



MENTAL HEALTH
ADVOCACY SERVICE

2025-2026

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.

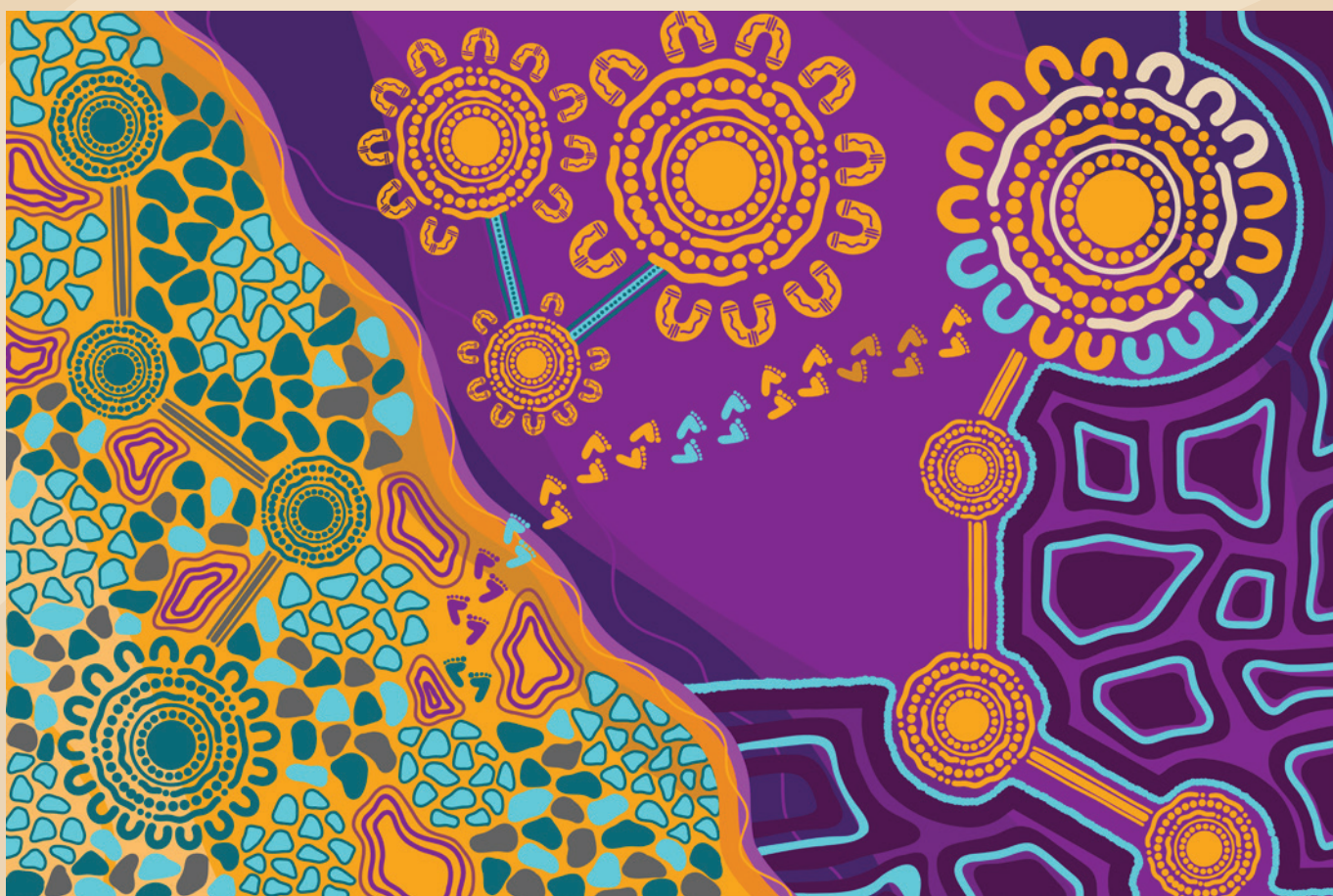
A note on terminology

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 licensed private psychiatric hostels.
- CLMI 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, depending on the context.

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.



The artwork 'Walking Together' used on the front cover of the annual report has been reproduced with the permission of the artist, **Rickesha Burdett**.

About the Artist

Rickesha Burdett is a Noongar artist and graphic designer from Albany on Menang Country, now based in Boorloo/Perth. Through her practice, Rickesha uses art as a way of connecting with culture, family and Country, creating contemporary work that draws on Noongar stories and traditional Aboriginal visual language.

About the Artwork

This artwork represents healing through difficult times – moving from sadness, stress and hard times towards hope, strength and connection.

The busy elements on the left reflect the complexity of people's experiences, their life stories and times when things can feel overwhelming or hopeless.

Footprints move across the artwork towards the larger yarning circle, representing people on their journey, with MHAS Advocates walking alongside them. The different coloured footprints reflect people from all backgrounds and the diversity of people the Mental Health Advocacy Service connects with.

This central yarning circle represents a safe place to support, care and connection with people. The larger patterns below this symbolise strength, while the surrounding meeting places in the artwork represent the communities across Western Australia that the Mental Health Advocacy Service works with and supports.

Behind the Artwork

The artwork story and concept were developed through initial conversations with Mental Health Advocacy Service workers and Aboriginal Elders and Youth. A collaborative workshop helped bring these voices together, ensuring Elders, Youth and MHAS workers played an important role in shaping the artwork and its meaning.



Hon Meredith Hammat MLA
**MINISTER FOR HEALTH; MENTAL
HEALTH; PREVENTATIVE 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 2026.

As well as recording the operations of the Mental Health Advocacy Service for the 2025-26 year, the report reflects on a range of issues that continue to affect people identified under the *Mental Health Act 2014*.

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 2026.

As well as recording the Mental Health Advocacy Service's second year of operations under the *Criminal Law (Mental Impairment) Act 2023*, the report reflects on a range of issues affecting identified persons with mental impairment in Western Australia, highlighting key themes and emerging trends in their experiences within the justice system.



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

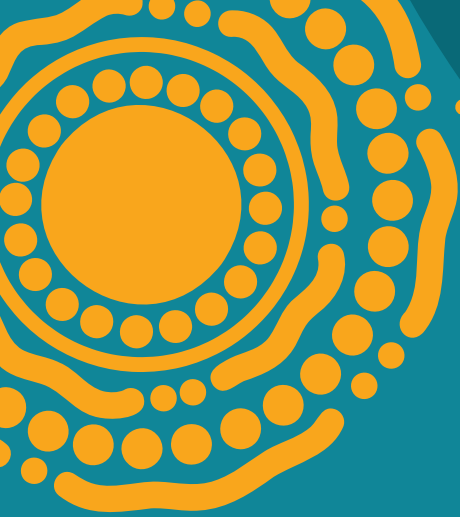
In accordance with section 56(3) of the
*Declared Places (Mental Impairment) Act
2015*, I submit for your information and
presentation to Parliament the Annual
Report of the Chief Mental Health Advocate
for the financial year ending 30 June 2026.

The report records the activities of
the Advocates who provided services
to residents of the Bennett Brook
Disability Justice Centre, a declared
place, during the 2025-26 year.



Dr Sarah Pollock
CHIEF MENTAL HEALTH ADVOCATE

September 2026



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Chief Advocate's foreword

Welcome to the eleventh annual report of the Mental Health Advocacy Service (MHAS). November 2025 marked the tenth year of operation under the *Mental Health Act 2014*. However, rights protection in mental health has a much longer history. The Lunacy Act 1871 obliged 'visitors' to attend every 'asylum' each week and inquire into 'systems of non-coercion', the conditions of 'pauper' patients and the occupation and 'amusements' provided for them.

More recently, the Council of Official Visitors was established under the Mental Health Act 1996 to protect the rights of involuntary patients, whether in hospital or community. Visitors also had an inspection function to identify gaps in mental health services. The *Mental Health Act 2014* further strengthened the rights of and safeguards for people being treated coercively and expanded the functions and powers of Advocates.

Since MHAS' inception in November 2015, demand for advocacy has steadily grown and the number and complexity of the issues Advocates respond to have increased. MHAS' capability in individual and systemic advocacy has developed and our stakeholder relationships in the clinical and non-government service sectors have strengthened. Our *Criminal Law Mental Impairment Act 2023* service continues to evolve and its stakeholder relationships mature.

Of the systemic issues highlighted in the first MHAS annual report, a number are reported again this year: bed pressure and the associated lack of appropriate accommodation and care in the community, access to specialist inpatient treatment for children aged 16-17 years and the conditions in licensed

Dr Sarah Pollock

CHIEF MENTAL
HEALTH ADVOCATE

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psychiatric hostels and their oversight and governance. The systemic issues we report on in relation to the *Criminal Law Mental Impairment Act 2023* are similarly predictable. A critical lack of forensic beds, delayed access to assessment reports and lengthy stays in prison without access to comprehensive mental health treatment threaten to undermine the promise of the reforms. And lastly, the excellent Bennett Brook Disability Justice Centre remains woefully under-utilised.

In response to the increased demand and complexity, MHAS received an increase in funding in 2025-26. This will help to address the demand pressures in future years. However, a historical deficit in funding continues to place a strain on service delivery.

I offer my thanks to the people we work with in the various services and agencies. I thank them for their willingness to work with us to achieve better outcomes for identified persons and their families. I know they want to see wider changes as much as we do.

Finally, while Advocates achieve positive outcomes for identified persons every day, it can be disheartening and difficult to maintain momentum when longstanding issues seem to show little sign of change. I thank our Advocates and the public servants who support MHAS, for their commitment and tenacity.



Executive summary

The 2025-26 financial year was one of consolidation, capability building and managing increasing service demand for MHAS.

Following the significant organisational growth and restructuring of the previous year, MHAS focused on embedding its new structure, strengthening governance and workforce capability, improving safe systems of work, and building the relationships required to support sustainable advocacy across Western Australia's mental health, criminal justice and disability justice systems. The year also marked the tenth anniversary of MHAS, providing an opportunity to reflect on a decade of independent advocacy and the continuing importance of safeguarding the rights of identified persons.

Demand for independent advocacy continued to grow. During 2025-26, MHAS supported 5,379 identified persons and Advocates delivered 53,114 hours of advocacy and related work across its three legislative service streams, representing a 16.9 per cent increase from the previous year. In addition to these recorded advocacy hours, Consumer Liaison Officers, Team Leaders and other MHAS workers provided direct support to identified persons, highlighting the broader organisational effort required to deliver advocacy services. The number of issues recorded across all three streams increased by 82.1 per cent to 21,613, reflecting both increasing service demand and the complexity of matters being raised, noting that operational changes also impacted these figures.

Advocacy throughout the year continued to highlight issues relating to safety, access to treatment and care, restrictive practices, procedural fairness, legislative compliance and the experiences of children, young people and other vulnerable groups. Identified persons consistently emphasised the importance of being heard, treated with dignity and respect, and supported to participate in decisions affecting their lives.

Through individual and systemic advocacy, MHAS achieved meaningful outcomes for people and contributed to broader service improvements. Advocacy resulted in amendments to medical records, improved communication with identified persons and families, access to treatment and accommodation, environmental improvements, staff education, formal investigations, and changes to policies, processes and practices. Advocacy also contributed to strengthened incident reporting, greater scrutiny of restrictive practices, improvements in ward conditions, safety management and better access to necessities and support.

The first full year of operation under the *Criminal Law (Mental Impairment) Act 2023* (CLMI Act) provided important insight into how the new framework is working in practice. MHAS received



**Thank you so
much for the
care & support
you give me.**

RESIDENT

519 notifications relating to 343 individuals. Overall, MHAS worked with 406 CLMI identified persons under the CLMI Act during 2025-26, including those who first entered the service in the previous reporting period. Advocates delivered 10,314 hours of advocacy, a 56.8 per cent increase from the previous reporting period. Advocacy activity increased across court proceedings, Mental Impairment Review Tribunal (MIRT) reviews and Community Supervision Orders (CSOs). However, CLMI identified persons continued to experience significant delays in court processes, assessments, access to treatment, accommodation and rehabilitation pathways, as well as challenges navigating multiple health, justice, disability and community service systems.

A major area of systemic advocacy during the year concerned access to mental health treatment for people in prison. Drawing on evidence from individual advocacy, engagement with prisoners and CLMI identified persons, forensic mental health information and stakeholder consultation, MHAS identified significant barriers to timely assessment, treatment and admission for prisoners with serious mental illness. In collaboration with the Office of the Chief Psychiatrist (OCP) and the Office of the Inspector of Custodial Services (OICS) and informed through engagement

with the Mental Health Tribunal (MHT), Health and Disability Services Complaints Office (HaDSCO) and other stakeholders, MHAS undertook a major program of systemic advocacy examining prisoner access to mental health care. This work reinforced the need for coordinated action across prison mental health services, forensic and civil hospitals, community treatment, disability supports, accommodation, transition services and cross-agency governance. This advocacy is ongoing.

Organisational capability remained a significant priority throughout the year. MHAS continued to strengthen its workforce, governance, work health and safety, enterprise risk management, data capability and operational systems to support a larger and increasingly complex statutory scope. MHAS also strengthened relationships with Aboriginal Elders and youth, people with lived and living experience, identified persons, community organisations and sector stakeholders. These relationships informed service development, enhanced cultural capability and helped ensure that the perspectives of these communities remained central to MHAS' work.

The growth in service demand was accompanied by significant pressure on the workforce and the organisation's operating model. Advocates and staff worked in increasingly complex and high-risk environments, responding to substantial growth in serious issues, safeguarding matters, distressing communications and multi-agency cases. Recruitment challenges, workforce capacity constraints, exposure to traumatic material and the need for stronger safety, supervision, wellbeing and risk-management arrangements, remain important organisational challenges. MHAS responded through structured training, peer reflective practice, risk assessments, improved escalation pathways and tailored workforce supports.

MHAS recorded expenditure of \$10.08 million against a budget of \$8.94 million, resulting in an overspend of \$1.14 million, or 13 per cent. The variance was primarily associated with salary expenditure, including unfunded positions necessary to meet legislative requirements and salary indexation not automatically incorporated into MHAS funding.

The Mental Health Advocacy Service 2025-26

The MHAS is an independent statutory office established under the *Mental Health Act 2014* (the MH Act) to protect the rights and amplify the voices of people using or seeking to use mental health services and people with mental impairment in the criminal justice system. MHAS provides advocacy across Western Australia under the MH Act, the CLMI Act and the *Declared Places (Mental Impairment) Act 2015* (DPMI Act).

What we do

Independence is central to the work of MHAS. The service operates independently from mental health services, hospitals, hostels, courts, prisons and other justice agencies, enabling Advocates to act in accordance with the rights, needs and preferences of the people they support. This independence promotes trust and confidence among identified persons, families, services, and government.

The people MHAS works with are experiencing some of the most vulnerable periods of their lives. They may be receiving involuntary mental health treatment, navigating complex legal processes, living in a declared place, or trying to understand and exercise their rights within systems that can be difficult to access and influence. Advocacy provides an important safeguard by helping people understand and access their rights, express their views, and participate in decisions that affect them.

MHAS occupies a unique position within Western Australia's mental health and criminal justice systems. Through daily contact with identified persons, families, mental health services, justice agencies and community organisations,

MHAS gains valuable insight into how legislation, policies and services are experienced in practice. This frontline perspective assists MHAS to identify emerging issues, highlight barriers to equitable access and draw attention to areas where policy, practice or service delivery may require improvement.

While individual advocacy remains at the heart of the organisation's work, MHAS also contributes to system quality, accountability and reform through inquiries, investigations, identified persons' complaints, stakeholder engagement and systemic advocacy. By connecting individual experiences to broader patterns and trends, MHAS supports learning and improvement across the sectors in which it operates.

MHAS delivers value to a wide range of stakeholders. For identified persons, it provides independent support during periods of significant vulnerability. For health services and justice agencies, it contributes to safer, more responsive and rights-focused services. For government, it provides independent oversight that supports transparency, accountability, and public confidence.

Our impact in 2025-26

5,379

People we supported¹



5,331

Involuntary treatment orders²



24

Education sessions on consumer rights and the role of the MHAS



1,491

Mental Health Tribunal hearings attended³



104

Mental Impairment Review Tribunal hearings attended⁴



683

Serious issues⁵



106

Complaint letters



47

Inquiry letters



21,613

Issues raised by identified persons



10,056

Calls answered by Consumer Liaison Officers



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 2025 and 30 June 2026.

² Involuntary treatment orders include inpatient treatment orders made in authorised hospitals and general hospitals, and CTOs.

³ Data provided by the MHT for 2025-26.

⁴ The MIRT attendance figures reported for 2025-26 may not fully reflect all Advocate participation. Differences in Advocate recording practice and limitations associated with the Hub data on MIRT-related tasks may have impacted the accuracy and completeness of the data.

⁵ A serious issue is an actual or alleged incident, risk, or circumstance that may significantly impact a consumer's health, safety, wellbeing, dignity, or rights and requires prompt assessment, escalation, and investigation.



Consolidation, capability and connection

The 2025-26 financial year was a year of consolidation and renewal for MHAS. Following the significant changes of 2024-25, including the commencement of the CLMI Act service, implementation of a new organisational structure and relocation to new offices, the focus shifted to embedding these changes and strengthening the systems, relationships and capabilities needed to support sustainable and well-governed service delivery.

Recruitment and deployment under the new structure were central to this work. Recruitment took place across both advocacy services and advocacy support services, strengthening the advocacy workforce and the public service functions that underpin effective statutory advocacy. Recruitment aimed to build organisational capacity, clarify responsibilities and ensure MHAS had the capability to meet its expanded mandate.

A strong focus was placed on governance, safe systems of work and consistent advocacy delivery. This included strengthening internal processes, responding to workforce feedback and alignment of operations with MHAS' extended obligations under the *Work Health and Safety Act 2020* (WHS Act), the needs of the people MHAS supports and the legislative environment in which the service operates. The year was marked by a deliberate shift from implementation to consolidation, with attention given to the structures, safeguards and practices that enable Advocates and staff to undertake their work safely, efficiently and to a consistent standard.

MHAS invested in leadership development, practice improvement, corporate support functions and service delivery capability. This work recognised that a larger and more complex organisation requires stronger internal systems, clearer guidance, and ongoing development opportunities for MHAS workers. Building capability supported workforce wellbeing and the quality of advocacy provided to identified persons.

During the year, MHAS continued to strengthen engagement with Ministerial offices, government agencies, health services and justice partners. These relationships are critical to the organisation being able to raise issues early, support system accountability and contribute constructively to service improvements. They also help ensure that the experiences of identified persons remain visible in policy, operational and reform discussions.

Top row, left to right: **Hon Meredith Hammat MLA**, Minister for Health; Mental Health, and **Dr Sarah Pollock**, Chief Mental Health Advocate.

Bottom row, left to right: Elders **Aunty Cheryl Phillips**, **Aunty Sandra Wilkes** and **Uncle Peter Wilkes**.



Celebrating 10 years of MHAS

The end of 2025 marked ten years since the establishment of MHAS in November 2015.⁶ This milestone was celebrated at an event attended by the Minister for Health; Mental Health; Preventative Health, the Hon Meredith Hammat MLA, Commissioners and Directors General, current and former Advocates, service leaders, MHAS service users and people with lived and living experience. MHAS was also honoured to be joined by Aboriginal Elders Uncle Peter Wilkes, Aunty Sandra Wilkes, Aunty Cheryl Phillips and Assoc. Professor Michael Wright whose guidance and leadership have been instrumental in supporting MHAS' cultural capability. The event was more than a celebration of organisational history. It brought together many of the people and systems that contribute to an identified person's journey, reflecting the importance of partnership, listening and shared responsibility in achieving safer and more humane services.

Together, these developments made 2025-26 a year of consolidation, capability building and organisational maturity. The work undertaken during the year strengthened MHAS' governance, workforce and stakeholder relationships, ensuring the organisation remains well placed to deliver high-quality advocacy while keeping the rights, voices and experiences of identified persons at the centre of its work.

Dr Sarah Pollock, Chief Mental Health Advocate.



Hon Meredith Hammat MLA, Minister for Health; Mental Health.

Left to right: Elders **Uncle Peter Wilkes**, **Aunty Sandra Wilkes**, Assoc. Professor **Michael Wright** and **Aunty Cheryl Phillips**.

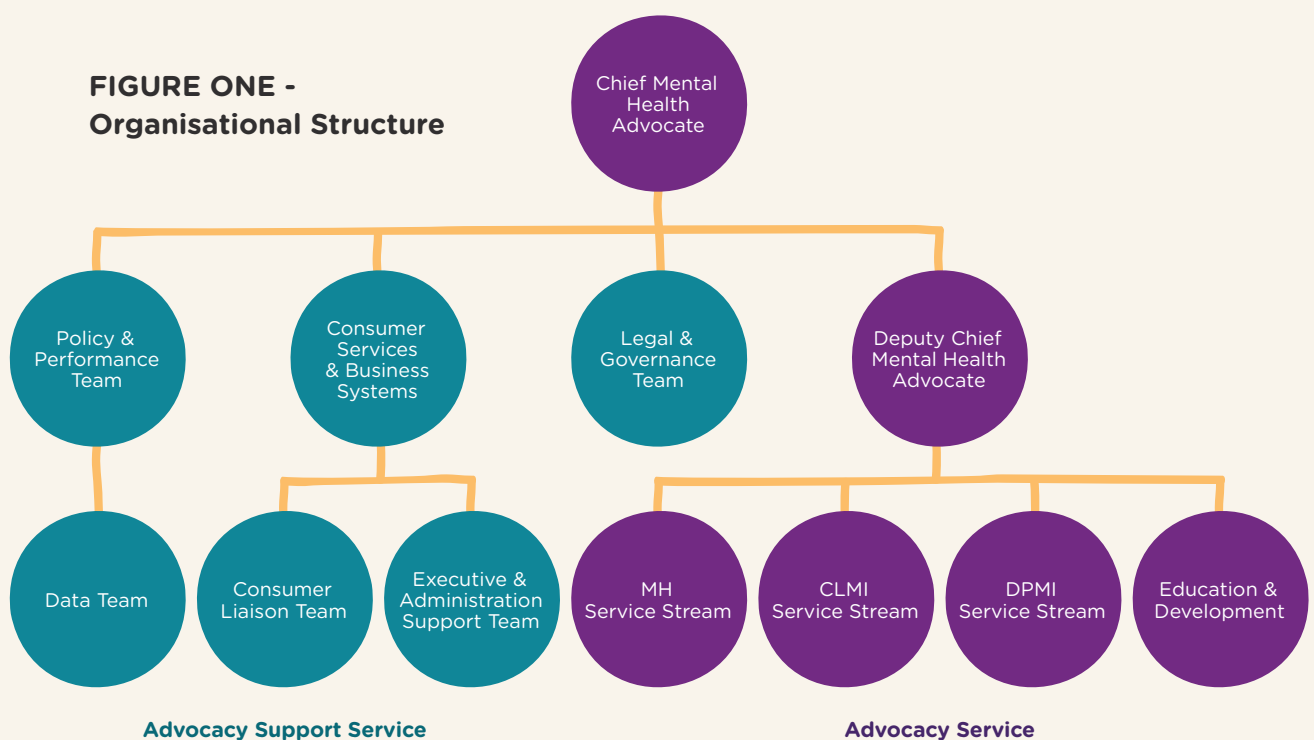


⁶ The Council of Official Visitors operated under the Mental Health Act 1996 and its functions protected the rights of consumers. The *Mental Health Act 2014* established the Office of the Chief Mental Health Advocate and continued and expanded those functions.

MHAS workforce structure and service delivery

The quality and reach of MHAS' advocacy relies on a skilled, diverse and supported workforce.

**FIGURE ONE -
Organisational Structure**



Thanks for your ongoing support.
I appreciate your empathy, validation
and listening. You have made me feel
heard, supported and like an actual
individual and human being.

RESIDENT

Advocacy services

In 2025-26, Advocates delivered 53,114 hours of advocacy and related work across the MH Act, CLMI Act and DPMI Act services. This represented a 16.9 per cent increase from the 45,453 hours delivered in 2024-25 and included direct advocacy, travel, on-call and call-out work. Of these hours, 42,802 related to advocacy provided under the MH Act, an increase of 2.5 per cent compared with the previous year. Demand continued to increase during the year, with the number of MH Act consumer issues recorded increasing by 77.1 per cent compared with the previous year.⁷

Under the MH Act, 3.8 FTE Team Leaders delivered 6,460 hours of work in 2025-26. While responsible for operational management and support of Advocates, Team Leaders also undertake substantial direct advocacy work. Approximately half of their time is dedicated to advocacy, primarily involving complex matters, complaints, inquiries and systemic issues.

Advocates also delivered 10,314 hours of advocacy under the CLMI Act, representing a 56.8 per cent increase in service delivery compared with the previous year and reflecting the continued growth of the service in its first full financial year.

As at 30 June 2026, the advocacy service comprised:

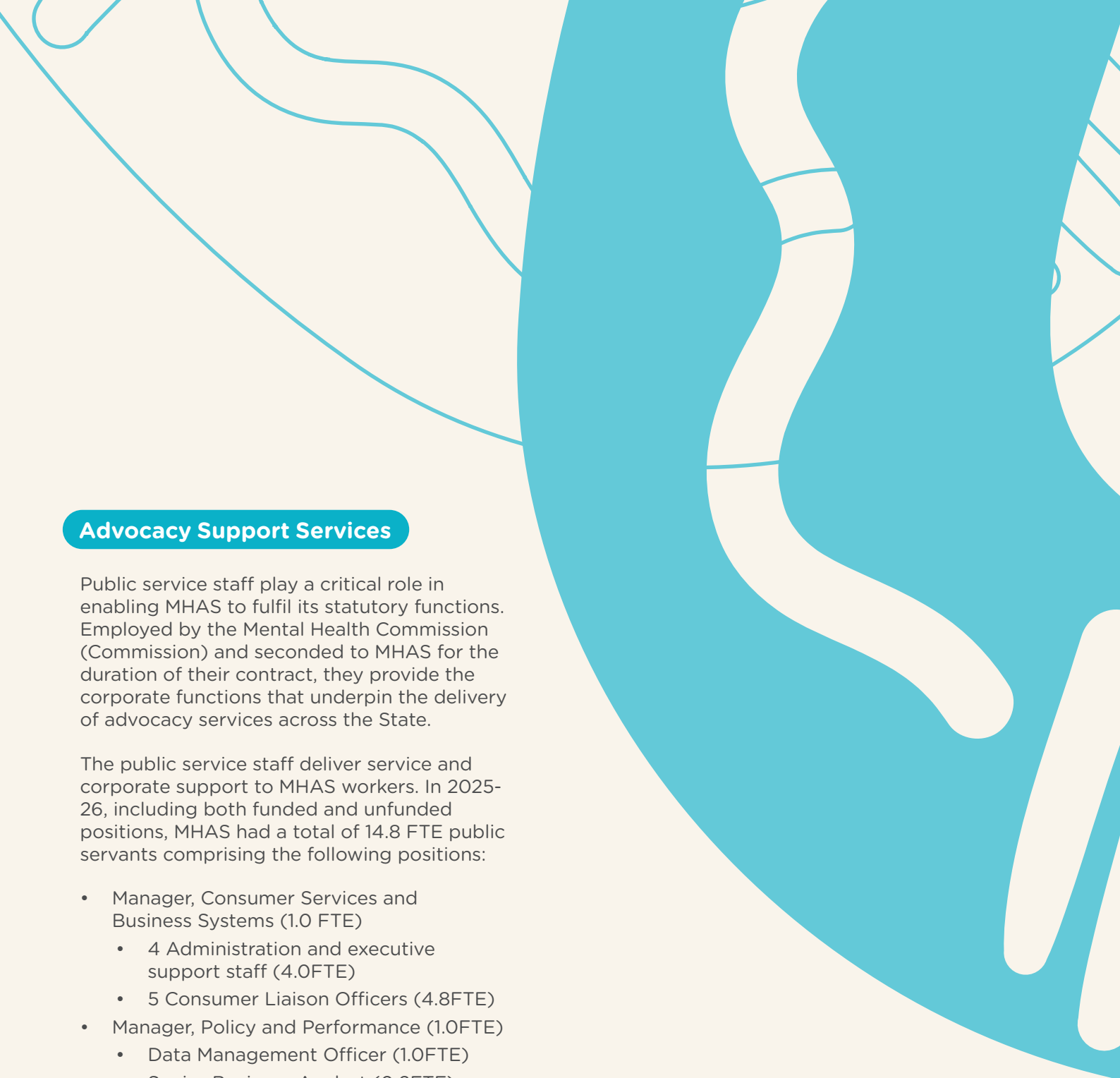
- Chief Mental Health Advocate (Chief Advocate)
- Deputy Chief Mental Health Advocate (Deputy Chief Advocate)
- Seven Senior Mental Health Advocates (Senior Advocates)
- Five Team Leaders
- Fifty-three Advocates
- Three Advocates on long term unavailability



⁷ Several factors are likely to have contributed to the increase in issues recorded by MHAS during 2025-26. These include improved data capture, increased advocacy capacity, greater awareness among consumers of their rights and available advocacy support, the expansion of CLMI advocacy responsibilities, and the increasing complexity of matters requiring advocacy intervention. The increase may therefore represent a combination of improved identification and reporting of issues, increased advocacy engagement, and changes in the number and nature of concerns raised by consumers.

FIGURE TWO – Facilities where Advocates delivered advocacy services in 2025-26





Advocacy Support Services

Public service staff play a critical role in enabling MHAS to fulfil its statutory functions. Employed by the Mental Health Commission (Commission) and seconded to MHAS for the duration of their contract, they provide the corporate functions that underpin the delivery of advocacy services across the State.

The public service staff deliver service and corporate support to MHAS workers. In 2025-26, including both funded and unfunded positions, MHAS had a total of 14.8 FTE public servants comprising the following positions:

- Manager, Consumer Services and Business Systems (1.0 FTE)
 - 4 Administration and executive support staff (4.0FTE)
 - 5 Consumer Liaison Officers (4.8FTE)
- Manager, Policy and Performance (1.0FTE)
 - Data Management Officer (1.0FTE)
 - Senior Business Analyst (0.6FTE)
- General Counsel (0.6FTE)
 - Senior Legal Counsel (1.0FTE)
 - Principal Project Officer, Work Health and Safety (1.0FTE)

Public service staff provide specialist expertise in consumer support, administration, legal services, policy, performance, governance and business operations. Together with Advocates, they are integral to MHAS' ability to fulfil its statutory functions and respond to the needs of consumers and the broader mental health system.

Recruitment and induction

During 2025-26, MHAS completed four recruitment campaigns. These comprised two major Advocate recruitment campaigns, targeted recruitment for an Aboriginal Advocate and a regional Advocate, and recruitment and training of Consumer Liaison Officers (LO) and administrative support staff. These activities supported workforce growth, service sustainability and capability development across the organisation.

Workforce diversity and inclusion

For MHAS, diversity is more than a workforce measure. The people the organisation supports come from a wide range of backgrounds and experiences. A workforce that brings diverse perspectives, identities and lived experiences strengthens the ability to listen, understand and advocate effectively.

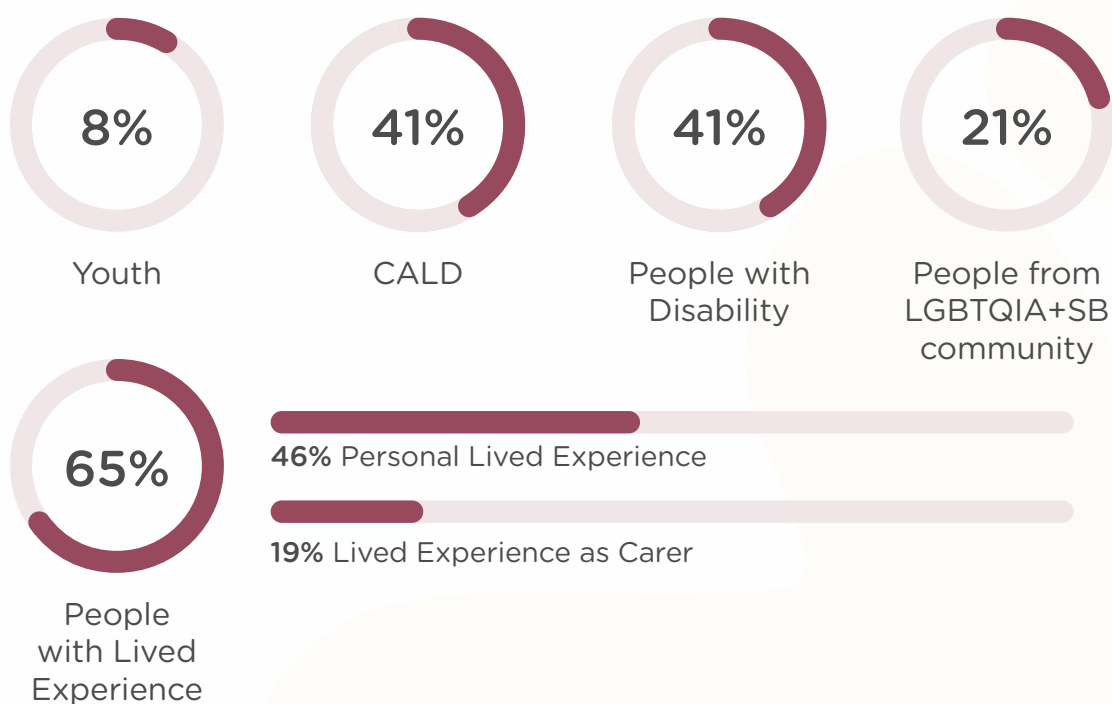
In 2025-26, MHAS repeated its workforce diversity survey following the inaugural survey conducted in 2024-25. The survey sought to capture workforce diversity across several key areas: youth⁸, First Nations, Culturally and Linguistically Diverse (CALD)⁹ backgrounds, Lived Experience¹⁰, disability¹¹, and LGBTQIA+¹² identities. The survey formed part of a broader focus on strengthening organisational capability following the implementation of the new organisational structure and supporting an inclusive workplace where people feel safe, valued and able to contribute.

Thirty-four MHAS workers completed the survey, representing 40 per cent of the workforce.

The survey highlighted the diversity that exists across MHAS' workforce. Respondents belonged to a range of age groups, cultural backgrounds, disabilities, LGBTQIA+ identities and lived experience. More than half of respondents identified some form of lived experience, either personal lived experience, as a carer, or both. Forty-one per cent of respondents identified as being from a CALD background, and 41 per cent identified as living with a visible or hidden disability.

The survey findings reinforced the importance of continuing MHAS' work to strengthen cultural capability and inclusion. This included ongoing engagement with Aboriginal Elders and younger community members, and continued efforts to embed culturally safe and inclusive practices across the organisation. The findings will help inform future workforce initiatives as MHAS continues to strengthen its culture, capability and responsiveness to the diverse communities it serves.

FIGURE THREE - MHAS workforce diversity



⁸ Younger than 24 years old for the purpose of this survey only.

⁹ 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.)

¹⁰ As per the Western Australian Lived Experience (Peer) Workforces Framework 2015-2024, Lived Experience describes an individual who has had a personal life-changing 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.

¹¹ 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.

¹² LGBTQIA+ refers to people who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, other diverse sexualities and gender identities.

Key organisational focus areas in 2025-26

Following implementation of MHAS' new organisational structure in 2024-25, the focus in 2025-26 shifted to strengthening the foundations required to support a larger and more complex service. This work was undertaken in a deliberate and consultative manner, with particular attention to legislative obligations, workforce safety, governance, data quality, practice consistency and the relationships necessary to support effective advocacy.

The following areas reflect key components of this foundation-building work. Together, they contributed to MHAS' organisational maturity and enhanced its capacity to deliver safer, more consistent and effective advocacy for identified persons across Western Australia's mental health and justice systems.

Education and development

In 2025-26, MHAS established a dedicated education and development function to strengthen workforce capability across the organisation. While a standalone education position was not approved through MHAS' budget submission to Department of Treasury and Finance, MHAS allocated a dedicated Senior Advocate position to lead this work, recognising the importance of building internal capability while working within available resources.

The function focused on improving Advocate recruitment, induction, training and practice improvement, in alignment with the Public Sector guidelines and requirements to ensure consistency across all of MHAS.

A revised induction program was introduced for new Advocates, incorporating smaller intake groups in response to feedback from workers and previous inductees, updated

presentations, practical case studies and collaborative workshops. Induction and training programs were also developed and delivered for Senior Advocates, Team Leaders and LOs, supporting implementation of the new organisational structure and improving confidence in systems, processes and practice from commencement.

Work also commenced on a whole-of-organisation learning framework, including assessment of learning management systems, development of a practice audit process for MHAS' client management system (the Hub), delivery of stakeholder education sessions, development of an Advocate practice framework and planning for organisation-wide training initiatives. This work supported more consistent practice, improved data quality, greater stakeholder understanding of MHAS' role and more comprehensive support for Advocates and staff.

Work health and safety and risk

As MHAS has grown and its legislative responsibilities have expanded, the organisation has required a structured approach to work health and safety (WHS) and risk management. In 2025-26, MHAS commenced the development of an integrated WHS and enterprise risk management framework that better reflects the organisation's size, complexity and operating environment.

A comprehensive review of the WHS management system was undertaken to assess alignment with the WHS Act and supporting legislation. The review examined governance arrangements, consultation processes, incident and hazard reporting, risk management, training, assurance activities and system documentation.

WHS risk assessments were also completed for all service delivery roles, informing the development of a WHS improvement action plan focused on strengthening controls, enhancing worker safety and supporting wellbeing.

In parallel, MHAS progressed development of an enterprise risk management framework to support a more consistent and organisation-wide approach to identifying, assessing and managing risk. This work supports stronger governance, more informed decision-making and proactive management of risks affecting workers, identified persons and service delivery.

MHAS also continued to invest in worker wellbeing through access to a free employee assistance program, tailored peer reflective practice sessions for our consumer-facing workforce, and trust and team-building activities facilitated by external consultants.

These initiatives supported a safe, healthy and collaborative workplace culture.

Policy, performance and data

The Policy and Performance team was established in 2025-26 to strengthen MHAS' capability in reporting, data management, privacy, information management and policy development. The creation of this function was an important step in building organisational maturity and strengthening the systems, governance and accountability arrangements that underpin statutory advocacy. The team also plays a critical role in supporting routine reporting to health services, government agencies and Ministerial offices.

Significant work was undertaken to prepare MHAS for the implementation of the *Privacy and Responsible Information Sharing Act 2024*, coming into effect on 1 July 2027. This included development of policies, guidance materials, privacy decision-making tools, breach management processes and governance arrangements to support organisational readiness and compliance.

A new framework was also developed for ministerial, executive and stakeholder reporting, including quarterly reporting on Health Service Providers (HSPs), licensed private psychiatric hostels and matters relating to advocacy activities and issues for the CLMI Act.

Responsibility for MHAS client management system, the Hub, also sits within this function. During 2025-26, work continued on implementation of the Data 2.0 program. Work included strengthening data governance, development of reporting guidance for users, and preparation for Power BI reporting and dashboards for internal stakeholders. Enhancements to the Hub Dynamics 365 application were also progressed to support a more rights-based reporting framework. Collectively, these initiatives are expected to strengthen data quality and consistency, improve MHAS' ability to evidence outcomes for identified persons and advocacy impact, and support identification and reporting of systemic issues.

Working with First Nations

and community

MHAS' engagement with Elders and community members continued to strengthen in 2025-26. This work builds on the Kaatadjiny Waalbraniny Danjoo project, meaning 'learning to heal together', and reflects MHAS' ongoing commitment to building relationships, strengthening cultural capability, and delivering culturally responsive advocacy for First Nations consumers.

During the year, MHAS continued to work with Elders Aunty Cheryl Phillips, Aunty Sandra and Uncle Peter Wilkes and younger community members Jamie and Tiana Culbong. Their involvement has supported MHAS' continuing efforts to embed cultural practice across the organisation, strengthening the way it builds relationships, welcomes new workers and reflects on its roles and responsibilities. The engagement has supported workers to better understand the experiences of First Nations people and the importance of cultural safety and relational ways of working with consumers, families and communities.

MHAS also partnered with an Aboriginal design agency and an Aboriginal artist to develop an artwork that reflects MHAS' values, story and identity. The artwork featured throughout this annual report is the result of that collaboration and will continue to form part of how MHAS presents itself and communicates its purpose. The project reflects the importance of First Nations' voices, stories and perspectives in shaping the way MHAS understands and expresses its role.

Engaging youth

MHAS is committed to creating meaningful opportunities for young people to contribute, learn and develop practical skills within the public sector. In 2025-26, MHAS partnered with the McCusker Centre for Citizenship at the University of Western Australia for the second consecutive year, hosting four Communications interns across different semesters. Through their placements, interns gained valuable real-world experience in communications, stakeholder engagement, digital content development and public sector operations, while contributing to projects that support MHAS' services.

The partnership delivered mutual benefits for both the students and MHAS. Interns brought fresh perspectives, creativity and enthusiasm to communication initiatives, while gaining practical insights into mental health advocacy, engagement with identified persons and the role of government services in supporting vulnerable Western Australians. The initiative also reinforced MHAS' commitment to fostering positive youth engagement and creating pathways for young people to develop professional skills, confidence and community awareness.



I think I can speak for all of the regular members of the [Mental Health Service] treating team in saying that your calm, professional and assertive advocacy has been noticed and valued by us (and more importantly, I think also your clients).

CLINICIAN

The Consumer Liaison Officers team

The Consumer Liaison Officers team plays a vital role in connecting identified persons with advocacy support and directing non-identified people who fall outside MHAS' scope to appropriate services and supports.

During 2025-26, MHAS focused on strengthening the capacity, safety and capability of the LO team. A new Consumer Liaison Coordinator position commenced in September 2025, providing dedicated leadership and support to the Senior LO and three LOs. This focus reflected the importance of the liaison function as the primary access point to MHAS for many identified persons, families and carers.

Given the nature of the role and the risks associated with responding to what are often complex and distressing calls, MHAS placed a greater emphasis on supervision, WHS, and capability development. A team-specific risk assessment and risk management plan were completed, supported by new processes for escalations, threatening communications and people expressing suicidal ideation. A comprehensive training manual and onboarding package were also developed, complemented by mentoring, coaching and regular feedback. Together, these initiatives improved consistency, staff confidence and safety.

FIGURE FOUR – How Consumer Liaison Officers support access to MHAS

1

First point of contact

Accessible entry point
Information and guidance
Identifying needs

2

Triage and pathway support

Assess urgency and risk
Identify legal status and location
Direct to the appropriate service pathway or referral to external support

3

Continuity across contact channels

Calls and voicemails
Emails, letters, inboxes
Structured rostering and service continuity across business days

4

Early identification of identified persons

Monitor statutory forms
Identification of new identified persons
Actioning notifications that require follow-up

5

Safe and responsive practice

Escalation pathways and safety processes
Staff support and capability building
Consistent responses to complex or high-risk situations

6

Learning from identified persons

Monitor enquiry and demand trends
Seeking to understand the needs of identified persons and their families
Inform service planning and improvement

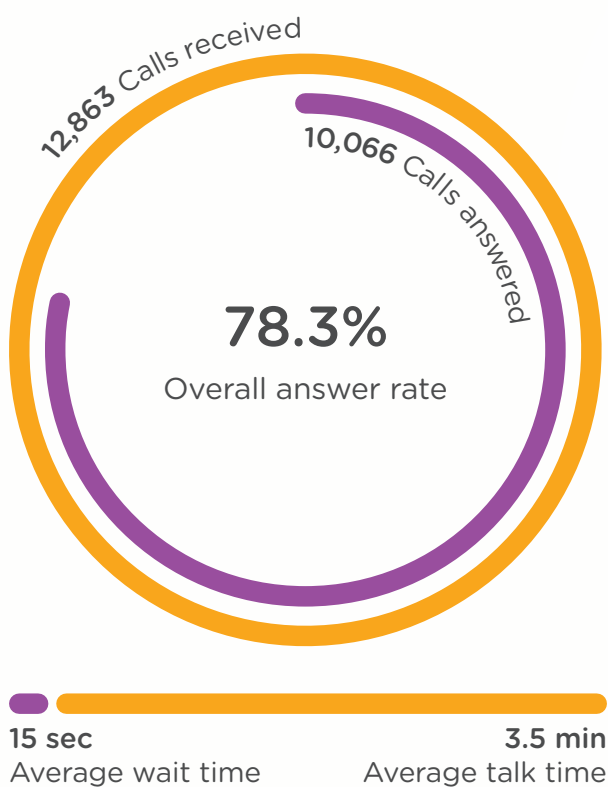
Consumer Liaison Officers Team call management and flow

Call data collected from 23 July 2025 to 30 June 2026 provides a practical measure of demand for the service and the responsiveness of the liaison function during the reporting period.

The LO team managed a substantial volume of incoming calls while maintaining short average wait times. Demand was highest at the beginning of the working week, with Mondays recording the highest numbers of both answered and abandoned calls. Despite this increased demand, average wait times remained low throughout the week, ranging from 14 to 18 seconds.

Unanswered calls that go to voicemail are attended to by the LO team through a call back system.

FIGURE FIVE - Call volume and wait times¹³



¹³ Data captured from 23 July 2025 till 30 June 2026.

Mental Health Act Service

MHAS provides independent advocacy to people who are subject to, or at risk of being subject to, compulsory processes under the MH Act. 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.

Advocates support a broad range of people, including people on inpatient or community treatment orders, people referred for psychiatric assessment, certain voluntary patients, and residents of licensed private psychiatric hostels. Mental health services are required to notify the Chief Advocate when a person becomes subject to an involuntary order and Advocates must make contact within the legislated timeframes.

Advocacy is guided by the wishes, rights and preferences of the person. Advocates work directly with consumers and residents to identify concerns, support participation in decisions affecting them, and seek resolution of issues relating to their treatment and care. They may also assist consumers and residents to access complaints processes, legal services and other supports.

In addition to providing individual advocacy, Advocates undertake investigations and inquiries under the MH Act. They may inquire into and investigate conditions of mental health services that affect, or may affect, the health, safety and wellbeing of consumers or residents. They may also inquire into and investigate the extent to which people have been informed of their rights by mental health services, and the extent to which those rights have been observed.

To support these functions, the MH Act provides Advocates with broad powers of access to people, places and records, and requires mental health services to provide reasonable assistance in the exercise of Advocates' duties. These powers enable Advocates to independently gather information, engage directly with consumers, residents and staff involved in their treatment and care to monitor service conditions and pursue resolution of complaints. Where issues remain unresolved, matters must be escalated to the Chief Advocate, who has additional powers to address systemic and intractable concerns.

Who we worked with and the issues they raised

Like previous years, demand for MHAS advocacy services increased in 2025-26. Almost 5,000 people were assisted by Advocates, equating to an increase of 13 per cent from the previous year and 38 per cent over the last five years. This consistent growth occurred alongside increasing pressures across Western Australia's mental health system.

TABLE ONE – The number of consumers, and their reported issues and complaints, increased again in 2025-26

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	Change
Total number of identified consumers	3,132	3,141	3,427	3,605	3,454	3,919	4,102	4,393 ¹⁴	4,970	▲ 13.1%
Number of issues and complaints recorded by Advocates¹⁵	7,373	5,081	8,970	7,581	7,226	9,937	10,610	11,689	20,704	▲ 77.1%



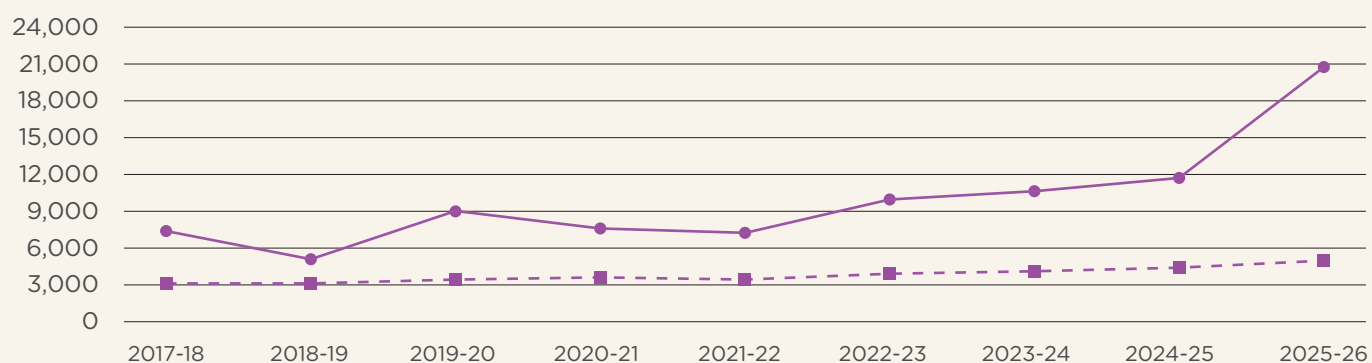
¹⁴ Figures for 2024/25 include consumers assisted on Custody Orders up until the commencement of MHAS' work under the CLMI Act on 1 September 2024. Any consumers assisted on Custody Orders (or any other category of CLMI Act identified person) after 1 September 2024 are not counted in this total but are reflected in the figures reported in later tables.

¹⁵ These totals are for Issues and Complaints raised on a consumer's behalf. They do not include general issues raised regarding facilities that were not related to a particular consumer.

There was also a significant increase in the number of issues and complaints recorded by Advocates, rising to 20,704, a 77 per cent increase from 2024-25. As a result, the average number of issues per consumer or resident also increased considerably, from 2.66 to 4.17. A greater practice focus on identifying and recording complaints contributed to this increase but does not explain the full extent of the growth. It also reflects the increasing complexity of peoples' circumstances and a rise in concerns about the care and treatment provided by mental health services, requiring more intensive advocacy intervention and greater time commitments from both Advocates and Team Leaders. Together with the 13 per cent increase in people assisted, the figures indicate a substantial increase in the volume of matters requiring advocacy support during 2025-26.

FIGURE SIX - The frequency of consumer issues and complaints in 2025-26 grew markedly on previous years

—●— Issues & Complaints
-■- Identified Consumers



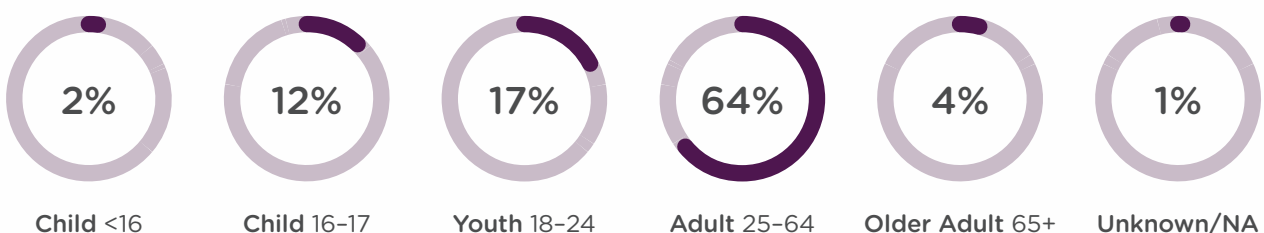
The issues consumers faced

MHAS' role is to support consumers and residents, ensure their voices are heard, protect their rights and assist them to address concerns about their treatment, care and circumstances. The issues reported in this section reflect concerns, experiences and allegations that consumers raised with Advocates, as well as matters identified through advocacy engagement. Advocates take these matters seriously and work with the person and relevant services to understand the concern, obtain relevant information, promote safety and wellbeing, and support an appropriate service response. In many cases, advocacy results in action being taken by services to address concerns, improve communication, provide additional information and explanation, review decisions or implement other changes. Advocates monitor and follow up matters and, where necessary, escalate concerns within the service or through MHAS. The data therefore provides important insight into the experiences of people receiving treatment and care and the issues requiring advocacy intervention. It does not, however, represent formal findings regarding individual allegations or establish the prevalence of issues across the wider mental health system.

As with previous years, consumer and resident issues and complaints data¹⁶ from 2025-26 provided valuable insight into the lived experiences of West Australians navigating the statutory mental health system. The data indicated notable increases across several areas of care and treatment and highlighted a concerning surge in issues and complaints classified by MHAS as 'serious'. MHAS classifies some issues and complaints as 'serious issues' where the matter involves an actual or alleged incident, risk or circumstance that may significantly affect a person's health, safety, wellbeing, dignity or rights. Such issues include allegations of assaults (physical, sexual, verbal, or financial), potential staff misconduct, neglect, or ill-treatment, and suicidality.¹⁷

In 2025-26, Advocates responded to 683 serious issues representing approximately three per cent of all issues and complaints raised throughout the year. However, the number of serious issues increased by 72 per cent from 397 in 2024-25 to 683 in 2025-26. A greater practice focus on identifying and recording serious issues is likely to have contributed to this increase, although it does not explain the overall scale of the growth. Almost 15 per cent of serious issues were recorded for children under the age of 18 years, while a further 17 per cent were recorded for young people aged 18 to 24 years.

FIGURE SEVEN - A significant proportion of serious issues were recorded for children and youth in 2025-26





Thank you again for your incredible support and hard work with my issues at [Hostel]. Your assistance was truly instrumental in giving me the courage and ability to navigate the situation.

RESIDENT

Particularly concerning is that the increase was not isolated to an issue type. Growth occurred across all major categories of serious issues, including physical harm, psychological or verbal abuse, sexual safety concerns, allegations of misconduct, and suicidality. This suggests the increase reflects a broader rise in serious incidents and safeguarding concerns requiring advocacy intervention, rather than a shift in one specific area of risk.

Much of the overall increase in serious issues was attributable to suicidality, which increased by more than 100 recorded occasions. This category includes deaths by suicide, instances where consumers or residents expressed a clear intention to end their lives, and acts undertaken with the intent of dying. Children under 18 accounted for 41 of the 185 suicidality serious issues recorded in 2025-26, or 22 per cent. This included 35 matters involving children aged 16 or 17. While the number of suicidality matters involving children increased, children accounted for a smaller proportion of the category than in 2024-25, when they represented 33 per cent of recorded suicidality serious issues.

Allegations of psychological or verbal abuse also rose considerably, increasing from 19 recorded instances in 2024-25 to 52 in 2025-26 (174 per cent).¹⁸ These reports were raised across a broad range of services and commonly involved allegations of verbal aggression, intimidation and other distressing interactions between consumers and residents in inpatient and residential settings. The increase is concerning. People should be able to access treatment and care in environments where they are treated with dignity and respect. While the increase may indicate a rise in incidents, it may also reflect improved awareness among people of their rights and of the standards of treatment they are entitled to expect, including through engagement with MHAS advocates. Regardless, the number of reports highlights the importance of respectful, rights-based care and the need to address consumer concerns promptly.



¹⁶ Consumer issues and complaints data are coded in the Hub by individual Advocates and may be influenced by variations in recording practices over time. Despite this, the observed trends are considered significant and reflective of increasing demand for MHAS advocacy services.

¹⁷ All serious issue allegations are escalated to a Senior Advocate, who oversees the response to ensure the consumer's immediate safety is prioritised and appropriate action is taken by the relevant service or individual.

¹⁸ Significant increases were recorded across several issue categories in 2025-26. These are likely to reflect a combination of factors, including greater advocacy activity and engagement with consumers or residents; increased consumer and resident awareness of their rights and the standards of treatment and care they are entitled to expect; and changes in the volume, nature and complexity of matters raised with advocates. Continued development of the Hub has also supported more consistent and detailed recording of issues. The figures should therefore be understood as measures of issues identified and recorded through MHAS advocacy. An increase in recorded issues reflects a combination of increased identification and reporting, and a genuine increase in issues experienced.

There was also a substantial increase in allegations of physical abuse, rising by 54 per cent, from 68 to 105 recorded allegations. Consumers and residents reported increasing concerns about peer aggression and violence within inpatient units and psychiatric hostels, often occurring in the context of rising acuity, behavioural disturbance and, in some settings, alcohol and other drug (AOD) use. While inpatient services have increasingly relied on security officers and nursing specials to manage risk, physical assaults and aggression between consumers or residents remain a significant concern including in licensed private psychiatric hostels.

Sexual safety issues also increased by 41 per cent to 97 recorded occasions. These matters ranged from allegations of sexual assault to sexually disinhibited behaviour, inappropriate sexual conduct and concerns about the vulnerability of consumers within treatment and care environments. Combined with the reported increase in physical and psychological harm, these figures raise broader concerns about the ability of some treatment environments to consistently provide safe, therapeutic and recovery-oriented care.

The substantial increase in serious issues recorded during 2025-26 raises significant concerns about the safety and quality of care being experienced by some people within mental health services. While MHAS does not determine whether allegations are substantiated, it takes each allegation at face value and works to ensure concerns are promptly escalated, investigated and responded to by the relevant service. Each report requires careful assessment and often intensive advocacy engagement to support the person and advocate for appropriate action. The growth in serious issues, particularly those involving suicidality, physical harm and sexual safety, highlights the need for continued focus on safeguarding within mental health services. People should be able to access treatment and care in environments that are safe, trauma-informed and recovery-focused, and the trends observed during 2025-26 suggest there is more work to be done to ensure services consistently promote safety, dignity, wellbeing and recovery.

TABLE TWO – The increasing number of ‘serious issues’ recorded by Advocates is concerning

	2023-24	2024-25	2025-26	Change
Alleged physical abuse	72	68	105	▲ 54.4%
Alleged psychological or verbal abuse	15	19	52	▲ 173.7%
Sexual safety	82	69	97	▲ 40.6%
Alleged financial abuse	6	7	8	▲ 14.3%
Potential misconduct, wilful neglect or ill treatment	106	87	101	▲ 16.1%
Other potential serious issues	48	66	135	▲ 104.5%
Suicidality	14	81	185	▲ 128.4%
Total	343	397	683	▲ 72.0%

Aside from issues and complaints categorised as 'serious', the most common concerns people raised with Advocates related to discharge (2,016 recorded issues, increasing by 72 per cent), access to grounds and leave (1,747 issues, up 83 per cent), involuntary status (1,330 issues, increasing by 47 per cent), prescribed medication (1,092 issues, up 70 per cent), and accommodation (890 issues, rising by 72 per cent). These issues consistently feature among the most frequently raised concerns reported to MHAS and continue to be monitored for potential systemic implications.

An emerging concern during 2025-26 was the more than tripling of issues and complaints relating to MH Act forms. These concerns increased by 223 per cent, from 80 recorded issues in 2024-25 to 258 in 2025-26. This category includes concerns that forms were incomplete or inaccurate, not signed by the appropriate authority, contained administrative errors, or were not provided to consumers, residents or guardians as required.

The increase is particularly concerning because MH Act forms are the legal instruments through which treatment authority and many statutory safeguards are enacted. Errors, omissions and failures in the completion or provision of statutory forms may undermine compliance with the MH Act, compromise peoples' legal rights and, in some circumstances, call the legal authority for treatment into question. The trend highlights the importance of robust administrative and governance processes and ongoing attention to legislative compliance.

Issues and complaints categorised as 'Other MHT' also more than tripled during 2025-26, increasing by 209 per cent. These matters included scheduling difficulties, reviews not occurring within statutory timeframes, concerns regarding hearing notification, conduct of hearings and dissatisfaction with MHT decisions. While the reasons for the increase are likely varied, the growth in these concerns highlights the importance of ensuring MHT processes remain accessible, timely and procedurally fair.

Issues and complaints relating to medical reports for MHT hearings continued the concerning trend first observed in 2024-25, when they increased by 160 per cent. A further increase of 156 per cent was recorded in 2025-26, representing an almost six-fold increase over the last two reporting periods. Advocates reported that most concerns related to delays in consumers and residents receiving medical reports before MHT hearings. People should generally receive their medical reports at least three days before a scheduled hearing, allowing sufficient time to review the information, seek advice and prepare a response. Delays can significantly limit a person's ability to participate effectively in proceedings and may adversely affect procedural fairness, a fundamental legal right.

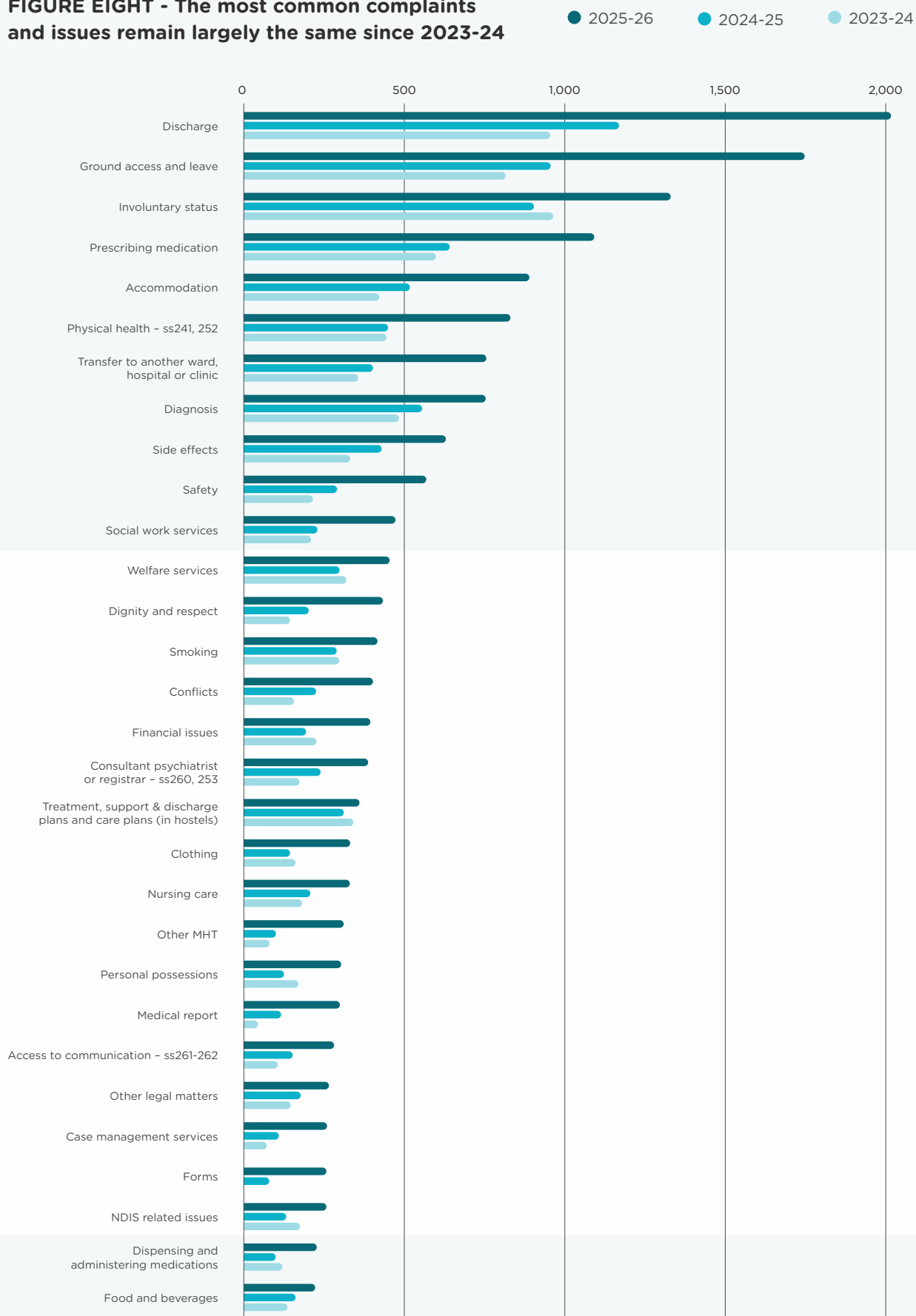
Notably, unlike previous years, no category of issue or complaint decreased in frequency during 2025-26. The widespread growth across both care-related concerns and issues associated with legal and administrative processes suggests increasing pressure across multiple parts of the mental health system. It also highlights the importance of maintaining effective governance, legislative compliance and procedural safeguards to protect people's rights and support meaningful participation in decisions affecting their treatment and care.



[Advocate] has been attentive, professional and has gone above and beyond to assist.

CONSUMER

FIGURE EIGHT - The most common complaints and issues remain largely the same since 2023-24



Who we supported

Since MHAS commenced operations in 2015, there has been a consistent and overall increase in the use of involuntary treatment orders in both hospital and community settings. In 2025-26, 5,331 involuntary treatment orders were made for 3,380 people, representing a modest increase of 1.5 per cent in involuntary orders from the previous year. While annual growth has slowed, the longer-term trend remains significant, with both the number of involuntary treatment orders and the number of people subject to those orders increasing by 28 per cent since 2017-18.

TABLE THREE - Small but consistent increases in involuntary orders and the number of consumers and residents are noted year on year

Type of Order	2018-19		2019-20		2020-21		2021-22		2022-23		2023-24		2024-25		2025-26		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	3,117	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	3,704	2,969	▲ 0.3%
Inpatient treatment orders in general hospitals - Form 6B	149	128	168	128	181	139	255	189	282	222	331	258	369	280	386	316	▲ 4.6%
Community treatment orders - Form 5A	850	679	839	702	884	718	884	726	963	781	1,005	808	1,188	934	1,241	967	▲ 4.5%
Total Involuntary Orders/Consumers	4,116	2,650	4,282	2,744	4,273	2,729	3,984	2,573	4,415	2,842	4,669	3,024	5,250	3,339	5,331	3,380	▲ 1.5%

Consumers and residents

on involuntary treatment orders

Only a marginal increase in the number of inpatient treatment orders (Form 6A) made in authorised hospitals was observed in 2025-26, rising from 3,693 to 3,704 orders (0.3 per cent). In contrast, inpatient treatment orders made in general hospitals (Form 6B) increased by five per cent, contributing to a cumulative increase of 188 per cent since 2017-18. As previously reported, this trend reflects growing demand for compulsory mental health treatment in medical settings, particularly among children and young people, who accounted for more than one-third of all Form 6B orders in 2025-26.

As previously reported, the increasing use of Form 6B orders appears to be driven in part by the involuntary treatment of people with eating disorders and disordered eating, particularly children and young people. In 2025-26, however, Advocates also observed what appeared to be an increase in the number of people receiving treatment on medical wards following serious self-harm injuries or suicide attempts. This observation aligns with trends in MHAS issue and complaint data, which highlighted growing concerns regarding self-harm and suicidality, particularly among young people.

The use of involuntary treatment on medical wards can present particular challenges for consumers. Unlike specialist mental health services, medical wards are primarily designed to treat physical health conditions and staff may have less exposure to the MH Act and less experience supporting people with acute mental health needs. Consumers may also be subject to restrictive interventions, including mechanical restraint and chemical sedation, in settings that operate under different legislative and governance arrangements to authorised mental health services. As the use of Form 6B orders continues to increase, it is important that services ensure that peoples' rights and dignity are protected, regardless of whether treatment is provided in a specialist mental health service or a general hospital.

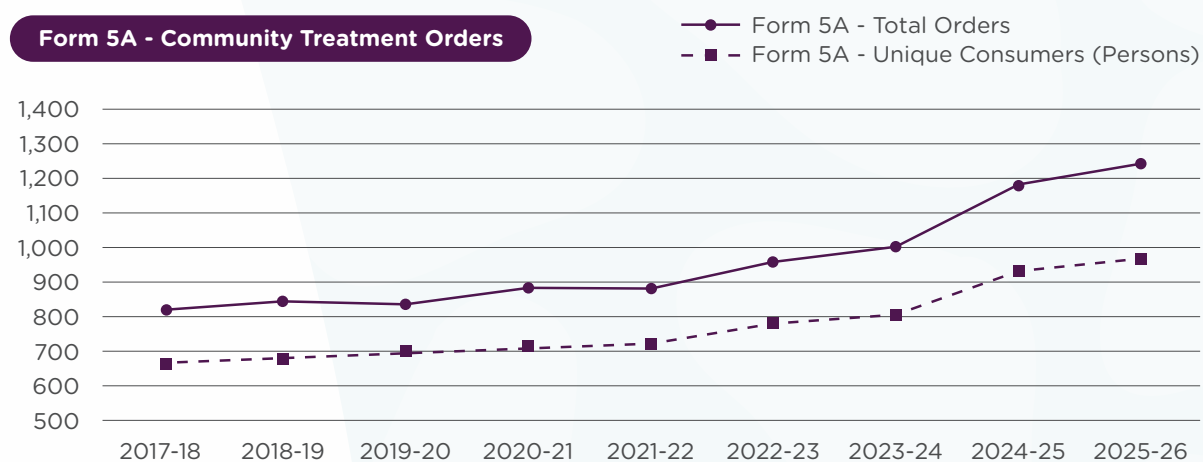
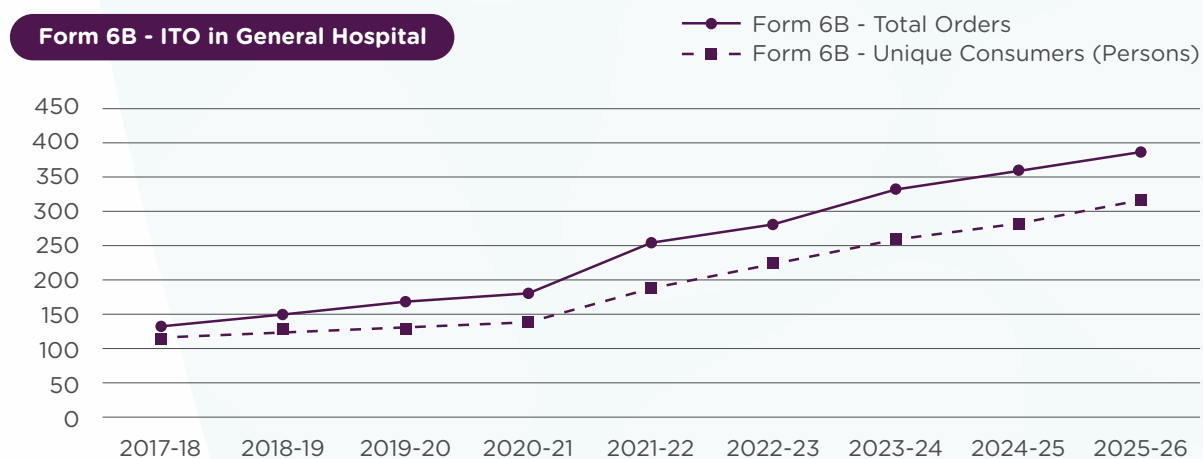
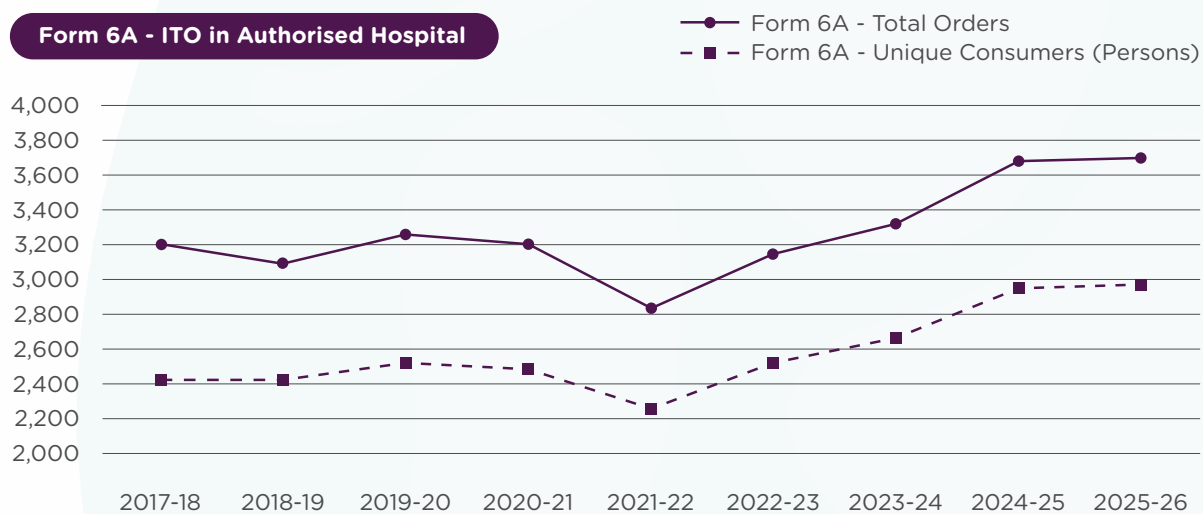
The concentration of Form 6B orders within major tertiary hospitals reflects the important role these services play in providing care for people who require both acute medical treatment and involuntary mental health care. In 2025-26, more than one-third of Form 6B orders were made at Fiona Stanley Hospital. Together,

Fiona Stanley Hospital, Royal Perth Hospital and Sir Charles Gairdner Hospital accounted for almost three-quarters of all Form 6B orders. Given the volume and often complex needs of people treated under Form 6B orders in these settings, it is important that hospitals maintain systems and processes that support compliance with the MH Act and promote the rights, safety and dignity of consumers. This includes ensuring that clinical and security staff have appropriate knowledge of the MH Act, access to mental health training, and skills in trauma-informed care and de-escalation techniques when working with people experiencing acute mental distress.

People can also be placed on an involuntary treatment order while living in the community in the form of community treatment orders (CTO). In recent years, there has been increasing investment in community-based models of care, including Hospital in the Home and other community mental health services, to enable people to receive treatment and support in less restrictive settings and avoid hospital admission where appropriate. Effective community supports can help people access care earlier, reduce the need for hospitalisation, support recovery and provide step-down pathways following inpatient treatment. They also enable many people to receive treatment and support while maintaining connections with family, community, education, employment and other aspects of everyday life. Nevertheless, CTOs remain a form of involuntary treatment that can significantly affect a person's autonomy, choices and legal rights.

In 2025-26, the number of CTOs (Form 5A) increased by 4.5 per cent, while the number of people placed on these orders increased by 3.5 per cent. The continued growth in CTOs means an increasing number of people are being subject to compulsory treatment while living in the community. The available data do not explain the reasons for this trend, including whether it reflects changes in clinical practice, pressures on inpatient services, or broader service-system factors. Regardless of the cause, the increasing use of community-based compulsory treatment reinforces the importance of ensuring people understand their rights, can participate in treatment decisions, and have access to independent advocacy where required.

FIGURE NINE: Continued growth in the number of involuntary treatment orders and unique consumers or residents



Children aged 0 to 17 years

Under the MH Act, MHAS is required to contact every child under 18 years who is placed on an involuntary treatment order within 24 hours of the order being made. This is to assist children to understand their rights under the MH Act, including their right to be heard, participate in decisions about their treatment and care, and have their views considered. In undertaking this role, Advocates must also have regard to the child's best interests and balance the perspectives of the child, their parent or guardian, and the treating team. Many children have external agencies involved in their care, and their views must also be considered. This broad consultation, and the often-competing views of the various parties, means advocacy involving children is often more time and resource intensive than advocacy provided to adults.

In 2025-26, there were 211 children in Western Australia treated under involuntary treatment orders, representing a 10 per cent reduction from the previous year. A modest increase in children receiving inpatient treatment orders in authorised hospitals (Form 6A) was offset by significant reductions in the number of children receiving inpatient treatment orders in general hospitals (Form 6B) and CTOs (Form 5A).

While the number of children treated involuntarily reduced from the unusually high levels observed in 2024-25, the longer-term trend remains concerning. The 211 children treated under involuntary orders in 2025-26 is still more than double the number recorded eight years ago. This suggests that the factors driving child and youth mental health presentations continue to place substantial pressure on Western Australia's mental health system.

Throughout 2025-26, MHAS continued to identify significant pressures affecting access to specialised youth mental health beds. These concerns were identified through MHAS advocacy involving young people aged 16

and 17 years admitted or seeking admission to an authorised hospital, as well as young adults aged 18 to 24 years who were receiving advocacy under the MH Act. Quarterly reporting highlighted ongoing capacity constraints within youth units, delays accessing inpatient services, and concerns regarding reductions in youth bed availability, including changes affecting specialist youth facilities. MHAS observed that these pressures could result in some children and young people experiencing significant delays in accessing the most appropriate care. In many matters, the issue was not whether inpatient admission was clinically indicated, but whether an appropriate age-specific bed was available at the time treatment was required. This was particularly significant for 16 and 17 year olds, who have access to a limited number of specialist youth inpatient and intensive care options. Consequently, the reduction in involuntary treatment orders should be interpreted cautiously and not necessarily as evidence of reduced demand for child and youth mental health services. Rather, it occurred in the context of ongoing service capacity pressures and continued concerns regarding access to developmentally and clinically appropriate inpatient care.

Importantly, the reduction in involuntary orders was not reflected by a corresponding reduction in the complexity of issues raised with MHAS. Throughout 2025-26, Advocates continued to support children and young people experiencing significant risks, including suicidality, self-harm and sexual safety concerns. These issues often involved children and young people with complex needs that required intensive support and ongoing multidisciplinary, and often multi-agency, responses. Together, the data suggests that while fewer children were subject to involuntary treatment in 2025-26, those requiring mental health services frequently presented with complex needs and high levels of vulnerability.

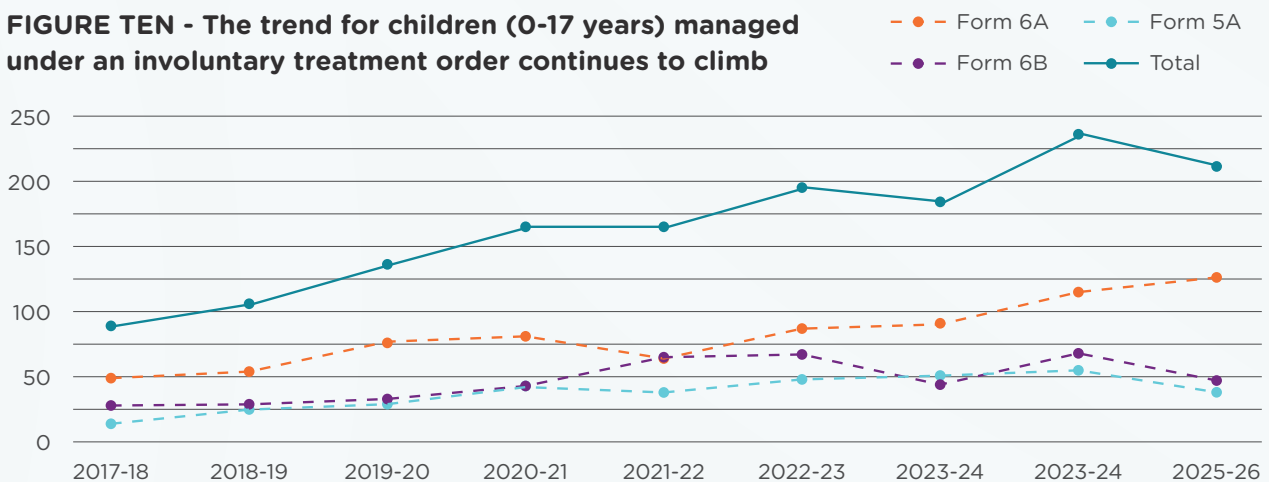
Thank you for going above and beyond the call of duty and thank you for taking an interest in my case as I got no traction until I met you as nobody was willing to do anything above the very bare minimum of their job description.

RESIDENT

TABLE FOUR - Fewer children (0-17 years) were managed under an involuntary treatment order in 2025-26

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2024-25	Change
Inpatient treatment orders in authorised hospitals - Form 6A	48	53	75	80	63	86	90	114	126	▲ 10.5%
Inpatient treatment orders in general hospitals - Form 6B	27	28	32	42	64	61	43	67	47	▼ 29.9%
Community treatment orders - Form 5A	13	24	28	42	37	47	50	54	38	▼ 29.6%
Total Involuntary Orders	88	105	135	164	164	194	183	235	211	▼ 10.2%

FIGURE TEN - The trend for children (0-17 years) managed under an involuntary treatment order continues to climb



On 1 January 2017, a Ministerial Direction expanded MHAS' jurisdiction in relation to certain classes of voluntary consumers. As a result, MHAS also provides advocacy for children who:

- are being treated, seeking admission, or are proposed to receive treatment in a public hospital or authorised hospital.
- have been assisted by an Advocate within the previous six months while a voluntary patient or involuntary inpatient and are receiving, or are proposed to receive, treatment from a community mental health service.

Children whose parent or guardian consents to treatment under section 302 of the MH Act are considered voluntary patients, even where the child does not consent to treatment.

In 2025-26, MHAS assisted slightly fewer voluntary children than in the previous year, with a one per cent reduction in the number of children accessing advocacy services. This continues a downward trend observed over the preceding two reporting periods and represents a cumulative reduction of 24 per cent since 2022-23, returning to levels last observed in 2021-22.

Caution should be exercised when interpreting this trend. Unlike children receiving involuntary treatment, there is no statutory notification process for voluntary children. Access to advocacy therefore depends heavily on Advocate visibility within services, referrals from treating teams, Advocate workforce availability, and awareness of MHAS among children and families. Consequently, changes in advocacy activity may not necessarily reflect changes in demand for child and youth mental health services.

Importantly, the reduction in the number of voluntary children assisted was not accompanied by a corresponding reduction in the complexity of concerns raised with MHAS. Throughout 2025-26, Advocates continued to respond to matters involving repeated admissions, barriers to accessing appropriate services, suicidality, self-harm, sexual safety concerns and other high-risk presentations. These matters often required significant coordination between treating teams, families and external agencies. These trends suggest that, while fewer voluntary children accessed advocacy services, the level of need and complex needs among those requiring support remained substantial.

TABLE FIVE – Fewer voluntary children were assisted by our Advocates in 2025-26

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	Change
Voluntary children (0-17 years) assisted	59	59	278	460	342	462	390	356	352	▼ 1.1%



[Advocate] always goes above and beyond for all patients, liaising between professionals, family, and the patient seamlessly.

CLINICIAN

MHAS Weekend Phone Service

Under the MH Act, MHAS is required to contact children aged 0 to 17 years within 24 hours of an involuntary treatment order being made. This includes both inpatient treatment orders and CTOs. The weekend phone service operates every weekend and public holiday to ensure MHAS can meet this statutory obligation when orders are initiated outside normal business hours.

The Advocate managing the weekend phone service routinely contacts child and youth mental health wards and relevant general hospital wards to identify whether any inpatient treatment orders have been made for children. Where advised that a child has been admitted to an adult authorised mental health service or regional hospital, the Advocate also contacts those services to identify any new inpatient treatment orders. Where a new order has been initiated, the Advocate undertakes the statutory initial contact by telephone or arranges for an on-call Youth Advocate to undertake an in-person visit where required. In addition to responding to statutory contacts for children, the service monitors urgent requests for Advocate contact received outside normal business hours and triages these in accordance with legislative requirements and MHAS operational protocols.

In 2025–26, there were 173 inpatient treatment orders (Forms 6A and 6B) made for children aged 0 to 17 years. Of these, 47 required an

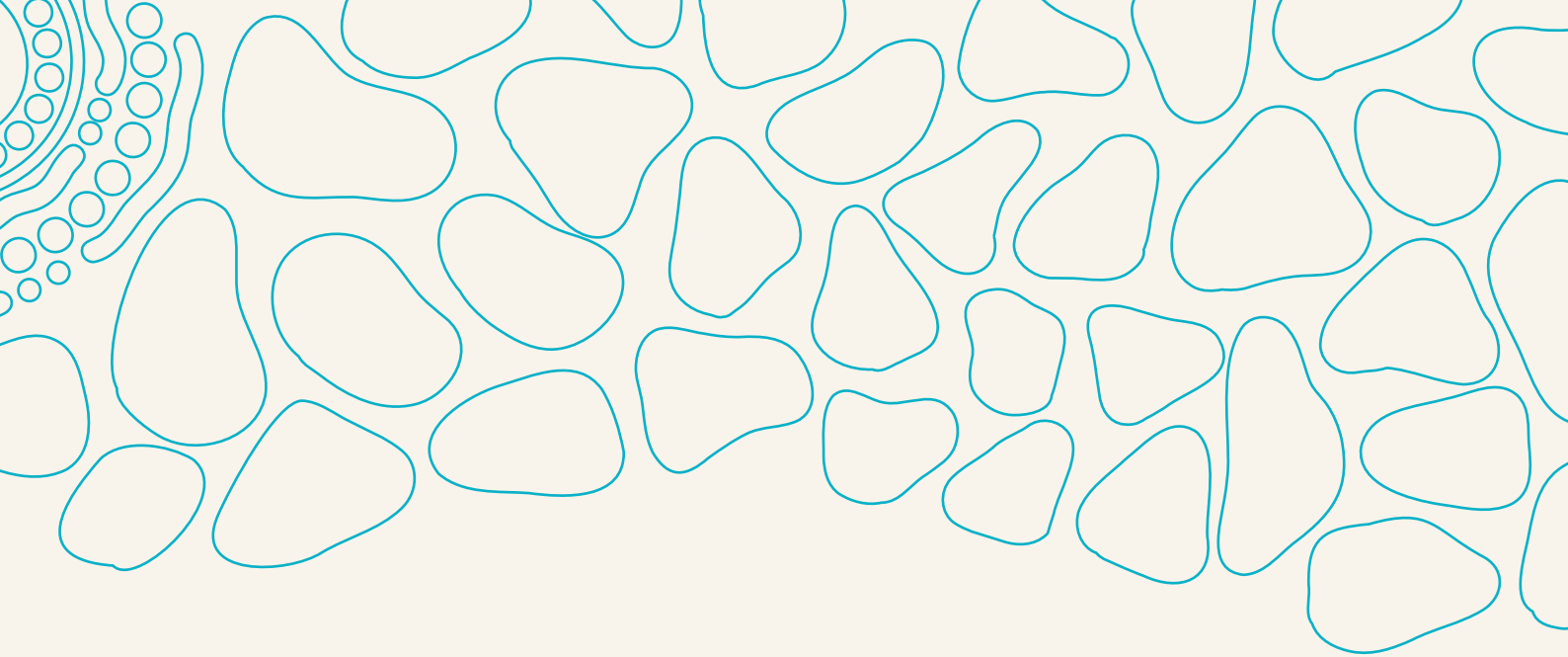
initial statutory contact through the weekend phone service, representing 27.2 per cent of all child inpatient treatment orders. This compares with 40 such contacts in 2024–25, representing 22 per cent of child inpatient treatment orders, and reflects the significant proportion of inpatient treatment orders initiated outside standard business hours.

Weekend statutory contacts¹⁹ arising from inpatient treatment orders were consistently required throughout the year, with between nine and 14 contacts each quarter. The highest number of contacts arose from inpatient treatment orders made at Fiona Stanley Hospital (20 contacts), Perth Children's Hospital (11 contacts) and East Metropolitan Youth Unit (10 contacts). Collectively, these services generated more than three-quarters of all weekend form-initiated contacts recorded during the reporting period.

The consistent demand for weekend statutory contacts with children throughout the year demonstrates the ongoing need for dedicated weekend advocacy capacity. By enabling MHAS to meet its statutory obligation to contact children within 24 hours of an involuntary treatment order being made, the service ensures children who become involuntary patients outside standard business hours receive timely information about their rights and access to advocacy support.



¹⁹ A 'statutory contact' occurs in response to an obligation to make contact with an identified person under the MH Act. A single identified person may have more than one statutory contact during any given period; the number of statutory contacts may not be the same as the number of unique individuals contacted.



Voluntary adult consumers

with ongoing issues

Continuity of treatment, care and support, and the ability to exercise rights throughout a person's mental health journey, are important principles underpinning MHAS' advocacy role. For this reason, Advocates may continue to assist consumers to resolve outstanding issues that they have been working on as they transition from involuntary to voluntary status. This support can continue while the person remains engaged with a public mental health service as a voluntary patient, whether in an inpatient setting or in the community, and where there is a reasonable prospect of resolving the issue.

In 2025-26, there was a large reduction in advocacy provided to voluntary adults with ongoing issues. The number of occasions on which people were assisted decreased by one-third, while the number of individual people supported more than halved from 46 in 2024-25 to 19 in 2025-26, a reduction of 59 per cent.

As previously reported, MHAS' ability to support people with unresolved issues ends when they are discharged from public mental health services. This can occur before a concern, complaint or advocacy issue has been fully addressed, limiting a person's access to ongoing support during the resolution process. As recommendations arising from the Statutory Review of the MH Act are implemented, MHAS anticipates that this limitation will be addressed.

Referred persons

Referred persons are individuals who have been directed by a medical practitioner or authorised mental health practitioner to undergo a compulsory psychiatric examination (Form 1A). This examination is often undertaken in an emergency department (ED) or Mental Health Observation Area (MHOA), and the person cannot leave until the examination process has been completed.

There is no automated process for MHAS to be notified when a person is placed on a Form 1A. As a result, access to advocacy relies largely on consumers, carers, families or service providers contacting MHAS directly. To improve access to support, MHAS has continued to raise awareness of advocacy services among consumers and residents' families, treating teams and other stakeholders.

In 2025-26, MHAS observed a significant increase in the number of occasions referred persons accessed advocacy services, increasing by 24 per cent. The number of unique consumers assisted also increased from 217 in 2024-25 to 232 in 2025-26. This increase may reflect growing awareness of advocacy services but is likely to also be associated with the increasing pressures and delays being experienced within EDs and MHOAs, where it is not uncommon for people to spend several days awaiting psychiatric examination, admission or transfer.

Despite this increase, MHAS considers the number of referred persons accessing advocacy is likely to remain substantially lower than the total number of people subject to a Form 1A. Without a notification pathway, many people may not be aware that independent

There are countless examples of [Advocate's] dedication and compassion, most notably her involvement in complex case discussions where she ensures that patient and family preferences are considered in all relevant decision making.

CLINICIAN

advocacy is available during the compulsory assessment process. While services are not required to notify MHAS when a Form 1A is made, section 357 of the MH Act enables any person with a sufficient interest in an identified person to request contact by an Advocate. Clinical staff can also support access to advocacy by providing MHAS information, explaining the person's right to advocacy and assisting the person to contact MHAS.

Access to advocacy at this stage is particularly important because the compulsory examination process is often a person's first interaction with the involuntary treatment system. Advocates can assist people to understand and exercise their rights, participate in decisions about their care and raise concerns regarding their treatment and environment. Advocacy may also address practical matters arising during extended stays in EDs and MHOAs, including access to meals, showers, toiletries, communication with family and carers, and information regarding treatment plans or delays in accessing inpatient care.

Prisoners who are referred for compulsory psychiatric examination under a Form 1A are also referred persons under the MH Act and are entitled to access MHAS advocacy for the duration of the referral. During 2025-26, MHAS worked with Corrective Services to improve awareness of this right and identify practical arrangements for alerting MHAS when a prisoner is placed on a Form 1A. This work also examined barriers to timely contact, including the processes required for prisoners to telephone MHAS, and sought to improve prisoners' access to advocacy within the short timeframe of a Form 1A referral.

Ensuring referred persons have access to independent advocacy during the compulsory examination process remains important for informed decision-making and the protection of consumer rights. MHAS will continue working with EDs, mental health services, Corrective Services, and other stakeholders to improve awareness of advocacy services and access to support for referred persons.

TABLE SIX - The frequency of people referred for examination increased but there were fewer voluntary consumers with ongoing issues

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	Change
Voluntary (adult) consumers assisted with ongoing issues	62	86	94	135	149	147	135	133	89	▼ 33.1%
Referred persons assisted (adults and children)	238	212	303	333	302	323	320	340	420	▲ 23.5%

Consumers or residents new to MHAS

In 2025-26, MHAS continued to see growth in the number of people accessing advocacy services for the first time. The number of new people assisted increased by almost 8 per cent, rising from 2,059 in 2024-25 to 2,218 in 2025-26. This follows a 14 per cent increase recorded between 2022-23 and 2023-24 and continues the broader trend of growth in first-time engagement with MHAS services.

New consumers or residents across all MH Act streams (2,218) accounted for approximately 45 per cent of all people supported by MHAS during 2025-26. This is consistent with recent years, during which between 44 and 47 per cent of all people assisted by MHAS had not previously accessed advocacy services. The proportion of new people illustrates the ongoing demand for information, support and advocacy among people entering the mental health system or engaging with MHAS for the first time.

The profile of new people also highlights the significant representation of cohorts often considered particularly vulnerable within the mental health system. One in five new people were children and young people aged under 18 years, while 12 per cent were older adults aged 65 years and over.

Both groups increased in 2025-26:

- the number of new children increased from 345 to 455 (31 per cent)
- the number of new people aged 65 years and over increased from 240 to 255 (6 per cent).

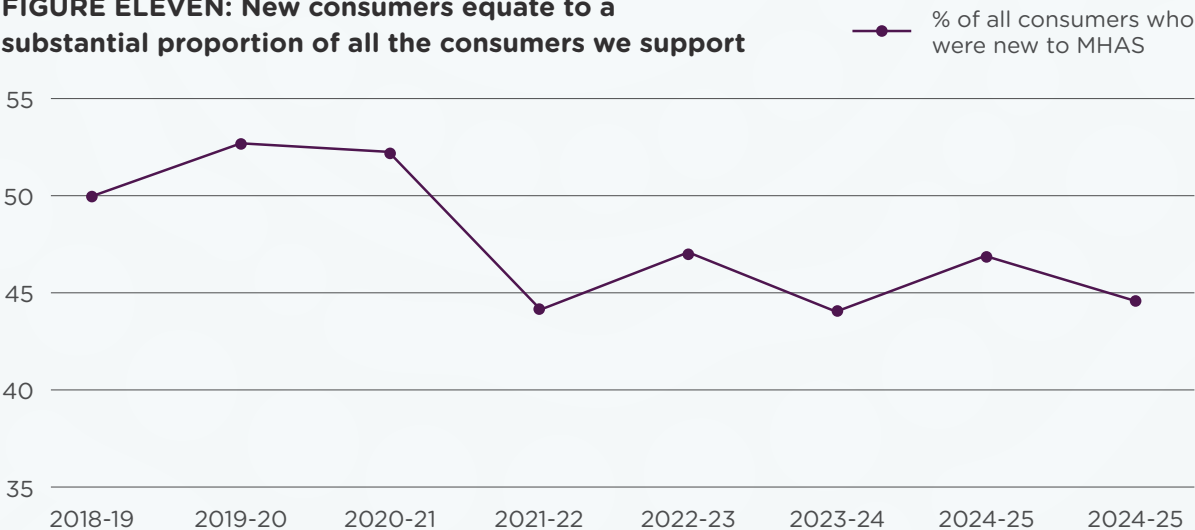
The continuing growth in children and young people accessing advocacy services aligns with broader patterns observed throughout this report, including increasing complexity of presentations, ongoing concerns regarding suicidality and self-harm, and sustained pressures across child and adolescent mental health services.

The growth in older adults accessing MHAS is also noteworthy. Older adults may experience a range of circumstances that affect their ability to understand, exercise and protect their rights, particularly where significant mental and physical health needs, and cognitive impairment are present. The increasing number of older adults engaging with advocacy services reflects a broader need that has been recognised through the Statutory Review of the MH Act, which recommended expanding access to statutory advocacy to voluntary older adult inpatients in authorised units.

TABLE SEVEN - The number of people new to MHAS continues to grow

	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25 ²⁰	2025-26	Change
Consumers new to MHAS	1,566	1,798	1,876	1,526	1,844	1,808	2,059	2,218	▲ 7.7%

FIGURE ELEVEN: New consumers equate to a substantial proportion of all the consumers we support



²⁰ Since 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. Totals are based on new consumers added to the Hub who were identified under the MH Act as at June 30, each year.

Numbers of authorised mental health beds attended

MHAS recognises the significant investment made by Government to expand mental health infrastructure, increase bed capacity and strengthen earlier intervention, community treatment and other alternatives to inpatient care. Bed capacity can affect admission pathways, transfer arrangements, service demand and the timeliness with which people are able to access appropriate care. The information presented in Table Eight and Figure Twelve is included as context for understanding the access-to-care concerns raised by consumers and residents during 2025-26.

Delays accessing inpatient care, prolonged stays in EDs and MHOAs and extended periods on general medical wards while awaiting transfer to a mental health bed were recurrent themes in MHAS advocacy during 2025-26. While bed capacity is not the sole cause of these issues, access to inpatient care remains a significant concern for some consumers and residents despite continued investment and growth in authorised mental health bed numbers.



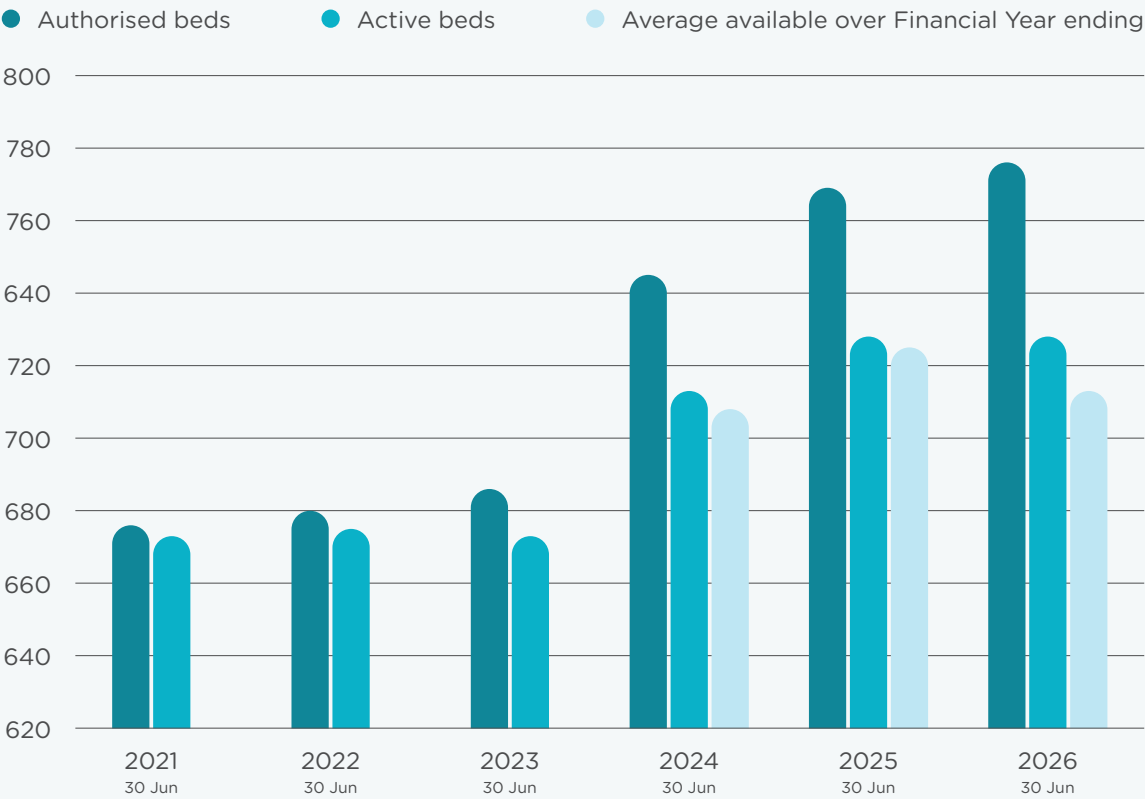
I now feel hopeful when I was despairing the day before. Today was appreciated and I don't think I would have gotten such a positive productive outcome, actually I think it would have ended badly for me otherwise.

RESIDENT

TABLE EIGHT – The number of inactive beds has increased negating the increase in authorised mental health beds²¹

Bed numbers as at 30 June	Authorised Beds	Active Beds	Inactive Beds	Average available over Financial Year ending ²²
2021	676	673	3	–
2022	680	675	5	–
2023	686	673	13	–
2024	745	713	32	708
2025	769	727	42	725
2026	776	728	48	713

FIGURE TWELVE – While the number of authorised beds increased last year, the average availability for the year reduced



²¹ Data supplied by DoH.

²² Represents the average daily availability over the whole financial year. Data only available since 2023-24.

Mental Health Tribunal hearings

Consumers and residents subject to involuntary treatment under the MH Act have the right to an independent review of their treatment order by the MHT. MHT hearings are one of the most important safeguards available to people, providing an opportunity for independent scrutiny of involuntary treatment decisions. Advocates assist people to understand the hearing process, express their views and participate effectively in proceedings. They also make applications to the MHT and, where appropriate, represent people in those proceedings. MHAS also works collaboratively with the MHT to improve people's experiences and participation in hearings.

In 2025-26, the MHT recorded Advocate attendance at approximately 40 per cent of hearings, consistent with the proportion recorded over the preceding five years. Advocates attended 1,491 hearings during the year, approximately 200 more than in 2024-25. This increase occurred alongside continued growth in the number of MHT hearings being conducted and reflects the important role advocacy plays in supporting people to participate effectively in decisions about their treatment, care and legal status.

TABLE NINE: The number of MHT hearings attended by Advocates increased at a greater rate than the number of hearings conducted²³

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2026-26
Number of hearings listed	3,446	3,618	4,253	4,007	3,908	4,118	4,550	5,056	5,816
Number of hearings conducted	2,247	2,320	2,627	2,659	2,742	2,557	2,841	3,223	3,727
Number of hearings attended by an MHAS Advocate	-	-	-	-	-	-	1,188	1,286	1,491
%	34.0%	36.0%	40.0%	40.0%	43.5%	41.0%	41.8%	39.9%	40.0%
Number of hearings attended by the MHLC	-	-	-	-	-	-	252	338	447
%	9.0%	9.0%	8.0%	11.0%	10.0%	9.0%	8.9%	10.5%	12.0%



²³ Data is based on information published in the MHT's Annual Reports from 2017 onwards.

Advocacy in action: systemic issues and outcomes

The concerns raised with Advocates during 2025-26 provide a unique perspective on the experiences of consumers and residents receiving treatment, care and support across Western Australia's mental health system. Advocacy identified recurring issues relating to safety, access to treatment and care, restrictive practices, procedural fairness, and legislative compliance. During the year, MHAS recorded 20,704 issues raised by consumers and residents subject to, or receiving services under, the MH Act, of which 683 were categorised as serious.

These issues reflect concerns, experiences and allegations raised through advocacy, as well as matters identified by Advocates through their engagement with consumers, residents, and services. Advocates work with consumers and residents, seek information from services, monitor outcomes and, where necessary, escalate concerns. Many issues result in action, clarification, review, or other responses by services. Consequently, the information presented in this section provides insight into the issues requiring advocacy intervention and the recurring themes identified through advocacy practice. Consumers and residents consistently emphasised the importance of being heard, treated with dignity and respect, and supported to participate in decisions affecting their lives.

Safety

Safety concerns reported by consumers and residents almost doubled during the year, increasing from 291 issues in 2024-25 to 569 issues in 2025-26 (as shown in Figure Eight). Table Two records 683 serious issues, including 105 alleged physical abuse matters, 52 alleged psychological or verbal abuse matters, 97 sexual safety matters, 101 matters involving potential misconduct, wilful neglect or ill-treatment, and 185 involving suicidality.

Safety concerns ranged from allegations of physical assault and sexual safety incidents to concerns about staff conduct, suicidality and responses to serious incidents. People reported feeling unsafe because of aggression, violence or intimidation from other people receiving services. In youth services, suicidality, significant self-harm, physical harm and sexual safety remained recurring concerns, often involving young people with complex needs and requiring sustained advocacy involvement.

The adequacy of service responses following incidents was a recurring concern. Some people reported that, despite incidents having occurred, they did not feel the actions taken by services adequately addressed ongoing safety risks or

restored their sense of safety. Some people described the impact of being assaulted, threatened or exposed to aggressive and volatile treatment environments, including the effect of witnessing violence, threats or restrictive interventions on their sense of safety, wellbeing and recovery. Concerns also arose where incidents were not documented or escalated, families received limited information about what had occurred, or actions taken by services did not appear proportionate to the identified risks.

Advocates reviewed records and closed-circuit television footage, supported people and families to participate in investigations, raised complaints and inquiries, and escalated unresolved concerns. Outcomes included formal investigations, retrospective documentation and notification of incidents, amendments to records, apologies, staff education, service reviews, environmental and security improvements, and changes to local practice and policies.

Despite these outcomes, the scale of growth in both consumer – or resident – reported safety concerns and serious issues, indicates that safety remained a significant concern across mental health services this year.

Use of restrictive practices

Concerns about restrictive practices and restrictions on communication have also increased.

Table Ten shows that concerns relating to restrictive practices and communication increased in 2025-26. Issues concerning seclusion increased from 30 matters in 2024-25 to 38 in 2025-26, restraint increased from 78 to 95, and issues relating to access to communication increased from 145 to 282. Separate Hub notification data recorded 630 Form 12C notifications concerning restrictions on freedom of communication, relating to 356 unique consumers.

TABLE TEN - Concerns relating to restrictive practices increased in 2025-26

No. of occasions	2024-25	2025-26	Change
Seclusion	30	38	▲ 26.7%
Restraint	78	95	▲ 21.8%
Access to communication	145	282	▲ 94.5%

Consumers described the distress associated with seclusion, restraint, sedation and communication restrictions. Advocacy concerns included prolonged or repeated restrictive practices; access to toilets, water, clothing and communication during seclusion events; the quality and frequency of monitoring and observation; the involvement of security staff; and whether less restrictive alternatives had been considered. Advocates also raised concerns regarding the use of chemical sedation and highlighted cases where consumers experienced serious physical health consequences, including requiring admission to medical wards or intensive care, before being able to access appropriate mental health treatment. Some incidents involving restrictive interventions resulted in significant injuries to consumers and resulted in complaints, inquiries, and reviews of practice.

For children and young people, concerns also included removal of clothing or underwear, access to bedrooms, leave and communication restrictions and restrictive responses to self-harm, with implications for privacy, dignity and developmentally appropriate care.

Advocates reviewed clinical records and CCTV footage, attended seclusion and restraint review meetings, supported complaints and inquiries, and escalated concerns. Outcomes included investigations, completion of mandatory notifications, amendments to records, staff education, reviews of restrictive-practice processes, and improved communication with consumers and families.



Thank you for all the help and support you have given me over the past few months. I honestly don't think I could have survived without it.

RESIDENT

Access to treatment and continuity of care

Access to timely and appropriate treatment remained a recurring concern. Consumers and residents described delays accessing inpatient beds, specialist assessments, community support services and suitable accommodation. Concerns included prolonged stays in EDs, MHOAs, and medical wards while awaiting admission or transfer to more appropriate treatment environments.

Children and young people faced particular pressures accessing specialist and developmentally appropriate care. Despite opening in August 2023, the Joondalup Health Campus Youth Unit remained not fully available, with beds closed because of staffing and consultant-coverage constraints. During the reporting period, the youth Psychiatric Intensive Care Unit (PICU) was repurposed to provide care for voluntary adults in response to broader service demand. While this increased capacity for one cohort, it also reduced the availability of specialist youth PICU beds. This had implications for 16 and 17 year olds requiring intensive inpatient treatment, as the East Metropolitan Youth Unit remained Western Australia's only other youth PICU option, providing three beds for this age group. The system has more options for adult consumers. MHAS also commenced tracking high acuity and involuntary youth admission numbers at Joondalup Health Campus Youth Unit and the resulting pressure on the East Metropolitan Youth Unit and Fiona Stanley Hospital Youth Unit.

People in regional Western Australia experienced separate access pressures. The redevelopment of the Bunbury Acute Psychiatric Unit involved bed closures and reduced local inpatient capacity, alongside environmental disruption and staged completion of the MHOA, PICU and Acute Psychiatric Unit East Wing. Regional services were also affected by workforce and consultant instability, limitations on remote advocacy,

accessibility barriers and gaps in allied health and social work support. While efforts were made to support consumers through Hospital in the Home and community-based service models during the redevelopment, people continued to raise issues with Advocates regarding access to timely and appropriate treatment.

Advocates assisted people and families to escalate concerns about delayed admissions, advocated for transfers to appropriate treatment settings, raised systemic concerns with health service executives and government agencies, and supported improvements within emergency care settings. Where people experienced extended waits for admission or transfer, Advocates also played an important practical role by helping them remain informed about what was occurring, supporting communication with treating teams and families, and advocating for access to necessities such as food, water, toiletries, showers and other supports. Where delays in accessing treatment were protracted or a bed was needed urgently, issues were escalated to the Deputy Chief Advocate and/or Chief Advocate who liaised with senior officers in HSPs and with the State Health Operations Centre (SHOC) to advocate for prompt access to treatment.

The conditions of treatment environments

The physical condition, accessibility and day-to-day operation of some inpatient and community mental health services affected consumers' dignity, safety and ability to participate in treatment and care. Advocates identified concerns about ageing or damaged fixtures, mould, heating and cooling problems, poorly maintained communal areas, inconsistent cleaning standards and broken communication equipment. Following advocacy, services undertook inspections, completed or committed to remedial works, replaced equipment and changed cleaning, maintenance and ward practices.

At one inpatient mental health service, consumers reported mice in bedrooms, communal areas and storage areas; clean laundry being left on the floor; personal nicotine-replacement sprays being stored together; milk being left unrefrigerated at a drinking station; and a damaged sanitary bin remaining full and exposed in a communal bathroom. MHAS raised these concerns with the Nurse Unit Manager, who referred the pest-control issue to the facilities team for immediate attention. Facilities works were completed, staff were reminded about laundry practices, labelled

individual storage bags were introduced for nicotine-replacement sprays, controls were implemented for milk left at the drinking station and the sanitary bin was replaced.

The suitability and accessibility of facilities also affected consumers' ability to exercise their rights and participate in legal processes. At one inpatient service, sound equipment did not work in a room used for MHT hearings, while hearings in another room were being conducted using a laptop. Advocacy led to repairs and the installation of videoconferencing equipment. MHAS also escalated the long-standing lack of wheelchair access at a regional community mental health service, where the wheelchair lift had reportedly been broken for two and a half years. The accessibility concern was acknowledged and progressed for further review.

These examples show that the condition, accessibility and functionality of mental health service facilities can affect more than consumers' physical comfort. They can also affect access to services, effective communication and participation in decisions and proceedings concerning treatment and legal status.

Compliance with

legislation and standards

Concerns relating to statutory forms, medical reports and MHT processes increased substantially. Figure Eight shows that issues concerning MH Act forms increased from 80 in 2024-25 to 258 in 2025-26, medical reports from 117 to 300 and other MHT matters from 101 to 312.

The principal concerns were:

- statutory forms not being completed accurately or provided as required
- consumers being unclear about their legal status or rights
- medical reports or hearing notifications not being provided early enough to support preparation and participation
- missing, inaccurate or difficult-to-locate clinical and incident records
- incomplete documentation for emergency psychiatric treatment, detention and restrictive practices

These issues could leave people uncertain about their legal status, limit their opportunity to understand or respond to medical information, and affect meaningful participation in Tribunal proceedings. For children and young people, advocacy also identified delayed medical reports and notifications, reliance on Advocate prompting, and concerns about participation in virtual hearings.

Advocacy outcomes included corrected or retrospective documentation, staff education, adjournments, administrative reviews, improved communication and changes to processes.

Participation, communication

and positive practice

Consumers and residents consistently reported wanting to be heard and involved in decisions affecting their treatment, care and support. Concerns arose when decisions were made without consultation, explanations about treatment, rights or legal processes were unclear, or people felt their views had been discounted because of their mental health condition. These concerns were particularly evident in matters relating to involuntary treatment, leave, discharge planning, accommodation arrangements and communication with treating teams.

Advocates frequently assisted people to obtain information about their treatment, understand the reasons for decisions being made about their care, clarify rights and options, and ensure their views were communicated to services. People described feeling frustrated when decisions were made without their involvement, when information was not provided in a way they could understand, or when repeated requests for information or explanation were not answered.

Participation concerns were also evident in MHT proceedings, particularly where consumers or residents felt insufficiently prepared or supported to engage effectively in hearings affecting their rights. Concerns were raised regarding virtual hearing arrangements and whether consumers had adequate opportunity to understand and participate in proceedings.

Advocates supported people to obtain information, understand their legal status and rights, prepare for hearings, participate in treatment and discharge planning, and raise concerns where communication or decision-making processes were inadequate. Consumers and residents also reported positive experiences where staff took time to listen, explain decisions, involve them in planning, and respond respectfully to concerns. Advocacy consistently demonstrated that clear communication, responsiveness, and genuine involvement in decision-making could significantly improve people's experience of treatment and care.

Coordination for

people with complex and

intersecting needs

Advocates worked with consumers and residents whose needs crossed mental health, physical health, AOD, disability, housing, child protection and justice systems. Advocacy work identified fragmented service delivery, delays and uncertainty about agency responsibility where multiple systems were involved. In practice, this contributed to incidences of repeated emergency presentations, prolonged admission, delayed discharge, placement breakdown, accommodation barriers, and gaps in sustained community support.

These challenges were particularly evident where mental illness intersected with disability, child protection involvement, homelessness risk or justice-system contact. Consumers, residents and families often described difficulty identifying which agency was responsible for responding to their needs, while services sometimes disagreed about roles, funding responsibilities or appropriate support pathways. As a result, consumers could remain in hospital longer than clinically necessary or experience delays accessing accommodation, disability supports or community services.

Advocates brought services together, clarified responsibilities, ensured consumers' views were heard and supported more coordinated responses. In several youth matters, persistent advocacy contributed to multi-agency responses to secure assessments, accommodation, funding, and support packages. Advocacy also assisted consumers and families to participate in decision-making and escalate barriers that could not be resolved at a local service level.

Experiences of hostel residents

Licensed private psychiatric hostels accommodate more than 700 residents across Western Australia and provide accommodation and support for people living with significant and ongoing mental health needs. MHAS reports separately on hostel advocacy because of the different regulatory and operating context from advocacy in authorised mental health units. Hostel residents' concerns frequently extend beyond mental health treatment and involve accommodation security, provider practices, daily living conditions, poor personal care support, access to clinical and AOD services, financial hardship and the risk of homelessness if a placement breaks down.

AOD use continued to affect resident safety, mental health and accommodation stability. Advocates identified matters involving aggression, conflict, property damage, warnings and threatened or actual eviction. Residents wanting to access detoxification or rehabilitation could experience difficulty managing their hostel accommodation charges while also meeting the cost of treatment. Advocates linked residents with treatment and harm-reduction services, engaged with providers about warnings and eviction notices, sought additional time for residents to address concerns and advocated for alternative accommodation where placements could not be maintained.

Safety, dignity and respect were also recurring concerns. Residents reported feeling unsafe where providers were unable to manage aggression or conflict involving other residents, particularly where mental health deterioration or AOD use was involved. Some residents considered that safety issues were not taken seriously or were responded to inappropriately. Residents also raised concerns about disrespectful treatment, limited involvement in decisions affecting their lives, privacy and sexual safety, and practices that reduced their autonomy within their living environment.

Residents experienced difficulties obtaining appropriate responses when their mental health deteriorated, including barriers to re-engaging with community mental health services. These difficulties were particularly evident for residents who had been discharged to general practitioner-led care and later experienced deterioration. Staffing levels, high turnover,



Hostels before and after advocacy.

reliance on inexperienced staff and inconsistent responses to mental health deterioration, conflict and crisis affected the continuity and quality of support. These concerns were particularly evident outside ordinary business hours and in larger congregate living environments.

The principal accommodation and daily living concerns included:

- poor food quality, insufficient quantity and limited choice
- ageing infrastructure and delayed maintenance
- inconsistent cleaning and compliance with accommodation standards
- inadequate heating and cooling
- deteriorated furniture, mattresses and other household items
- difficulty securing rooms or obtaining replacement keys
- delays accessing clothing, toiletries and other essential items
- accommodation-related charges affecting residents experiencing financial hardship

These matters affected residents' comfort, safety, dignity, autonomy and quality of life. Older residents, residents with physical or mobility limitations, residents without regular family or guardian oversight and residents dependent on providers for essential household items and environmental supports were particularly affected by some of these concerns.

Advocates engaged directly with hostel

licensees, raised complaints and inquiries, escalated licensing concerns and advocated with clinical, housing and other services. Outcomes included the withdrawal or extension of eviction notices, prevention of homelessness, alternative accommodation, access to Department of Communities (Communities) housing, repairs and security improvements, furniture replacement, improved cleaning and food arrangements, access to clothing, toiletries and other essential items, access to medical appointments, financial redress, apologies, reinstatement of resident meetings, improved family contact and stronger communication with providers. Some significant environmental and service concerns remained unresolved despite ongoing advocacy.

Accountability for hostels is shared between the Commission, through funding and contractual arrangements; the Change to Department of Health (DoH) Licensing and Regulatory Unit, through licensing standards; the OCP, through the Chief Psychiatrist's standards for clinical care; and MHAS, in relation to protecting residents' rights. Pathways for resolving issues varied in effectiveness. Some providers responded constructively, while other matters required escalation to one or more agencies with relevant oversight responsibilities and did not always result in timely or effective resolution. The persistence of some issues indicates gaps in the collective accountability these agencies share for the care, support, safety and living conditions experienced by hostel residents.



Complaints and inquiries about mental health services

When a consumer or resident raises a concern about their experience of a mental health service, MHAS can provide support in navigating the issue and seeking an appropriate response. Under section 352 of the MH Act, Advocates may also inquire into whether people have been informed of their rights and whether those rights have been observed, as well as investigate circumstances where the delivery of a service is having, or could have, a negative impact on the health, safety or wellbeing of consumers or residents.

There is no single approach to resolving a concern. Depending on the circumstances, an Advocate may raise an issue directly with ward staff, support the person to communicate their concerns verbally, assist them to prepare their own written complaint or prepare correspondence on their behalf. Where concerns raise broader systemic issues, involve potential breaches of people's rights, or otherwise warrant further examination, an Advocate may also prepare a formal inquiry letter.

In 2025-26, Advocates, Senior Advocates, the Deputy Chief Advocate and the Chief Advocate collectively wrote 106 complaint letters and 47 inquiry letters, representing a 23.4 per cent increase in formal correspondence overall compared with the previous year. The increase was driven largely by complaint letters, which rose from 82 in 2024-25 to 106 in 2025-26, a 29.3 per cent increase. Inquiry letters also increased from 42 to 47 over the same period.

Quality of service responses

Submitting a complaint can be a significant experience, often involving consumers or residents recounting difficult or distressing experiences. For many, the purpose extends beyond having their individual concern acknowledged. There is an expectation that speaking up may contribute to improvements in services and help prevent others from experiencing similar issues.

Consequently, the response to a complaint is itself an important part of the process. How an organisation acknowledges the issues raised, explains its position and responds to the person can influence whether they feel their experience has genuinely been heard. Responses also provide an opportunity to demonstrate accountability, identify opportunities for learning and improvement, and strengthen trust in the complaints process.

Responses to the complaint and inquiry letters received during 2025-26 were variable. While most described a degree of investigation and provided an explanation of the service's position, some demonstrated a more comprehensive consideration of the concerns raised than others. In some instances, there was scope for greater use of trauma-informed and person-centred language and more careful communication where differing views were expressed. There was also variation in how responses identified actions taken or planned, in response to the issues raised.

Outcomes achieved

During the reporting period 95 complaint letters and 42 inquiry letters were sent and had received responses. The outcomes were varied and are summarised below:

FIGURE THIRTEEN - Outcomes of complaints and inquiries about mental health services in 2025-26

Financial redress	1	0
Amendments to medical records	3	1
Environmental improvements	2	2
Changes to policy, process or practice	9	17
Consumer or resident and family communication or involvement	6	2
Staff support measures or Human Resources involvement	38	11
Apologies	77	6

● Consumer/resident complaints
● MHAS inquiries

Apologies

An apology was included in 77 complaint responses (81 per cent) and six inquiry responses (14 per cent). The wording of apologies impacted the way responses were experienced with some services providing an individualised and open apology. In other responses, a standard statement apologising for not meeting the person's expectations was provided. Such statements may be less effective in demonstrating that the person's individual experience and the concerns they raised have been genuinely heard.

Staff supports or

Human Resources involvement

The responses highlighted the role that staff support can play in improving the quality and safety of care provided. In 38 complaint responses (40 per cent) and 11 inquiry responses (26 per cent), organisations identified measures to better support staff. Depending on the circumstances, these included additional supervision, targeted education, and involving human resources where appropriate. These measures can help strengthen staff capability and build a more supported and supportive workforce, contributing to safer, more effective, high-quality care. Examples included:

- Staff education on topics including clear communication, trauma-informed care, neurodiversity awareness and caring for people with disordered eating
- Up-skilling staff in respectful and safe de-escalation strategies
- Discussions with staff regarding respectful communication and effective handover practices
- Liaison with external agencies to reinforce and clarify roles and responsibilities
- Delivery of training to agency security guards on cultural competency, effective communication and safe de-escalation practices
- Audits of cleaning standards and compliance with visual observation requirements
- Decisions not to re-engage individual agency staff members following review of concerns

Consumer, resident

and family communication

or involvement

When service providers strengthen communication and engagement with consumers, residents and families it can support recovery, build trust and contribute to more effective service delivery. Outcomes aligning with this principle were reported in six complaint responses (6 per cent) and two inquiry responses (5 per cent). Examples included:

- Facilitation of a meeting between a consumer or resident and service leadership to discuss concerns in greater detail and explore opportunities for resolution
- Allocation of staff members based on consumer or resident preference and therapeutic rapport
- Commitment to implement a model including supported decision-making practice

Changes to policy, process or practice

When organisations respond to identified issues by changing the way they work, they create opportunities to strengthen service, embed learning and improve consumer and resident experiences. Commitments to changes in policies, processes or practices were identified in nine complaint responses (9 per cent) and 17 inquiry responses (40 per cent). Examples included:

- Development of a statewide perinatal pathway for consumers with acute mental health needs and, as part of this work, implementation of an integrated birth plan to improve coordination of care and support informed decision-making
- Development of a process to clarify accountability and decision-making responsibilities for admissions involving people with dual acute needs, together with improvements to communication practices regarding significant care decisions
- Establishment of a working group to improve compliance with nicotine management policy, promote consistency across facilities, and clarify expectations
- Development of a standardised care plan for people experiencing long-stays in EDs
- Development of training modules on the MH Act and culturally sensitive care for First Nations people
- Revised processes for updating and implementing Treatment, Support and Discharge Plans
- Provision of toiletry packs to consumers

I've always felt listened to, respected and safe in the way you approach things ... and that has made a significant positive impact on my recovery, confidence, self-efficacy and living situation and NDIS stuff.

RESIDENT

Environmental improvements

The quality of the care environment can shape the experience of everyone who uses it. Well-maintained, safe and fit for purpose surroundings help create an environment where consumers and staff feel respected, supported and able to maintain their wellbeing. Two complaint responses and two inquiry responses identified environmental improvements.

Examples included:

- Increased focus on ward cleanliness and access to hygiene products
- Prioritisation of ward maintenance and repair works
- Overhaul of facility cleaning processes and standards
- Implementation of a working group focused on improving the ward environment
- Plans for facility upgrades and redevelopment works, including installation of door locks and bathroom improvements

Amendments to medical records

Reliable clinical records are an important part of building trust between consumers, residents and health services. Taking concerns about the information recorded seriously, and making appropriate corrections where required, can promote transparency and strengthen relationships. As a result of concerns raised, amendments were made in three complaint matters and one inquiry matter. Examples included:

- Retrospective documentation of serious incidents and concerns raised by MHAS
- Inclusion in medical records of documents and statements reflecting consumers' experiences
- Communication to staff regarding documentation requirements

Financial redress

One complaint response resulted in financial reimbursement for a personal item that was initially documented and stored, then misplaced prior to the consumer's discharge.

Criminal Law (Mental Impairment) Act Service

The 2025-26 financial year marked the first full year of operation of the *Criminal Law (Mental Impairment) Act 2023* (CLMI Act), which commenced on 1 September 2024. The CLMI Act represents the most significant reform to Western Australia's response to accused persons with mental impairment in almost three decades, replacing the former Criminal Law (Mentally Impaired Accused) Act 1996 with a more structured framework intended to improve procedural fairness, oversight, rehabilitation opportunities and access to less restrictive pathways.

The reforms introduced a range of important changes, including special proceedings hearings, limiting terms on orders made by the courts, CSOs, expanded review mechanisms through the MIRT, and greater opportunities for people to progress towards rehabilitation and community reintegration. The legislation also established a statutory right to advocacy for CLMI identified persons, recognising the importance of independent support for people navigating complex legal, mental health, disability and correctional systems.

While the previous reporting period focused on commencement of MHAS' CLMI service and implementation of

the reforms, 2025-26 provided the first opportunity to examine how the new framework is operating in practice. As increasing numbers of people progressed through fitness proceedings, review hearings, Custody Order (CO) and CSOs, Advocates gained a clearer understanding of the experiences of CLMI identified persons and the challenges associated with implementation across courts, prisons, forensic mental health services, community supervision arrangements and disability support systems.

The year demonstrated both the strengths of the new legislative framework and practical challenges associated with its operation. The reforms have created fairer pathways for accused persons with mental impairment, increased oversight of restrictive orders and expanded opportunities for rehabilitation and community-based supervision. However, advocacy undertaken during the year also identified recurring issues relating to court delays, access to fitness assessments, treatment pathways, accommodation and support options, information sharing between agencies and the experiences of children and adults with highly complex needs.



**Thank you [Advocate] for being
such a pleasure to deal with –
[CLMI Identified Person] has been
fortunate that you became involved.**

LAWYER

Many of the issues raised by CLMI identified persons reflected inadequate or inappropriate interactions between justice, health, disability, child protection and community support systems. As a result, advocacy frequently involved supporting people to access treatment, participate in review processes, understand their rights, navigate multiple agencies and overcome barriers to rehabilitation and community reintegration.

This section outlines who MHAS worked with during 2025-26, the issues raised by CLMI identified persons, emerging trends identified through advocacy, and the systemic issues observed during the first full year of implementation of the CLMI Act. It also highlights MHAS' contribution to improving operational arrangements and promoting better outcomes for people subject to the legislation.

Who we worked with and the issues they raised

In 2025-26, MHAS received 519 notifications relating to 343 unique individuals across the notification categories reported in Table Eleven, compared with 391 notifications relating to 326 unique individuals during the previous reporting period. Given that 2024-25 captured only the first ten months of operation following commencement of the reforms on 1 September 2024, an increase in overall notifications was anticipated.

These figures should not be interpreted as the total number of CLMI identified persons assisted by MHAS during the year. In 2025-26 MHAS worked with 406 people, including those who first came into contact with the service in a previous reporting period.

The most common notification type continued to occur under section 30 of the CLMI Act, where a person's fitness to stand trial was raised during a court proceeding. Notifications of this type increased by 11 per cent, while the number of unique individuals increased by five per cent. This growth suggests courts and legal representatives are becoming increasingly familiar with the legislation and more willing to utilise the pathways available under the CLMI Act.

The notification data should, however, be interpreted with caution. Throughout the year, MHAS continued to identify issues regarding the timeliness, completeness and accuracy of court notifications. MHAS and Courts and Tribunal Services remained engaged in ongoing efforts to improve notification processes, including regular communication, escalation of issues and process improvements. While these efforts supported some improvements, MHAS continued to identify matters that were not notified by the court and instances where notifications did not include information such as notification dates or relevant hearing dates. As a result, reported notification figures are likely to understate total CLMI activity and do not fully reflect how promptly people were identified and connected with the statutory advocacy pathway.

Notwithstanding these limitations, the pattern of notifications provides important insight into how the reforms are evolving. While fitness to stand trial proceedings remained the largest source of referrals, growth in review-related notifications suggests increasing numbers of CLMI identified persons are progressing beyond initial court proceedings into ongoing supervision and review processes established under the CLMI Act. Together, these trends suggest demand is becoming increasingly distributed across multiple stages of the criminal justice pathway.

Custody Orders and Community

Supervision Orders

One of the most notable developments during the year was the significant increase in matters involving the MIRT. The MIRT oversees CSOs and COs made by the court to ensure decisions are regularly reviewed and appropriately based on the person's risk and rehabilitation potential. Notifications relating to review proceedings increased from 50 to 209, while the number of unique individuals almost doubled from 39 to 72. This growth reflects the increasing number of people progressing to the review and oversight mechanisms established by the CLMI Act.

Similarly, notifications regarding orders made under section 48 (court makes a CO or CSO) increased during the year. Six new COs were made, compared with four during the previous reporting period, while there was a sizeable increase in the number of CSOs, rising from two to 21. Only one of these CSOs was issued for a child. Although these numbers remain relatively small, and should be interpreted with caution, they represent an important shift in the operation of the reforms. CSOs did not exist under the previous legislative framework and are intended to provide a less restrictive pathway for suitable individuals while maintaining community safety.

TABLE ELEVEN – CLMI related notifications increased in the past year, largely via MIRT review proceedings

Notification type	2024-25		2025-26	
	Notifications	Individuals	Notifications	Individuals
Fitness to stand trial raised (s30)	236	209	259	220
Transitional cohort	79	54	NA	NA
MIRT review proceedings	50	39	209	72
Notification of place of custody (s63)	5	3	5	5
Adjournment to see if become fit (s36)	5	5	5	5
Notification of order (s48) – Custody Order	4	4	6	6
Notification of order (s48) – Community Supervision Order	2	2	21	21
Custody order discharged	3	3	2	2
Other miscellaneous	7	7	12	12
Total	391	326	519	343

TABLE TWELVE - There was some minor variability to the place of custody for existing Custody Orders

		1 Sep 2024 – 30 Jun 2025	2025-26
Number of notices received under Reg 3 Under CLMI Act and s48 of CLMI for Custody Orders made by the court		4	6
Total Custody Orders in place where the place of custody was	Authorised Hospital	33	38
	Declared Place	3	3
	Prison	8	4
	Total	44	45

The increase in review proceedings and CSOs suggests advocacy needs are changing as the reforms begin to mature. Increasingly, Advocates are supporting people not only through fitness proceedings but also through review hearings, rehabilitation planning, supervision arrangements and progression towards less restrictive options.

The total number of COs in place at any time during 2025-26 remained broadly consistent with the previous year. Information provided by the MIRT indicated a shift in the recorded place of custody, with the number of COs involving a prison falling from eight to four and the number involving an authorised hospital increasing by five. This suggests that a greater proportion of consumers subject to a CO were being managed within hospital settings rather than prison settings during 2025-26.

MHAS considers it preferable for people with mental illness who are subject to the CLMI Act to receive treatment and support in therapeutic environments rather than prison. People subject to the CLMI Act who remain in prison may be particularly vulnerable, and custodial environments are not designed to provide therapeutic care. Limited access to mental health assessment, treatment and psychiatric services can adversely affect wellbeing and recovery.

I affirmed [Advocate] for being so proactive in approaching me as many families find this process completely confusing and not even be aware of CLMI. Often the court process is overwhelming, the lawyer is appearing for the individual and rushing off to other cases. So, her proactive and informed approach was what we need more of in courts!

PARENT OF CLMI IDENTIFIED PERSON

Children aged 0 to 17 years

Children represented approximately 11 per cent of section 30 CLMI notifications received during 2025-26. MHAS received 29 notifications relating to 23 unique children, six of whom were recorded as being First Nations. All notifications were received under section 30 of the CLMI Act, where the child's fitness to stand trial was raised. Of the 29 notifications, more than half (16) were for children younger than 16 years of age.

As the CLMI legislation has become more embedded, the work of Advocates has increased in frequency and complexity. The time Advocates spent on individual tasks more than doubled compared to the previous reporting period (increasing from 2,462 hours to 5,769 hours). For children, this was even more stark with Advocate task hours increasing by 155 per cent. Like last year, Advocates spent most of their time on tasks related to processes involved in determining the fitness of the accused.

FIGURE FOURTEEN – Advocate task hours supporting CLMI identified children more than doubled over the last year

2025-26	535	18	13	0
2024-25	174	32	9	3

- Unfit Accused
- Community Supervision Order
- Hospital Order
- Custody Order

Issues raised by identified persons

Advocate functions include responding to issues and complaints raised by CLMI identified persons. In 2025-26, the issues raised by CLMI identified persons reflected the increasing complexity of the CLMI cohort and the systems within which they are supported.

In 2024-25, 178 issues were raised, with almost one in five of these issues (19 per cent) relating to rights. Ten issues were categorised as serious. In 2025-26, Advocates recorded 909 issues. More than five times the total number of issues raised in the previous year.

Thirty-six issues recorded in 2025-26 were classified as serious. MHAS uses this classification for matters involving an actual or alleged incident, risk or circumstance that may significantly affect a person's health, safety, wellbeing, dignity or rights and which requires prompt assessment, escalation or investigation. Serious issues may include significant safety concerns, allegations of harm, serious treatment concerns or circumstances where urgent intervention is required to safeguard the person's wellbeing.

The ten most frequently raised issues for CLMI identified persons changed over the last two years. Remaining steady, attendance at court (11 per cent in both 2024-25 and 2025-26) and legal representation (dropping to 9 per cent from 11 per cent in 2024-25) continued to be raised most often. However, thereafter the types of issues raised for CLMI identified persons shifted.

Issues relating to transition management became substantially more prominent in 2025-26, increasing from four recorded

issues in 2024-25 to 67 in 2025-26. These matters commonly arose when identified persons were preparing to move between custodial, health, disability and community settings and required coordination across multiple agencies and service providers.

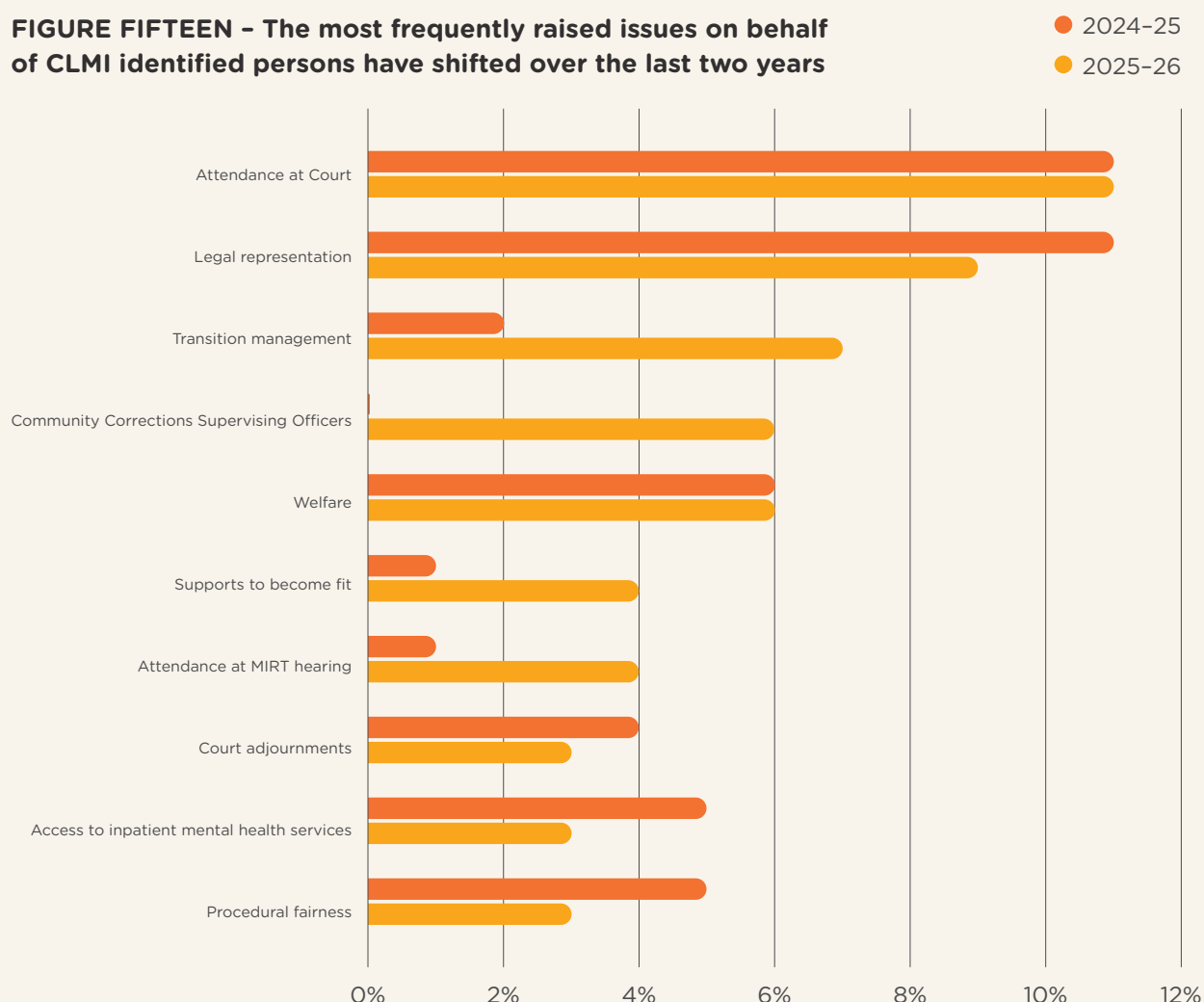
Concerns relating to Community Corrections and Case Conference Groups also emerged as a significant issue category, increasing from one recorded issue in 2024-25 to 61 in 2025-26. These matters related to the broader coordination and operation of community supervision and support arrangements under the CLMI framework. Concerns relating to Adult Community Corrections (ACC) supervising officers also emerged as a significant issue category, increasing from no recorded issues in 2024-25 to 52 in 2025-26. These matters related to supervision arrangements and the interaction between identified persons and community supervision processes. Together, these trends highlight the increasing importance of effective interagency coordination as greater numbers of people progress through supervision, rehabilitation and community reintegration pathways under the CLMI Act.

The frequency of welfare issues remained comparable over both years, equating to roughly five per cent of all issues raised for CLMI identified persons. However, procedural fairness issues, which were similarly recorded in five per cent of cases in 2024-25, dropped to just three per cent. These matters typically involved concerns that a CLMI identified person had not been afforded procedural fairness in the administration of court proceedings, review processes or the management of an order.

Issues associated with attendance at MIRT hearings also emerged as a notable concern. Advocates raised 39 issues relating to participation in review proceedings. These included concerns regarding attendance arrangements, the practical availability of alternative participation options such as audio-visual links, and barriers that affected the ability of some identified persons to participate in proceedings. Concerns regarding attendance, representation and effective participation in MIRT proceedings were also raised through MHAS ministerial reporting and stakeholder engagement during the reporting period, including at a meeting with the MIRT in February 2026.

Taken together, the issues raised by CLMI identified persons suggest the greatest areas of concern are not confined to treatment access alone. The most frequent issues also involved court attendance, legal representation, transition management, supervising officer arrangements, MIRT attendance and procedural fairness. This indicates that CLMI identified persons often require support across intersecting legal, justice, disability and mental health pathways, and that complexity arises from navigating the CLMI framework as much as from the person's mental health needs.

FIGURE FIFTEEN - The most frequently raised issues on behalf of CLMI identified persons have shifted over the last two years



[Supervising Officer] has on a number of occasions reiterated to me how invaluable [the Advocate's] input and collaboration has been.

ADULT COMMUNITY CORRECTIONS

Demand for advocacy support

While the CLMI service's Hub dataset continues to mature, MHAS is increasingly able to identify where CLMI identified persons require the greatest levels of support throughout the criminal justice pathway. As the reforms become more embedded and the number of people subject to the CLMI Act increases, the data is providing a progressively clearer picture of advocacy demand and the points at which intervention is most frequently required.

Consequently, MHAS is increasingly confident that the data provide a meaningful indication of where advocacy support is most often required. Consistent with other CLMI data presented in this report, the greatest advocacy effort remains concentrated around court processes, review proceedings and ongoing engagement with CLMI identified persons as they progress through the criminal justice system. This reflects the breadth of advocacy required under the CLMI Act and reinforces the need for support across multiple stages of a person's interaction with the justice system.

FIGURE SIXTEEN – Areas of greatest demand for advocacy support from CLMI identified persons

Attending court with identified person and preparation for this



Visiting identified person in prisons and following up on issues raised during those visits



Attending and preparing for appearances with or for identified person at MIRT



Visiting identified person in hospitals and following up on issues raised



Attending case conferences



Advocacy in action: systemic issues and outcomes

From implementation to operation

While the previous reporting period focused on establishing the service and supporting implementation of the reforms, 2025-26 provided the first opportunity to observe how the CLMI Act was operating in practice and how identified persons experienced the new framework.

As the legislation became more established, advocacy demand increased steadily across courts, prisons, the Banksia Hill Detention Centre, the Frankland Centre and State Forensic Mental Health Services (SFMHS), and community settings. Advocates observed growing utilisation of the CLMI Act by courts and legal representatives, increasing numbers of review proceedings before the MIRT, and more CLMI identified persons progressing to the community supervision pathway.

The first full year of operation demonstrated that the challenges experienced by CLMI identified persons were rarely confined to a single agency or decision. Instead, difficulties often emerged at the intersection of justice, health, disability, child protection and community support systems. Delays, fragmented communication, competing responsibilities between agencies and limited service capacity frequently combined to create barriers for CLMI identified persons seeking treatment, rehabilitation or progression to less restrictive arrangements.

Advocates consistently heard concerns from people who felt they had little control over decisions affecting their lives and limited understanding of what was happening within the legal process. Many described lengthy periods of uncertainty, a lack of information about proceedings and difficulty understanding decisions relating to fitness assessments, custody arrangements, treatment pathways and review processes. For many, the complexity of the system itself became a significant barrier to participation.

The experiences of CLMI identified persons throughout the year highlighted an important reality of the CLMI framework. While the legislation creates safeguards, reviews and pathways intended to improve outcomes, the effectiveness of those protections depends heavily on timely assessments, access to treatment, effective communication between agencies and the availability of appropriate supports in the community.

Delays, complexity and

navigating the CLMI pathway

The most consistent theme identified through advocacy during 2025-26 was delay. Delays were evident across multiple stages of the CLMI pathway, including court proceedings, fitness assessments, psychiatric and psychological reporting, access to treatment, admissions to the Frankland Centre, review hearings and transition planning. Advocates regularly encountered matters where expert reports took many months to complete, hearings were repeatedly adjourned, or CLMI identified persons remained in custody awaiting treatment, accommodation or support services.

For many people, these delays had consequences extending well beyond the legal process. Court proceedings were often described as slow, confusing and difficult to understand, particularly where matters were repeatedly adjourned, or progress depended on specialist assessments and reports. Many people reported feeling powerless, excluded from decision-making and uncertain about what needed to occur before their matter could progress. Advocates played a key role in ensuring procedural fairness by helping CLMI identified persons understand the process, obtaining information about the status of their matters, communicating with legal representatives and agencies and participating more effectively in decisions affecting their lives.

Advocates observed that prolonged delays could have serious consequences for wellbeing, recovery and progression through the CLMI pathway. Extended periods of uncertainty, detention and untreated needs often contributed to increasing distress, frustration and hopelessness. In custodial settings, Advocates frequently encountered people who had been waiting for extended periods for psychiatric review, hospital admission or access to treatment while their legal matters remained unresolved. Delays in assessment and treatment were associated with increased risks of self-harm, suicidality, worsening psychosis or other symptoms and behavioural escalation. In some matters, Advocates observed that unmet mental health needs appeared to contribute to further offending behaviour or incidents within custodial settings, highlighting the importance of timely

access to assessment, treatment and therapeutic intervention. Where concerns arose, Advocates worked with services, legal representatives and families to address barriers, escalate concerns and progress access to assessment, treatment, accommodation and support services. In some matters, this resulted in improved access to assessments, treatment planning and pathways to less restrictive arrangements.

A particular challenge was the availability of specialist fitness assessments. Limited clinician availability, combined with increasing demand, contributed to lengthy waiting periods for reports required by the courts. In some matters, individuals remained subject to detention and ongoing legal proceedings for several months while awaiting assessments necessary for decisions about fitness, treatment or progression through the CLMI pathway. Advocates assisted CLMI identified persons and their families to understand the assessment process, monitored the progress of matters, sought information regarding delays and anticipated timeframes, and regularly followed up with relevant agencies to advocate for timely completion of assessments and reports.

The first full year of operation highlighted the complex relationship between legislative safeguards and practical outcomes. While the CLMI framework provides important protections and review mechanisms, the experiences of CLMI identified persons demonstrated that delays in assessments, hearings, treatment pathways and accommodation options can significantly reduce the practical benefits of those safeguards. This was particularly evident where suitable treatment, rehabilitation or community-based alternatives were unavailable, resulting in people remaining in restrictive environments longer than necessary. Advocates regularly worked with agencies, legal representatives and support providers to explore less restrictive options, promote access to treatment and supports, and facilitate planning for transitions where opportunities became available. However, these efforts were often constrained by broader system capacity, workforce shortages and the availability of suitable services and accommodation.

Understanding and participating in legal processes

Many CLMI identified persons told Advocates they found the CLMI process difficult to understand and even more difficult to navigate.

Court proceedings, fitness determinations, MIRT reviews, supervision arrangements and custody pathways frequently involve multiple agencies, unfamiliar terminology and complex legal concepts. Advocates regularly encountered people who were unsure why decisions had been made, what options were available to them, or what they needed to do to progress towards less restrictive arrangements.

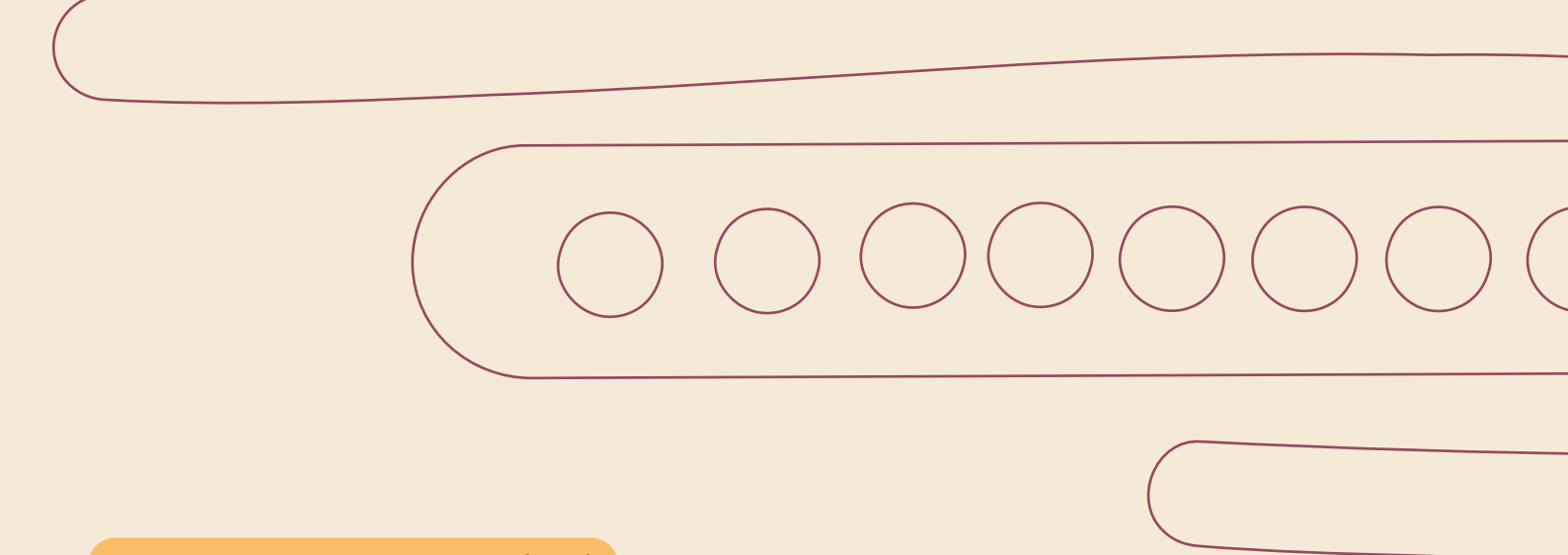
CLMI identified persons commonly described feeling unheard and excluded from decisions affecting their liberty, treatment and future. Some reported receiving limited information about proceedings, while others struggled to understand information that had been provided because of communication barriers, cognitive impairment, intellectual disability, mental illness or other factors affecting their ability to understand and participate in proceedings. These concerns arose despite the availability of supports designed to facilitate communication and participation in some matters. Advocates therefore spent considerable time helping people navigate legal processes, access information, communicate their views and participate in decision-making.

Understanding of the CLMI framework among legal representatives emerged as an important advocacy theme throughout the year. While specialist providers such as Ruah Legal Services, Legal Aid WA and the Aboriginal Legal Service demonstrated strong expertise in the legislation, the relative newness of the reforms meant this knowledge was not always consistent across the broader legal sector. Advocates frequently assisted CLMI identified persons to clarify information and facilitate communication with their legal representatives. This support was particularly important where misunderstandings about the legislation and available pathways had the potential to affect outcomes for people.

Participation in MIRT proceedings emerged as an increasingly important area of advocacy. As greater numbers of people entered review and supervision pathways, Advocates were regularly involved in supporting attendance at review hearings, assisting people to understand recommendations and outcomes, and ensuring CLMI identified persons had an opportunity to express their wishes, preferences and concerns.

Ahh! Life is good. Great. Extremely excellent and outstanding thanks to you and I still can't believe I'm here.

RESIDENT



Access to treatment remained

one of the most significant advocacy issues

Access to appropriate treatment, assessment and mental health care remained one of the most significant advocacy issues identified during the year. Advocates continued to encounter individuals who appeared to require urgent psychiatric assessment, treatment or admission to hospital but faced significant barriers accessing appropriate care. Concerns were commonly raised by CLMI identified persons, family members and prison staff regarding access to psychiatrists, medication reviews, specialist mental health services and ongoing treatment within custodial settings.

A recurring advocacy issue was the extent to which appropriate treatment could be provided within custodial environments. Advocates encountered matters where clinically indicated treatment was delayed, interrupted or unavailable because the necessary specialist input, therapeutic supports or treatment environment could not readily be provided within custody. These matters included concerns regarding continuity of treatment, access to specialist mental health care, access to inpatient treatment and the availability of supports required to meet complex clinical needs. Concerns were also raised regarding limited access to psychological and other therapeutic interventions, with treatment options substantially more limited than those available in community or hospital settings. While a range of initiatives are being implemented to recruit and retain mental health staff within custodial settings, Advocates continued to observe workforce-related constraints affecting access to psychiatric assessment, specialist treatment and ongoing mental health care during 2025-26.

Noting that systems exist within custodial settings to identify and respond to mental health deterioration, the treatment available within prisons often does not provide access to the range or intensity of interventions available in community or hospital settings. Demand for such services also often exceeds availability. Advocates observed matters where people continued to experience significant mental health deterioration despite engagement with prison health services, because access to specialist treatment, inpatient care or other clinically indicated interventions was unavailable, delayed or difficult to obtain. In these circumstances, Advocates observed worsening symptoms, increasing distress and heightened risks to wellbeing and safety. Advocates also observed matters where treatment arrangements changed following entry into custody because the treatment options available in prison differed from those available in community or hospital environments. Sometimes, these changes were associated with deterioration in a person's mental health or wellbeing. Particular concern was expressed regarding prisoners with significant mental health needs who remained in custody despite presenting with symptoms that Advocates and prison mental health staff considered warranted examination and/or treatment in a specialist therapeutic environment. Advocates also observed situations where pathways into hospital-based care were unclear, delayed or subject to competing responsibilities between DoH services and Corrective Services. In these matters, Advocates frequently raised concerns with health and custodial services, sought information about treatment pathways

and anticipated timeframes, and advocated for access to assessment, treatment and admission where clinically indicated. Where barriers remained unresolved, Advocates escalated concerns within MHAS and through to service executives and other decision-makers, seeking timely access to treatment and care.

Constraints on the interaction between the CLMI framework and the forensic mental health system became increasingly apparent throughout the year. Limited forensic mental health bed capacity, sustained pressure on civil authorised hospital beds and competing demand for treatment services all affected the ability of CLMI identified persons to access timely care. Daily reporting by the SHOC regarding people awaiting mental health beds highlighted the significant and ongoing demand for authorised hospital services across the State, including the Frankland Centre, Western Australia's only dedicated forensic mental health hospital.

[Senior Community Corrections Officer] has reported to me the invaluable collaboration with the Hospital MHAS Advocate who has been key in supporting [CLMI Identified Person] engage with agencies available to assist her. The shift in engagement has been incredible, giving [CLMI Identified Person] a really good chance at transitioning in the community safely.

ADULT COMMUNITY CORRECTIONS



Statewide forensic bed capacity

While government has commenced a major program of work to expand forensic mental health capacity, including through the Graylands Reconfiguration Project and subsequent expansion of the Frankland Centre, demand for forensic mental health services continued to exceed available capacity during 2025-26. Advocacy work undertaken through MHAS' CLMI service stream and broader prisoner access to mental health project also continued to identify substantial barriers to timely access to treatment.

As at 30 June 2026, the Frankland Centre comprised 30 beds, while Dryandra Ward provided a further 14 forensic rehabilitation beds available only to prisoners on COs (13 operational at 30 June 2026). Together, these 43 operational beds served a prison population of approximately 8,700 people.

Access to forensic mental health services became a significant advocacy issue during the reporting period. Through individual advocacy, engagement with people subject to the CLMI Act, prison visits and MHAS' systemic work examining prisoner access to mental health treatment, Advocates continued to encounter matters where access to hospital-based care was delayed or difficult to obtain.

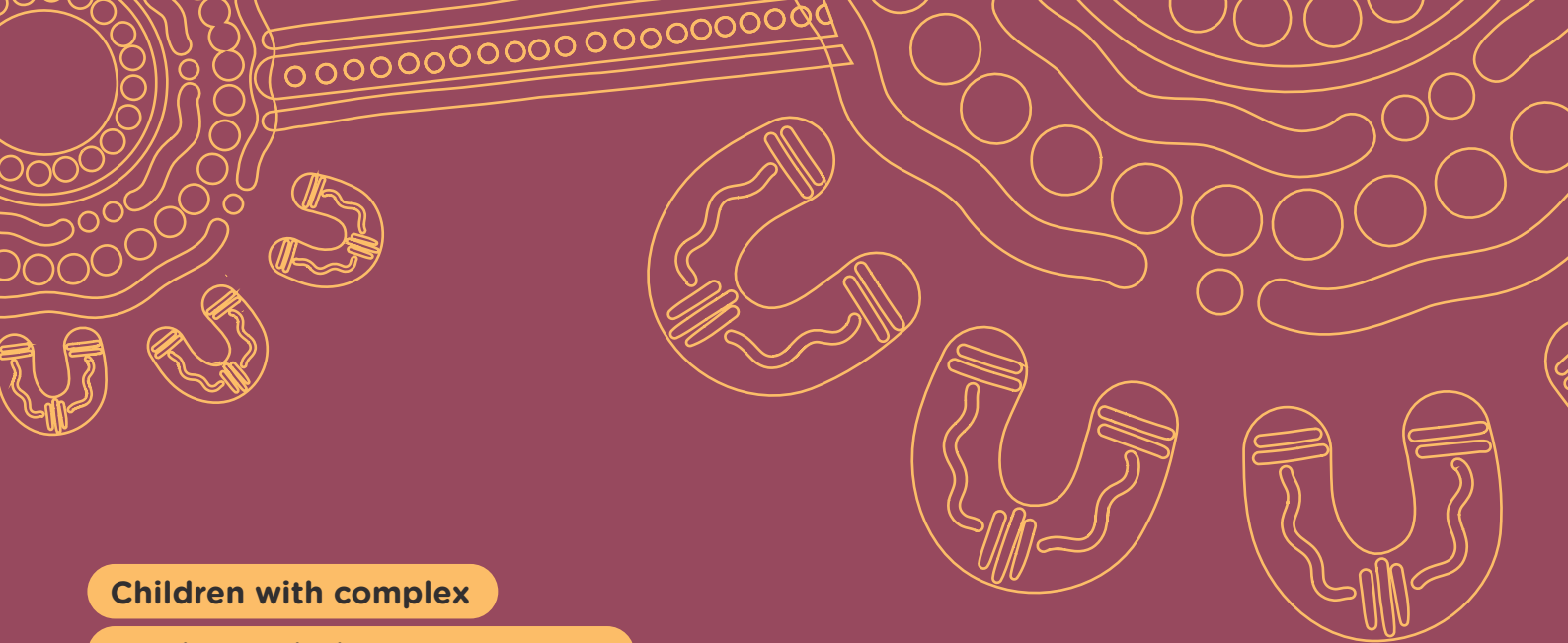
MHAS' quarterly reporting data indicated that 20 of the Frankland Centre's 30 beds were occupied by CLMI identified persons on COs. Of the remaining 10 beds, five were occupied by long-stay prisoners receiving treatment under the MH Act. As a result only five beds were available for other prison referrals. As at 30 June 2026, Acacia Ward, which provides treatment for people requiring the highest levels of care, was operating at near-full capacity, with seven of its eight beds occupied and the remaining bed reserved for a person on a CO awaiting transfer from prison. Dryandra Ward was similarly operating at near-full capacity, with all 13 of its operational beds occupied.

Collectively, these capacity pressures limited the availability of beds for prisoners requiring admission to forensic mental health services.

Furthermore, in the first six months of 2026 there was an average of 22 prisoners referred for treatment to the Frankland Centre.²⁴ For CLMI identified persons, this could mean remaining in custodial environments for extended periods of weeks or months while awaiting access to treatment services more appropriately delivered in a therapeutic setting.

Access to inpatient treatment was not solely affected by bed availability. Advocates observed that access to hospital-based mental health care could also be influenced by the coordination required between health and justice agencies, differing views regarding the most appropriate treatment setting and uncertainty regarding available admission pathways. While mechanisms existed to facilitate assessment, referral and coordination, including through SHOC and other established liaison arrangements, Advocates continued to encounter matters where treatment options, admission pathways and agency responsibilities required clarification before access to care could be progressed. These experiences suggest opportunities for greater consistency, clearer protocols and improved coordination between health and justice agencies in supporting access to mental health treatment for prisoners. MHAS acknowledges ongoing work across agencies to strengthen these arrangements.

The systemic advocacy work undertaken by MHAS regarding prisoner access to mental health care reinforced concerns identified through individual advocacy. While advocacy contributed to improved access to assessment, treatment and admission in some matters, these outcomes were often difficult to achieve and did not resolve the underlying barriers affecting access to care. Progress remained constrained by bed availability, workforce shortages, competing service demand and uncertainty regarding treatment pathways. The experiences of CLMI identified persons throughout the year reinforced the need for improved access to treatment, clearer pathways, a shared understanding of roles and responsibilities, and coordinated responses across health, justice and disability systems.



Children with complex needs caught between systems

One of the most significant issues identified during 2025-26 involved children with highly complex needs who were subject to CLMI proceedings and also in the care of Child Protection and Family Support.

Many of these young people presented with multiple and overlapping vulnerabilities, including intellectual disability, fetal alcohol spectrum disorder, neurodevelopmental disorders, complex mental health diagnoses and significant trauma histories. Their needs frequently exceeded the capacity of traditional youth justice, child protection, disability or mental health service responses.

One case highlighted the significant challenges facing children with highly complex needs who become involved in the CLMI pathway. Despite broad agreement that detention was not the most appropriate setting and the Magistrate's stated position that bail would have been granted had suitable accommodation, supports and supervision arrangements been available, no service arrangement could initially be identified that was capable of safely supporting the child in the community. As a result, the child remained in detention for several months while agencies attempted to identify an appropriate therapeutic and accommodation pathway.

Following sustained advocacy and escalation by MHAS and other agencies, a comprehensive accommodation and support package was ultimately developed. However, achieving this outcome required considerable time,

resources and coordination across multiple agencies and service providers. The child remained in detention throughout this process, highlighting the significant consequences that can arise when appropriate accommodation and support pathways for children with highly complex needs are not readily available.

MHAS raised concerns regarding this and similar issues with the Director General of Communities and other senior stakeholders. MHAS was advised that Communities and the Commission were working collaboratively to develop an alternative model of care and accommodation for children whose needs cannot be met through existing out-of-home care arrangements.

While MHAS welcomes this work, these matters highlight a significant gap in the service system. For some of the State's most vulnerable children, the primary obstacle was not the CLMI legislation itself but the absence of suitable accommodation and therapeutic services and supports capable of meeting complex needs safely within the community.

The impact on young people can be profound. Many have already experienced significant trauma, instability and disadvantage. Extended periods in detention can further affect development, wellbeing and rehabilitation opportunities. The experience of these children demonstrates how systems intended to protect and support vulnerable young people can inadvertently contribute to further harm when appropriate alternatives are unavailable.



²⁴ Average number of prisoners awaiting admission to the Frankland Centre between 27 January and 30 June 2026, based on SFMHS Wait Listed Referrals data.

CLMI court notifications: Supporting timely access to advocacy

The CLMI Act provides important rights and protections for people who are identified as potentially unfit to stand trial or who become subject to CLMI proceedings. A key safeguard is the requirement for MHAS to be notified when fitness to stand trial is raised, so that advocates can offer timely support.

During 2025-26, MHAS identified significant concerns about the timeliness, consistency, and quality of court notifications. These concerns were raised formally with the DoJ and remained a significant focus of MHAS' systemic advocacy throughout the year. MHAS and Courts and Tribunal Services continued to engage constructively throughout the reporting period to better understand the issues, develop interim solutions and identify opportunities to improve notification processes.

MHAS' analysis found that approximately 18 per cent of cases were not initially notified by the court and that only 19 per cent of notified cases contained both the notification date and relevant hearing date. These gaps meant MHAS could not consistently determine whether notification occurred at the time fitness was raised or offer advocacy at the earliest point intended by the CLMI Act.

Although Courts and Tribunal Services introduced an interim manual process in which courts were expected to email MHAS on the day fitness was raised and provide formal notification in the following days, MHAS continued to experience gaps. In some cases, same-day advice was not received. In others, later notification did not contain the required information, or bulk documents were provided for MHAS to examine and interpret.

FIGURE SEVENTEEN - What MHAS found

Missing or delayed

18 per cent of cases were not initially notified to MHAS by the court. Where notifications were received, delays ranged from several days to several weeks and, in some cases, longer.

Multiple pathways

MHAS continued to identify CLMI matters through ACC, courts, lawyers, Advocate attendance at court, and other sources rather than through a single reliable notification pathway.

Incomplete content

Only 19 per cent of notified cases contained both the notification date and the relevant hearing date, limiting MHAS' ability to assess notification timeliness.

Manual workaround

An interim same-day email process was introduced in May 2026, but MHAS analysis found that it was not consistently applied and had not resolved the notification issues.

Why this matters for

CLMI identified people

Timely notification is critical because the earliest stages of CLMI proceedings can shape a person's understanding, participation, and access to support. Delayed, missing or incomplete notification can mean that a person is not offered independent advocacy at the point intended by the legislation resulting in:

- reduced opportunity to explain rights, processes and available advocacy support early in proceedings
- missed opportunities to identify concerns about wellbeing, detention, treatment, communication or understanding
- increased risk that people with mental illness, cognitive impairment, intellectual disability or other vulnerabilities do not receive timely information, advocacy and support to understand and exercise their rights
- greater risk that people remain in court or custodial processes without timely support to raise and resolve issues

Impact on MHAS advocacy

service and functioning

Notification issues also affect MHAS' ability to perform its statutory advocacy functions efficiently. When required information is delayed or incomplete, Advocates and staff must spend additional time reconstructing procedural history and clarifying whether CLMI provisions have been engaged. This often involves:

- checking dates and hearing information across multiple sources
- following up with courts and other agencies for missing or unclear information
- reviewing bulk material or transcripts to identify relevant CLMI information
- diverting advocacy resources from direct engagement with identified people to administrative and system coordination work

What MHAS did in response

Throughout 2025-26, MHAS worked with justice stakeholders to improve notification practices and strengthen access to advocacy for people entering the CLMI pathway. This work included:

- formally escalating concerns about court notification practices to the DoJ
- maintaining and analysing notification data to identify delays, gaps and inconsistency
- sharing emerging findings with justice stakeholders through operational engagement
- continuing to monitor whether interim notification arrangements were being applied in practice
- advocating for notification arrangements that are timely, consistent and include sufficient information to enable advocacy to be offered

What this work showed

The CLMI reforms represent an important advancement in rights and safeguards for accused persons with mental impairment. However, MHAS' experience during 2025-26 demonstrated that effective implementation depends on the operational systems that sit behind the legislation.

Delayed, incomplete or inconsistent notifications limited MHAS' ability to identify people at the earliest stage of proceedings and offer advocacy when it was intended by the Act. The issues identified through this work reinforced the importance of timely, reliable and complete notification processes in giving practical effect to the protections established by the CLMI Act.

Prisoner access to mental health services

A major program of systemic advocacy

During 2025-26, MHAS undertook significant ongoing systemic advocacy work examining access to mental health care and treatment for people in Western Australian prisons. The work was undertaken in partnership with the OCP and OICS with engagement from HaDSCO and other stakeholders.

The work was prompted by recurring issues identified through individual advocacy, engagement with people subject to the CLMI Act, prison visits, stakeholder consultation and concerns raised by Advocates about barriers to treatment for people with serious mental illness and mental impairment.

Recognising that these issues extended beyond individual cases, MHAS committed policy, research, analysis and stakeholder engagement resources, along with engagement from OCP, OICS, MHT and HaDSCO, to better understand the problem and identify opportunities for system reform. The work drew evidence from advocacy practice to identify systemic barriers, explain their impact, and influence practical improvement across the mental health and justice systems.

Good news. [CLMI Identified Person] was unconditionally released in Court this morning. No record. No fine & no conditions...free to live his life. Finally. Thank you again for all your support to me and [CLMI Identified Person] through the worst period of our lives.

PARENT OF CLMI IDENTIFIED PERSON

What MHAS did

MHAS undertook a structured body of work that combined advocacy evidence, policy analysis, consultation and report drafting. This included drawing together information from individual advocacy matters, prison engagement, CLMI work, forensic mental health data, oversight material, and stakeholder discussions. This work:

- Analysed advocacy trends and recurring issues identified through individual cases involving prisoners and CLMI identified persons
- Examined pathways into forensic mental health services, including access to the Frankland Centre and barriers to hospital admission
- Reviewed available referral, admission and service capacity information to better understand the difference between recorded demand and likely unmet need
- Consulted with SFMHS, Corrective Services, OICS, OCP, MHT and HaDSCO and other stakeholders
- Considered access to advocacy for prisoners referred for mental health assessment and treatment, including practical issues associated with Form 1A pathways
- Developed briefing material, analysis and reform options to support discussion with Government, senior decision-makers and mental health stakeholders

What MHAS produced

The work produced a substantial evidence-informed briefing paper on prisoners' access to mental health care and treatment in Western Australia. It also generated internal briefing material, presentation content, advice for executive-level discussions, analysis of referral pathways, and sharper articulation of the links between prison mental health access, forensic bed pressure, CLMI implementation, disability pathways and broader system reform.

What MHAS achieved

Through this work, MHAS elevated prisoner access to mental health care as a significant systemic issue. It provided a clearer evidence base for reform discussions and helped shift the conversation from a narrow focus on forensic beds to a broader whole-of-system response.

MHAS advocacy emphasised that forensic beds are critical, but they are only one part of a wider continuum of care. Reform also requires effective prison mental health services, timely assessment pathways, civil hospital and emergency pathways where appropriate, community treatment and support, disability justice pathways, supported accommodation, step-down options and stronger cross-agency governance.

FIGURE EIGHTEEN: What the evidence showed for prisoners in WA²⁵



1. Demand for forensic mental health services exceeds available capacity

Service data and stakeholder consultation consistently indicated that demand for forensic mental health assessment and treatment exceeds available capacity. Capacity constraints were identified as a key barrier to timely access to hospital-level care.

2. Data underestimates unmet need

MHAS identified concerns that referral and admission data may not fully reflect demand for forensic mental health services. Consultation suggested that prisoners can remain awaiting bed availability without progressing through ongoing referral pathways, reducing the visibility of unmet need within reported data.

3. Prisoners often experience extended periods awaiting access to treatment

The work identified concerns that prisoners requiring specialist mental health treatment may experience significant delays before hospital admission occurs. This can prolong time spent in custodial environments that are not designed to provide hospital-level care.

4. Forensic beds are only one component of a broader treatment pathway

While forensic bed availability emerged as a significant issue, MHAS found that access to treatment is also affected by prison mental health services, admission pathways, discharge arrangements and community supports. Increasing bed capacity alone is unlikely to resolve broader system pressures. There is also an assumption that all prisoners require a forensic bed, whereas many prisoners' treatment in a civil hospital would be appropriate for their inpatient care.

5. Prison mental health reform requires a system-wide response

The work concluded that improving access to mental health treatment requires coordinated action across health, justice, and related service systems. Effective reform depends on strengthening pathways between assessment, treatment, hospital care and ongoing supports.



²⁵ Source note: SFMHS data provided to MHAS for the year from 1 September 2024 to 31 August 2025 reported 1,641 MHA referrals of prisoners to the Frankland Centre for 166 unique individuals, with 34 admissions. The same advice reported an average Frankland Centre occupancy of 99% in the current financial year and noted that new admissions could only occur into the acute eight-bed Acacia ward.

Declared Places (Mental Impairment) Act Service

The Bennett Brook Disability Justice Centre

MHAS' third service stream provides statutory advocacy to residents of the Bennett Brook Disability Justice Centre (DJC), Western Australia's only declared place under the DPMI Act. The DJC is a secure therapeutic facility operated by Disability Justice Services within Communities for people who are detained under the CLMI Act and require specialised disability supports. At 30 June 2026, the DJC remained the State's only declared place and had capacity for 10 residents.

Part 10 of the DPMI Act provides residents with a right to access independent statutory advocacy. MHAS Advocates work to protect and promote the rights, safety and wellbeing of residents, support them to understand and exercise their rights, and assist them to participate in decisions that affect their lives. Advocates also work alongside residents and services in relation to individual development planning, rehabilitation, community inclusion and transition pathways.

While community safety is the primary consideration underpinning the DJC model, the framework also aims to support residents' development, rehabilitation and increasing independence. MHAS contributes to these objectives by providing independent advocacy that protects rights and supports residents to participate in decisions about their lives, goals and future pathways.

The residents of the DJC

Like previous years, the number of people residing at the DJC continued to remain low in 2025-26. Again, only three people were accommodated at the facility throughout the year and only one new MIRT determination directed that a person subject to a CO be placed at the DJC. All three residents were First Nations people. In contrast, 11 new determinations were made to place people on new COs at authorised hospitals, increasing from five the year before. At the end of the reporting period, only three of the DJC’s 10 beds were occupied, continuing a pattern of low utilisation observed in previous years, as there has never been any more than three residents at any time since the centre opened.

The custody data also indicate that placement patterns remained relatively stable despite the increased number of new MIRT determinations in 2025-26. The total number of COs where the place of custody was the DJC remained unchanged at three, while the number where

the place of custody was an authorised hospital increased from 33 to 38. Although 13 new MIRT determinations were made during the year, the total number of people on COs increased by only one. This reflects that new determinations are only one factor affecting the total number of COs in place at any point in time, with the figures also influenced by people exiting orders or changes in place of custody during the reporting period.

MHAS Advocates received seven initiations through MIRT Review Proceedings during the year involving three DJC residents. Advocates completed 70 advocacy tasks²⁶ across the three residents which included contacting each resident at least four times throughout the year as a minimum requirement. Residents are not required to engage with advocacy services and may decline advocacy contact at any time. However, all residents engaged with MHAS during the reporting period.

TABLE THIRTEEN - The number of new determinations at Authorised Hospitals doubled last year

		1 Sep 2024 - 30 Jun 2025	2025-26
Number of notices received under Reg 3 Under CLMI Act and s48 of CLMI for Custody Orders made by the court		4	6
Total Custody Orders in place where the place of custody was	Authorised Hospital	33	38
	Declared Place	3	3
	Prison	8	4
	Total	44	45
Total new determinations made by the Tribunal for place of custody to be	Authorised Hospital	5	11
	Declared Place	1	1
	Prison	3	1
	Total	9	13



²⁶ Advocacy tasks are individual actions undertaken by an Advocate on behalf of a resident. Tasks may include contact with the resident, provision of rights information and advice, preparation for MIRT proceedings, attendance at hearings, liaison with services, follow-up work and other advocacy activities recorded in the Hub.



The advocacy service

Independent advocacy is a central safeguard within the declared places framework. Under the DPML Act, residents of the DJC have a right to access advocacy services that support them to understand and exercise their rights, participate in decisions affecting their lives, and raise concerns about their treatment, care and future planning. Advocate functions include safeguarding residents' rights, health and safety, assisting residents to raise complaints and concerns, monitoring restrictions on rights, supporting participation in planning and review processes, assisting access to legal services, and ensuring residents' views, wishes and preferences are heard and considered in decisions affecting their lives.

The role requires Advocates to navigate the complex intersection between disability, criminal justice, health and community services. While community safety remains the primary consideration within the declared places framework, advocacy provides an important mechanism for ensuring residents remain active participants in decisions about their lives and future pathways.

What residents told advocates

Residents generally reported feeling safe and well supported at the DJC. Positive relationships with staff were a consistent feature of advocacy discussions, with residents describing staff as caring, supportive and invested in their wellbeing. Advocates similarly observed strong rapport between residents and staff and noted the benefits of a structured environment that supports skill development, rehabilitation and day-to-day living.

While residents acknowledged the supports available to them, some also spoke about autonomy, choice and independence. Residents frequently expressed a desire for greater control over aspects of their daily lives and frustration with restrictions associated with living in a declared place. Issues relating to leave, smoking arrangements, daily routines and the pace at which residents could progress towards greater independence were recurring themes. Residents often expressed a wish to move forward more quickly, particularly in relation to community living and exercising greater control over their future.

Planning, rehabilitation and community participation were also important advocacy themes throughout the year. Residents consistently identified community access, leave opportunities, skill development and future living arrangements as priorities. As part of their statutory functions, Advocates supported residents to participate in Individual Development Plan (IDP) and Leave of Absence (LOA) processes, communicate their views and preferences, and ensure their aspirations were considered in decisions affecting rehabilitation, community participation and future pathways. Advocates also assisted residents to understand their rights, participate in review and planning processes, raise concerns and complaints where required, and engage with disability, health and community service providers involved in their care and support.

While planning processes generally sought to reflect residents' goals and aspirations, progress often depended on factors outside residents' direct control, including

service availability, access to appropriate supports and broader system constraints. Residents expressed frustration when opportunities for leave, rehabilitation activities or community participation were delayed or unable to proceed as planned. Advocates regularly raised these concerns through planning, review and service coordination processes and worked with residents, providers and other stakeholders to progress opportunities that supported increasing independence, community participation and preparation for future transitions. Advocates also observed that access to capable disability providers and community supports remained important to successful rehabilitation and progression towards future community living.

Family, community and cultural connections remained important. Residents valued opportunities to maintain contact with family members and participate in activities outside the DJC where possible. Given all residents accommodated at the DJC during 2025-26 were First Nations people, Advocates also identified the importance of culturally responsive supports and maintaining connections to culture, Country and community. Advocates supported residents to communicate their cultural needs and preferences and promoted consideration of these factors in planning and service delivery.

Despite some frustrations, residents consistently described the DJC as a place where they felt safe and cared for. The challenge identified through advocacy discussions was not one of immediate safety or wellbeing, but of balancing community safety requirements with residents' aspirations for greater independence, participation and control over their future. Advocacy therefore focused on ensuring residents remained active participants in decisions affecting their lives, that their rights and preferences were heard and considered, and that opportunities for rehabilitation, skill development and community participation were progressed wherever possible.

The Advocates' work

During 2025-26, MHAS Advocates completed 70 advocacy tasks across the three residents accommodated at the DJC and received seven initiations arising from MIRT Review Proceedings involving three residents. Advocates' work included supporting residents to participate in review proceedings, IDP processes and discussions regarding rehabilitation, community participation, LOA arrangements and future accommodation pathways.

Advocates maintained regular contact with residents, monitored the protection of residents' rights and assisted residents to raise concerns, seek information and participate in decisions that affected them. Advocacy frequently involved supporting communication between residents, DJC staff, disability providers, legal representatives and other stakeholders involved in residents' care and rehabilitation.

Advocates also attended meetings, contributed to planning processes and supported residents to navigate complex systems across the disability, justice, health and community sectors. Where issues arose, Advocates worked to ensure residents' views, preferences and concerns were considered alongside safety, support and service delivery considerations.

Throughout the year, Advocates maintained constructive relationships with DJC management and external stakeholders. Advocates observed positive collaboration between the DJC, residents' support networks and service providers, while continuing to provide residents with access to an independent source of support and advice.

Emergency restraint and seclusion

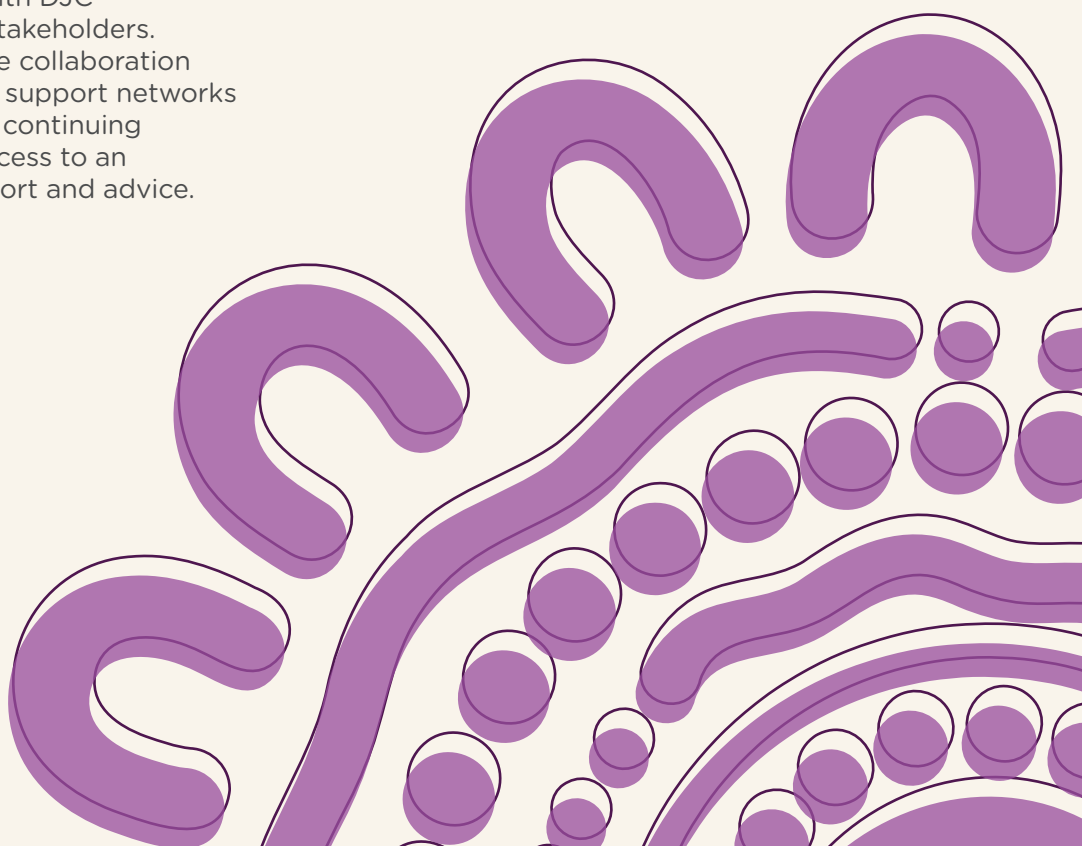
The Chief Advocate was notified of one emergency seclusion and no emergency restraints during the year. The matter was reported directly to the Advocate at the time it occurred. Advocates investigated the matter and determined that no further action was required.

Meetings with the Minister for Disability Services

The Chief Advocate had one meeting with the Minister for Disability Services and one with her office 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 2025-26 was \$ 12,393.



Advocacy in action: systemic issues and outcomes

Although the experiences of three residents cannot be assumed to represent a larger cohort, their advocacy matters provided insight into barriers arising at the intersection of disability, health, justice and community services. The most prominent issues related to the continued under-utilisation of the DJC, rehabilitation and transition pathways, the availability and capability of community supports, access to health care, resident participation in planning, and culturally responsive pathways to community inclusion.

Whilst I'm aware it is his role to be there for the patient, I do feel [Advocate] excelled in being "there" for the patient...[Advocate] remained empathic, respectful and provided highly supportive advocacy for this patient and represented his wishes in a skilful fashion.

CLINICIAN

Under-utilisation of the DJC

The role of the DJC within the broader forensic disability, mental health and justice systems remained an area of discussion during 2025-26. While the DJC is intended to provide a secure, therapeutic and residential alternative to custody for people subject to the DPMI Act, Advocates and legal stakeholders continued to raise questions about the facility's limited utilisation.

Concerns focused on whether the current approach is sufficiently responsive to people with complex or intersecting needs, including neurodivergent people and those whose circumstances do not align neatly with more traditional disability categories, especially those who had not been assessed for disability during childhood. MHAS observed a lack of clarity regarding decision-making responsibility for placement at the DJC. While the MIRT advised that it relies heavily on the eligibility and suitability assessments provided by Disability Justice Services, Disability Justice Services noted that the final determination regarding placement rests with the MIRT. This created uncertainty for identified persons, legal representatives and Advocates seeking to understand the basis of placement decisions or avenues for review.

Advocates observed that there is currently no clearly defined pathway for reconsideration of placement where a person is initially assessed as unsuitable for admission to the DJC. This may create barriers for individuals whose circumstances have changed (for instance, effective symptom management through treatment for mental illness) or whose support needs could potentially be met through a different service response at a

later point in time. Greater clarity regarding reassessment pathways may assist courts, legal representatives and decision-makers to identify appropriate alternatives and ensure placement options remain responsive to changing circumstances. During the 2025-26 year MHAS was encouraged by advice from the Disability Justice Service that the eligibility criteria are intended to be reviewed during 2026-27.

MHAS also recognises that the suitability of the DJC for some residents is influenced by the availability of timely mental health and physical health support pathways when a resident's condition deteriorates. Access to specialist assessment, treatment and inpatient care can be an important component of managing complex needs within a disability justice setting. Strengthening these pathways may enhance the DJC's capacity to safely support residents with complex and intersecting needs and increase confidence in considering referrals for people who may previously have been assessed as requiring a higher level of health system support.

Greater transparency regarding assessment processes, eligibility criteria and placement decisions would assist identified persons, legal representatives and decision-makers to better understand the role of the DJC within Western Australia's forensic disability system. It may also support more consistent pathways for people whose needs sit at the intersection of disability, mental health and justice services.

Rehabilitation and transition pathways

Residents consistently identified greater independence, increased community participation and future living arrangements as important goals. Advocates observed positive efforts by DJC staff to support residents' rehabilitation, including goal-setting, independence-focused planning and the development of skills necessary for community living. Despite this commitment, progression towards longer-term outcomes was often affected by factors beyond the control of residents or DJC staff, including the availability of suitable accommodation, disability supports, service coordination and opportunities for rehabilitation in the community.

Successful transition planning requires alignment between rehabilitation goals, leave opportunities, support availability and long-term accommodation pathways. Delays or uncertainty in any of these areas can affect residents' ability to progress towards greater independence, even where substantial progress has been made within the DJC. Continued collaboration between disability, health, justice and community service providers will be important to supporting timely and sustainable transitions to less restrictive environments.

Thank you for all the help and support you have given me over the past few months. I honestly don't think I could have survived without it.

RESIDENT

Accessing suitable community supports

The availability and capability of external disability providers remained one of the most significant barriers to residents' rehabilitation and transition into the community. Residents experienced delays, cancellations and interruptions to National Disability Insurance Scheme (NDIS) funded supports, together with difficulties identifying providers able to meet complex needs consistently. Advocates reported that some providers lacked the workforce capability, training and/or funding required to deliver the necessary level of support.

Some NDIS-related matters were resolved during the year, but difficulties later re-emerged. This created ongoing uncertainty and disappointment for residents who wanted to progress towards greater independence and their own accommodation. It also affected the practical exercise of leave and participation in activities outside the DJC.

These experiences highlight that transition readiness cannot be assessed solely by reference to a resident's progress. Successful transition also depends on the availability of suitable accommodation, adequately funded support arrangements and providers with the capability and willingness to support people with complex needs and a forensic history. Where those components are unavailable or unstable, a resident's progression may be delayed even when they have undertaken substantial preparatory work within the DJC.

The small number of residents makes it difficult to draw broad conclusions about the NDIS market in relation to a group of people with high and complex support needs. Nevertheless, the recurrence of provider delays and capability issues across the resident group indicates the importance of early provider engagement, realistic assessment of workforce capability and contingency planning where a provider withdraws or cannot deliver agreed supports.



Access to health care

Advocates identified difficulties with residents' access to some forms of health care for physical health issues. A local general practitioner was reported to provide consistent and positive support, but concerns were raised about access to hospital-based treatment and other health services. Advocates, residents and DJC staff reported difficulties when residents required assessment or admission to hospital, including perceived reluctance to admit or treat residents and concerns about apparent stigma and discrimination.

Residents of the DJC should be able to access health care on an equitable basis, with appropriate adjustments and support for disability, communication and behavioural needs. Difficulties obtaining timely treatment may affect physical health and wellbeing and can place additional responsibility on DJC staff and community practitioners.

The experience with the local general practitioner demonstrates the value of consistent relationships and providers who understand residents' needs. A person's legal status, disability or place of residence should not create barriers to timely assessment, treatment or admission when health needs arise.

MHAS also noted that issues accessing specialist psychiatric care remained evident during 2025-26. MHAS is not able to report on individual cases, but unmet mental health needs and challenges accessing appropriate specialist mental health services continued. These concerns demonstrated the continued importance of ensuring effective pathways to both emergency and ongoing specialist psychiatric care. Such pathways remain essential if the DJC is to support the full range of people that fall within its legislative remit.

Finances and disclosures

Budget and expenditure

In 2025-26, MHAS progressed with a streamlined budget process. The total budget was \$8.94 million, including \$670,000 in resources received free of charge (RRFoC) from the Commission. The budget also included \$415,000 provided by the Commission to support the enhanced advocacy program in licensed psychiatric hostels.

MHAS' budget allocation comprised 76 per cent salaries and 24 per cent Other Goods and Services (OGS). Actual expenditure at 30 June 2026 was \$10.08 million, representing an overspend of \$1.14 million (13 per cent) against budget.

MHAS actual expenditure included the following RRFoC payments:

- Commission: \$802,105
- Department of Housing and Works: \$13,784
- State Solicitors' Office: \$503

I wanted to thank you for your support, teaching and advocacy for patients, and overall for human rights and decency.

CLINICIAN

Total salaries

Budget \$6,608,780



Actual \$7,761,431



In relation to advocacy service delivery at the DJC under the DPMI Act, MHAS invoices Communities for its service delivery to the DJC residents. In 2025-26, MHAS invoiced Communities \$12,393.

Total OGS

Budget \$2,331,220



Actual \$2,321,219



Overspend analysis

MHAS overspend against budget in 2025-26 was \$1,142,650 (13 per cent). This was mainly driven by salaries of unfunded positions such as the Team Leader positions, the legal team positions and the annual percentage indexation that has been Ministerially approved since 2018 but is not automatically included in MHAS funding.

Overspend breakdown:

Indexation 4 per cent \$200,000 (approx)



Team Leaders salaries \$484,590



WHS Principal Project Manager \$200,000



0.3 FTE General Counsel \$47,060



Advocacy hours \$210,000

(managing increase in demand and complexity)



Operational impact

MHAS' current MH Act service funding model supports approximately 24 FTE MH Act Advocates. Based on MHAS workforce and activity data, an Advocate FTE can actively support a caseload of an estimated 22 authorised mental health beds per year, although this varies depending on the complexity of matters and the needs of individual consumers.

Based on this model, MHAS' current MH Act advocacy workforce has capacity to actively support approximately 528 authorised beds, while also undertaking CTO work and other statutory advocacy functions. As at 30 June 2026, there were 728 active authorised mental health beds across the State, exceeding MHAS' current advocacy capacity by 200 beds. Based on the costing formula above, MHAS would require funding for an additional 9 FTE Advocates to cover these 200 beds to meet statutory obligations under the MH, CLMI and DPMI Acts and its responsibilities under the WHS Act.

The 2025-26 data showed a 15 per cent increase in the number of people supported by MHAS across all streams, reflecting increased demand for advocacy services. This had a corresponding increase in Advocate workload. Without a parallel increase in resourcing, MHAS faces a heightened risk of being unable to meet its statutory obligations under the MH, CLMI and DPMI Acts, as well as its obligations under the WHS Act.

The majority of the overspend in the MH Act budget envelope is captured within the advocacy salaries cost centres, which includes the Team Leader positions and the largest indexation impact.

As the second operational year of CLMI service delivery, MHAS sought to manage the CLMI budget cost centre in alignment with the funded positions. Salary expenditure exceeded budget by \$92,000 while OGS expenditure was \$213,120 below budget. This includes the CLMI RRFoC costs paid to the Commission; however, these costs were recorded against the MH Act OGS cost centre due to an internal systems misalignment that has been rectified for the 2025-26 financial year.

MH Act Service Expenditure and Budget 2025-26

Budget \$6,235,000



Actual \$7,498,848



CLMI Act Service Expenditure and Budget 2025-26

Budget \$2,705,000



Actual \$2,583,802



Year on year funding comparison

Prior to 2024-25, MHAS' financial reporting focused primarily on MH Act funding, as this was the main legislative advocacy service delivered by the organisation. Since the implementation of the CLMI advocacy service, MHAS has revised its financial reporting structure to enable meaningful comparison of financial years.

MHAS Total Expenditure and Budget 2025-26

2024-25

Budget \$9,310,000



Actual \$9,249,113



2025-26

Budget \$8,940,000



Actual \$10,082,650



Thank you for being that one person who isn't afraid to go that extra mile & be there for me when I've had no one.

RESIDENT

Disclosures

Records management reporting

In accordance with section 19 of the State Records Act 2000, MHAS maintains a record keeping plan which governs the management of its records. The plan required MHAS to finalise its record-keeping procedures manual and classification system, which was completed in 2025.

Freedom of information disclosures

In 2025-26, MHAS received and processed seven Freedom of Information (FOI) Requests. All FOIs were pertaining to personal records.

Electoral Act requirements

As required under the Electoral Act 1907, section 175ZE (1), MHAS recorded \$15,783 in expenditure related to the designated organisation types between 1 July 2025 and 30 June 2026, which is broken down as follows:

MHAS advertising expenses

Organisation	Amount	Specifics
Bigwig Advertising Pty Ltd	\$8,144	MHAS Annual Report 2024-25 development and creation
Optima Press	\$3,639	Development and production of MHAS collaterals for workers' use.
Initiative Media	\$4,000	Fees for job advertisement, organised through HSS

Complaints

In 2025-26, MHAS received six complaints about its service, each of which was handled according to MHAS' complaints policy. All six 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.

Compliments

In 2025-26, MHAS received 24 official compliments about its service. Eleven were received from identified persons, two from family members of identified persons, three from justice agencies, and eight from mental health services.

MHAS breaches of the MH Act

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 involuntary order being made for a child.

In 2025-26, consumers were contacted within the statutory timeframe for 95 per cent of involuntary treatment orders, a slight improvement from 94.8 per cent in 2024-25.

The most common reason for a breach was an order being revoked, or a subsequent order being made, before contact could occur within the required period. These circumstances accounted for 61.9 per cent of all breaches, compared with 69.9 per cent in 2024-25. Orders revoked within two days accounted for 13.4 per cent of all breaches, down from 14.7 per cent in 2024-25.

While the proportion of these breaches has decreased, revocations shortly after an involuntary treatment order is made remain a concern. Such circumstances may indicate that the person could have been further assessed using a Form 3C examination order, potentially avoiding the need for an involuntary treatment order.

Children were contacted within the statutory timeframe for 94.8 per cent of orders (200 of 211), compared with 95.3 per cent (224 of 235) in 2024-25.

MHAS breaches of the CLMI Act

The CLMI Act establishes statutory timeframes for informing CLMI identified persons of their right to advocacy and for contact by an Advocate.

During 2025-26, MHAS was unable to reliably assess compliance with these requirements due to ongoing issues related to the completeness and timeliness of court notifications. Consequently, MHAS cannot accurately report on compliance with the statutory timeframes set out in the CLMI Act.

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 2025-26 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 2025-26.

The Minister for Corrective Services may issue written directions to the Chief Advocate about general policy to be followed by the Chief Advocate in performing functions under the CLMI Act, and the Chief Advocate may request the Minister to issue a direction (under s132 of the Act). During 2025-26, no directions were issued, nor did the Chief Advocate request directions.



Appendices

Committees, reference group and working groups

The Chief Advocate, or nominated proxy, was a member of the following committees in 2025-26:

- Licensed Accommodation Multi-Agency Committee
- NMHS Interagency Forum on Hospital Orders
- SMHS Fremantle Hospital Mental Health Bed Expansion and Crisis Centre Steering Committee
- Mental Health Agencies CLMI Implementation Working Group
- MH Act Implementation Oversight Group and its working groups
- Skills Academy Working Group, Public Sector Commission
- MH Act Resources Working Group, Commission

Education and information sessions to external stakeholders

During 2025-26, MHAS delivered 24 education and information sessions to promote awareness of consumer rights and MHAS' role, powers and functions across the mental health and justice sectors:

- Education sessions on the role of MHAS and consumer rights for mental health services (10)
- Education sessions on the role of MHAS and consumer rights as part of clinician training programs (4)
- Education sessions on the role of MHAS and advocacy under the CLMI Act for justice and legal stakeholders (2)
- Information sessions in prisons (5)
- Education sessions on the role of MHAS for other stakeholders (3)

I appreciate the help that you were to me, by being my advocate. Thank you. My last tribunal hearing lasted for nearly an hour, so it was good to have someone on my side during that time.

CONSUMER

Submissions, forums and consultations

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

- A Trauma-Informed Approach – Guidance for Western Australian State Government - Commission – Submission - September 2025
- MH Act Resources Working Group Feedback – Commission – Submission - September 2025
- Review of WA Mental Health Emergency Centres – Commission – Consultation – October 2025
- Performance Audit: Infant, Child and Adolescent Mental Health System Transformation Program – Office of the Auditor General for Western Australia – Consultation – January 2026
- Commissioning of the Geraldton Acute Psychiatric inpatient unit – WACHS – Consultation – February 2026
- CLMI Guide – OCP – Consultation – March 2026
- Community Visitors Scheme - Commonwealth consultations linked to the Disability Royal Commission – Communities – Submission – April 2026
- Issues Paper - Recommendation 26 of the Report on the Review of the *Mental Health Act 2014 (WA)* - Reasonable Force – Commission – Submission – April 2026
- Issues Paper - Licensing of Mental Health Supported Accommodation in Western Australia – Commission – Submission – June 2026
- Inquiry into guardianship and administration in Western Australia - Community Development and Justice Standing Committee – Submission – June 2026
- Response to request for feedback on the proposed revisions to the National Statement of Principles relating to Persons Unfit to Plead or Not Guilty by Reason of Cognitive or Mental Health Impairment – DoJ – June 2026
- Feedback on the Implementation of the CLMI Act – DoJ – June 2026



[Both Advocates] approach complex situations in a sophisticated, fair and collaborative way. Their strong psychological understanding of patients has resulted in a balanced communication of the patients' wishes and view.

CLINICIAN



[Both Advocates] are inquisitive and seek to understand more about the patient's clinical care and thus understand the contextual factors. This helps them contribute constructively to work through possible barriers and challenges. I feel this has resulted in positive outcomes for patients and a helped develop positive collegiality between them and my clinical team.

CLINICIAN

Glossary of abbreviations, acronyms and terms

ACC	Adult Community Corrections
AOD	Alcohol and other drug use
CALD	Culturally and Linguistically Diverse
CCTV	Closed circuit television
Charter	Charter of Mental Health Care Principles
Chief Advocate	Chief Mental Health Advocate
CLMI Act	<i>Criminal Law (Mental Impairment) Act 2023</i>
CLMI	Criminal Law (Mental Impairment)
CLMI identified person	An unfit accused or supervised person within the criminal justice system who can access advocacy services under the <i>Criminal Law (Mental Impairment) Act 2023</i>
CO	Custody order
Commission	Mental Health Commission
Communities	Department of Communities
Consumer	A person as defined by section 348 of the <i>Mental Health Act 2014</i> , who is eligible for advocacy services. This excludes residents of licensed private psychiatric hostels.
CSO	Community supervision order
CTO	Community treatment order, also called a Form 5A
Deputy Chief Advocate	Deputy Chief Mental Health Advocate
DPMI Act	<i>Declared Places (Mental Impairment) Act 2015</i>
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
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
HSC	Health Safety Committee
HSP	Health Service Provider
Hub	MHAS' Client Management System
Identified person	Used when referring to the totality of people MHAS work with, to indicate the group of people who are in legislative scope to engage with MHAS services
IDP	Individualised development plan
ITO	Involuntary treatment order
LGBTQIA	People who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, or other diverse sexualities and gender identities
LOA	Leave of Absence Order
LO	Consumer Liaison Officer
MH Act	<i>Mental Health Act 2014</i>
MHAS	Mental Health Advocacy Service
MHOA	Mental Health Observation Area
MHT	Mental Health Tribunal
MIRT	Mental Impairment Review Tribunal
NDIS	National Disability Insurance Scheme
OCP	Office of the Chief Psychiatrist
OGS	Other goods and services
OICS	Office of the Inspector of Custodial Services
Resident	A person residing in a private licensed psychiatric hostel, or at the Bennett Brook Disability Justice Centre.
RRFoC	Resources received free of charge
Senior Advocate	Senior Mental Health Advocate
SFMHS	State Forensic Mental Health Service
SHOC	State Health Operations Centre
WHS	Work health and safety
WHS Act	<i>Work Health and Safety Act 2020</i>



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