity, courtesy and compassion in the delivery of mental health care

Treating people with dignity, equality, courtesy and compassion and in ways that do not discriminate against them or stigmatise them is the first principle in the Charter of Mental Health Care Principles in the MH Act.

An estimated 20 per cent of the complaints that consumers raised with Advocates related to undignified, disrespectful or inhumane treatment from staff. This is a 40 per cent increase compared to the previous reporting period. The impact that involuntary admissions and treatment have on people's sense of dignity and safety cannot be under-estimated, even when they receive excellent care. In the past year, consumers told us that having someone to speak up for them and call out disrespectful care has an immediate impact on their sense of self, their wellbeing and their recovery. Advocates played an important role in raising concerns about disrespectful care, and services generally responded promptly by investigating allegations and taking appropriate remedial or disciplinary action where required.

Issues spanned a range from staff behaviours and communication that were experienced as disrespectful or lacking compassion to a lack of access to hygiene products or clean clothing. Personal care was an area of sensitivity including a lack of privacy whilst undertaking activities of personal care, hygiene and toileting. Issues were raised that related to ward environments, emergency departments and community clinics.

One area of concern to MHAS is the experience of residents in some private licensed psychiatric hostels. Poor quality food and lack of accommodation of dietary needs (for instance soft foods for people with poor dentition), inattention to physical healthcare needs and untreated minor injuries, lost aids and prosthetics that were not replaced, and no lockable cupboards to safely store possessions represent the types of issues that residents raised with Advocates. Issues such as these dehumanise the individual and leave them feeling devalued, with consequent impacts on their mental health and wellbeing.

For residents of some private licensed psychiatric hostels, many concerns raised with Advocates regarding these kinds of indignity and disrespectful treatment remained unresolved because residents feared repercussions and eviction if they complained.

Compliance with legislation and standards

Consumers' rights are upheld when services comply with the conditions of the MH Act and have regard for the Charter of Mental Health Care Principles. Apparent breaches arose frequently during Advocates' work in the past year.

Confusion about or lack of understanding of MH Act requirements was evident in the actions of some services, including asking Advocates questions about the application of the MH Act in various circumstances. In these cases Advocates are advised the refer the service to the Office of the Chief Psychiatrist as the appropriate body to provide authoritative advice.

Compliance issues also related to failure to complete MH Act forms, or complete them inaccurately or incompletely, and failure to provide them to the consumer. In response Advocates raised issues directly with services and escalated if no change in practice was apparent. Advocates were more likely to report non-compliant use of forms in general wards, EDs, Mental Health Emergency Centres (MHEC), and Mental Health Observation Areas (MHOA) settings, suggesting a need for education and oversight where mental health services are delivered outside authorised wards.

Apparent breaches of the licensing standards for private psychiatric hostels remained a major concern for Advocates during the reporting period. Advocates received reports from consumers, or observed times when staffing numbers and/or presence of experienced staff did not comply with licensing standards. Residents also reported that night staff on 'wake' shifts had been non-contactable as they have been sleeping. Other apparent breaches related to lack of cooling during high summer temperatures, lack of personal care, insufficient clothing and footwear, inadequate amounts of food and lack of access to hot and cold drinks.

Pathways to resolution of issues in hostels were variable in effectiveness. Whilst some managers and licensees were responsive, others were not. Some issues were escalated to the agencies with accountability for aspects of the care and support provided to hostels (OCP, LARU, the Commission), also with variable impact. There is an opportunity to improve collective accountability for hostels.

Complaints and inquiries about mental health services

Advocate functions include inquiring into and seeking to resolve complaints raised by consumers, as well as inquiring into conditions of mental health services that are adversely affecting, or are likely to adversely affect, the health, safety or wellbeing of identified persons. They do this in various ways, including raising the issue with ward staff, attending mediation sessions, helping the consumer write their own letter of complaint, writing a letter of complaint on behalf of the consumer, or conducting a formal inquiry under section 352(1) of the MH Act.

In 2024-25, Advocates, Senior Advocates, the Deputy Chief Advocate, and the Chief Advocate, collectively, wrote 82 complaint letters and 42 inquiry letters.

Quality of service responses

When consumers lodge complaints with the support of MHAS, they invest significant time and emotional energy in providing unique and valuable feedback. A key motivation for complainants is the hope that their concerns will lead to meaningful changes, preventing others from experiencing similar distress. Accordingly, the tone, language and commitments expressed in response letters can have a profound impact, not only on the complainant, but also on future consumers and on staff culture.

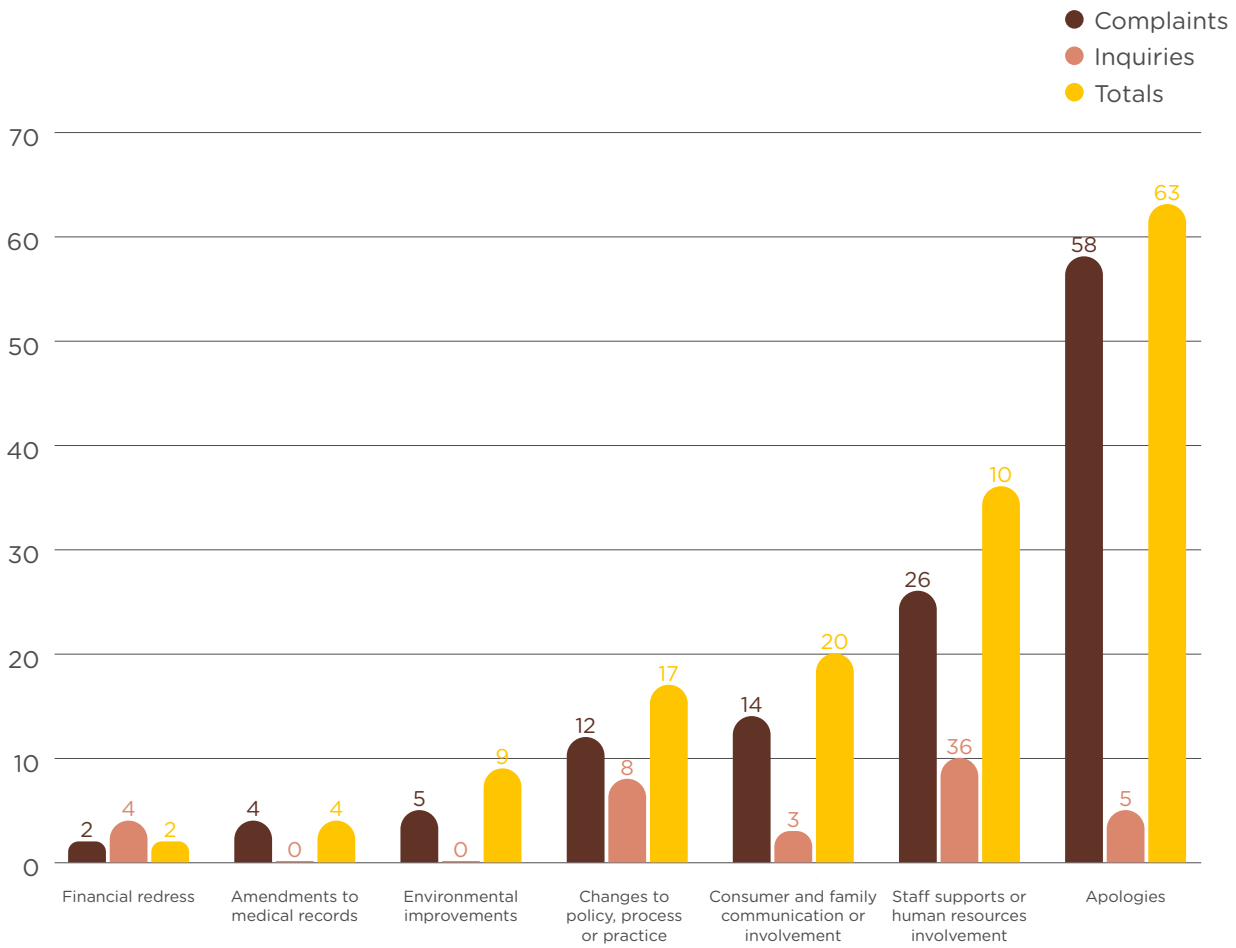
The quality of responses to complaint and inquiry letters received in 2024-25 varied considerably, particularly in terms of demonstrating:

- Thorough consideration of the reported concerns.
- Respectful ways of presenting differing views.
- The application of trauma-informed and person-centred language.
- The commitments made to making improvements.

Building on work commenced in 2024-25, in the coming year MHAS will focus on the quality of responses, particularly those that miss opportunities to fully hear and respond to consumers' concerns and make meaningful change.

Outcomes achieved

CHART EIGHT - Outcomes of consumer complaints and MHAS inquiries during 2024-25



During the reporting period, responses were received to 64 complaint letters and 29 inquiry letters. Chart eight illustrates the frequency and type of outcomes achieved from complaint and inquiry letters sent in 2024-25.

While the responses reflected a range of outcomes, all included acknowledgement of the issue, as well as some level of investigation and explanation. Further details of the identified outcomes are as follows:

Apologies

An apology to the consumer was included in 58 complaint responses (91%) and five inquiry responses (17%). Apologies were frequently offered even when investigations concluded that a complaint was unsubstantiated, reflecting an opportunity for recognition of individual experiences and an openness to identifying potential areas for improvement, regardless.

Staff supports or Human Resources involvement

Enhancing staff support contributes to a safer and more effective workforce with improved capacity to deliver high quality care.

Responses to 26 complaint letters (41%) and ten inquiry letters (34%) indicated actions to strengthen staff support through additional supervision, targeted education or occasional involvement from Human Resources. Examples included:

- Additional staff training in conflict resolution, incident reporting, infection prevention, and the role of the MHAS.
- Upskilling in key areas such as sexual safety, restrictive practices and trauma-informed care.
- Education related to internal policy requirements stemming from medication errors, legislative breaches, and confidentiality concerns.
- Discussions between staff and line managers addressing identified issues.
- Delivery of targeted education by senior clinicians to reinforce best practice.

Consumer and family communication or involvement

Improved involvement and communication with consumers and families support recovery and enhances service productivity.

Improvements in communication and engagement with consumers and their families were reported in 14 complaint responses (22%) and three inquiry responses (10%). Examples included:

- Introduction of clear signage clarifying courtyard access arrangements and the availability of food and drink outside mealtimes.
- Commitment to offering family meetings following the communication of difficult news to support families' understanding.
- Upgraded intercom systems in seclusion rooms.
- Audit of consumer preferences.
- Agreement to use interpreters whenever possible.
- Increased access to peer support workers to identify consumer needs.
- Relocation of several consumers to wards better aligned with their preferences.

Changes to policy, process, or practice

A willingness to make changes to policy, processes or practice can represent an organisation's commitment to continuous improvement and the seeking of best practice for the benefit of all.

Twelve complaint responses (19%) and eight inquiry responses (28%) referenced changes to existing policies, processes, or practices. Examples included:

- Implementation of a service-wide sexual safety action plan.
- Adjustment of staffing assignments to ensure that individuals who present as a high-risk to themselves and/or others are cared for by suitably qualified and experienced nursing staff.
- Development of a tailored discharge pathway to facilitate better access to medication and community support.
- Updates to daily staff duty lists to prioritise consumer needs.
- Revisions to restraint processes to allow greater input from female staff in specific scenarios.

Environmental improvements

The physical environment plays a critical role in the delivery of treatment and care for both consumers and staff. Clean, functional and safe spaces enhance dignity, respect and overall comfort and wellbeing.

Five complaint responses (8%) and four inquiry responses (14%) identified environmental improvements. Examples included:

- The securing of additional funding to complete major courtyard remediation works.
- Improvements in ward cleaning and maintenance regimes.
- Enhanced independent consumer access to secure storage and improved bedroom locking arrangements.
- Improvements in food quality, quantity and variety.
- Installation of screens on CCTV monitors to improve privacy.
- Improvements to ventilation and pest control.

Amendments to medical records

Responsiveness to concerns about documentation accuracy has the potential to increase collaboration and promote overall trust.

Amendments to medical records were made following four complaint responses (6%). Examples included:

- Inclusion of a consumer's objection to disputed content in a MHT report, with a commitment to exclude the content from future documentation.
- Revised discharge summary at the request of family members.
- File alerts noting facility preferences and requests regarding staff allocations during potential future admissions.

Financial redress

Two complaint responses (3%) resulted in financial reimbursement for lost personal items. These items were essential to consumers' health and transportation needs. Reimbursement helped to mitigate the impact of the loss.

Criminal Law (Mental Impairment) Act Service

Establishing and commencing a new service

The criminal law mental impairment reforms

On 1 September 2024, MHAS began providing advocacy to people within the criminal justice system in accordance with its obligations under the CLMI Act. Under this Act, people with mental impairment charged with offences where fitness to stand trial has been raised, or have been found unfit, or are supervised persons under a CO or CSO, have a right to an Advocate. The new Act replaced the *Criminal Law (Mentally Impaired Accused) Act 1996* (CLMIA Act) and introduces significant reforms with positive impacts for mentally impaired accused people.

The reforms were brought in to address known deficits with the previous legislation. Under the repealed CLMIA Act, there were multiple examples of where people with mental impairment, accused of a crime, were held indefinitely in the criminal justice system, and there were no limiting terms on their sentence. The repealed Act did not contain provisions to test the evidence for those accused of crimes, nor to make judgements about the equivalence with sentences that might be handed down in mainstream court processes. Nor was there the option of supervision in community. The only access to the community was under limited leave of absence order provisions. Otherwise, people had to be held in custody, and for the majority, this meant long periods in prison, even for a minor offence. Because of these deficiencies, lawyers often advised their clients against using the CLMIA Act, and it was never used for children, including those who might have benefited from its provisions.

The new legislation is shaped by its objects and principles, with a clear emphasis on procedural fairness. The CLMI Act introduces special proceeding hearings to consider evidence relevant to a case, a limiting term on orders made by the court, and new CSOs. It establishes a new Mental Impairment Review Tribunal (MIRT) with expanded powers and separation from the Prisoners' Review Board. There are changes to leave of absence arrangements that expand opportunities to access community as part of the supervised person's journey to rehabilitation and community reintegration. A case conferencing structure and escalation pathway is included to manage and resolve complex case and system issues.

Although the reforms introduce many provisions that benefit the accused person, the paramount consideration in decision-making under the CLMI Act remains the safety of the community.

The MHAS observes positive impacts from these reforms for people subject to its terms, their families, and those who work with them across courts, prisons, other correctional settings, health services, and mandatory services in the disability and alcohol and other drugs sectors. The MHAS anticipates that the appetite of lawyers and courts for raising questions of a person's fitness to stand trial will continue to increase because of these positive impacts and fairer sentencing terms. The legislation is now being used for children, and there will be more people supervised in the community and on COs (noting that placement at the Frankland Centre is severely limited by bed availability). We also hope more people will reside at and benefit from the services of the DJC.

Increased demand requires sufficient, scalable resourcing to meet the promise of these reforms. Adequate resourcing for timely court hearings and psychiatric reports, access to forensic mental health services (community, inpatient and in-reach) at all points along the CLMI Act pathway, and for correctional and health staff within prisons, is critical to ensuring the success of the reforms.

> [Advocate] also explains clearly about the rights as residents of psychiatric hostel and I was beginning to feel comfortable in telling the truth about my situation.
>
> **RESIDENT**

A new role for MHAS – the right to advocacy

The right to advocacy for persons with mental impairment in the criminal justice system[28] is a new provision and expands the MHAS' jurisdiction into courts, prisons and community corrections, as well as continuing current work with unfit accused and supervised persons at the Frankland Centre, people on hospital orders, and people on COs at the DJC (see the Declared Places (Mental Impairment) Act Service section). People whose mental impairment is caused by mental illness, intellectual disability, acquired brain injury or dementia, or any combination of these, are in scope for MHAS advocacy. They are referred to as 'identified persons' in this section of the annual report.

Under the new CLMI Act, advocacy is available to people in the following circumstances:

- Those for whom the question of fitness to stand trial has been raised.
- Those found unfit with the possibility of becoming fit.
- All supervised persons on COs in all places of detention (prison, authorised hospitals, detention centres).
- All supervised persons on CSOs, and those on leave of absence orders (LOA) from a place of detention.

Advocacy ceases if the identified person is found fit, or the charge is dropped, including those who are found to be fit when supports are provided to them, and for those who complete their sentence and are thus discharged from their order.

The CLMI Act introduces six notification points with statutory timeframes for the MHAS to contact the person. An identified person, or someone with a significant interest in their wellbeing can request a contact from an Advocate. Advocates can also make contact on their own initiative. Once in contact with the identified person, Advocates:

- Listen to the person, gain an understanding of what they need, and support them to have their voice heard in proceedings, meetings and reviews that relate to them.
- Look into any problems they have and help them make a complaint about their place of custody or the services they are receiving.
- Assist them in relation to court proceedings, including attending court with them.
- Support them at the MIRT.
- Refer them to other services they need, in consultation with their treating team.
- Help them access legal services, and work with their lawyer.
- Talk to people involved with the person's treatment, care and support including doctors, nurses or other health professionals.
- Liaise with their guardians and administrators.
- Find an interpreter if the person needs one.

Advocates are also required to refer unresolved issues to the Chief Advocate who may give a report to the relevant Ministers or Chief Executive Officers of services. Anyone given a report is obliged to respond.

Advocates have appropriate powers to support these functions, including access to identified persons, the places they are detained, records and documents about them, and to the staff who work with them. Staff are obliged to assist Advocates perform their functions and respond to their inquiries.

[28] See section 7(2)(b) of the CLMI Act.

Implementation of the new service

July and August 2024 saw intense activity as MHAS prepared to commence service delivery on 1 September. Work included completing, testing and implementing the build of the new client information management system (the Hub), developing training materials on Hub use and on Advocate practice aligned to the functions and powers in the CLMI Act and the new context in which advocacy would be provided. Two Senior Advocates and seven Advocates were recruited and trained for service provision across metropolitan Perth and in the regional centres of Derby, Broome, Roebourne, Geraldton, Kalgoorlie, Bunbury and Albany. Information materials for identified persons, families and services were developed, designed and produced. Letter templates to enable response to statutory notifications were prepared. Work instructions for the MHAS CLMI liaison service were finalised. Mandatory policies were developed and endorsed, and development of a practice framework including an advocacy approach commenced.

Across the year, senior MHAS staff also took part in a range of activities to support continued system development and contribute to the success of the reform.

- The Chief Advocate and Senior and/or General Counsel met with the Head of Jurisdiction for each court, including Perth Children's Court and established preferred ways of working, and commitment to continued routine meetings. A follow up series of meetings to reflect on the first year of operation is planned.
- The Chief Advocate and Senior Advocates commenced a series of visits to all metropolitan and regional prisons, meeting the Superintendent and other senior staff, negotiating preferred ways of working and protocols for access where required.
- The Chief Advocate and Manager Policy and Performance commenced work with Correctional Services to expand options for where Advocates meet identified people in prisons, currently limited to Official Visits Centres because of a lack of custodial staff to escort Advocates to the health centres. Correctional Services and the MHAS agree on the benefits of some meetings taking place in the health centres and will work to an arrangement where this can be implemented consistently across all prisons.
- The Chief Advocate, Senior Advocates and Advocates held several meetings with the Communications Partners[29] program within Courts and Tribunals Services and have established a strong service-to-service relationship, including pathways to access the service.
- The Chief Advocate and Senior Advocates had a preliminary meeting with the Public Advocate and members of her office to establish working arrangements for referrals, liaison in relation to individual identified persons, and protocols for Advocates to request assessments. A follow-up is planned for the first quarter of the 2025-26 year.
- The Chief and Senior Advocates continued to take part in the Mental Health Agencies CLMI Implementation Group. The group monitors implementation within mental health agencies, identifies issues, and considers solutions and ways forward.
- The Chief Advocate and Senior Project Officer (Information Technology) worked with the Commission to develop a comprehensive reporting framework for the MHAS. Development and refinement are ongoing to provide meaningful, reliable reports.

[29] The Communication Partners program is an expert service set up within the DoJ to assist courts in their interactions with mentally impaired accused persons. Communication Partners undertake assessment of the identified person's communications needs and provide a report to the court or MIRT with recommendations to support the person's communication needs during proceedings.

Who we worked with and the issues they raised

The data contained in this section represents the first ten months of MHAS' new service provided under the CLMI Act. Advocates' workflow with all identified persons are recorded in the Hub. As with the information collected under our MH Act service work, the data is heavily reliant on the consistency and rigour of practice by Advocates, including their recording practices. This year has seen the MHAS invest in building capacity to improve data collection, but we acknowledge this is still a developing area of our organisational capability. Data for 2024-25 CLMI services is to be treated as an indicative baseline. Reliability will improve as practice develops and the recording system matures.

Notifications

From 1 September 2024 to 30 June 2025, the MHAS received a total of 391 CLMI Act related notifications. This included 328 statutory notifications and 63 other notifications and forms. The most common notification was under section 30 of the Act, where fitness to stand trial had been raised, followed by notifications relating to individuals in the transitional cohort, and then those received via MIRT review proceedings.

In addition, MHAS also received 507 direct requests for contact related to CLMI Act service provision, from 145 unique identified persons.

Just over 20 per cent of notifications received by the MHAS were from regional Western Australia. This represented 80 out of the 391 total notifications received since 1 September to 30 June 2025. With a significant portion of the demand for Advocate support coming from regional areas, the MHAS recognises the importance of recruiting, training and supporting Advocates in locations where there is need. It also presents further evidence of the demand and need for ongoing and enhanced mental health services and resources to be directed to regional Western Australia.

TABLE NINE - Notifications received by the MHAS and individuals involved

Notification type	Notifications	Individuals[30]
Fitness to stand trial raised (s.30)	234	209
Transitional cohort	79	54
MIRT review proceedings	50	39
Notification of place of custody	5	3
Adjournment to see if become fit (s.36)	5	5
Notification of order (s.48) – CO and CSO	5	5
Custody order discharged	3	3
Custody order (detained in hospital)	3	3
Other miscellaneous	7	7

[30] Individuals may be subject to more than one order in succession or at any one time. These figures represent the total number of unique individuals that notifications for each category relate to.

Custody orders and community supervision orders

Under the CLMI Act, the court can make an order in relation to an accused person who has been acquitted on account of mental impairment (at a special proceeding or trial), and an unfit accused who, in a special proceeding, has been found to have committed an offence. The court can make a CO, a CSO, or an order that the accused be released unconditionally (usually following a summary offence). The accused is then referred to as a supervised person. The MIRT plays a key role in reviewing and administering the order made by the court, throughout the duration of the order.

A CO is an order that a person be detained in custody and is used where an offence was serious, and the person presents as a risk to the safety of the community. The MIRT determines a place of custody, which can be at a prison, a declared place, or an authorised hospital. At the end of the limiting term of the order, the court, on recommendation from the MIRT and the Attorney General, can decide to extend the CO or extend supervision on a CSO. The extension of an order occurs when there is risk of the person committing a serious offence, and is necessary for the protection of the community. An extension is not automatically granted and requires grounds for doing so.

A CSO is an order that a person, while residing in the community, must comply with specified conditions. The conditions are determined by the court, however, are administered and reviewed by the MIRT. The maximum term is five years, although this can be subject to an extended order.

TABLE TEN - Number of custody orders as at 30 June each year

Location as at 30 June each year	2018	2019	2020	2021	2022	2023	2024
Authorised Hospital	9	11	22	29	28	32	31
Community	17	18	15	10	14	13	14
Subject to a condition they undergo treatment for a mental illness	-	15	12	7	10	10	12
Not subject to conditions about treatment for a mental illness	-	3	3	3	4	3	2
Declared Place	2	3	2	3	3	3	2
Prison	10	10	11	10	10	9	8
Total	**38**	**42**	**50**	**52**	**55**	**57**	**55**[31]

TABLE ELEVEN - Number of new and discharged custody orders[32]

	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25[33]
New custody orders	11	6	7	5	4	0
Discharged by Executive Government	3	4	2	2	4	4

[31] As of 1 September 2024, one identified person had been released from their custody order, bringing the transitional cohort number to 54.

[32] Data supplied by the DoJ Tribunal and Review Boards

[33] For 2024-2025, figures are totals up to 30 August 2024, prior to commencement of the CLMI Act on 1 September 2024.

The transitional cohort

When the CLMI service began in September 2024, there were 54 people already in the justice system under the former CLMIA Act. This group of people was referred to as the 'transitional cohort' because their orders would be transitioned to the new CLMI Act on 1 September 2024. They required a significant amount of Advocates' time during the early months of service implementation.

The 24 identified persons detained at the Frankland Centre were already in scope for the MHAS under the MH Act prior to 1 September, and Advocates were able to assist this group in preparing for the transition in the months leading up to implementation. Of the additional 30 individuals, two were at the DJC and eight were in prison, and the remaining 20 were either on leave of absence orders (LOA) or conditional release orders in the community. Except for those in the DJC, 28 were out of scope for the MHAS until 1 September.

The second transitional cohort of 68 individuals were those people for whom fitness had been raised in court under the CLMIA Act. However their next hearing fell after the commencement of the legislation and were thus to be considered under the new Act.

Between 1 July and 1 September 2024, Advocates worked with lawyers and doctors to support identified persons who had been found unfit to stand trial in preparing for new hearings and potential discharge from custody. Legal Aid WA and Ruah Legal Services delivered education sessions at the Frankland Centre to help identified persons understand the new legislation.

Following 1 September, and throughout the reporting period, Advocates played a significant role in continuing to deliver information to identified persons.

Advocates performed a variety of tasks to prepare people in the transitional cohort for the implementation of the new legislation and advocated for them once proceedings commenced. These tasks included:

- Providing information to identified persons on the new legislation and explaining their options.
- Advocating for referrals to be made to other supports and allied health services.
- Preparing briefs for court, in consultation with lawyers and identified persons, including the collation of documentary evidence from medical files, supporting identified persons during interviews, and advocating for their voices to be heard and considered.
- Attending court and MIRT proceedings, including providing advocacy at MIRT reviews.
- Playing an active role in discharge planning alongside treating teams at the Frankland Centre and advocating for aspects such as medication management, social supports, National Disability Insurance Scheme (NDIS), and housing.
- Family liaison, support and advocacy.

The impact of the new legislation on the 54 consumers in the transitional cohort varied depending on the defence that had been raised in their original trial pleadings. Identified persons who had been found 'unfit to stand trial' under the old legislation were to become eligible for a process that allowed for a limiting term to their CO, providing them with a possible time frame for release. Those who had raised the defence of 'unsoundness of mind' were subsequently found guilty by the court on that basis. Thus there were alternative pathways, including, for some, hearings to consider sentencing options and to establish precedents for this new cohort of accused persons.

At the time of the transition to the new legislation, there were 24 identified persons who had been found unfit to stand trial and 30 identified persons who had pleaded unsoundness of mind (or mental impairment, as it is referred to in the new legislation).

Of the identified persons who were able to have limiting terms set, a small number were found to have already spent more time in custody than they would have if they had been convicted through the standard criminal justice process.

- Four identified persons who had been deemed unfit to stand trial were discharged outright from their COs following hearings before the courts and MIRT, which found that they had met their limiting terms.
- One identified person was discharged to an authorised hospital other than the Frankland Centre for ongoing mental health treatment.
- Three identified persons were discharged to their own homes or supported accommodation with the support of family and/or the NDIS.
- The remainder in this category continue to progress towards discharge under similar terms.

Reflections on our work with transitional cohort

The initial support required by identified persons from Advocates was understandably and overwhelmingly focused on legal assistance, information and resources. Advocates achieved positive results for identified persons in part due to the dedication and work by lawyers from Legal Aid WA and Ruah Legal Services. Their commitment to our mutual clients was exemplary.

Discharge planning for identified persons securing release from custody has been a challenge. Advocates are learning to navigate the system to acquire the necessary support and resources for those in custody, and to facilitate their return to the community. It is especially difficult to secure suitable accommodation for those facing the dual challenge of leaving custody and experiencing the effects of an enduring mental health condition.

Adding to this, Advocates have reported that some treating teams are hesitant to provide timely, sufficient support for discharge planning and transition from custody to community settings. Insufficient allied health support, both within and outside hospital settings, exacerbates this issue. While many identified persons exiting custody are eligible for NDIS support, securing funding requires several hurdles to be overcome, some of which require allied health reports to be prepared. However, there is a shortage of staff necessary to prepare these reports, leading to delays that can extend over several months. Even when funding is secured, it can be difficult to access providers with the capabilities to work with this cohort, especially in regional and remote areas.

Children

As previously noted, one anticipated positive outcome from the implementation of the CLMI reforms was that children would be able to use the legislation to secure appropriate support and go through legal processes aligned with their assessed mental health needs. The first 10 months of operation has shown this to have been the case.

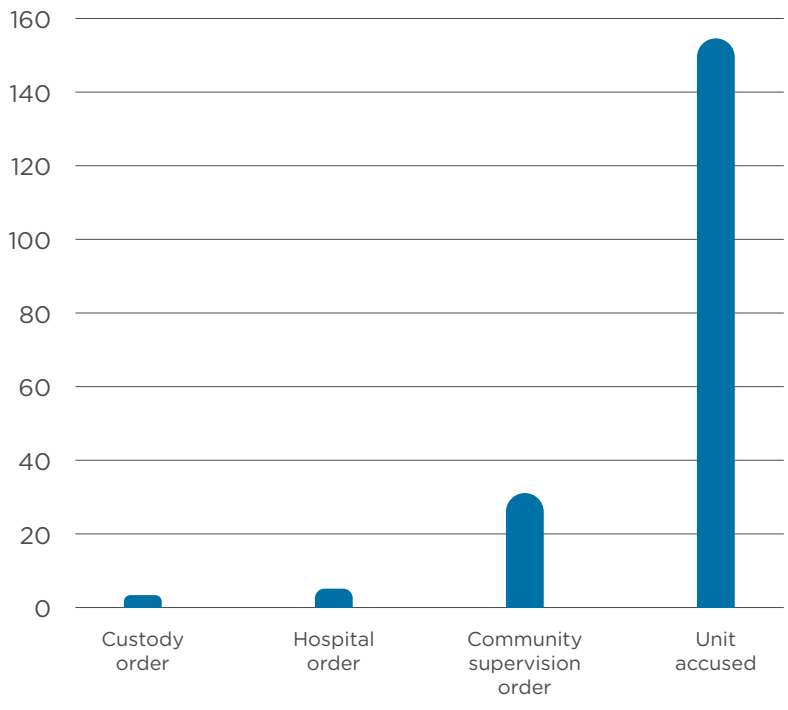
The MHAS received a total of 16 notifications related to children aged under 18 years during the reporting period. Of these, 15 were related to instances under section 30 where fitness to stand trial had been raised, and eight of those were for children aged under 16 years. Of the 16 notifications related to children, 11 were for children who identified as First Nations.

The overall number of notifications makes it difficult to draw definitive conclusions about the use and impact of the CLMI legislation. However, initial indications showed an even distribution of notifications, with a small increase in the final quarter of the financial year. Perhaps the clearest finding from the data collected was the over-representation of First Nations children among those who applied to be assessed under the new legislation.

Given that most notifications related to instances where fitness to stand trial were raised, it is unsurprising that Advocates supporting children spent most of their time on tasks related to the processes involved in determining the fitness of the accused.

And for identified children, the most common issues raised were those uniquely related to their status as children. These included ensuring the availability of a responsible adult, the inability to access education or training while involved in their justice processes, and negotiating the involvement of the Department of Communities (Communities) or other entities in their case.

CHART NINE – Advocate task hours supporting CLMI identified children

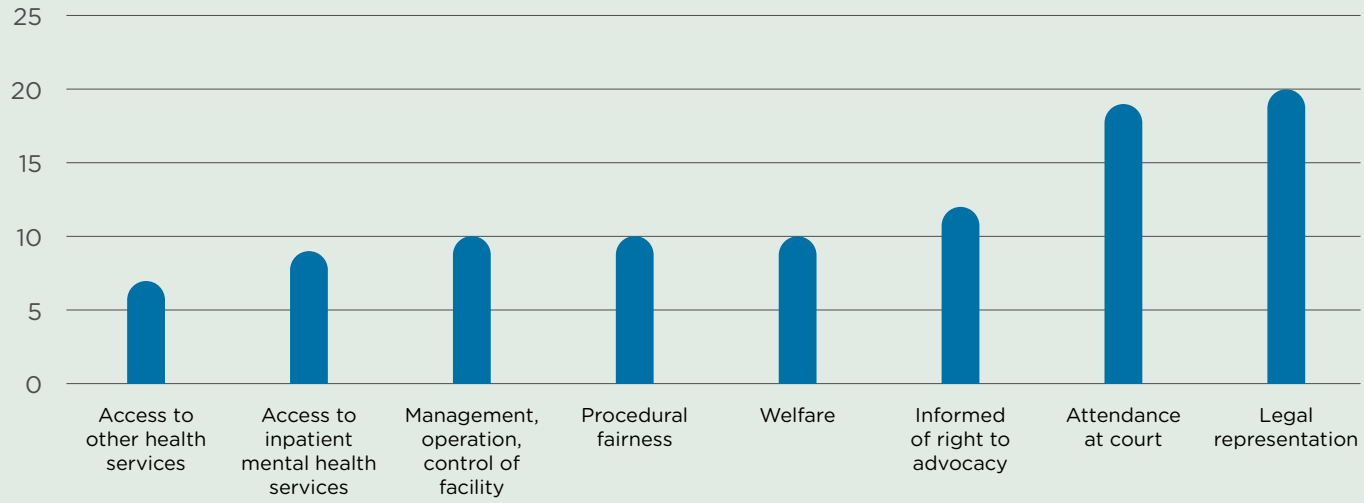


Issues raised by identified persons

The functions of Advocates include investigating issues raised by identified persons, resolving those issues, and/or assisting them to make a complaint about their place of custody or the mandatory services they are, or are not, receiving. The most frequent issues for which identified persons sought help during the reporting period (in descending order from most frequent to least) were:

- Legal representation, such as dissatisfaction with their lawyer or concerns that their lawyer lacked understanding of the new legislation.
- Attendance at court, for example being required to attend via video when they would have preferred to attend in person or being unable to participate effectively via video due to mental impairment.
- Informed of the right to advocacy, including not being informed of the role or availability of Advocates.
- Procedural fairness, such as being compelled to participate in judicial processes while unable to understand due to mental impairment.
- Welfare, including difficulty accessing services in the community.
- Management, operation, control and good order of facilities, such as poor conditions caused by overcrowding and prison lockdowns.[34]

CHART TEN - Most frequently raised issues on behalf of identified persons



[34] Procedural fairness, welfare, and management, operation, control and good order of facilities were raised with equal frequency.

The MHAS also captures the time spent (in hours) on tasks supporting identified persons. This data will allow us to identify the points within the justice processes where identified persons required the most support. It will provide insights into areas where the MHAS may need to increase resources or provide additional training for Advocates, and where collaboration with other services could help improve outcomes for identified persons.

Several factors have affected the accurate recording of this data over the first 10 months of operation, impacting its reliability for reporting purposes. Firstly, for the first few months of CLMI service delivery, advocacy was provided by experienced Advocates from the existing Mental Health team working across both services. This allowed for continuity of supports to existing consumers and for Advocates to transition between service streams. This led to some inconsistency in data entry in allocating task hours. As Advocates have now been allocated to set teams, this issue has been resolved. The introduction of the new Hub data system was also an issue, with Advocates' continued training and experience in its use improving data integrity.

The current system also does not comprehensively capture the administrative and training time dedicated to tasks, nor the time of consumer liaison officers, Senior Advocates, Deputy and Chief Advocate, and public service staff.

What has been clearly evident since the service commenced is the hours per month on CLMI-related tasks increasing substantially over time up to June 2025, as compared to the early months of the CLMI Act being implemented. This was expected as the CLMI service had become more established, and the new legislation was being used more often. The complexity and breadth of supports required are also increasing. It is expected that this increasing trend will continue in the new financial year as the CMLI Act becomes more embedded into the broader system.

Despite the initial identified issues with the CLMI task hours, by reviewing the recorded data alongside feedback from Advocates about their work, we have begun to develop an understanding of the areas where identified persons require the greatest support from our service.

FIGURE FIVE - Areas of greatest demand for advocacy support from identified persons

This year, a great deal of Advocate time has gone into helping identified persons understand what is happening, what their options are, helping them work through what they want, and helping them express their needs and preferences, or speaking on their behalf. As shown in figure five, the greatest demand for Advocate time has been on tasks where they are in direct contact with identified persons.

Overwhelmingly, identified persons have told Advocates they are pleased and feel relieved to have this support. For those who had been in the justice system for many years, they told Advocates it was often the first time they had someone 'in their corner'.

Families have similarly reported how much they appreciate having someone to help them navigate complex systems during times when they may feel vulnerable, uncertain and afraid.

Courts, prisons and corrective services staff have been open to working with Advocates and the MHAS, collaborating to establish processes that ensure identified persons can exercise their right to advocacy in safe and efficient ways. Services have largely recognised the benefits that come from having clients who are well-supported by an agency that specialises in advocacy and empowers and supports individuals to speak up for themselves.

Systemic and emerging issues

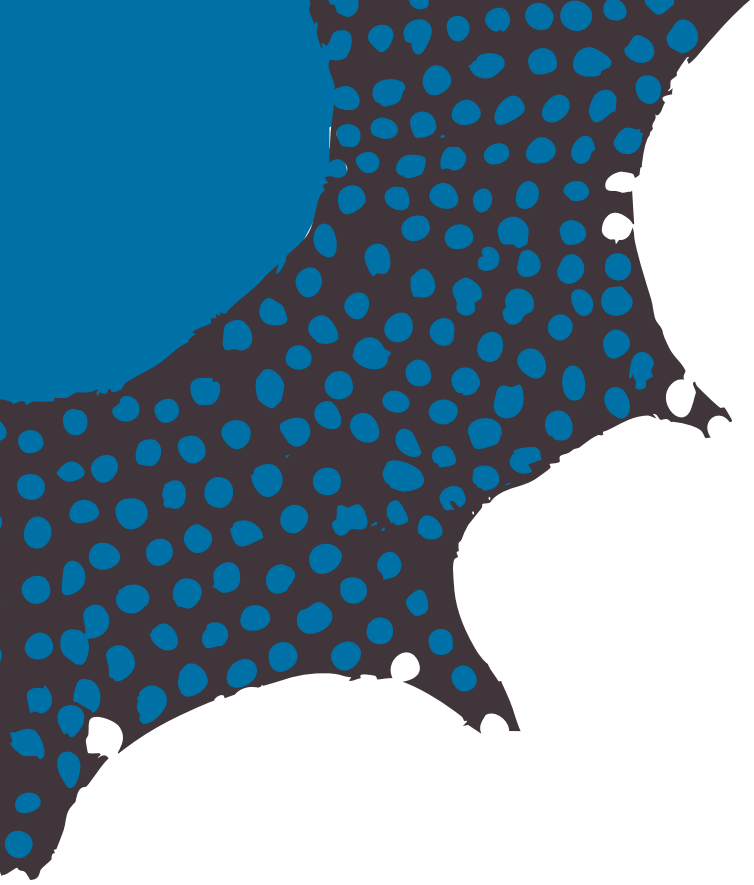
The unlikelihood of becoming fit in prison and implications for procedural fairness

The first group of MHAS Advocates who visited prisons under the CLMI reforms were amongst the most experienced in the service. Between three of them, they had 60 years of advocacy experience. They were used to working with the most unwell people in the state's authorised mental health facilities. However, the first time they visited a prison to see nine identified persons, eight of them were so unwell the Advocates were unable to explain who they were and the persons' rights, nor could they understand what the identified persons wanted. The ninth person was so unwell they could not be brought from their cell. None could instruct a lawyer, a key tenet of procedural fairness.

The most concerning issue that Advocates have encountered in this first year of the CLMI reforms is the lack of access to specialist mental health care for people whose fitness is raised by a court. Those who are remanded whilst they await a fitness assessment, or because the court has adjourned to see if they will become fit, are detained in prison where there is limited access to mental health care and almost no access to psychiatry services. For those who are very unwell, the possibility of getting admitted to one of the eight beds in the 30-bed high-secure Frankland Centre, the state's only inpatient forensic mental health facility,[35] is miniscule, as the majority are already taken up by people on COs. It can take up to 20 weeks to access a fitness assessment for most people, during which time the identified person is unlikely to be able to access the mental health treatment they need. It is not possible to become fit when there is almost no possibility of access to treatment and care that might support fitness. This results in an unintentional denial of procedural fairness.

Although many judges and lawyers are aware of the problems with access to mental health treatment and care in prison, not all are. The risks are twofold. Firstly, the judicial system will lose faith in the ability of the corrective services and health systems to provide access to the mental health treatment, care and supports needed by people who are liable under the CLMI legislation. Secondly, others will continue to use the system as if it were fully functional, thus sending CLMI people into prisons where, sometimes, the lack of mental health and disability interventions make it unsafe for them, other prisoners, those that guard them, and those that visit them.

35 The North Metropolitan Health Service Mental Health Service and Dental Health Services, SFMHS operate the Frankland Centre. In September 2023 a 15-bed low-secure forensic mental health rehabilitation ward (Dryandra) was transferred to the SFMHS to address the overwhelming demand for forensic mental health beds. Admission to the 13 operational beds in Dryandra ward only occurs via internal transfer from the Frankland Centre and is limited to consumers on a Custody Order under the CLMI Act.



The impact of delayed fitness assessments

An identified person was accused of offences for which a custodial sentence of no more than 18 months would normally be expected. However, delays arising from the identified person being acutely unwell and refusing to engage with lawyers and other parties resulted in them remaining on remand for over 12 months. Their fitness was then formally raised and an order for a psychiatric assessment was made. This took more than four months to be delivered, at which point the person refused to engage with the psychiatrist, triggering a further delay. The assessment was finally completed and submitted to court, and the CLMI process continued. By this time, the identified person had spent more time on remand than if they had pled guilty and been sentenced at the first opportunity.

It is encouraging that magistrates are using the CLMI Act for people where fitness appears to be an issue. However, many people identified in the CLMI system are placed on remand once fitness is raised, including those accused of low-risk offences. By the time they have waited for the fitness assessment and ensuing court processes, some will have already served more time than they would have if they had entered a plea and been sentenced (if found guilty).

Differing standards for identified people in prison

An accused person on remand was put on a Form 1A for examination by a psychiatrist at a named authorised hospital other than the Frankland Centre. They were taken by ambulance to the hospital, however, w ere examined in the ambulance in the car park and returned to prison.

During the past year, Advocates have liaised with the relevant senior nursing staff in prisons and in the Frankland Centre to try to secure beds for identified persons who are very unwell and seeking treatment. On occasion, Advocates have suggested that a prisoner should be referred for assessment because they are so unwell they cannot instruct their lawyer for an upcoming hearing, however the Frankland Centre is unable to admit them because of the level of acuity of those already admitted or on the waitlist. This has led to further delays in accessing treatment and the adjournment of court proceedings. When they have liaised with the Frankland Centre, they are told there are no beds. They have also, on occasion, raised the matter with the court Clinical Nurse Specialist, advocating that they recommend a hospital order to the judicial officer. However, our involvement in the system this year suggests that hospital orders no longer guarantee an admission to an authorised hospital for assessment.

Trying to get a prisoner into an authorised bed or, similarly, trying to get a civil bed for an identified person in the Frankland Centre whose criminal proceedings have been dropped, concluded, or they have been granted bail during the admission, can also be delayed. Although the majority of transfers happen in a timely manner, challenges present when a civil bed is not immediately available (generally because of competing bed pressures for people waiting in EDs). These instances are one of the most frequent causes of escalation within MHAS requiring intervention from the Deputy Chief Advocate or Chief Advocate.

There are not enough beds, and the recommissioning work of the Graylands Hospital site, which will deliver greater forensic capacity, is still at least five years away. The situation is compounded by the lack of services for CLMI liable and subject people currently detained in prison.

Access to lawyers

A person was arrested while acutely mentally unwell and awaiting an appointment with a psychiatrist. Their experienced criminal lawyer, however, was not familiar with the CLMI Act, its implications for the accused, nor the hospital order made by the court. While on remand in prison, and without access to the correct medication, the person's condition deteriorated rapidly. The lawyer's lack of familiarity with the CLMI legislation, combined with the accused person's ill-health, delayed court processes and the person's access to justice.

Another acutely unwell accused person who had been in remand for almost a year prior to MHAS involvement could not engage with a lawyer or provide instruction. As a result, they were remanded without having any charges heard or the case considered. Fitness was raised; however, a report was unable to be completed because the person was unable to comply with requirements

Advocates reported that one significant impact of untreated mental health conditions was that some identified persons refused legal representation. In one month alone, three people refused representation, despite the Advocate explaining the risks of doing so. Combined with those who are too unwell to give instruction, the MHAS is concerned that vulnerable people are going through the court system without the protection of legal representation.

One of the criteria for determining fitness in section 26 of the CLMI Act is the inability to give instruction to a lawyer. In criminal proceedings, lawyers are required to act on instructions from their client. Although the CLMI Act has provisions for lawyers to act in a person's best interests without instruction from their client, Advocates have observed that lawyers may not like to do this. Advocates have reported that they have seen proceedings stall due to the inability of the client's inability to instruct and the lawyer's reluctance to act without instruction, thus prolonging the time the identified person remains stuck in custody. We hope that as the system matures lawyers' confidence in using the best interests provisions of the CMLI Act will increase.

In these situations, Advocates, through the trusting relationships they have built with parties, have been able to liaise between the lawyer and identified person so that matters progress in the best interests of the identified person. However, both lawyers and Advocates face challenges in gaining access to, and sufficient time with, identified persons in custody so they can explain legal processes, options, and possible outcomes. Access and time are essential to build the trust that underpins effective representation.

Although Advocates report that access to lawyers who understand the CLMI Act is improving, ongoing co-ordinated legal education (including the reality of mental health care that is available to prisoners) would assist with this matter.

The MHAS will continue to work with Corrective Services to increase identified persons' access to Advocates and lawyers.

Identified people's safety in prison

An identified person was seriously injured in prison on two separate occasions. On the first occasion they were stabbed requiring hospitalisation. On the second they were physically assaulted.

People who are in prison because they are under the CLMI Act are vulnerable within the prison population. Several identified persons have told their Advocate about their vulnerability in prison, including physical and sexual assaults and serious self-harm. However, they do not want the Advocate to raise this with prison staff because of fear of reprisals from other prisoners or being put in observation cells (seen as a poor outcome by prisoners who would rather remain at risk in the general population). This situation is known to prison staff who take measures to protect vulnerable people by considering where they locate them within the prison and whom they are housed with.

Accommodation and the need for a CLMI pathway

The lawyer of an identified person advised relevant stakeholders that it was highly probable the identified person would meet their limiting term. Despite advocacy for over six months to source accommodation, the identified person could not be released from their order because an updated functional assessment had not been completed, and there was no appropriate supported accommodation available.

Currently, there is not a defined pathway for community reintegration for people with a mental health related impairment who require ongoing treatment. Unlike people with mental impairment due to intellectual disability, acquired brain injury or other cognitive impairment who can be detained at the DJC which has a specific focus on capability building for community reintegration, there is no step-down community facility for those with a primary mental health condition other than Dryandra Ward at the Frankland Centre. The Dryandra model of care is focused on monitoring, assessment and treatment in a secure setting and does not adequately provide for capability building for community living. For instance, it does not have a laundry or kitchen facilities where people could build skills for living independently in the community. And the infrastructure is not appropriate for the functional assessments that are required to determine whether someone can safely be returned to live in community, with or without supports, and including those who remain on orders.

The situation is even more concerning for women on COs at the Frankland Centre. Because of safety concerns relating to placing sole women on Dryandra (wholly occupied by men, including those with histories of predatory and sexual offending) treating teams are reluctant to recommend a move to the less restrictive Dryandra environment.

The MHAS has advocated at individual and systemic levels for the need to establish a clear step-down pathway that provides varying levels of security in appropriate accommodation, both within and beyond treatment settings.

We remain concerned at the general lack of forward planning relating to accommodation pathways, alternate options and the over-reliance on the Graylands Recommissioning Project to resolve these matters.

The need for a system response for older adults

During this year, the MHAS has been involved in protracted advocacy for two older adults with significant ageing-related health issues, including physical and cognitive impairments. Each was at a different stage in the CLMI Act journey and were in different types of facility yet, in both cases, the only options available were not suitable, despite considerable sector-wide effort and collaboration by senior decision-makers keen to come up with more suitable alternatives. Work to resolve the matters is ongoing but, taken together, they point to the need to plan for a cohort whose frailty, medical, psychiatric and security needs require a specific response that the system cannot at present provide.

These cases highlight the need to develop agreements around the placement of unfit accused and supervised persons whose frailty means that the regular places of custody (i.e. prisons and the Frankland Centre) and/or treatment are not suitable. There is a particular need to consider the system response to those whose mental impairment is due to dementia.

> **You went out of your way to give help and support when no one really cared about my situation.**
>
> **CONSUMER**

Declared Places (Mental Impairment) Act Service

The Bennett Brook Disability Justice Centre

The MHAS' third service stream is advocacy provided to residents of the DJC, run by Communities. This service is provided under the DP Act which mandates the delivery of advocacy services to residents of declared places in Western Australia. A 'declared place' is a 'place declared to be a place for the detention of mentally impaired accused by the Governor by an order published in the Government Gazette' under the CLMI Act[36]. At present the 10 bed DJC in Caversham in is the only declared place in the state.

Part 10 of the DP Act makes it a right of people detained at a declared place to have access to, and the protection of, statutory advocacy services. These services are intended to provide rights protection, while also fostering the development of the resident, with Advocates working alongside the resident in formulating their individual development plan (IDP) and supporting its implementation, as described in the DP Act.

The DJC model and the DP Act give precedence to protection of the community, while facilitating development of residents with the aim of them transitioning back to living in mainstream society.

[36] Unless otherwise noted, definitions and explanations in this section are drawn from the CLMI Act rather than the previous legislation.

The residents of the DJC

During the 2024-25 period, a total of three residents were detained at the DJC – two of them for only portions of the year.

The supervised persons detained at the DJC are subject to a CO under the CLMI Act. People detained at the DJC have either been determined to be unfit to stand trial and have had special proceedings to determine their charges but have had no judgement of conviction entered or have been found to be not guilty on account of mental impairment. Under the former CLMIA Act people who were put on a CO were detained indefinitely until the Governor ordered that they be released.

This arrangement changed on 1 September 2024 when the CLMI Act came into force, replacing the prior legislation. Under the new legislation, if a court makes a CO, they must set a limiting term which is equivalent to the time the person would have been sentenced to if they had been found guilty of the offence at trial (but with the benefit of a 25 per cent reduction as if they had pleaded guilty at the first opportunity).

There are four possible places of detention for a person on a CO:

- An authorised hospital (when the accused has a mental illness and is receiving treatment).
- A declared place.
- A detention centre (when the accused is under 18 years of age).
- A prison.

Eligibility for the DJC is based on the definition of 'disability' as defined in the *Disability Services Act 1993*, namely people with a disability 'attributable to intellectual, psychiatric, cognitive, neurological, sensory or physical impairment, or a combination of those impairments. However, both the previous CLMIA Act and the current CLMI Act exclude those people for whom the predominant reason for the disability is a mental illness. Further, those who have a dual disability (i.e. a combination of intellectual, cognitive, neurological, sensory, or physical impairment, and a mental illness) are technically eligible only if the mental illness is not the 'predominant reason' for their disability. In practice, this is applied to circumstances where the person's mental illness is treated and well-managed.

> **[Advocate] has seen us at our worst, and she was so compassionate.**
>
> **FAMILY MEMBER**

Placement at the Disability Justice Centre

The decision to place residents at the DJC rests with the MIRT under the CLMI Act. The MIRT replaced its predecessor organisation under the CLMIA Act, the Mentally Impaired Accused Review Board (MIARB), and exercises broadly similar powers.

To be eligible for placement at the DJC, a person must meet all the following criteria:

- Be a mentally impaired accused on a CO.
- Have reached 16 years of age.
- Have a disability as defined in the *Disability Services Act 1993.*
- The predominant reason for the disability is not mental illness.[37]

The purpose of the DJC is to provide a detention option that is appropriate and habilitative or rehabilitative for people with predominant intellectual or cognitive disability, or autism, as an alternative to prison and to help prepare residents for release into the community.

Under the former CLMIA Act, the MIARB and the Minister for Disability Services decided whether a person on a CO could be detained at the DJC. However, under the new CLMI Act, the decision no longer requires ministerial approval. Under the new legislation, when someone is placed on a CO and where an intellectual disability, acquired brain injury or dementia is the main contributing factor to their mental impairment, reports on suitability are prepared for consideration by the MIRT, which then determines the place of custody, including the possibility of detainment at the DJC.

TABLE TWELVE – Identified persons place of custody on 30 June 2019 each year to 30 June 2024, and for the period 1 July 2024 – 31 August 2025[38]

Location as at 30 June each year	2019	2020	2021	2022	2023	2024	2025
Authorised Hospital	11	22	29	28	32	31	40
Community	18	15	10	14	13	14	2
Subject to a condition they undergo treatment for a mental illness	15	12	7	10	10	12	2
Not subject to conditions about treatment for a mental illness	3	3	3	4	3	2	0
Declared Place	3	2	3	3	3	2	6
Prison	10	11	10	10	9	8	7
Total	**42**	**50**	**52**	**55**	**57**	**55**	**55**[39]

37 Referred to as 'learning disability' in this report.

38 Data supplied by the Mental Impairment Review Tribunal. The data for 2025 was provided in a different format to the previous years, making direct comparison between 2025 and previous years impossible. Previous years gave a point in time count on 30 June, whereas the 2025 data provided a cumulative total for all orders whose place of custody had been DJC, regardless of whether they were resident at DJC on 31 August 2025 or on a leave of absence order in the community.

39 As of 1 September 2024, one identified person had been released from their custody order, bringing the transitional cohort number to 54.

Table twelve shows point in time data for the location of people on custody orders on June 30 for the years 2019 to 2024. The data for 2025 is different, providing a cumulative total for all orders over the fourteen months from 1 July 2024 to 31 August 2025, and the location of each custody order (as a cumulative total) on 31 August. Despite the changes in how the data is calculated and presented, it shows that six individuals had resided in the DJC at some point in the fourteen months from 1 Jul 2024 to 31 August 2025,. However, because the total is cumulative, it does not mean that there were six people resident at the DJC on 31 August, or at any time before that. Only three people were detained at the DJC at any point during the fourteen month period. The other three residents were subject to orders where they substantially resided in the community but counted as a DJC resident for accountability purposes. Following the implementation of the new CLMI Act in September 2024, Advocates were able to provide support to them while they were completing these orders.

Table thirteen reflects the place of custody for individuals under the new CLMI Act as a cumulative total over the period from 1 September 2024 to 30 June 2025. Previously, the MHAS had been provided with data as a point in time figure, allowing a comparison at the end of each financial year. With the change to cumulative accounting of those in custody, it is difficult to do so for this reporting period.

TABLE THIRTEEN – Place of custody for existing Custody Orders and new determinations made by the Mental Impairment Review Tribunal[40]

		2024-25[41]
Number of notices received under Reg 3 under CLMIA and s48 of CLMI for Custody Orders made by the court		4
Total Custody Orders in place where the place of custody was	Authorised Hospital	33
	Declared Place	3
	Prison	8
Total new determinations made by the Tribunal for place of custody to be	Authorised Hospital	5
	Declared Place	1
	Prison	3

The number of people residing at the DJC has remained low for this financial year, as it has since it was opened. Only three individuals have been accommodated there between 1 September 2024 and 30 June 2025. Of these, there was only one new determination by the MIRT that the DJC was the appropriate place to accommodate someone on a new CO.

The number of people placed on orders at authorised hospitals and prisons have also remained relatively stable, although the new data parameters make it difficult to be definitive about any change.

[40] Data supplied by the DoJ Tribunal and Review Boards.

[41] For 2024-2025, figures are totals between 1 September 2024 and 30 June 2025 under the CLMI Act 2023.

Leave of Absence Orders

LOAs allow a person to gradually increase their access to community whilst remaining on a CO. Residents at the DJC are usually granted very limited LOAs soon after arrival. The exercising of those LOAs is at the discretion of the DJC manager, giving flexibility in how they are used. They may include conditions to mitigate risk, such as the number of support staff to accompany the resident, and requirements for line of sight to be maintained.

Residents typically begin using LOAs to visit parks, beaches and other public locations, with visits to cafes and other businesses introduced later to permit interactions with others in controlled settings. Over time, the length and frequency of LOAs is increased, and may include participation with community groups, shopping trips and use of public transport.

As residents approach the time when they are ready to leave the DJC, planning is put in place for them to transition to the community. This includes arrangements for accommodation, and for external providers to take over all supports. At this stage, overnight LOAs are introduced, with frequency increasing until the person is effectively living full-time in the community.

Breaches of LOA conditions are reported to MIRT. The MIRT may vary conditions or cancel the LOA in response.

Community reintegration

As residents of the DJC are assessed as having a significant and permanent disability, they are generally eligible for supports under the NDIS. The NDIS provides funding for residents to engage external services that can support them during their transition to community and beyond. In consultation with stakeholders, including Advocates, staff at the DJC engage community providers to begin working with residents while they are still at the DJC. This allows providers to get to know the residents, build an understanding of their needs, and identify the supports required for them to live well and safely in the community.

When they work well, the community supports deliver positive results. One resident's presentation and behaviours dramatically improved after commencing LOAs with supports. The resident began to express hopes for the future, and an understanding of the legal processes they faced.

However, the quality of supports remains inconsistent, and conditions may be imposed under one set of rules that appear to breach rules under another. In the reporting period Advocates noted apparent conflicts between the providers' commitment to achieving positive outcomes for residents and the perceived need to impose unauthorised restrictive practices on the residents on at least one occasion. In this case the provider maintained that the practices were a condition imposed by the leaseholder of the property who asserted that they could impose 'house rules' on any residents who were to live in the property.

Advocates also reported delays in transition to community living for residents on at least one occasion whilst modifications were made to the property to improve safety. Delays such as this may mean that residents remain in custody for longer than required by their orders.

The advocacy service

The DP Act places obligations on the DJC to inform the Chief Advocate of the arrival of every new resident in the declared place no later than 48 hours after their arrival. The Chief Advocate must then ensure that the resident is visited or otherwise contacted by an Advocate within seven days of arrival. Residents can request visits or contact outside the statutory contact and an Advocate must contact a resident within 72 hours when this occurs. Additionally, the Chief Advocate must ensure that an Advocate contacts each resident at least four times a year. Residents can, however, decline to be contacted.

In the 2024-25 period, two Advocates were delegated to provide advocacy services to DJC residents.

In accordance with the requirements of the DP Act:

- Each resident received at least four visits during 2024-25 or the equivalent proportion.
- The Chief Advocate received quarterly reports for each resident as to whether there had been any regulated behaviour management.

The Advocates' work

The Advocates monitor the safety, rights and welfare of residents, and work closely with them (as well as DJC staff and external agencies) to seek successful and sustainable reintegration into the community. They protect the rights of residents and advocate on their behalf. Advocates have broad powers of access to individuals and information in fulfilling their roles.

Advocates attend and participate in MIARB/MIRT hearings and other legal processes, though these activities now generally fall under the MHAS' CLMI Act service stream. During the 2024-25 year, Advocates attended all hearings, and advocated for:

- Increased LOA to support transition to community.
- Placement at DJC for person/s detained in prison.

This financial year, Advocates received 32 notifications for initiations (equivalent to occasions of service), or requests for involvement, from DJC residents. Due to the complex circumstances of many DJC residents, significantly more contacts and tasks are often required, despite the smaller overall cohort of consumers. This year, the MHAS received initiations via the courts, MIRT, or because the individual was part of the transitional cohort moving from the old to the new legislation. All requests related to just three individuals.

TABLE FOURTEEN - Numbers and types of service initiations and form notifications received by MHAS related to DJC residents 2024-2025

Financial Year 1 July to 30 June		2024-25
Requests for Contact	Initiations	22
	Individuals	2
MIRT Review Proceedings	Initiations	4
	Individuals	2
Transitional Cohort Initiation	Initiations	6
	Individuals	3
Totals	**Initiations**	**32**
	Individuals	**3**

Advocates' functions and powers under the DP Act are broadly like those under the MH and CLMI Acts. Section 53 of the DP Act includes additional specific functions:

- Acting as the personal Advocate of residents to safeguard their health and safety and foster their development.
- Monitoring the use of regulated behaviour management (emergency restraint and seclusion).
- Participating in the planning and provision of services received by residents and the preparation of their IDPs.

The DP Act stipulates that an IDP is to be prepared for each resident, and the resident's plan is to be managed, and they are to receive 'care, support and protection' as required by that plan. The Advocate must be consulted as part of the preparation, review and any proposals to change a resident's IDP, and this is a major part of their work with residents. In 2024-25 Advocates' work included:

- Working with residents and staff to help people stabilise their mental health and prepare for developing goals in the IDP.
- Meeting with stakeholders to review residents' goals, their achievements, and barriers impacting progress.
- Meeting frequently with stakeholders to support residents making the transition to living in the community.

If a DJC resident were to be admitted to hospital under the MH Act, advocacy would be delivered under the powers granted to the MHAS under both Acts. The implementation of the CLMI Act has meant that residents also receive advocacy services under that Act. In practice, this means that advocacy matters relating to the DJC are covered under the DP Act, while those relating to the legal process and other external matters, are handled under the CLMI Act. Where possible, the same person will provide advocacy under the DP and CLMI Acts; provision of advocacy under the MH Act is dependent on Advocate availability and the hospital to which the DJC resident is admitted.

Navigating the relevant legislation has required clear division in the applicable powers and functions of the MHAS for each resident and for each set of circumstances they encounter.

On occasion, a resident may need a period of hospitalisation in response to a deterioration in their mental health or to trial a new medication regime. When hospitalisation is required MHAS ensures continuity of service via a handover from the DJC Advocate to the relevant hospital Advocate. The handover will involve the resident meeting the (temporary) hospital Advocate, along with their NDIS support team where relevant.

Emergency restraint and seclusion

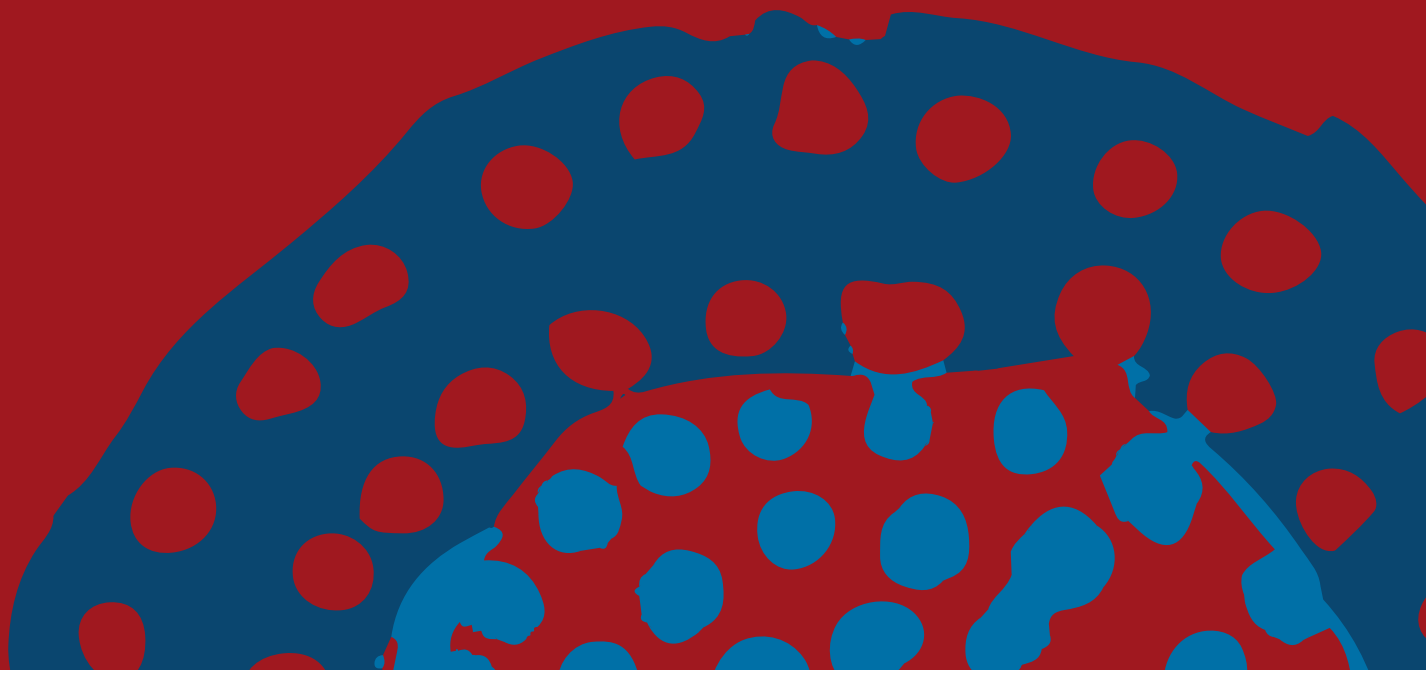
The Chief Advocate was notified of one emergency restraint or seclusion during the year. This matter was reported by the DJC directly to Advocates at the time it occurred. Advocates investigated and found no further action was required.

Meetings with the Minister for Disability Services

The Chief Advocate had one meeting with the Minister for Disability Services during the year.

Cost of the advocacy service

In accordance with the agreed funding arrangements, Communities is invoiced for advocacy services. The cost of advocacy services in 2024-25 was $4,765.



Systemic issues

In 2024-25, Advocates reported the DJC staff and management were proactive in seeking positive outcomes for residents, and diligent in ensuring their rights were observed and welfare fostered while at the centre.

The MHAS notes the professionalism, dedication and empathy of DJC staff and appreciates their enthusiasm for facilitating the work of Advocates.

Under-utilisation of the DJC

Of continuing and significant concern is the under-utilisation of the DJC. Of the three residents in the 2024-25 period, one was there for two months, one for five months, and one for the entire year. A maximum of two of the 10 DJC beds were occupied at any time over this period.

Advocates working in prisons report interactions with identified persons who they believe would benefit from placement at DJC instead of being held in prisons that cannot provide the same level of support and planning.

This issue straddles several departments and ministerial portfolios, and resolution is not within the power of Communities alone.

A key obstacle remains the requirement that a potential resident's disability not be predominantly due to mental illness. The state's prisons hold many people whose intellectual disability is overshadowed by acute mental illness which is either not treated, or not treated effectively. Identified persons who are prisoners may decline to comply, or comply ineffectively, with treatment regimens delivered by stretched prison services. Behaviours related to mental illness then become amplified. Consequently, prisoners with intellectual disabilities and acquired brain injury (and to a lesser extent, dementia) are found to be experiencing mental illness and are excluded from the DJC.

From the MHAS' perspective, the process for placement at the DJC is not as transparent as it could be. There appears to be no clear mechanism for reassessing people if or when their mental illness is treated and thus ceases to be the predominant cause of disability.

Residents of the DJC typically have diagnoses of both intellectual disability/acquired brain injury and mental illness, generally referred to a dual disability. Dual disability recognises that impairment is caused by the interplay of cognitive conditions and mental illness and can be compensated for by appropriate treatment and good supports.

While the issue of access for people with dual disability remains unresolved, it appears likely the DJC will continue to be under-utilised.

Accessing appropriate supports in the community

Exiting the DJC has also continued to be problematic. DJC staff and Advocates work closely with external agencies and service providers to ensure comprehensive and quality supports are provided to residents as they transition to the community. Despite these efforts, some service providers have not been able to provide the expected standard of support, or to sustain it safely.

The combined issues of co-ordination, quality and compliance in NDIS-funded services has been raised in previous annual reports and is ongoing.

Access to psychiatric services

On a positive note, arrangements to provide mental health care to DJC residents have proven more effective in 2024-25, after a period of some uncertainty and instability. Credit for this is due to both Communities and DoH.

Advocates reported improved access to mental health services for DJC residents in the 2024-25 year. Arrangements negotiated between Communities and HSPs proved largely effective. Residents received appropriate support and treatment both while at DJC and while in the community on LOAs. The willingness of the Statewide Forensic Mental Health Service (SFMHS) to step in with supports when necessary was an important back-up to these arrangements.

Finances and disclosures

Budget and Expenditure

In 2024-25, the MHAS' initial total budget was $7.73M, including $628,000 in Resources Received Free of Charge (RRFOC). Of this total, $2.27M was dedicated to support setup and delivery of the new CLMI service.

In addition to the operational budget, MHAS received a further one-off funding amount of approximately $1.1M to support the fit-out for its new offices from the Department of Treasury. A second additional amount of $404,000 was provided by the Commission to fund the enhanced advocacy program in licensed psychiatric hostels.

These additional amounts increased the budget to $9.31M for the full year.

Expenditure for 2024-25 was $9.25M, including $5.8M for salaries (public servants and Advocates) and $3.45M for Other Goods and Services (OGS). The OGS amount includes office relocation fees, hire agency staff payments, Advocate mileage and transport fees, and other operational running costs.

Expenditure was 99 per cent of the total budget. This is the first year since 2010 that the MHAS has remained within budget. While it appears a positive outcome, it is worth noting that two factors have contributed to this. Firstly, the delay in deploying the new organisational structure resulted in an underspend on public servant salary costs, leading to an unavoidable and undesirable increase of workload on existing staff. Secondly, shortages in the Advocate workforce created similar pressures on workers, and under-servicing in facilities across the board.

MHAS previously reported on its budget and expenditure under the MH Act. With the commencement of the CLMI service in September 2024, reporting will reflect both MH Act service and CLMI Act service budget and expenditure for a better representation of funds, financial status and need.

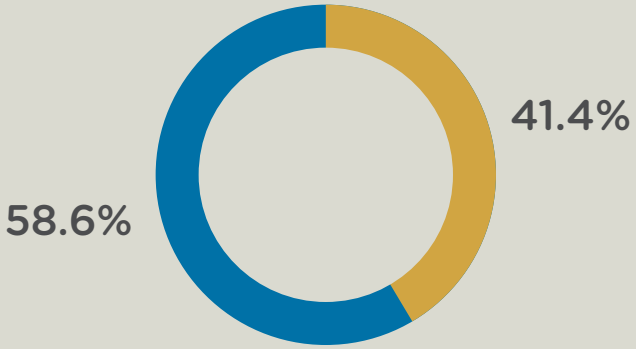
MHAS recorded an overspend in Advocate salaries and in OGS, including the cost of the one-off office fit-out. See Table Fifteen.

This the first year that MHAS has received funding for CLMI service delivery as part of its budget. Some OGS costs that should have coded to the CLMI cost centre were coded in error to the MH Act cost centre. This resulted in an apparent overspend against budget for the MH Act service, and a parallel underspend against budget for the CLMI service. See tables fifteen and sixteen.

FIGURE SIX – MHAS' Actual Spend 2024-25

MH Act Service (78.2% of total budget)
Total: 7,229,184

- **Employment Costs** 4,234,689 (58.6%)
- **Other Goods and Services** 2,994,496 (41.4%)



CLMI Act Service (21.8% of total budget)
Total: 2,019,928

- **Employment Costs** 1,557,512 (77.1% of CLMI)
- **Other Goods and Services** 462,416 (22.9% of CLMI)

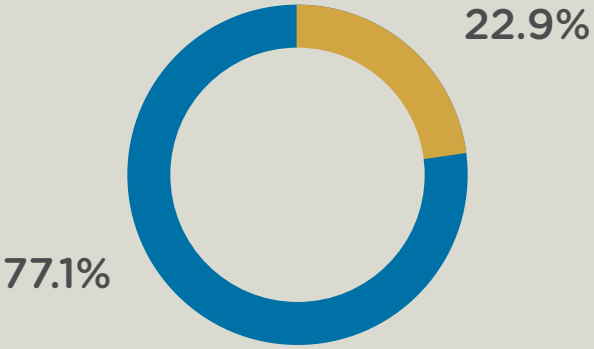


TABLE FIFTEEN – MH Act Service Funding 2019-20 to 2024-25

MH Act Funding	2019-20	2020-21	2021-22	2022-23	2022-23	2024-25
Expenditure	$3,017,802	$3,095,685	$4,129,100	$4,810,557	$5,303,723	$7,229,185
Budget	$2,719,000	$2,858,000	$4,060,000	$4,294,000	$4,858,000	$6,411,000

TABLE SIXTEEN – CLMI Act Service Expenditure and Budget 2024-25

CLMI Act Funding	2024-25
Expenditure	$2,019,928
Budget	$2,899,000

TABLE SEVENTEEN – MHAS Total Expenditure and Budget 2024-25

MHAS Total Funding	2024-25
Expenditure	$9,249,113
Budget	$9,310,000

Disclosures

Records Management Reporting

In accordance with section 19 of the *State Records Act 2000*, the MHAS maintains a Record Keeping Plan (RKP) which governs the management of its records. The plan required the MHAS to finalise its record-keeping procedures manual and classification system, which was completed in 2018.

RKPs are required to be reviewed within five years of being approved. The MHAS reviewed its RKP in August 2023 with a timeline for August 2025 to review or revise the plan again. The MHAS intends to revise its RKP in August 2025 for a full submission due to newly implemented systems and tools.

Freedom of Information Disclosures

In 2024-25, MHAS received ten Freedom of Information (FOI) Requests. One was later withdrawn by applicant. Five of those FOIs were pertaining to personal records and four to non-personal information.

Electoral Act requirements

As required under the Electoral Act 1907, section 175ZE (1), the MHAS recorded $8558 in expenditure related to the designated organisation types between 1 July 2024 and 30 June 2025, which is broken down as follows:

- Advertising agencies: Bigwig Advertising Pty Ltd $8,558 (Graphic design of two annual reports [MH Act and DP Act] and production of CLMI brochures)
- Media advertising organisations: Nil
- Market research organisations: Nil
- Polling organisations: Nil
- Direct mail organisations: Nil

Complaints

In 2024-25, the MHAS received 10 complaints about our service, each of which was handled according to the MHAS complaints protocol. All 10 complaints related to advocacy services and none to advocacy support services. All were resolved to the satisfaction of the complainant, and none remain in process.

The MHAS complaints policy is published on the organisation's website.

Compliments

In 2024-25, the MHAS received seven official compliments about its service. Six were received from mental health consumers and one was received from a mental health service.

MHAS breaches of the Mental Health Act 2014

The MH 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 94.8 per cent of involuntary treatment orders. This is a very slight drop compared to 2023-24 when 95.0 per cent of consumers were contacted within the statutory period.

The most common reason for a breach was due to the order being revoked or a subsequent order made within that timeframe (69.9 per cent of all breaches). In addition, 14.7 per cent of breaches (down from 16.7 per cent in 2023-24) 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 whether a continuation of detention to enable a further examination by psychiatrist (Form 3C) should have been used with the possible outcome of avoiding the need for an involuntary treatment order.

Contact was achieved within statutory timeframes for 95.3 per cent of children (224 out of 235 orders). This is an improvement on the previous year when 94.5 per cent of children were contacted in time.

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 2024-25 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 2024-25.

Appendices

Committees, reference group and working groups

The Chief Advocate, or nominated proxy, was a member on the following committees in 2024-25:

- Licensed Accommodation Multi-Agency Committee
- Urgent Need to Identify Alternate Hostel Accommodation Working Group
- Hostel Cessation Steering Committee, Mental Health Commission
- Mental Health Act Resources Working Group, Mental Health Commission
- CLMI Mental Health Agencies Implementation Group
- CLMI Implementation Steering Committee
- CLMI Transitional Provisions Steering Committee
- National Disability Insurance Agency Adult Community Corrections CLMI Working Group

Presentations and education sessions to external stakeholders

The Chief Advocate, Deputy Chief Advocate, and Senior Advocates regularly deliver presentations to mental health staff and other stakeholders to promote awareness and understanding of the role, powers and functions of MHAS and consumer rights. With the commencement of CLMI, MHAS has also been proactive in engaging with a broader range of stakeholders across the state to help develop an understanding of MHAS' role in providing advocacy to CLMI identified persons.

During 2024-25, MHAS delivered a total of 45 presentations and education sessions as follows:

- Kaatadjiny Walbraaniny Danjoo Project Report to Community
- Mental Health Week Closing Panel: Employment, Empowerment, and Expectations, Panel Member
- Education sessions on the role of MHAS to mental health services (21)
- Education sessions on the role of MHAS and consumer rights at clinician trainings (4)
- Education sessions on the role of MHAS and CLMI advocacy to prisons, courts and the Disability Justice Centre (14)
- Education sessions on the role of MHAS to other stakeholders (4)

Submissions, forums and consultations

MHAS regularly makes submissions and participates in forums and other consultative processes to support system and service development:

- Smoke Free Policy Review, DoH – submission – October 2024
- Ward 5A Refurbishment Project - Project Team and Consumer / Carer Post-Design Review – consultation – October 2024
- Health and Disability Services Complaints Office (HaDSCO) Statutory Review, HaDSCO – submission – October 2024
- Review of LARU Standards, LARU – submission – December 2024
- Mental Health Commission Mental Health and Alcohol and Other Drugs Strategy - mental health workshop and submission – December 2024
- Kaatadjiny Walbraaniny Danjoo Project Report – submission – January 2025
- Armadale Health Service Mental Health Emergency Centre Planning – consultation – January 2025
- Review of Statewide Mental Health Bed Access, Capacity and Escalation policy, DoH – submission – February 2025
- 2025 - 2030 North Metropolitan Health Service Youth Mental Health Service Strategy – Youth Mental Health Service Project – consultation – April 2025
- Key Stakeholders on Exploring Alternate Models of Support for Large Congregate Licensed Private Psychiatric Hostels – workshop and consultation – April and May 2025
- Nous Focus Group with Casson Home Residents – Exploring Alternate Models of Support for Large Congregate Licensed Private Psychiatric Hostels – consultation – May 2025

Glossary of abbreviations, acronyms and terms

ACC	Adult Community Corrections
Advocate	Mental Health Advocate
CALD	Culturally and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Service
CCTV	Closed circuit television
Charter	Charter of Mental Health Care Principles
Chief Advocate	Chief Mental Health Advocate
CLMIA Act	*Criminal Law (Mentally Impaired Accused) Act 1996*
CLMI Act	*Criminal Law (Mental Impairment) Act 2023*
CLMI	Criminal Law (Mental Impairment)
CLO	Consumer Liaison Officer
CO	Custody order
Commission	Mental Health Commission
Communities	Department of Communities
Consumer	A person as defined by section 348 of the Mental Health Act 2014, who is eligible for advocacy services. This excludes residents of private licensed psychiatric hostels.
CSO	Community supervision order
CTO	Community treatment order, also called a Form 5A
Deputy Chief Advocate	Deputy Chief Mental Health Advocate
DP Act	*Declared Places (Mental Impairment) Act 2015*
DoH	Department of Health
DoJ	Department of Justice
DJC	Bennett Brook Disability Justice Centre
ED	Emergency department
First Nations	Refers to both Aboriginal and Torres Strait Islander Peoples in recognition of them as the original inhabitants of Australia.
FOI	Freedom of Information

Form 1A	Referral for examination by a psychiatrist
Form 3C	Continuation of detention to enable further examination by psychiatrist
Form 5A	Community treatment order
Form 6A	Inpatient treatment order in an authorised hospital
Form 6B	Inpatient treatment order in a general hospital
FTE	Full-time equivalent
HaDSCO	Health and Disability Service Complaints Office
HSP	Health Service Provider
ICMS	Integrated Client Management System, now upgraded to the Hub
Identified person	An unfit accused or supervised person within the criminal justice system who can access advocacy services under the *Criminal Law (Mental Impairment) Act 2023* Also, used when referring to the totality of people the MHAS work with, to indicate the group of people who are in legislative scope to engage with MHAS services
IDP	Individual development plan
ITO	Inpatient treatment order (including Forms 5A, 6A and 6B)
JHC	Joondalup Health Campus
KWD	Kaatadjiny Walbraaniny Danjoo project
LARU	Licensing and Accreditation Regulatory Unit, Department of Health
LGBTQIA+SB	People who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, or other diverse sexualities and gender identities, Sistagirls, Brotherboys
LOA	Leave of Absence Order
MH Act	*Mental Health Act 2014*
MHAS	Mental Health Advocacy Service
MHEC	Mental Health Emergency Centre
MHOA	Mental Health Observation Area
MHT	Mental Health Tribunal
MIARB	Mentally Impaired Accused Review Board
MIRT	Mental Impairment Review Tribunal
NDIS	National Disability Insurance Scheme
NUM	Nurse Unit Manager
OCP	Office of the Chief Psychiatrist
OGS	Other goods and services
Resident	A person residing in a private licensed psychiatric hostel, or at the Bennett Brook Disability Justice Centre.
RKP	Record Keeping Plan
RRFOC	Resources received free of charge
Senior Advocate	Senior Mental Health Advocate
SFMHS	State Forensic Mental Health Service
WHS Act	*Work Health and Safety Act 2020*

MHAS

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