MHAS MENTAL HEALTH ADVOCACY SERVICE

Annual Report

2016–2017

Artwork

The artwork on the front cover and throughout the Annual Report is titled *'here be dragons'* by donelle toussaint. It is reproduced with the kind permission of the artist.

Hon Roger Cook MLA

MINISTER FOR MENTAL HEALTH

In accordance with sections 377 and 378 of the *Mental Health Act 2014*, I submit for your information and presentation to Parliament the Annual Report of the Mental Health Advocacy Service for the financial year ending 30 June 2017.

As well as recording the operations of the Advocacy Service for the 2016-2017 year, the Annual Report reflects on a number and range of issues that continue to affect consumers of mental health services in Western Australia.

Debora Colvin

CHIEF MENTAL HEALTH ADVOCATE

September 2017

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FOREWORD BY THE CHIEF MENTAL HEALTH ADVOCATE

It is with pride and appreciation that I present this Annual Report representing the work of the Mental Health Advocacy Service for 2016-17. I do so on behalf of the dedicated and hard-working team of Senior Advocates, Manager, Advocates, Youth Advocate, Aboriginal Advocate, and Advocacy Service Officers who make up the Mental Health Advocacy Service.

This is the second annual report of the Advocacy Service and the first report for a full 12 months. It has been an extremely busy year of continued growth, and learning about the *Mental Health Act 2014* (the Act), which only came into operation in November 2015.

Key issues reflected in the Annual Report are:

- the crisis of care of 16- and 17-year-olds who have been stuck in emergency departments for days and/or placed on unsuitable adult wards
- the almost universal breaching of the Act in relation to treatment, support and discharge plans
- the failure of any health service to fully comply with the further opinion requirements of the Act
- safety issues on wards
- lack of appropriate supported accommodation for consumers with the most complex needs.

The Youth Advocate role has come into its own this year, and a more detailed report on youth issues has been provided to the Minister for Mental Health.

A positive development was the Minister's Direction for voluntary patients, which allows Advocates to assist children even if they are not subject to involuntary treatment orders and to continue to assist people who were involuntary with complaints and issues when they are made voluntary, instead of having to refer them on to another agency.

If the workload of the Advocacy Service continues to increase, issues of capacity and resourcing will be challenges in the coming year, and some Advocacy Service work will have to be curtailed.

Debora Colvin

CHIEF MENTAL HEALTH ADVOCATE

September 2017

PART ONE – OVERVIEW OF THE MENTAL HEALTH ADVOCACY SERVICE

The Chief Mental Health Advocate (Chief Advocate) is required by Part 20 of the *Mental Health Act 2014* (the Act) to ensure that advocacy services are provided to certain classes of mental health patients (called 'identified persons' in the Act), with a view to ensuring their rights are protected.

These are mainly involuntary patients, including those on community treatment orders (CTOs), but also people referred for psychiatric assessment, some voluntary patients, and psychiatric hostel residents. Identified persons are referred to by Mental Health Advocates (Advocates), and hereafter in this Annual Report, as consumers. Further details are provided in appendix 9.

An advocate must contact every adult who is made involuntary in Western Australia within seven days of being made involuntary, and every child within 24 hours (see s357 of the Act), referred to in this report as the 'statutory contact'. The Act, therefore, also requires that the Chief Advocate be notified by mental health services of every person who is made involuntary. Other contact by Advocates is at the request of the consumer or someone acting on their behalf.

The Minister for Mental Health (the Minister) appoints the Chief Advocate, who engages the Advocates under contracts for services. They must include a specialist Youth Advocate. Public service officers are also appointed, or made available under the *Public Sector Management Act 1994* Part 3, to assist the Chief Advocate. Together they form the Mental Health Advocacy Service (the Advocacy Service).

Advocates' functions

The Advocates' functions (as set out in s352 of the Act) include checking consumers know why they are subject to provisions of the Act and have been told their rights, assisting them to exercise those rights or resolve complaints, inquiring into and investigating the extent to which their rights are being observed, advocating for and facilitating their access to other services, and assisting consumers in Mental Health Tribunal and State Administrative Tribunal hearings.

While visiting hospital wards and carrying out the statutory contacts and responding to requests for assistance, Advocates are also required to inquire into or investigate conditions of mental health services that do, or are likely to, adversely affect the health, safety or wellbeing of consumers.[1] Specific inquiries and regular visits to some psychiatric hostels are also conducted under this inquiry power in s352 (1) (b) of the Act.

1 As required by s352(1)(b) of the Act.

Advocates' powers

Advocates have considerable powers of inquiry and right of attendance (see s359 of the Act), including the power to:

- attend wards and hostels any time the Advocate considers appropriate
- see and speak with consumers, unless the consumer objects to them doing so
- make inquiries about the admission or reception, referral or detention, and provision of treatment or care of a consumer, and staff must assist with those inquiries – and there are offence provisions if staff do not assist
- view and copy a consumer's medical files and other documents about them, unless the consumer objects to them doing so
- doing 'anything necessary or convenient' for the performance of their functions.

Further detail on Advocates' powers is provided in appendix 9.

Advocacy Service structure

As at 30 June 2017, the Advocacy Service comprised the Chief Advocate, two Senior Advocates, a Youth Advocate, an Aboriginal Advocate, 34[2] Advocates in the metropolitan area, Bunbury, Albany, Kalgoorlie and Broome, and six Advocacy Service Officers including a Manager, who are public servants.

The Senior Advocates are engaged to carry out delegated duties of the Chief Advocate (see s374 of the Act), in particular providing advice, assistance, control and direction to the Advocates, ensuring identified persons are contacted, developing standards and protocols, ensuring Advocates are adequately trained, and preparing an annual report to Parliament. In practice, Senior Advocates and Advocacy Service Officers work closely to coordinate Advocates' responses to notifications and requests for assistance.

An executive team, comprising the Chief Advocate, the two Senior Advocates and the Advocacy Service Manager, acts as the advice and decision-making body in relation to protocols and operational decisions, as well as planning and conducting training for the Advocates.

'Pure advocacy' approach

The Advocacy Service has adopted the 'pure advocacy' approach to individual advocacy, which means Advocates act as a mouthpiece for the consumer and are partial to the consumer. The exception to this is children, as the Act requires best interests advocacy for people under 18 years old.

2 Another three Advocates were not active but still under contract.

Following Advocacy Service protocol, the Advocate tells the consumer their rights and options as well as consequences of taking particular actions (the ROC principle) and will then act according to the consumer's wishes. They do not make decisions for the consumer and are not counsellors, though they do need to be good listeners and sometimes act as a support person.

Where a consumer is not able to say what they want and the Advocate is concerned that rights are being infringed, they will take action to ensure the consumer's rights are observed. Advocates may in such cases use 'non-instructed advocacy', which is described in the Advocacy Service code of conduct.[3]

Dealing with complaints and issues

Advocates may attempt to resolve any issues by dealing directly with staff members, or refer the issue to the Chief Advocate if they cannot resolve the issue or consider it appropriate (see s363 of the Act). The Chief Advocate may provide reports about any issues raised to the person in charge of the relevant mental health service, the Minister, the Chief Psychiatrist, the Mental Health Commissioner and the Director General of the Department of Health (DOH). These parties must advise the Chief Advocate of the outcome of any further inquiry or investigation.

In practice, Advocates deal with issues at hospital ward and community mental health service level to the extent that they can. If the issue cannot be resolved at that level or if, for example, it involves a serious or systemic issue, it is taken to a Senior Advocate, who may discuss the issue with the Chief Advocate. A letter or email might be drafted, a meeting requested or telephone call made by the Senior Advocate to appropriate parties (examples include the clinical director of the hospital or service concerned, the Chief Psychiatrist, the Mental Health Commissioner and, when warranted, the Minister).

Similarly, Advocates first try to deal with issues in psychiatric hostels by speaking to the hostel supervisor or licensee, but where a matter cannot be resolved they will speak to their Senior Advocate. The Senior Advocates or the Chief Advocate may meet with the licensee or raise issues with other bodies involved in the oversight of hostels.

In addition, the Chief Advocate meets with or contacts the Minister, the Mental Health Commissioner, the management teams of each of the authorised hospitals, the Chief Psychiatrist, the executive directors of North Metropolitan, South Metropolitan and Country Mental Health Services, the president of the Mental Health Tribunal and others from the government and non-government sectors involved in the protection of consumer rights and the provision of mental health services in WA. At these meetings, significant and ongoing issues identified by Advocates are raised and discussed, with the aim of resolving them through effective and timely action.

3 Available on the Advocacy Service website : www.mhas.wa.gov.au

PART TWO - ACTIVITIES OF ADVOCATES AND CONSUMER RIGHTS AND ISSUES

A key requirement of the Act (in s357) is that every adult who is made involuntary must be contacted by an Advocate within seven days and children within 24 hours of the order being made.

This includes people put on CTOs and people who are mentally impaired accused (having been found not guilty by reason of unsound mind, or not fit to stand trial) when they are required to be detained in an authorised hospital (which is a dedicated mental health unit authorised by the Chief Psychiatrist).

Based on notifications to the Chief Advocate, 2618 people were put on 4041 involuntary orders[4] between 1 July 2016 and 30 June 2017.[5]

Of those:

- 2478 people were detained on 3245 inpatient treatment orders in an authorised or general hospital. Of these:
  - 2417 people were detained on 3148 inpatient treatment orders in an authorised hospital (form 6A), including 30 children on 37 inpatient treatment orders
  - 86 people were detained on 97 inpatient treatment orders in a general hospital (form 6B), including 10 children who were detained on 14 inpatient treatment orders
- 656 people were put on 796 CTOs (form 5A), including 10 children who were put on 14 CTOs
- five mentally impaired accused were required to be detained on six occasions in an authorised hospital.

Advocates are also required to contact people on request, which includes people on inpatient treatment orders, CTOs and orders for referral for examination by a psychiatrist, some classes of voluntary patient, mentally impaired accused on conditional release orders, and people living in psychiatric hostels.

The stories highlighted in this part of the report reflect the experiences of consumers and the activities of Advocates.

4 Based on notifications by health services to the Advocacy Service as at 22 August 2017. Includes inpatient treatment orders and CTOs and some people were subject to more than one order during 2016-17. Verification of ICMS data is ongoing and figures may be subject to change.
5 See appendix 3.

Children

Children (defined as a person under 18 years of age) can be involuntarily detained and treated under the Act as inpatients and on CTOs. In 2016-17:

- 41 children on 65 involuntary orders were detained or put on a CTO
- 40 children were detained on wards on 51 inpatient treatment orders
- their ages ranged from 13 to 17, but most were 16 or 17 years old.

Part 18 of the Act sets out provisions for the care and treatment of children. The Chief Advocate is required by the Act to engage at least one Youth Advocate with qualifications, training or experience relevant to children.

The Chief Advocate has engaged one Youth Advocate, who is assisted by two Advocates who have been trained by her and who take direction from her.

Following the Classes of Voluntary Patient Direction 2016 which came into operation on 1 January 2017, voluntary children were also able to request contact by an Advocate. Sixteen children were assisted under the Direction across six mental health services. Requests for assistance were often via referrals from treating teams and were complex cases due to the length of stay in hospital, lack of collaboration between agencies, concerns regarding collaboration with the Child Protection and Family Support Division of the Department of Communities (CPFS), and issues around discharge planning and access to community services.

Systemic issues raised by consumers or identified by the Advocacy Service in 2016–17 relating to children are set out below.

Children on adult wards and crisis of care for 16- and 17-year olds

During the year, some 16- and 17-year-old children waited days in an emergency department (ED) for a bed and some were admitted to adult mental health wards:

- seven orders were made to detain children on adult wards in Albany, Graylands, Armadale, Broome, and Sir Charles Gairdner hospitals[6]
- 15 orders were made for children to be detained on the Fiona Stanley Hospital youth ward, which takes young people up to the age of 24
- other children were voluntarily admitted or detained on adult wards for referral for an examination by a psychiatrist.

6 Form 6A and 6B orders, so some children were detained on general wards.

Some of those admissions were, in the view of the Advocacy Service, in breach of the Act because it cannot be said that every child admitted had the age and maturity to be on an adult ward or that the wards could specifically cater for such children as required by s303 of the Act. Further data is provided in appendices 3B and 4B.

The crisis began when the Child and Adolescent Mental Health Service (CAMHS) decided to no longer admit 16- and 17-year-olds to the Bentley Adolescent Unit (BAU) in March 2016.[7]

- *On one Friday evening in September 2016, there were five children on adult wards and three in EDs, one of whom was there for five days. The response in these situations appears to be multiple emails going to multiple people until the problem is resolved.*
- *A child waited two days in an ED while the respective treating teams in the BAU and Fiona Stanley Hospital argued over the admission. Children, including 16- and 17-year-olds, are not covered by the assertive patient flow arrangements. This urgently needs to be rectified, especially as once the Perth Children's Hospital (PCH) opens, 16- and 17-year-olds could be sent anywhere.*
- *A parent who left their child overnight in an ED awaiting a bed was told the next morning they had been transferred to a hospital 40 kilometres away.*

The implications for children being placed on an adult ward or unit can be, and in some cases have been, significant, from being in an unsuitable environment to the lack of access to a child and adolescent psychiatrist:

- *Children have been restrained and secluded on adult wards by staff who have no experience dealing with a child.*
- *Sexual safety is another concern, with one child raising fears with the Youth Advocate; issues of sexual safety on adult wards are raised further under* Sexual safety on wards *later in this report.*
- *In one case, a Mental Health Tribunal hearing was brought with the support of the adult ward treating team to try to force a transfer to the Fiona Stanley Hospital youth ward or BAU, both of which had refused to take the child. The tribunal was sympathetic but declared that because there was no pathway onto the wards (as they had refused to take the child) an order for transfer could not be made under the Act.*

When PCH opens, it will not admit anyone 16 years of age or over. Only two youth wards (for ages 16 to 24) will be available for 16- and 17-year-olds, at Bentley and Fiona Stanley hospitals. When the two youth wards are full, 16- and 17-year olds will be either left in an ED or placed on an adult ward with lack of access to appropriate care. There is particular concern about children who fall within the catchment area of the North Metropolitan Health Service, which will not have a youth ward.

7 CAMHS said this was in anticipation of the opening of the Perth Children's Hospital and later agreed to start admitting 16-year-olds again, but only until the Perth Children's Hospital opens.

At the same time, these children and their parents or guardians will be accessing community mental health services through CAMHS. The Advocacy Service is concerned that continuity of care across the acute and community mental health services will become fractured to the detriment of children, as they and their parents or guardians have to navigate in and out of at least two, and often three, mental health services in a system which is already difficult to traverse.

The Advocacy Service has delivered numerous representations, letters and briefing notes raising concerns about the issue, both for matters arising during the year and for the future when PCH opens, and recently provided a report to the Minister with a number of recommendations.

Uncoordinated community care

The Youth Advocate has been engaged in a number of very complex cases which highlighted issues with lack of coordination and continuity in relation to discharge, and eligibility, access and equity in mental health services in the community:

- *The very sad story of one child's mental health care journey told of protracted difficulties navigating the mental health system, with evidence of poor collaboration and communication between agencies, and circumstances where the young person was denied access, or deemed ineligible, to services despite there being no alternative service to access.*

The Chief Advocate wrote about the case to the then Minister for Mental Health, Andrea Mitchell; the Mental Health Commissioner, Timothy Marney; and the then CEO of the Child and Adolescent Health Service (CAHS), Frank Daly.

Mr Marney wrote back, saying 'the issue of access to and coordination of youth mental health services is currently the subject of considerable focussed work led by the DOH as system manager' and that the letter had been passed on to inform that work.

Professor Daly wrote back acknowledging the issues, stating CAMHS was committed to 'collaborative discharge planning' and there had been improvements in sharing of information between CAMHS community-based facilities and the CAMHS inpatient unit.

The issue is not resolved and the Youth Advocate recently dealt with another case where protracted transition between services (Fiona Stanley Hospital, community CAMHS and three other agencies) meant the Youth Advocate had to coordinate all five agencies. The result was the establishment of a youth interagency service improvement group. An outcome included the development of a pre-admission form, to be completed in collaboration with the consumer, and a standard process to communicate information between all agencies following discharge. Lack of treatment, support and discharge plans as required by the Act contributes to these issues. See *Right to treatment, support and discharge plans* later in this report for further discussion of this subject.

Care of children with eating disorders

Broad concerns with the eating disorders inpatient program run by CAHS at Princess Margaret Hospital (PMH) were raised by the Youth Advocate, including the use of restraints, communication processes, staffing issues, and treatment, support and discharge plans.

One parent wrote:

> *My 15-year-old daughter, Tessa[8], at 37 kg approx., walked calmly with me into PMH Emergency five weeks ago. We walked in with the confidence that she would get the appropriate level of care, consistency, nutrition, support and confidence required to return to school life in a couple of weeks/month.*
>
> *Five weeks on, she is now 35.75 kg, miserable/flat and extremely anxious. Today, she didn't have a 'feed' as now she needs 'holding' and there wasn't the staff available to assist. She was ready for the feed early during the early part of the day. When it came much later she refused as the anxiety had set in due to the waiting. Security and staff did not inform her she would not be held/fed. That was left to me at 1700hrs. What if I hadn't have asked? What are we doing to this child?*
>
> *This is not the first time since her admission she has gone without nutrition, information, and time has lapsed. I was told by the doctor that staff were not available to support. It is ironic that she suffers from an eating disorder, is malnourished, deteriorating in 'Obs' but yet we do not have staff to support her and feed her.*
>
> *My daughter has not been outside in the sun except for two occasions in the past few weeks where I have been allowed to sit with her for around 15 minutes on each occasion. There are no televisions in the room and I have been informed I cannot bring one in. Is this a punishment? Because I am sure as hell she has done nothing wrong except get a disease where she needs some constant support.*

A review of CAHS management of children and adolescents with eating disorders followed, including an interview with the Youth Advocate, who was then invited to take part in a series of PMH eating disorder improvement meetings and a service improvement team to help support the planning stage of the review.

Consumers have also raised concerns about the transition of 16- and 17-year-olds from PMH outpatient services to CAMHS community clinics once PCH opens. A number of families have reported that some community CAMHS clinics lack the capacity to provide the specialist therapeutic intervention needed to treat long and enduring eating disorders.

8 Name has been changed.

Disability issues and poor access to neuropsychiatrists

The Youth Advocate has supported a number of children and young people who have a dual diagnosis of intellectual disability, foetal alcohol spectrum disorder and/or autism spectrum disorder with a mental illness. Services to these children and young people are inconsistent across the sector and there is a lack of neuropsychiatric services for children and adolescents in WA. There also needs to be a state-wide collaborative approach to improve service delivery.

In some cases, the Youth Advocate's involvement has been requested to support consumers when different services (CAMHS, Disability Services Commission[9] and CPFS) disagree whose responsibility it is to provide management, and question if a child's presentation is a core part of their intellectual disability (often referred to as being behavioural) or a separate definable mental health diagnosis. The effect on the child can be delay in accessing, and/or ineligibility for services.

Aboriginal and Torres Strait Islander children

The rights of Aboriginal and Torres Strait Islander children have not been well met during the year. In several cases, the Advocacy Service's Aboriginal Advocate attended where the health service failed to provide access to an Aboriginal Liaison Officer (ALO), although the Act requires this:

- *Fiona Stanley Hospital told the Advocacy Service that, while the hospital had an ALO service, none of the staff had specialist mental health skills and knowledge. The issue was to be included on the risk register.*
- *At the BAU, the Youth Advocate was told that the ALO from PMH was not allowed to attend the unit. CAMHS later advised this was not correct but there was no ALO on site. This has since been rectified, with a part-time ALO now available.*

The Youth Advocate also raised the following issues during the year:

- the need for more culturally secure care when children are admitted as inpatients under the Act, including reviewing the treatment, support, and discharge planning process to be more individualised and culturally appropriate
- the paucity of culturally appropriate services for children once they return to their communities, and need for better supports for first episode psychosis and comorbid drug and alcohol issues in remote regions
- making Mental Health Tribunal hearings more culturally appropriate for Aboriginal and Torres Strait Islander children.

9 The Disability Services Commission became the Department of Communities on 1 July 2017.

General rights issues

There are 438 pages and 677 sections in the Act which both take rights away and give rights back to people who are made involuntary. It is the Advocate's job to try to make sure rights are observed, which includes having the Act followed in all respects - a right in itself - as well as other rights such as the National Standards for Mental Health Services.

On the way to being made involuntary

The road to being made involuntary usually begins with a referral order, or form 1A, being made for compulsory examination by a psychiatrist. The person can also be detained while waiting for the psychiatric examination on a form 3, though there are time limits. The process can be very frightening, especially if the person is in an ED. The Advocacy Service is not notified of people on a form 1A, so is reliant on consumers knowing they have the right to call or ask the mental health service to call.

There were 127 consumers on a 1A who requested assistance:

> *A consumer rang on a weekend and left a voicemail to say she was being held against her will in hospital and wanted to leave. The Advocate on the weekend phones roster returned the call to the consumer, who said this was their first contact with mental health services. They didn't understand what was happening and were very frightened. After confirming the person's status with hospital staff and that they expected the psychiatric examination to happen that afternoon, the Advocate explained the process to the consumer and what was likely to happen. Together they went through the criteria for being made involuntary under the Act. The consumer rang back later to say they had been made voluntary after agreeing to stay another night in the hospital while waiting for a friend to come and stay with them at home.*

Validity of involuntary orders

Advocates are trained to check that inpatient treatment orders (form 6As and 6Bs) and other orders reducing consumer rights (such as phone and visitor restrictions) comply with the Act:

- *A consumer and their personal support person complained that the consumer came to hospital as a voluntary patient but was made involuntary and not told their rights. The consumer said they didn't know they were involuntary until they had gone on leave from the hospital and were ordered to return. A complaint was lodged with the hospital and a letter of apology to the consumer followed.*
- *A consumer was put on an inpatient treatment order (form 6A), having been on a CTO. Because there were no beds in the hospital, the person was left at home on the 6A for almost two weeks before the order was revoked. There appeared to be nothing in the Act to prevent this, but the fact that it happened raised the question as to whether the person really needed an inpatient treatment order. There was also a question as to who was responsible for the consumer's care – the community team or the inpatient team. Another issue was that the database which records the status of people under the Act (PSOLIS)*

recorded the consumer as being on an inpatient treatment order, so they could mistakenly be considered absent without leave. Misunderstandings and unintended consequences can arise, and a different approach might be taken to the person in these circumstances.[10]

- *An inpatient treatment order (form 6A) was held invalid by the Mental Health Tribunal because the form 1A referral for a psychiatric examination had been written up after the 6A. The tribunal ordered that another 1A could be written up and the process started again. Apart from ensuring that the Act was complied with, by this stage the person was on an extended involuntary order lasting three months. The tribunal decision meant the new order could only be for 28 days before review, which was an advantage to the consumer.*

Issues with invalid CTOs seem to arise regularly. A consumer can be picked up by police and brought in for failing to comply with a CTO:

- *A consumer was put on a CTO from the ED but not given any information about their rights. Neither the Advocacy Service nor the Mental Health Tribunal were notified of the CTO, so when the consumer asked for an Advocate two months later they had missed their right to a tribunal hearing and access to an Advocate. A complaint was lodged and the hospital wrote back apologising for the error and explaining modifications that had been made to ensure it didn't happen again.*
- *A CTO was invalid because neither the treating psychiatrist nor medical doctor was nominated on the form, and the required 72 hours to advise a supervising psychiatrist had lapsed.*
- *Issues were raised about the validity of a CTO before the Mental Health Tribunal due to numerous errors on a series of CTO forms issued by the psychiatrist. Ultimately the psychiatrist did get the forms right, but the experience was distressing for the consumer.*
- *A consumer was discharged from hospital and told they were on a CTO, but days later still did not have a copy of the CTO or know what they were obliged to do. Correspondence followed and it was acknowledged that the original order had been defective.*
- *A CTO was made listing the supervising psychiatrist and treating doctor in another state, which is not legally valid.*

Access to psychiatrists, doctors and nursing staff

One of the fundamental rights of a consumer who is on an involuntary order is the right to an interview with a psychiatrist. The Act does not specify how often this should happen but it is a common complaint and/or request by consumers that they want to see their psychiatrist:

- *Three consumers on an acute ward hadn't been seen by a psychiatrist, or any doctor, for days - in one case, for up to 11 days. The Advocate raised the issue at various levels and a psychiatrist went to see the consumers shortly after. The hospital's clinical director later acknowledged the issue, saying they agreed with the Advocate's concerns. They said that although the psychiatrist did not have to see the patient every day, people in acute wards*

10 Similarly, a number of patients have been discharged, but the discharge order not put on to PSOLIS so the person appears to still be involuntary, or could mistakenly be considered absent without leave.

should be reviewed medically by the medical officer or registrar, sometimes both, every day, and by the psychiatrist weekly and probably twice weekly (though there is no set rule as to how often) – and this hadn't happened. The clinical director said they were following up on the issue and invited Advocates to email them directly if there was a recurrence.

- *A consumer hadn't seen a psychiatrist for two weeks since being made involuntary. The Advocate was told a new psychiatrist was starting in a few days but successfully advocated for another (locum) psychiatrist to see the consumer in the meantime.*
- *An on-call doctor over a weekend refused to see a consumer who said they were in pain and had other symptoms. Ward staff had unsuccessfully tried to get the doctor to visit the consumer. The Advocate visiting the ward called the doctor but was also refused. Contact was then made with the on-call psychiatrist, who said they would ensure the doctor saw the patient, but it still didn't happen. In the written response to the complaint lodged with the hospital, the Advocacy Service was told the doctor no longer worked for the service. An apology was given to the patient, other staff reminded of the importance to promptly attend a review of patients when requested, and a review of the hospital's escalation protocol was conducted.*

Right to be treated with respect and compassion

Principle 1 of the Charter of Mental Health Care Principles, which is Schedule 1 to the Act, requires mental health services to treat consumers with 'dignity, equality, courtesy and compassion and must not discriminate or stigmatise them':

- *A consumer who had tried to commit suicide on a hospital campus while on unescorted ground access received a letter from police threatening charges and a potential fine of up to $6,000 for creating a disturbance. In the end, a warning was given but it added to the stress of the consumer and they were told next time they would be fined. The Advocacy Service wrote to the hospital raising concerns about the issue because police were not involved in the incident and it appeared someone from the hospital called them to make the complaint. The health service responded that the letter had been a result of collaboration between the hospital and police in an effort to reduce the frequency of such incidents, and that such warnings from police were proving effective.*
- *A consumer said they could not bear to be reviewed by a particular medical officer who had told them their self-harming was 'selfish'. The consumer asked the Advocate to speak with the consultant and attend the next medical review with them. With the Advocate's encouragement, the consumer brought up the concern themselves with the consultant, who promised to raise the issue with the medical officer.*
- *A consumer complained that they felt disrespected and unsupported, had waited seven days for a medical test, and were not being taken seriously about being suicidal and having a plan. The Advocate discussed the right to make a complaint, and a letter was drafted but then not sent because the consumer said they were now getting assistance from the Advocacy Service and this was making a difference.*

- *A consumer asked their Advocate to help them write a letter of complaint to the hospital explaining how they 'felt scared' to knock on the window of the nurses' station and that the nurses did not have time for them. The consumer had overheard a nurse making a disrespectful comment about them. The hospital responded, saying the feedback had been discussed with the lead nurse on the ward, who would increase her vigilance in those areas and reiterate with staff that they must 'treat people with dignity and respect and be attentive to patients' needs'.*

Ward conditions

Ward conditions are very important when a person is detained. A dilapidated environment makes consumers feel disrespected and devalued, or, worse, as though they are in a prison and not a hospital ward. It can be the little things that matter:

- *An Advocate wrote to one hospital noting that the walls of the ward were damaged, dirty and in desperate need of plaster and paint work. Many of the walls had been written on, including offensive language, and despite cleaning, the writing was still evident. Room number plaques had been removed and instead of being replaced, the numbers had been drawn on with pen. The heavy duty chairs all had rips and stains and there were not enough of them. Bedroom doors couldn't be locked, creating a further safety issue, beds were sagging and there was mildew in bathrooms. Consumers had told the Advocate that they felt they were 'being treated like an animal' and 'conditions are better in prison'. The hospital wrote back, noting a number of improvements including painting and replastering of the walls, some replacement beds, and that a budget was being submitted for further work to be completed.*
- *Missing persons notices in the waiting area of a community mental health service were removed following a complaint by the Advocate. Consumers told the Advocate it made the clinic look and feel like a police station.*
- *A hospital established a designated smoking area and policy for involuntary patients following a higher than usual number of aggression and restraint incidents, and patients going absent without leave. Advocates had raised concerns for the safety and wellbeing of the consumers, saying these matters outweighed the health issues of smoking while patients were very unwell on a locked ward. The change only happened towards the end of the year so no specific data is available to show the impact, but anecdotally the ward has become a safer place. All but two mental health services make some provision for people to smoke on locked wards. The Advocacy Service continues to receive complaints from consumers in those two mental health services.*
- *Advocates have been asking for toilet paper holders in one hospital because the toilet paper currently sits on the floor and can get wet. Advocates were told the cost of installing holders that were ligature point-free and not an infection control risk was too expensive.*

Right to an independent further opinion

One of the most important protections under the Act for involuntary patients is the right to request a further opinion under section 182.

The Act requires that the further opinion must be given to the consumer in writing and the consumer must be examined, so the opinion cannot just rely on what is written in the medical file. There are also Chief Psychiatrist's guidelines about the independence of the psychiatrists from whom the opinions are obtained, and an operational directive by the Director General of the DOH stating that the provision of further opinions is to be based on principles of independence, timeliness, flexibility and choice, amongst other things. Timeframes and key performance indicators for the provision of further opinions are also given in the directive – 80% within three working days for an opinion from a psychiatrist within the same health service site, and otherwise 80% within five working days.

The Act and operational directive are not being fully complied with.

The number of further opinion requests

Between 1 July 2016 and 30 June 2017, according to Advocacy Service data, Advocates were involved in making requests for 304 further opinions. This figure only relates to the requests for a further opinion in which an Advocate was involved. Such requests are sent by email from the Advocacy Service office and logged into the Advocacy Service database by the Advocate.

Of the 304 requests, 276 were for consumers on inpatient treatment orders and 28 for consumers on CTOs. The data is for the number of requests, not the number of people - some consumers may have made more than one request over the year.

The number of requests for further opinions by involuntary inpatients in which Advocates were involved in 2016-17 equated to 8.5% of all inpatient treatment orders and 3.5% of CTOs.

It might be expected that there would be more requests for further opinions made in those hospitals where there were more involuntary inpatients, but the data collected by the Advocacy Service does not reflect this. Other factors might include:

- the length of stay of patients, or the length of time consumers are kept on involuntary orders
- the ability of treating teams to engage with and gain the trust of involuntary patients
- the approach of Advocates, combined with the experience of the Advocates and patients in relation to getting a further opinion and the value of the further opinion.

Advocate survey on compliance

A survey of the Advocates was conducted in June 2017. They were asked five questions which were based on previous anecdotal feedback from the Advocates, and correspondence and meetings with various clinical directors. In summary, the responses were as follows:

- It is near impossible to get a further opinion from someone outside the hospital.
- The process of obtaining a further opinion from within the same hospital is operating satisfactorily.
- Further opinions from within the same hospital are mostly obtained within three days of making the request.
- Consumers are sometimes being given a copy of the further opinion as required by the Act, but Advocates often have to chase this up.
- Consumers mostly opt for a further opinion from within the hospital after being told of the difficulty or long delay in accessing a further opinion from outside.

A report has been sent to the Minister for Mental Health, Director General of the DOH, the Mental Health Commissioner, and heads of the health services with the following recommendations:

- Health services must put formal processes into place to ensure they comply with the Act and consumers' rights are not being breached.
- A roster system between hospitals and community health services should be devised to ensure involuntary patients have a choice of external psychiatrists to provide further opinions in a timely manner and maximise the independence of further opinions. This may need to include external psychiatrists paid by the health service. The current system of the clinical director emailing colleagues in another hospital and asking them to assist is not working.
- The 'system manager' should be funded to manage the roster and requests for further opinions, including arranging for the provision of specialist psychiatrists where necessary, in accordance with the time limits noted in the operational directive, Alternatively, the Office of the Chief Psychiatrist could be funded to do this.
- The 'system manager' should ensure that the data required by the mandatory operational directive to be collected by health services is collected and provided to the 'system manager'. The data should be provided to the Chief Psychiatrist and the Mental Health Advocacy Service at the end of each financial year to ensure transparency and accountability about compliance with the Act and operational directive.

Right to feel safe - restraint, seclusion and rough treatment

It is an object of the Act to ensure that people with a mental illness are protected. Principle 4 of the Charter of Mental Health Care Principles states that a mental health service must be safe; and one of the criteria for making a person involuntary and detaining them on a ward is that there is a risk to the person's safety (implying that the inpatient treatment order is to protect the person). Not feeling safe on the ward and not being safe on the ward are therefore clearly breaches of the Act, and human rights in general.

Advocates dealt with 46 allegations of physical and sexual abuse and harm across 13 hospitals and two hostels. Of the 46 allegations, 21 concerned staff abuse of a consumer, 17 were consumer on consumer abuse, five were about police abuse and three cases were where a consumer was accused of threatening someone.

The first response of the Advocate is to ensure that the consumer feels safe on the ward. Incidents like this impact on other consumers on the ward as well. It is hard to feel safe when witnessing assaults or restraints. People who already have a history of being assaulted and who are subject to violence and abuse can be re-traumatised.

In some cases, the Advocate was unable to continue following up on the issue or be copied into the outcome of an investigation because the consumer who complained was made voluntary and it happened before the Classes of Voluntary Patient Direction came into force on 1 January 2017. In other cases, the consumer chose not to make a complaint or later withdrew the complaint.

The Classes of Voluntary Patient Direction and revised procedures by the Advocacy Service will allow better follow-up in future of the outcomes of these serious complaints.

Complaints about staff abuse

Of the 21 allegations about staff, 16 were about nursing staff, two about security guards, two about doctors and one about an external staff member:

- two resulted in staff being stood down but the results of the investigations are unknown, as are the outcomes in another five cases
- one is still being investigated
- two were withdrawn
- eight were determined to be unsubstantiated (including one allegation about a doctor)
- three consumers did not want to complain (including one involving an allegation about a doctor).

Complaints about abuse by nursing staff are very hard to prove unless captured on CCTV or witnessed by another staff member:

- *A consumer alleged that a nurse used threatening behaviour and body proximity, made offensive comments, pointed at the consumer in a threatening way, and then pushed the consumer 'hard in the forehead'. The incident took place in the early hours of the morning*

and another consumer witnessed the incident, but the consumer didn't know that person's name. The mental health service said that a review of the patient's medical record, and statements provided by employees could find no evidence of an incident occurring and that it was satisfied nursing staff behaved in a professional manner. It did note that 'feedback' had been given to clinical staff to be aware of being courteous, caring and understanding to patients at all times. In this case, the consumer was interviewed, which is not common in the Advocacy Service's experience, but it was by the clinical nurse and not a person independent of the staff who had been accused. The patient was made voluntary, so it is not known if they made a further complaint to the Health and Disability Services Complaints Office (HaDSCO).

Complaints about police abuse

Of the five allegations made to Advocates, one consumer did not want to make a formal complaint, the outcome in three cases is unknown, and one was held by the police investigation to have been 'reasonable force'.

Sexual safety on wards

Safety issues are compounded by wards which do not have locks on bedroom doors, and the lack of a female-only ward. There is one male-only ward. This raises risk for patients who, because of their illness, are sexually disinhibited and for the other patients they approach. It is not uncommon for two patients on a ward to have sex but there are questions of consent and whether the person would have participated had they been well. Young people are particularly at risk.

Cases in which Advocates have been involved included:

- *one consumer masturbating another. The first consumer said this was consensual*
- *a consumer saying they got into bed with another consumer while unwell and complaining later about how this could happen*
- *an 18-year-old victim of sexual abuse being propositioned for sex by a consumer in their 60s*
- *a consumer who woke up to find another consumer fondling them.*

In each case, the Advocate provided advocacy for moving one of the patients or nurse-specialling (when a nurse is assigned to provide constant care and supervision of a patient), as well as counselling and other services, and helping the person with a complaint letter if they wished.

In another case, a consumer had previously been sexually assaulted on a ward at the hospital and asked not to be put on that ward again, but their request had been ignored. It was extremely distressing for the consumer. The Advocate got the consumer moved off the ward and made arrangements to ensure the consumer's file noted the issues. The case is also an example of a lack of trauma-informed care and, had the consumer been involved in a treatment, support and discharge plan, the situation could have been avoided.

A complaint letter was sent to the hospital, which apologised and acknowledged these points, saying it was not an 'acceptable standard of nursing and medical practise' and that treatment, support and discharge plans would be regularly audited over the next 12 months.

An Advocacy Service inquiry into sexual safety is planned for the second half of 2017-18, subject to funding and resourcing. The Chief Psychiatrist is planning a working party to develop sexual safety standards.

Restraint and seclusion

Complaints about restraint and seclusion are recorded separately:

- there were 18 complaints about restraint and four about seclusion
- eight alleged excessive force was used
- seven related to being held down for an injection or blood test
- one was for restraint while using a naso-gastric tube
- two were difficult to categorise
- five consumers didn't want to complain
- one complaint was withdrawn
- the outcome in 11 cases was unknown, mainly because the consumer was discharged or made voluntary
- in one case, the consumer was given a verbal apology by the hospital.

Advocates check that the relevant forms have been completed, as well as assist consumers with complaints and/or raise issues with ward staff. In many cases, consumers choose not to follow through with a complaint because they are still detained on the ward and are concerned that it may delay their release. In other cases, they were discharged or made voluntary and it was not known if the consumer followed up with a complaint:

- *Mechanical and bodily restraints, clinical holds and other restrictive practices are frequently used to support nasogastric feeds in both adults and children with severe anorexia nervosa. Prolonged use is traumatic and has had long-term implications for some children. The youth advocate has been following up these issues.*
- *A consumer complained after being put into seclusion five times in 34 hours that they had not been given access to a toilet or drinks. The hospital confirmed that its records showed the consumer had only been offered fluids twice and there was no record of being offered access to a toilet. The clinical director stated this was clearly unacceptable and apologised to the consumer. The consumer was also advised that the hospital had changed its practices to allow the toilet door off the seclusion room to be kept unlocked and that staff had to offer hydration every 60 minutes.*

Cultural diversity rights

The Act requires that any communication under the Act must be in a language, form of communication and terms that the person is likely to understand, and use an interpreter if necessary. There are also provisions regarding the assessment and care of people of Aboriginal and Torres Strait Islander descent. The Charter of Mental Health Care Principles reiterates this and requires that a mental health service must recognise, and be sensitive and responsive to, diverse individual circumstances, including those relating to gender, sexuality, age, family, disability, lifestyle choices, and cultural and spiritual beliefs and practices.

Advocates are required by Advocacy Service protocols to:

- offer an interpreter to any person for whom English is not their native language
- attempt to find out if a consumer is, or identifies themselves as, an Aboriginal or Torres Strait Islander to ensure they know their rights under the Act and the Charter, and to ask if they would like to speak to the Advocacy Service's Aboriginal Advocate.

Aboriginal and Torres Strait Islander rights and issues

Advocacy Service data shows there were 160 people who identified themselves to the Advocate as Aboriginal or Torres Strait Islander on 284 involuntary orders.[11] This equated to 6.1% of the total number of people on inpatient treatment orders and 7.0% of all involuntary orders, a significant overrepresentation of Aboriginal and Torres Strait Islanders, who form 3.1% of the state's population (based on 2016 ABS figures).

Broome Hospital had the highest number of such cases (58 orders), followed by Midland (33 orders), Graylands (32 orders), Frankland (21), and Albany, Armadale, Bunbury and Rockingham hospitals (with 10 orders each).

Cases of concern included the following:

- *An Aboriginal consumer was turned away from a hospital mental health triage. The clinicians involved were of the view that the person was really only interested in a bed for the night and the suicidal risk was low. The person was told to go to a different hospital (in another catchment area), given the bus fare, and escorted from the hospital by security guards. The consumer never made it to the other hospital and the Advocacy Service called police due to concerns for the consumer's wellbeing. A complaint was made to the mental health service about the treatment, including that the consumer had been discriminated against and that the service failed to offer an Aboriginal Support Officer. The hospital denied the allegations and said it did not employ an Aboriginal or Torres Strait Islander mental health worker. The complaint has gone to HaDSCO.*
- *A female Aboriginal consumer from the country was very distressed and wanted a healer to come and 'block off her head to get rid of the voices'. The Advocate liaised with the Statewide Specialist Aboriginal Mental Health Service for a further opinion and they organised (and paid) for a healer to visit the consumer. The result was that the consumer's mental health quickly stabilised and she was able to return home. The healer was male and the consumer said it would have been better to have a female healer.*

11 The figure includes people on a 6A, 6B and CTO, and relies on the Advocate and the entry by them of the information into the Advocacy Service database, so may be an underestimate.

Also see *Aboriginal and Torres Strait Islander children* earlier in this report.

The Advocacy Service has one Aboriginal Advocate, who worked primarily across three hospitals – Joondalup, Graylands and Midland - as well as with children when requested by the Youth Advocate, and provided telephone advice to other Advocates, especially in regional areas. He was often the only Aboriginal contact for Aboriginal consumers, particularly at those hospitals that do not have ready access to ALOs.

The Aboriginal Advocate has highlighted a number of ongoing issues:

- the need for culturally appropriate treatment, support and discharge planning by treating teams, including the ongoing training of psychiatrists in Indigenous spiritual and cultural beliefs
- the need for culturally appropriate Mental Health Tribunal hearings for Aboriginal consumers, particularly for those consumers who have been regularly placed on inpatient treatment orders for more than five years. The Aboriginal Advocate reports there is a perception the tribunal is using its functions under the Act to merely rubber stamp reviews. He suggests that members of the Aboriginal and Torres Strait Islander community should be encouraged to apply to sit on the tribunal as community members
- suitable subsidised accommodation closer to the BAU for parents of young people from regional and remote areas of the state.

Interpreter and CALD issues

Advocates arrange interpreters and deal with culturally and linguistically diverse (CALD) issues on a regular basis:

- *In one case, the consumer was initially reluctant to use an interpreter but, because of the language barrier, did not understand their involuntary status. Their native language was unusual and the hospital told the Advocate that the company used to provide interpreters did not have that language, although the company used by the Advocacy Service did. Ultimately, an interpreter was provided so that reviews and discussions between the treating team and the consumer could take place with better understanding.*
- *Advocates have referred consumers to ASeTTS, which provides support to refugee survivors of torture and trauma.*
- *Hospital staff wanted to give a consumer information in Vietnamese about a prescribed medication. The pharmaceutical company said it was not available. Medication sheets were found online but they were unable to read them to clarify if it was the correct information they were giving to consumer. The Advocacy Service wrote to the Chief Psychiatrist, who contacted the Office of the Chief Medical Officer. The response was to get an interpreter. The Chief Psychiatrist said he would refer the issue to the WA Therapeutics Advisory Group. Given the Act requires that any communication must be in a language, form of communication and terms that the person is likely to understand, and the same applies when assessing whether a person has capacity to make a treatment decision, it might have been thought that at least the more common medications would have information readily accessible in alternative languages.*

Right to treatment, support and discharge plans

The Act states[12] that all involuntary patients (including those on a CTO) must have a treatment, support and discharge plan (TSD plan), that they and any personal support person must be involved in the preparation and review of the plan, and they must be given a copy. The Mental Health Tribunal is also required to have regard to the TSD plan. This is not happening, and the Act is being breached on a regular basis.

The Advocacy Service is using Advocates' inquiry functions and powers to educate consumers and mental health services, with a view to achieving increased compliance with the Act.

Importance of TSD plans

The TSD plan provision in the Act is aimed at *maximising the involvement of people experiencing mental illness, recognising the role of carers and families, and promoting a collaborative, holistic and recovery oriented approach.*[13]

If done properly, the process provides an increased prospect of a therapeutic relationship, which has been shown to be one of the most significant factors in improving treatment outcomes and quicker recovery. Other benefits include:

- all information is available and accurate
- the consumer having some "buy-in" or feeling some control or say in what is happening to them
- a holistic, patient-centred approach as required by the Act
- a reduction in consumer and carer frustration and complaints about inaccurate or missing information, and lack of planning and consultation for discharge
- better planning for discharge and care in the community and therefore a reduced prospect of readmission
- better continuity in and safer hand-over to other health services
- more informed and succinct information for Mental Health Tribunal members to improve their decision-making.

TSD plan inquiry process

The inquiry required Advocates from March to June 2017 to inquire into whether consumers' rights to a TSD plan were being observed and to assist consumers to exercise those rights. The outcome of the inquiries was for each Advocate to facilitate and advocate for the production of a **'**good**'** TSD plan for each of three consumers. A report on the Advocates' experiences would also be sent to mental health services and other relevant parties.

12 Sections 186-188 of the Act.
13 See the Explanatory Memorandum to the 2014 Mental Health Bill.

Prior to the inquiry, the Chief Advocate undertook stakeholder consultation with clinicians, consumers and carers to find out why the Act was not being complied with. It was evident that there was overall lack of knowledge about the rights, and confusion and disagreement in mental health services about how to go about it. The consultations were also used to draft a 'prompt sheet' to guide Advocates, consumers and carers on what types of issues should and could be canvassed in development of TSD plans.

The Office of the Chief Psychiatrist (OCP) was consulted and gave some training to Advocates, as the Act requires that the Chief Psychiatrists' standards on TSD plans be observed. A training day for Advocates including the OCP and consumer and carer representatives was held, and letters were sent to all hospital clinical directors and upper management advising of the inquiry.

Subsequently, in many hospitals, Advocates and the Chief Advocate gave presentations on TSD plan requirements to clinicians.

TSD plan inquiry outcome

It became evident that more time would be needed to complete the inquiry so it was extended for a further three months. There are several reasons for this but a major factor has been the slow pace of most mental health services in engaging in the process.

The first problem is that there is no document titled a TSD plan on the mental health PSOLIS data base. Many mental health services seemed unaware of a mandatory operational directive from the DOH requiring them to use the management plan document on PSOLIS instead. The Advocacy Service originally took the view that as long as the consumer and any personal support persons were involved and a copy given to the consumer, it didn't matter what the TSD plan was written on. The Advocacy Service did, however, prepare a TSD plan template which could be used on PSOLIS and sent this to mental health services. However, this issue continued to vex some services. Advocacy Service education on this issue continues.

Another issue was how to involve the consumer and personal support persons, and mental health services staff saying they had insufficient time, or no-one to 'write it up'. There were also issues as people moved from locked wards to open wards and the treating team changed.

Advocates continue to work with the mental health services. In the case of Graylands Hospital, the lead nurse of each ward has been asked to produce two 'gold standard' TSD plans as part of the hospital's own work on the issue.

Comments by Advocates:

Although the TSD plan inquiry is not complete, below are some comments by Advocates on the experience so far:

- *At the start of the TSD plan inquiry, the treating team and nursing staff were unsure of how the process would work within PSOLIS but were very eager to learn from the experience. They particularly enjoyed understanding how to enter patient delusions and disagreements between the treating team in a recovery-focused way.*

- *The consumer was so pleased to see a document about himself that did not start with the line '40-year-old man with paranoid schizophrenia'.*
- *The immediate desired outcomes of the consumer were met – the consumer was transferred to another ward, as they requested, where they were less bored and less traumatised than they had been by the acuity and loudness on the closed ward.*
- *It was also pleasing to see how staff incorporated the consumer's baseline delusions in a recovery-focused manner in the document. This was a priority when the consumer stated that what they believed (i.e. the delusion) was the reason they get out of bed each day.*
- *The community treatment plan had much more relevant detail and was closer to a recovery-focused TSD plan than the inpatient document. When the first attempt at the inpatient plan did not fulfil the needs of a recovery-focused TSD plan, the staff and CNS welcomed the feedback and continued to strive for a recovery plan without feeling defeated.*
- *The driving force behind the success of the plan was definitely the designated nurse, who continuously sought the views of the consumer – even if it required politely interrupting the treating team when this was not happening. He had developed a good relationship with the consumer – addressed the consumer by their Chinese name, and demonstrated respect towards the consumer and their aspirations throughout the process.*
- *The biggest success was that the consumer was able to attend and have some input. Everyone was surprised. The consumer said they could only do this if they had an Advocate with them. The consumer took the opportunity to tell the team what they wanted from accommodation, as they had just learned that going home was not an option. Comparing the pre-Advocate management plan and the TSD plan post Advocate involvement, you wouldn't recognise the two documents as for the same person – the new, improved version talks in the first person and has things which the person said would help them to stay calm and called for other services to help manage better in future.*

One of the benefits of the TSD plan process is getting the input and involvement of family and other personal support persons. As noted by the Advocates:

- *The consumer's mother has been a continuous presence throughout the process, providing additional insight into his progress, barriers and requirements.*
- *When the treating psychiatrist was first advised about the inquiry and the expectations regarding the TSD plan, she was clearly put out, but at the subsequent family meeting was very cooperative.*
- *I think the process necessitated the family involvement earlier in the piece. We managed to negotiate some freedoms, and the plan forced the thinking of the treating team into transition and discharge.*

Right to review – tribunal hearings

Along with the Advocacy Service and the Chief Psychiatrist, the Mental Health Tribunal is one of the three pillars of rights protection for people put on involuntary treatment orders.

Every involuntary patient must be reviewed by the Mental Health Tribunal within 35 days of being made involuntary and, thereafter, every three months while they remain involuntary.[14] Hearings for children must be held within 10 days and, thereafter, every 28 days and should have a child psychiatrist on the tribunal.

Advocates assist consumers to make applications to the Mental Health Tribunal and support them in the ensuing hearings and periodical reviews of their involuntary status.

Advocates also support people in State Administrative Tribunal (SAT) hearings. SAT reviews decisions of the Mental Health Tribunal, and appeals can be made from SAT to the Supreme Court. SAT also makes guardianship and administration orders, which are sometimes used instead of the Act. Hospitals regularly apply to SAT for such orders while people are involuntary.

Representation in Mental Health Tribunal hearings

The Mental Health Tribunal advised that it completed 2101 reviews during the year:

- Advocates represented consumers in 749[15] review hearings.
- Consumers were therefore represented by an Advocate in 35.6% of reviews.
- Lawyers from the Mental Health Law Centre (MHLC) attended 147 reviews.
- Paralegals[16] attended 28 reviews.
- Consumers were therefore represented by an Advocate, lawyer or paralegal in 924, or 44%, of Tribunal reviews.

The number and percentage of reviews attended by Advocates is significantly higher than under the previous Mental Health Act 1996, or the first seven months of operation of the new Act (219 in 2014-15 and 279 in 2015-16). Some of this will be due to improved recording by Advocates. Tribunal data for the first seven months of the operation of the new Act is not available. The overall representation rate of 44% is also higher than in 2014-15, when consumers had representation in 38.4% of Mental Health Review Board hearings.

Sixty referrals were recorded as having been made by Advocates to the MHLC, but many more consumers would have been advised of the MHLC by Advocates and given their contact details to make their own arrangements. The MHLC struggled during the year to keep up with demand, which meant more consumers were represented by Advocates. Advocates do not attend with a MHLC lawyer unless in exceptional circumstances and after approval by a Senior Advocate.

14 Which includes people on a CTO up to 12 months after which time it becomes every six months.
15 Based on Mental Health Tribunal data provided on 11 August 2017. Advocacy Service data showed attendance at fewer hearings (680) but some Advocates were not properly recording their attendance at the beginning of the 2016-17 year.
16 It is assumed that the paralegals were from the MHLC.

Failure to provide medical reports, and natural justice

Under the previous *Mental Health Act 1996*, Official Visitors (the predecessors of Advocates) complained about the regular failure of psychiatrists to provide consumers with a copy of the medical report sent to the tribunal and to discuss it with the consumer three days before the hearing. The new Act has not changed this issue, which impacts on the consumer's right to natural justice.

Advocates say it is unusual to get the medical report three days before a hearing, and often they only get it on the morning of the hearing or in the hearing itself. Having the treating team take the patient through the report prior to a hearing is extremely rare. TSD plans are meant to be referred to in the report but, as TSD plans made in accordance with the Act are rare, this is also an issue.

Similarly, it is not uncommon for the treating psychiatrist to be absent, and sometimes no-one familiar with the consumer's treatment is present. The tribunal requests only that the psychiatrist or a member of the treating team attend in person or by phone. In some cases, the tribunal cancelled the review because there was no-one from the treating team able to answer questions from the tribunal, or the consumer and/or their representative. This means that the consumer remains involuntary because there cannot be a proper consideration of their case. This should not be allowed to happen. The tribunal will usually order that another hearing take place as soon as possible but there is often at least a two-week delay.

Advocates follow up these cases with complaints to the head of the mental health service and by checking with the tribunal to ensure the hearing is relisted promptly, but would like to see some rules made by the tribunal and to have them enforced. In one case, a clinical director replied noting that the tribunal could direct doctors to attend.

Other Mental Health Tribunal applications

The Act provides consumers with the right to make a number of applications as well as seek a review of their involuntary status. Some of these provisions are new to the Act and others have had changes in wording. There are no rules or guidance from the tribunal about making the applications so it has been a learning curve for Advocates:

- ***Compliance orders:*** *No-one from the treating team turned up for the hearing and there was no medical report or TSD plan, so the Advocate asked for a compliance order for a TSD plan. The Tribunal ordered that a TSD plan be provided 48 hours before the next hearing, which was scheduled eight days later. The consumer was made voluntary just prior to the rescheduled hearing, however, so the compliance order could not be enforced.*

  After the hearing, the tribunal president advised that he considered the tribunal did not have the power to make the compliance order because, amongst other things:

  '(a) notice of the tribunal's intention and notice of the application should be given to the psychiatrist or service provider, so that they have the opportunity to be heard (before) any order is made, and

'(b) if this is not done, any compliance order that the tribunal makes in the absence of notice to a party and without giving the party the opportunity to be heard is made without power and therefore void.'

The Act requires that the names of any 'service provider' issued with a compliance notice during the year be published in the annual report of the tribunal. The question in this case is where was the procedural fairness for the consumer? The medical director of the hospital involved was also contacted, and instructed the treating team to comply and sent a letter of apology to the consumer.

- ***Application for transfer to another hospital:*** *Another, more suitable, mental health service, was refusing to take the consumer so the treating psychiatrist felt they could not make a transfer order. The application had the benefit of getting the many parties in the same room to discuss the issues but failed in getting the consumer moved to another hospital. The tribunal said it reluctantly held that the psychiatrist's 'refusal' to make a transfer order was appropriate because 'there was no pathway' as the other hospital had no beds available.*
- ***Application to remove an order restricting communication (form 12C):*** *In most cases involving restrictions, Advocates are able to negotiate a revised restriction or the restriction only lasts a short time so these applications are rare. A restriction which had been in force for nine days was lifted the day after the application was made, so the hearing did not proceed.*
- ***Incorrect statements in medical report to tribunal:*** *The report stated the person had had two previous involuntary admissions, which was not correct. The Advocate raised the issue in the tribunal hearing, including asking for a correction in both the patient's medical file and the tribunal's file. A history of involuntary orders presents a different picture to anyone reading a medical file, which may influence their decision-making, and this could include a tribunal. It is also of personal importance to the consumer. The tribunal president refused to amend the tribunal's file but the psychiatrist provided an amended medical report with two explicit corrections, which satisfied the consumer.*

Electroconvulsive therapy (ECT) and psychosurgery hearings

ECT can only be given to involuntary patients and voluntary children aged over 14 years if agreed to by the Mental Health Tribunal:[17]

- ***Hearings scheduled too quickly:*** *ECT hearings are scheduled by the tribunal much faster than other applications, which makes it difficult to get a lawyer to represent the person. The Advocacy Service endeavours to make sure the consumer is represented. In one case, the ECT hearing was held 25 hours after the consumer was made involuntary.*

17 It should be noted that some patients appreciate the benefits of ECT and that advocacy is based on the consumer's wishes and not the views of the Advocate.

- ***Opposing ECT:*** *The family of a consumer who had been mute for two weeks rang the Advocacy Service saying the consumer was always vehemently opposed to ECT when well. In the hearing, on listening to what was being said the consumer suddenly spoke clearly and eloquently about why they did not want ECT. The doctors responded by saying they would defer starting it for two weeks. The Advocate argued the treating team should go back to the tribunal if that was the case and the Tribunal agreed; the application was refused.*
- ***Delays in accessing ECT:*** *ECT can only be given in authorised units. In two cases where ECT orders were made and the consumer wanted the ECT, it took two weeks for another hospital in the same health service or another health service to agree to provide the treatment. In both cases, the consumers' health deteriorated in this period; in one case the consumer was put into seclusion while waiting for the transfer. This is unacceptable and is being followed by the Advocacy Service and the Chief Psychiatrist.*
- ***ECT on children:*** *There have been a number of cases involving children. In most cases, the parents or guardians were in favour of the treatment but the Youth Advocate attended the hearing to ensure the rights of the child were observed.*
- ***Psychosurgery application:*** *No applications could be made for psychosurgery because the Act requires a five-member tribunal, including a neurosurgeon who is appointed as a member after consultation by the Minister with the Health Minister, held after consultation by the Health Minister with the Royal Australasian College of Surgeons. The Act also requires the patient to consent. In one case, the treating team was considering deep brain stimulation. The tribunal heard an initial application regarding the patient's capacity while arrangements were made to establish the tribunal and an Advocate assisted the consumer in the hearing. The application has not been pursued but it is understood a neurosurgeon has now been appointed.*

Reviews of Mental Health Tribunal hearings

SAT hearings to review Mental Health Tribunal decisions are not common, partly due to the time it takes to get such a hearing. If the person is made voluntary in the meantime, the SAT hearing is dismissed because there is no order to review. The SAT hearing is by way of a hearing *de novo* and is not an appeal as such but looks at the facts at the time of the SAT hearing. The Advocate will endeavour to get a MHLC lawyer to attend these hearings as they can lead to an appeal to the Supreme Court and precedent decisions.

Advocates were involved in three applications to SAT which went to a hearing, and in two of the cases the consumers were made voluntary, over-turning the decision of the Mental Health Tribunal on the basis that the risk was not significant enough. One of the criteria for being involuntary is significant risk to health or safety or of serious harm to the person or others and, in the case of CTOs, risk of serious physical or mental deterioration:

- *A consumer told the Advocate that the CTO made them feel 'like a little child' who couldn't be trusted to make decisions. The SAT overturned the decision of the Mental Health Tribunal, saying the risk of deterioration did not outweigh the balance of life factors which were so distressing to the consumer.*
- *The Advocacy Service was also peripherally involved in a case which went to the Supreme Court. The consumer ran the case themself but the Advocacy Service was subpoenaed for documents. By the time the case got to be heard by the Supreme Court, the Mental Health Tribunal had held other reviews continuing the involuntary order and then the consumer was made voluntary. Justice Michael Corboy held, however, that it was in the interests of justice for the appeal to still be determined. The consumer's appeal was ultimately dismissed.*

SAT decisions under the Guardianship and Administration Act 1990

Consumers regularly have a guardian or administrator appointed while they are involuntary and often while they are detained in hospital. Advocates reported assisting consumers in 29 hearings for either guardianship or administration orders (or both). In many more cases, Advocates explained to consumers their rights and arranged for legal representation. Cases included the following:

- *A consumer wasn't told about the application and it was only because the Advocate saw a reference on the medical file that they found out. Making sure that the consumer is able to attend the hearing (preferably in person - if not, by video-link), is another key aspect of the role of the Advocate, but there were still hearings where the person took part by teleconference, which is unacceptable.*
- *An application by the hospital included a restraint plan. The restraint plan was not enforced but the Advocacy Service is concerned about any orders empowering restraint outside the Act, which has considerable protections, checks and balances and provision for review far exceeding those provided under the Guardianship and Administration Act 1990.*
- *The Chief Advocate, Public Advocate and Chief Psychiatrist were asked for submissions on an application by the hospital for orders allowing the guardian to agree to and instruct the treating team to impose a complete ban on the consumer smoking. The Chief Advocate opposed the orders on the basis that:*
    - *it was arguable that the Guardianship and Administration Act did not allow such orders because giving a person the right to allow another person to physically prevent the consumer from smoking was not 'other health care' and therefore not a treatment decision, and no other provision of that Act could authorise such an order. Ordinarily a doctor cannot ban a person from smoking in the name of their health care*
    - *if the Guardianship and Administration Act 1990 did apply, it was not the least restrictive order that could be made, as the legislation required*

- *the definition of treatment in the Act could be used to limit smoking if it was a psychosocial intervention to alleviate or prevent the deterioration of a condition that was a consequence of a mental illness*
- *the Act had far more protections than the Guardianship and Administration Act 1990, such as regular Mental Health Tribunal reviews*
- *the concern was that the Guardianship and Administration Act 1990 could be used to control what a person eats, for example, just because the doctor says it is generally unhealthy to be overweight or eat fatty food.*

The SAT member agreed that the smoking restrictions proposed were not a treatment decision under the Guardianship and Administration Act 1990, but was also of the view that the facts did not meet the definition of treatment under the Act either. This left a vacuum. Orders were made that the guardian should negotiate with the treating team about a management plan in relation to smoking by the consumer which included consent or refusing to consent to a complete ban.

The consumer was represented by a lawyer from the MHLC and, given the importance of the case, joint attendance approval was given for the consumer's Advocate to attend as well. The Advocate assisted the consumer in preparing written submissions in their own words.

Right to contact by Advocates

Adults on 92.6% of inpatient treatment orders (2958 out of 3194 orders) were contacted by an Advocate within seven days of the order being made.

The vast majority of adults on inpatient treatment orders were contacted within four days of the order being made (2354 out of 3194 orders, or 73.7%).

Children on 84.3% of involuntary inpatient treatment orders (43 out of 51 orders) were contacted by an Advocate within 24 hours.

Appendix 6 sets out the time taken for facilities to notify the Advocacy Service, and the time taken for Advocates to contact consumers. The Advocacy Service is reliant on the timeliness of the notifications. This has significantly improved in 2016-17 because orders are now being put into the health services' mental health database, PSOLIS, and the Advocacy Service has been given access to that part of PSOLIS. There are still delays and mistakes and the Advocacy Services has to manually transfer the orders into its database (ICMS).

Advocate contact - adults

According to the ICMS database,[18] adults on 297 involuntary orders were not contacted by the end of the seventh day after the order was made. See Table 1 below. There were a variety of reasons for this, but the majority were because the involuntary order was revoked within seven days (168 out of 297 orders, or 56.6%) and before the Advocate made contact. In many cases, the person was still contacted by an Advocate but they were no longer involuntary at the time of the contact. In some cases they had been discharged.

The other major reasons for no contact within the seven days were:

- 63 due to Advocacy Service error
- 26 CTOs where the Advocacy Service could not contact the person because it did not have either correct or any contact details
- 33 because the order was not received by the Advocacy Service within seven days.

18 ICMS data is subject to change due to the late notification of orders or ongoing verification of data.

Table 1: Contact by Advocates following notification of involuntary treatment orders.

Reason	Form 5A	Form 6A	Form 6B	Total
Orders for children (see reasons below)	4	6	2	12
Notification was not received within 7 days of the order being made	23	7	3	33
Notification was received within 7 days but: - contact was made after 7 days - the consumer was not contacted - the order was revoked within 7 days - a subsequent order was made within 7 days (and the consumer was not contacted in time about the initial order)	1 - 3 1	16 32 158 5	3 4 7 -	20 36 168 6
CTO: - no address available, unable to contact by phone - letter was returned, unable to contact by phone	4 22	- -	- -	4 22
Advocacy Service administration error	7	-	-	7
Other	-	1	-	1
Total	65	225	19	309

Advocate contact - children

Twelve children were not contacted within the 24-hour time period but all but two of those were contacted shortly afterwards. The 24-hour time limit for contact is very tight and mental health services had agreed to notify the Advocacy Service within two hours of the order being made. Eight of the 12 instances were caused by notification by the mental health service after the 24-hour time limit and four others were outside the two-hour agreed notification time. In one case, the contact was only 15 minutes over the limit and was because the consumer was being treated by health staff when the Advocate arrived on the ward. Four late contacts were for children on CTOs, and in each case there had been regular contact with an Advocate while in hospital prior to being put on the CTO.

There would have been more children and adults not contacted within the time frames of the Act but for Advocates being regularly on the wards and their protocols requiring them to always check with staff.

Revocation of orders within seven days and repeat orders

Advocacy Service data identified a trend where very high numbers of people were being made involuntary by being put on an inpatient treatment order, followed by revocation of the order only a few days later. This led to a desk-top inquiry into the data and discussions with the OCP. It raised a number of questions:

- were people being put on an inpatient treatment order too readily by some psychiatrists
- were psychiatrists aware of and/or using the provisions in the Act allowing them extend the period for examination (from 24 hours to a maximum of 72 hours) which would give them more time to decide whether an involuntary order was necessary
- were people being put on an inpatient treatment order to secure a bed
- were people being discharged too soon
- did the data reflect an influx of patients due to drug-induced psychosis?

Putting someone on an involuntary order when it is not necessary is not only a breach of the Act, but it has potentially serious ramifications for the person as it remains on their record, can be stigmatising, and affect other aspects of their life such as insurance and visa and job applications. Alternatively, if people are being discharged too soon, that could impact on their recovery and increase re-admission rates.

Form 6As made from 1 July to 31 December 2016 (1,563 orders as notified to the Advocacy Service) were analysed and the inquiry is ongoing. It was determined that diagnostic criteria would be needed to better assess what was happening. Some preliminary investigation shows that:

- 20.1% of form 6A orders (or 314 orders) were revoked within seven days of the order being made
- almost one in ten revocations occurred within three days of the order being made
- almost one in five orders revoked within seven days were made for Aboriginal and Torres Strait Islander people[19], although this group made up 12% of all form 6A inpatient treatment orders (and represent only 3.1% of the total WA population, based on the 2016 ABS census).

As part of this inquiry, the instances of repeat 6A orders made during the six month period (for all consumers, not just those whose order was revoked within seven days) was also briefly examined:

- 194 consumers were subject to 433 repeat 6A orders
- 35 of these consumers were put on inpatient treatment orders three or more times in the six month period
- 16.7% of repeat 6A orders were made for Aboriginal and Torres Strait Islander people.

19 Identification of Aboriginal and Torres Strait Islander people was based on information supplied by the DOH from their 'Hospital Morbidity Data Collection' for a proportion of Advocacy Service data (i.e. 'separations' as at 31 December 2016) and this data will not correspond to Advocacy Service data (i.e. based on information provided by Advocates).

Within the group of consumers whose orders were revoked within seven days and who were subject to repeat involuntary orders in the six month period, more than three-quarters were for female consumers and there was a cluster in the 18- to 31-year-old group.

Other contact requests

Apart from the statutory contacts, consumers may make a request for contact while on an involuntary treatment order. Requests are also received by other types of identified persons, including people waiting in EDs on referral orders, hostel residents, and people on custody orders or hospital orders under the MIA Act. The vast majority of requests are made by phone calls to the Advocacy Service, although requests can also be made via Advocacy Service mailboxes on hospital wards, by email or in person to an Advocate at the mental health service.

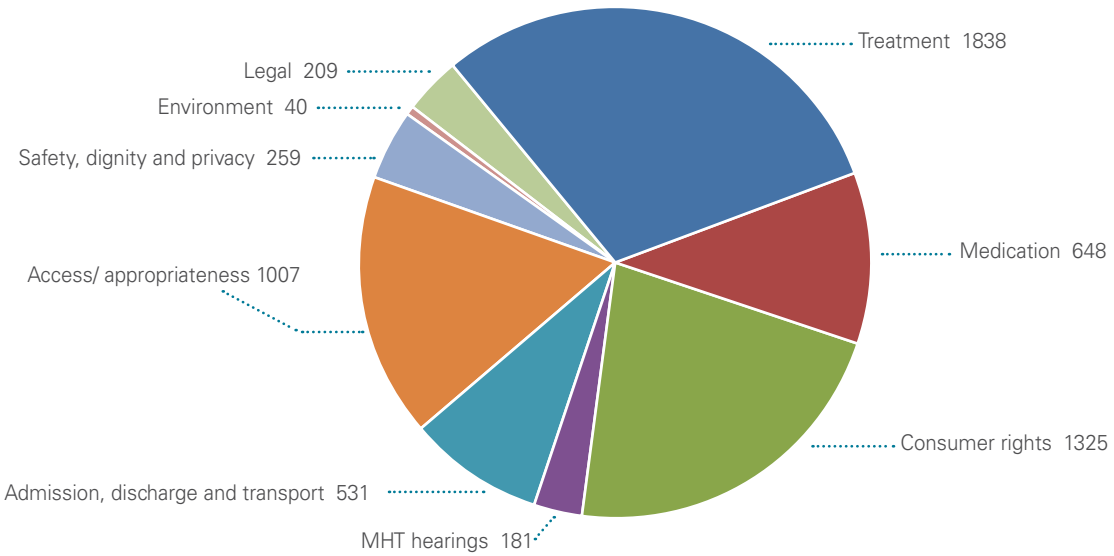
The number of phone call requests made to the Advocacy Service office was 9120, or 760 per month. In the first seven months of operation of the new Act (to 30 June 2016) there were 4161 calls or 594.4 per month. This reflects an increase of 166 calls per month, or 28%.

Complaint issues

Advocates are required to categorise the complaint or issues raised with them by consumers when they write up their report in the Advocacy Service database. A full list of the categories (or code) is provided in appendix 7. The majority of issues raised relate to the consumer's treatment, including diagnosis, treatment, support and discharge plans, getting ground access and wanting transfer to another hospital or ward (usually an open ward rather than the locked ward).

Consumer rights categories also feature frequently and include the single highest sub-category, being consumer complaints about their involuntary status and what they can do to over-turn it. Complaints about medication and side effects, and accommodation issues all feature highly as well. See the pie-chart below.

Graph 1: Issues recorded by Advocates raised by consumers



Mentally impaired accused

Under the Act, people who are a mentally impaired accused under the *Criminal Law (Mentally Impaired Accused) Act 1996* (MIA Act) and who are required under that act to be detained in an authorised hospital, are also identified persons. They must be contacted by an Advocate within seven days of being detained in hospital (24 hours for children).

Mentally impaired accused people have been found unable to stand trial for a crime or not guilty of a crime by reason of unsound mind, and put on a custody order. They may be given a conditional release order allowing them to live in the community and, if required to receive mental health services, can also request advocacy.

In 2016-17 there were five mentally impaired accused people detained in an authorised hospital on six occasions.

Support and assistance was provided during the year to the consumers and their families, including making submissions to the Mentally Impaired Accused Review Board. In one case, the Advocate worked closely with Legal Aid lawyers to get changes in the orders to allow the person, who had a major physical health issue, more freedom of movement and access to their family.

A need to amend or rewrite the legislation imposing custody orders has been the subject of considerable advocacy, and therefore reviews, over the past few years. The Chief Advocate was invited to be a member of the working group addressing recommendations 13 and 16 from the Review of the MIA Act, which gave its final report in October 2016.

The Chief Advocate also:

- gave written submissions to the Inquiry by the Senate Community Affairs References Committee Into Indefinite Detention Of People With Cognitive And Psychiatric Impairment In Australia in November 2016. The committee had held a number of hearings and received submissions but sought further evidence on the people subject to involuntary mental health orders
- provided a short comment and submission to the Department of Justice in January 2017 on the National Statement of Principles Relating to Persons Unfit to Plead or Not Guilty by Reason of Cognitive or Mental Health Impairment, drafted by a cross-jurisdictional working group, established under the Law, Crime and Community Safety Council in November 2015. The principles recognise the rights of people with cognitive or mental health impairment and the importance of preventing harm to others, and seek to identify safeguards throughout legal processes and during the period in which a person who is unfit to plead or not guilty by reason of cognitive or mental health impairment is subject to orders.

Disability Justice Centre

The Chief Advocate provides advocacy services to the residents of the Bennett Brook Disability Justice Centre for people with intellectual impairment on a custody order, pursuant to the *Declared Places (Mentally Impaired Accused) Act 2015*. A separate annual report and funding is provided for this work.

Bed pressures and lack of supported accommodation

Bed pressures impact on consumers seeking admission and on discharge, and people continue to be stuck on wards because there is no appropriate supported accommodation.

Last year there were 648 available authorised beds; this year there were 653 beds according to the DOH (see appendix 1) but the average number of beds available through the year was 648.[20] Six beds were opened on the youth ward at Fiona Stanley Hospital during the year. Four beds at Rockingham Hospital and one bed at SCGH were closed at 30 June 2017.[21]

The predecessor to the Advocacy Service, the Council of Official Visitors, started a snapshot survey of authorised hospitals in 2013 asking how many patients were stuck on wards on 30 June. The Advocacy Service conducted the same survey on 30 June 2016 and again this year.

The combination of both surveys show people being discharged more quickly but a continuing shortage of appropriate supported accommodation for patients with the most complex needs and older adults.

Bed pressure issues

- *A consumer was discharged to a backpackers' hostel with no money because their wallet had gone missing and their car had been impounded. The Advocate was able to continue to assist the person, who was now voluntary, because the discharge issue had been raised while they were involuntary and it was after the Classes of Voluntary Patient Direction was operative. They were connected with other services and provided with support.*
- *A ward had five beds closed for many weeks because of the high care needs for one consumer – this issue has been raised previously and a swing-bed arrangement would avoid the stress to other consumers and their families and the stress it puts on the system. The hospital kept the Advocacy Service well informed so the consumers who were transferred to other hospitals could be supported in the move.*
- *A consumer in a regional hospital waited weeks for accommodation and ended up in the metropolitan area. The hospital started to talk about charging the consumer an accommodation fee but it was pointed out by the Advocate that the consumer was still involuntary and would be discharged on a CTO so could not be charged.*
- *Consumers are finding themselves moved across mental health services after long waits in EDs. It is not uncommon to be sent to a hospital a long distance from home, which places further pressure on families who are often already exhausted. Anecdotally, and as reported by mental health services, there are not nearly enough beds in the Rockingham area. There are also concerns about bed priority being based on location rather than patient priority. The assertive patient flow agreement put into place in 2011 by the DOH needs to be improved and agreed to by the new area health services.*

20 Beds are closed from time to time for various reasons including maintenance.
21 Four older adult beds were closed at Rockingham Hospital in 2015-16 and through 2016-17. They were expected to open in mid-August 2017.

- *Patients feeling at risk of self-harm have been given a crisis admission plan promising them a voluntary return to hospital when they feel they need it to stay safe, but find themselves waiting in EDs for days and denied admission. These patients often have a personality disorder diagnosis and struggle to avoid self-harm. It places carers and loved ones under enormous pressure as the mental health system struggles to cope.*

Hospital survey results

All 18 authorised hospitals responded to the survey, which asked for the number of patients in the hospital on 30 June who had been there for: less than 30 days, 30 to less than 90 days, three to less than six months, six months to less than one year, one to less than two years, and more than two years. They were also asked to identify how many of the patients were still in hospital due to accommodation issues, either because there was no accommodation available, or no suitable accommodation.

Unfortunately, Graylands Hospital was unable to answer the questions about accommodation this year so the data cannot be compared with previous years, though it does appear that overall there were fewer people stuck on wards.

Based on the responses of the other mental health services, 72 patients were on wards and unable to be discharged due to accommodation issues on 30 June 2017 – either because there was no accommodation available, or what was available was unsuitable. It seems very likely that a significant number of the 59 people at Graylands Hospital, who were reported as having been on a ward for over a year, would also have had their discharge delayed due to lack of appropriate accommodation. The results of the survey are in Table 2.

Table 2. Summary of number of people in hospitals due to lack of suitable accommodation on 30 June 2017 and 2016.

	Responses as at 30 June 2017 (18 authorised hospitals comprising 653 beds)		**Responses as at 30 June 2016 (15 out of 18 authorised hospitals comprising 567 beds)**	
	Number of patients	Discharge delayed due to lack of suitable accommodation[22]	Number of patients	Discharge delayed due to lack of suitable accommodation
In hospital for 30 days and over	115	45	177	92
In hospital for 90 days and over	43	19	95	67
In hospital for 6 months and over	25	6	58	47
In hospital for over 1 year	20	1	50	43
In hospital for 2 years and over	39	1	43	38
TOTAL	242	72	423	195

22 The numbers do not include Graylands Hospital so cannot be compared with previous surveys.

The number of people who had been in hospital for two years or more on 30 June 2017 remained very high at 39, compared with 43 last year. Of those people, 34 are in Graylands Hospital and the other five in the Frankland Centre.

The number of people in hospital for a year or more has, however, gone down significantly and there appear to be major decreases in length of stay generally. The survey is only a snap-shot so should be viewed with caution.

The 20 people who had been in hospital for a year or more (but less than two years) were spread across Graylands, Selby and Bentley hospitals and the Frankland Centre. The patients in Bentley and Selby hospitals were all on older adult wards, reflecting issues in getting accommodation for people over 65 with a mental illness. It should be noted that they are not eligible for NDIS services.

The 25 people in hospital for six months or more were spread across Graylands, Fremantle and Bentley hospitals, the Frankland Centre, Selby, Midland and Mt Lawley hospitals. Of the 25, at least eight people were on older adult wards.

Every hospital except for the four country facilities, Fiona Stanley and the Mother and Baby Unit at King Edward Memorial Hospital, had at least one person on 30 June 2017 who had been there for three months or more. Every hospital in WA except for Kalgoorlie and Fiona Stanley had a patient on a ward who had been there for a month or more.

The responses also appeared to indicate that on 30 June 2017 there were 31 empty authorised hospital beds.

Comments from mental health services about difficulties discharging patients and the effect of the lack of suitable accommodation included the following:

- The shortage of suitable accommodation has resulted in several situations where patients with severe and complex health needs and complex social and family situations have on discharge quickly ended up homeless or in prison.
- The patient flow requirement frequently results in accepting unsatisfactory placements which people may live in long-term because of the structural barriers to relocation.
- There is a reluctance of community accommodation providers to house consumers with mental health needs – perhaps due to stigma and negative media.
- Community services exclusion criteria including drugs and alcohol makes it more difficult.
- Five patients are clinically well to go home but in need of extra support in the community, which is not available, while two patients have had their functioning decrease such that they cannot return to their home or previous hostel.

Hostel survey results

Information was also sought from the licensees of 37 licensed psychiatric hostels regarding the number of beds and vacancies on 30 June 2017.

All licensees responded to the survey, representing 832 licensed psychiatric hostel beds. They reported 96 vacancies. Last year, 78 vacant beds were reported out of 820 hostel beds (noting that not all licensees responded last year):

- Once again 35 (last year 36) of the vacancies came from two hostels, and 15 of those beds are licensed but un-useable due to renovations which have been continuing for more than 12 months.
- In a repeat of last year's survey, a common reason given for vacancies was that inappropriate referrals were being made for people whose needs were too high, requiring 24-hour support which could not be offered. This reflects the experience of the Advocacy Service.
- Those hostels offering the highest level of care did not have vacancies or, in one case, the vacancies on 30 June were filled a few days later.
- Another issue raised was that people did not want to share bedrooms, and a lot of the older style hostels offer mainly shared bedrooms.
- One licensee said when vacancies do occur, it is difficult to let mental health services know about the vacancy because there is no central contact.

The overall number of licensed beds has decreased from 854 last year to 832. However, the Joondalup Sub-Acute Service, which is a 22-bed step-down short-term stay facility, is no longer required to be licensed, and a similar facility in Rockingham with 10 beds opened in October 2016 and also does not have to be licensed.

The number of short-term (28-day) and low-care facilities has therefore increased but there has been no increase in the high-care and long-term bed numbers, which is where there is the greatest need for consumers assisted by the Advocacy Service and consumers stuck on hospital wards.

A full list of the hostels and bed numbers is set out in appendix 2.

Voluntary patient issues

Voluntary patients are often admitted to locked wards. The mental health wards in the Joondalup, Midland, Fiona Stanley, Selby, Albany, Kalgoorlie and Bunbury hospitals and the BAU are all locked, as are all older adult wards. Voluntary patients must ask to be allowed to leave the ward and cannot leave the ward unless a staff member unlocks the door for them. Most voluntary patients cannot be assisted by Advocates and are referred to either the Health Consumers' Council (HCC) or Helping Minds.

Classes of Voluntary Patient Direction

Following submissions by the Chief Advocate in 2016, the then Minister for Mental Health, Andrea Mitchell, agreed to a Ministerial Direction pursuant to s248(j) and 254 of the Act declaring certain classes of voluntary children and adults to be identified persons under the Act so that they could be supported by Advocates:

- Any child on a mental health ward or waiting in an ED for admission can now be assisted. A child who has been supported by an Advocate in the previous six months who is being treated by a community service can also be assisted in the community.
- Adults who were involuntary and become voluntary while they have an ongoing complaint or issue which remains unresolved, and where some further action can reasonably be taken to resolve it, can also now be assisted. Previously the Advocate would have to refer the person on to another agency the moment they became voluntary.

The full wording of the Direction is in appendix 9.

Advocacy needed for other voluntary patients

The Advocacy Service remains unable to help many voluntary patients on locked wards. There are particular concerns about people on locked older adult wards, where very few are made involuntary. Selby Hospital, for example, is a 32-bed unit with eight acute beds, yet only 29 inpatient treatment orders were made for consumers on these locked wards during the year. It means the voluntary patients miss out on regular reviews by the Mental Health Tribunal and access to an Advocate, though they can still be restrained and secluded. They may apply to the tribunal for a review if they have been a voluntary patient for more than six months, but few would know they have this right. It also means Advocates do not visit these wards regularly.

The Advocacy Service refers voluntary patients to the HCC or Helping Minds. During the year, HCC wrote advising it was putting a business case to the Mental Health Commission (MHC) for specific funding to assist voluntary mental health patients due to the influx of requests for advocacy they were receiving. The Chief Advocate wrote a letter of support, noting the following:

- research cited by the HCC has shown that voluntary mental health patients experience fear at a high rate – partly because they fear being made involuntary
- fear and trauma also comes from being on a locked mental health ward where a patient may witness restraints involving security guards, and people being secluded
- the disempowerment of a voluntary patient on a locked ward is almost as strong as an involuntary patient, especially if the person has no family support or other form of advocacy
- advocacy can be therapeutic in giving the patient back some dignity and control, and in improving the therapeutic relationship with the treating team as they can get a better understanding of the patient and their needs.

Locked wards

Concerns about the rights of voluntary patients on locked wards continued this year, however two major hospitals (Midland and Joondalup) agreed to put up notices telling voluntary patients (and reminding staff) that it was the right of voluntary patients to leave the ward. The signage was based on notices used in wards in the UK. Where staff are concerned about the mental health of a patient demanding to leave the ward they have the ability to detain them for six hours to arrange an assessment, so there is no risk to patients.

The Chief Advocate has recommended that the Act be amended to contain some protections, including that voluntary patients are entitled to leave the ward and/or that patients in older adult locked wards be designated 'identified persons' so they can be assisted by Advocates.

Psychiatric Hostels – residents' rights and issues

Private psychiatric hostels[23] (hereafter called hostels) play a pivotal role in mental health in freeing up expensive hospital beds, helping people to avoid hospital admission or transition out of hospital sooner, or by providing intensive care, and rehabilitation and recovery services to those whose illness and hospitalisation is very disabling. In some cases, they provide a home and care for life. They must be licensed, and licensing and national mental health standards apply to protect residents' rights.

Hostels are defined in Part 20 of the Act as mental health services so are within the jurisdiction of the Advocacy Service, and residents are 'identified persons' under the Act so can request contact by an Advocate. Requests for contact were made by 106 hostel residents.

The type of hostels and amount of MHC funding varies greatly, which means the level of psychosocial support and quality of care to residents also varies greatly. There are particular disparities in relation to those people with very complex needs and severe disability, and a shortage of appropriate supported accommodation for them. Many residents are very vulnerable because they have been disempowered by institutionalisation and the real fear of eviction and homelessness.

A full list of the hostels and bed numbers is set out in appendix 2.

Hostel inquiries

The Advocacy Service set aside funding in 2016-17 so that those hostels where there were the greatest number of vulnerable residents (identified hostels) could be visited by an Advocate every two months, and all other hostels visited at least once. The visits were conducted as part of the inquiry function in s352 (1) (b) of the Act, with the aim of ensuring the health, safety and wellbeing of residents.

Two formal visits were also conducted – one focusing on care plans and one on safety. Lack of funding resources and Advocate capacity, however, meant not all identified hostels had either or both inquiries, and two smaller hostels were not visited at all by an Advocate during the year:

- **Care plan inquiry:** Care plans developed in consultation with the resident are required by the national standards for mental health services and the MHC. In a number of hostels, the plans not only did not involve the resident or any family support, but were grossly inaccurate or inadequate, or non-existent, and had never been shown to the resident. Meetings were held with the relevant licensees to raise the issues and Advocates are continuing to follow up with hostel staff. Improvements have been made but ongoing work is required.

23 Private psychiatric hostel is defined under the Act to have the same meaning as s26P of the *Hospital and Health Services Act 1927* which is: private premises in which three or more persons who are socially dependent because of mental illness; and are not members of the family of the proprietor of the premises, reside and are treated or cared for.

- **Safety inquiry:** The national standards for mental health services promote optimal safety and wellbeing of the consumer in all mental health settings. Issues raised included no locks on bedroom doors, residents not permitted to lock their rooms at night, lack of access to a private room for confidential appointments, broken locks on bathroom doors, and no locked cabinets for residents to store their personal belongings. These issues have been followed up with licensees and some improvements made.

Conditions in hostels

Issues raised and dealt with by Advocates during the year included:

- *Lack of adequate heating and cooling in residents' rooms: The Advocate visited the facility on a day when it was 41 degrees. Air-conditioning units at the hostel were not turned on. The majority of the residents that the Advocate spoke to said they were very hot.*
- *Complaints about food: These complaints are common in some hostels. In one facility, according to a resident, dinner on most nights was a sandwich and salad. Vegetarians have particular difficulty getting food for their needs. One resident was only being given the vegetables that went with the meat dish served to other residents, and a resident in another hostel was reduced to eating cereal for their main meal. In another case, a resident with a serious health issue was getting vouchers from a charitable body to buy healthy food.*
- *Complaints about boredom: In some facilities there are residents sitting alone; pacing; mumbling due to lack of meaningful activities and interaction. In one facility, many of the residents stayed in bed during the day as there was nothing to occupy them.*
- *No staff interaction: Due to many high-needs people in one facility, there was a marked lack of staff interaction with residents. Facility staff said this was due to insufficient funding.*
- *Clothing not supplied: Under the licensing regulations,[24] licensees are to ensure that all clothing necessary is provided to residents, as well as basic toiletry items. In many hostels the residents (and often family members) are unaware of this right. Advocates observe residents in poorly fitting, dirty and worn clothing. It is important to note that residents pay up to 87.5% of their pension to the licensee so have little spending money left over and are reliant on this right. Advocates raised the issue (as they do every year) in several hostels, including telling residents their rights to clothing. In some cases, staff also seemed unaware of the right. Advocates have asked one hostel to make a point of telling residents, and another hostel to keep a register of clothing supplied. In one case, the resident had lost a lot of weight but no allowance had been made for this.*
- *In another hostel, residents wanted deodorant as part of the basic toiletries and this was advocated for.*
- *Bedrooms with broken blinds and no privacy – since rectified.*
- *Dinner being served at 4.30pm even though the regulations and standards say it cannot be served before 5pm. Undertakings have been given to stop the practice.*

24 Regulation 12 of the Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997.

Eviction issues

Hostel standards require hostels to have an exit plan for residents, but it is not uncommon for the exit plan to be taking the resident to hospital and refusing to let them return. There is no independent arbiter to decide if the eviction process is fair, even though the hostels are funded by the MHC.

In these cases the Advocates worked for the resident, trying to avoid or over-turn the eviction and then advocating for and facilitating their access to another hostel. There have been successes in avoiding evictions, but in some other cases the person remains stuck on a hospital ward.

In three cases, a more detailed inquiry was made due to concerns about the increasing number of evictions of people with more complex behaviours:

- *In one case, the person was evicted for allegedly posing too high a risk for staff, but the treating team had a different view and the person ended up in another hostel where the MHC funding was 10 times less - and so staffing and psychosocial support was so much less and hostel conditions greatly reduced.*
- *In another case, the Advocate's investigation indicated that the reasons for evicting the person from a low-funded hostel were properly based on concerns for the safety of the resident, although the method of eviction was not well-handled and the case raised a number of systemic issues.*
- *The third case was still being investigated but the consumer remained stuck in hospital.*

The systemic issues emerging include:

- well-funded hostels refusing to take some people, saying that there are high risk factors, their model of care is unsuitable and/or not sufficiently funded and/or they are not sufficiently supported by community mental health services
- less well-funded hostels taking the consumer or, alternatively, they are stuck in an expensive hospital bed
- the only other option is the rehabilitation program at Graylands Hospital, but there are delays in referral
- a need for more community supported accommodation facilities for people with complex needs like the four Community Options housing sites, and/or some form of transitional facility other than the Graylands Hospital rehabilitation stream

- residents being threatened with eviction for 'failing to engage' with the programs being offered by the hostel:
    - In one case the hostel had decided to adopt a new recovery-based model of services, which was welcomed. But residents complained to the Advocacy Service that they were being required to attend recovery meetings. When they chose not to attend, services previously being received were withdrawn. A resident who had been told they could stay for life was then told this was dependent on them attending recovery meetings. Three separate Advocates worked with hostel staff on these complaints and subsequently the model was amended to be a non-compulsory one, where residents are encouraged to engage with recovery programs but not compelled to. In addition, those residents who had been told they had a place for life had that reaffirmed.

Dental inquiry

Advocates regularly raise concerns on behalf of hostel residents about their dental and podiatry needs. In late 2015 the Advocacy Service contacted the Kimberley Dental Team Ltd (KDT), a not for profit, non-government, volunteer organization. KDT agreed to undertake a pilot study in two hostels into the dental needs of the residents:

- Of the 54 residents seen over 99 appointments, 31 were classed as emergency, which means people presented with symptoms including pain, swelling or discomfort.
- Active dental treatment performed included a total of 30 extractions, 26 restorations for active decay and 47 scale and cleans / removal of calculus.
- Preventive services, oral hygiene instructions and demonstration, dietary and smoking advice, denture adjustments, referral for radiographs, provision of antibiotics and smoothing sharp teeth were also carried out.
- The total value of the dental care provided using the Treasury scale of fees was $26,782.

In summary KDT reported:

- Those residents seen were very receptive to advice, new brushes and having treatment.
- Many of the dental problems were very long-standing (5-10 years).
- Almost all who attended were very appreciative that the service was by volunteers and that KDT had gone to them, rather than them having to go outside their comfort zone.

KDT made a number of recommendations:

- Government and private dental health services / providers should be lobbied to re-establish a visiting clinic service as provided by KDT. Mental health patients were much more comfortable in their own place and not a threatening external clinical environment. Ideally, clients should be seen three times per year to minimize deterioration of their dentition.
- Oral health therapists / hygienists or dentists should be contracted to perform regular, preventive services and minor restorative care.

KDT will revisit both hostels again at the end of 2017. The Advocacy Service is writing to relevant parties regarding the recommendations.

Oversight of hostels

The oversight and governance of hostels is complex. Three parties are involved apart from the Advocacy Service:

- The Licensing and Accreditation Regulatory Unit (LARU) within the DOH, which licenses hostels, approves supervisors working in hostels, and does annual inspections to check whether its *Licensing Standards for the Arrangements for Management, Staffing and Equipment - Private Psychiatric Hostels 2006* (LARU standards) have been met.
- The MHC, which funds hostels pursuant to a contract and conducts evaluations of hostels every three years.
- The OCP which is responsible for overseeing the treatment and care of hostel residents.[25]

Activities of the Advocacy Service in relation to the oversight and governance of hostels included:

- quarterly meetings as part of a psychiatric hostel agency committee to share information
- taking part in a review of the LARU standards, which is chaired by the Chief Psychiatrist and includes the MHC and other stakeholders such as the DOH and hostel licensees
- taking part in a working party in relation to complaints about one hostel.

25 See s515 of the Act.

NDIS

The Advocacy Service's involvement in the National Disability Insurance Scheme (NDIS) is patchy and mainly concentrated on work with hostel residents in the hills area. While the Advocacy Service welcomes the opportunities offered by the NDIS, particularly in relation to those hostel residents who get little more than 'bed and board', many residents are not in areas yet covered by NDIS.

Reports from hospitals indicate that NDIS is not yet benefitting patients with more complex needs who are stuck on hospital wards. One hospital also reported as part of the snapshot survey of patients stuck on wards (see *Hospital survey results* earlier in this report) that aged care sector services which previously provided services to some patients (even though they were under 65), were now requiring that applications first be made to NDIS. This was delaying discharge.

There are unintended consequences for some people because state funding given to some programs has been stopped and passed over to fund the NDIS. The NDIS, however, does not apply to anyone over 65 years. Residents who get approved for NDIS before turning 65 can keep their entitlements after turning 65 unless and until they enter a commonwealth-funded program such an aged care facility:

- *Funding for art classes was stopped by the MHC because of NDIS funding transfers. A hostel resident had been attending the classes for 10 years and was over 65 years old so could not access NDIS funding. The Advocacy Service wrote to the MHC, which confirmed the funding of the agency had been impacted and suggested the person try other funding possibilities. The Advocate located an alternative source of funding for 2016-17.*
- *A hostel resident, who had been given an NDIS package before turning 65, moved into a nursing home (and so lost the NDIS package). When, after a few weeks, they moved back to the hostel because the nursing home didn't work out, they were no longer entitled to the NDIS.*

In a positive story, a hostel resident was helped by NDIS to go to another state to see their son, and arrangements were made to continue the NDIS support in that other state.

Advocacy Service workload

The Advocacy Service's workload continued to increase in 2016-17:

- the average number of people put on an inpatient treatment order (as advised to the Advocacy Service) increased from 265 a month in the first seven months of the new Act to 270 a month
- 1629 of the people were new consumers i.e. new to the Advocacy Service and possibly on their first involuntary order, which means an Advocate may need to provide further explanation of their rights and contact can take longer
- the number of requests made by consumers calling the Advocacy Service office increased by 28%, reflecting increased workload on Advocates and Advocacy Services Officers
- Advocates attended 62 Mental Health Tribunal hearings a month on average,[26] in comparison to an average of 40 a month in the first seven months of operation of the new Act
- notifications by mental health services via PSOLIS, which began on 28 June 2016, meant a significant increase in the number of orders received - from a monthly average of 518 to 600 orders. But there were (and continue to be) issues with many more duplicate orders sent to the Advocacy Service (i.e. the same order sent multiple times), all of which have to be handled manually by Advocacy Services Officers
- the Classes of Voluntary Patient Direction meant that voluntary children were able to be assisted from 1 January 2017 and, although the numbers are relatively low (16 children), many of these cases are complex and time-consuming
- the Classes of Voluntary Patient Direction also meant Advocates were able to continue to assist people when their involuntary order was revoked or expired, where their complaint had not been resolved but there was further action that could reasonably be taken. Advocates assisted 23 such consumers and, again, these cases tended to be more complex
- preparation and undertaking the TSD plan inquiry was a major piece of work involving breach of patient rights, which necessitated additional work for Advocates explaining the inquiry and negotiating systemic service level change
- extra resourcing had to be put into a number of issues arising out of hostels
- the number of committees and submissions the Advocacy Service was involved with increased
- extra Advocates had to be taken on to assist with the increased workload and to replace retiring Advocates whose contracts ceased during the year, which involved extra training and mentoring.

26 Based on tribunal data; Advocacy Service data is slightly lower at 56 a month but still significantly higher than in the first seven months of operation of the new Act.

Budget and resourcing

The Advocacy Service's budget for 2016-17 was $2.654 million. As the Advocacy Service is an 'administered item', the budget allocation was published in the WA State Government's Budget Paper No.2 – Budget Statements on 12 May 2016. In previous years the Advocacy Service's budget, and that of its predecessor, the Council of Official Visitors, was included as part of the MHC's appropriation. The actual expenditure for the Advocacy Service, as advised by the MHC, was $2 702 475, which was $48 475, or 1.8%, over the allocated budget.

There have been ongoing difficulties with the Advocacy Service budget in terms of input into the process and monitoring of expenditure. The Advocacy Service did not have input into the budget for 2015-16 or the subsequent years:

- provision was not made for superannuation for the Chief Advocate (shortfall of $15 000)
- remuneration for Senior Advocates did not include superannuation (shortfall of $22 000)
- Senior Advocate remuneration was only available for 7 months of the year from 2016-17 onwards (shortfall of $106 000)
- no allowance was made for any increase in remuneration over the four years.

Complaints were made about this at the time and the fact that it was difficult to assess the workload of the new organisation. The Advocacy Service was also not consulted during 2016-17 regarding recommendations to revise the 2017-18 budget.

In 2016-17, the workload continued to increase (see above) resulting in increased expenditure on Advocates, and other extra costs had to be incurred for the following reasons:

- changes were made to the way pays for Senior Advocates are handled so that these pays were no longer 'accrued', and this resulted in additional unanticipated expenditure of $9 000
- expenditure as a consequence of moving premises in June 2016 was incurred in 2016-17
- the MHC agreed to additional funding for the Advocacy Service of $18 250 to enable Advocates to assist certain classes of voluntary patients (the Classes of Voluntary Patient Direction 2016) and, although it was noted that ongoing recurrent funding of $36 500 would be needed, this was not part of the eligible parameters of the 2017-18 budget process
- additional Advocates had to be recruited during the year to meet consumer demand, resulting in recruitment and training costs, and higher costs overall as more Advocates attend monthly meetings and ongoing training
- additional Advocacy Services Officers were required from time to time due to:
    - the introduction of notifications being sent by PSOLIS resulting in additional workload. The Advocacy Service is now sent notifications via email, fax and through PSOLIS. It is more time-consuming to enter notifications received through PSOLIS, and many notifications are sent multiple times.
    - permanent staff going on parental leave and extended leave.

- a 2.5% pay increase to Advocacy Services Officers in June 2016 (Advocates' pay rates are unchanged).

As noted, extra Advocacy Services Officers were required during the year to assist the Chief Advocate to perform her functions under the Act, however the FTE as at 30 June 2017 was equivalent to the same time last year.

As required under the *Electoral Act 1907,* s175ZE(1), the Advocacy Service recorded $8 317 in expenditure related to the designated organisation types between 1 July 2016 and 30 June 2017, which is broken down as follows:

a) advertising agencies: $517 Thomas Reuters Australia Ltd; and $350 Whistling Moose Graphics

b) media advertising organisations: $7 230 Adcorp Australia Ltd; and $220 Ethical Jobs

c) market research organisations: nil

d) polling organisations: nil

e) direct mail organisations: nil.

Advocate remuneration

Advocates (including the Chief Advocate) are entitled to remuneration as determined by the Minister (ss365, 370 of the Act). The Advocates (including Senior Advocates) are paid an hourly rate plus superannuation but, as they are required to be engaged by the Chief Advocate on contracts for service, they have no entitlement to paid leave; they must supply their own car but can claim mileage; in very limited circumstances some Advocates can claim travel time; and they have to supply and maintain their own equipment such as mobile phones and computers with internet connection (although in August 2016 the MHC supplied some laptops with mobile data connection).

The Advocates' rates have not changed since November 2015 and are:

- Senior Advocates - $60 per hour
- Advocates - $50 per hour.

The remuneration of the Chief Advocate has also not changed since November 2015.

A submission was made in November 2016 to the then Minister to increase the rates by 1.5% in line with the government's wages policy (which was 1.5% at the time) but this was not approved before the State election. The briefing notes were re-submitted in March 2017 but the new Government announced a new wages policy and asked for the briefing notes to be re-submitted. Concerns about the Advocacy Service expenditure and future funding have meant that another submission is yet to be made.

Records management

In accordance with the *State Records Act 2000*, s19, the Advocacy Service has a record-keeping plan governing the management of all its records. The State Archivist has acknowledged that the Advocacy Service is working in accordance with the Council of Official Visitor's Recordkeeping Plan and the Advocacy Service had until August 2017 to submit a new plan.

As part of the development of a new recordkeeping plan, a half-day customised training session in the Hewlett Packard Enterprise Records Manager (version 8) system was provided to office-based personnel (i.e. Chief Advocate, Senior Advocates and Advocacy Services Officers), and one-and-a-half days' advanced training for super-users. Advocacy Services Officers also completed online refresher training in January 2017.

Refer to appendix 8 for the statement of compliance with s19 of the *State Records Act* and State Records Commission, Standard 2, Principle 6.

Committees, submissions and presentations

The Chief Advocate is increasingly being asked to take part in committees and provide submissions. The Advocacy Service is well placed to make submissions reflecting the experience of consumers treated under the Act and in psychiatric hostels. Such committees and submissions also provide an opportunity to seek systemic change and promote compliance with the Charter of Mental Health Care Principles. A list of the committees and submissions is provided in appendix 10.

It is also a regular part of the Advocacy Service work to give presentations on the role of the Advocacy Service and consumer rights. The presentations are given by the Chief Advocate, Senior Advocates and Advocates. The presentations are an important educational tool which helps to protect consumers' rights and improve communication with mental health services staff about the role of the Advocacy Service and of Advocates.

The Advocacy Service also presented two papers at the Towards Elimination of Restrictive Practices national forum in Perth from 4-5 May titled *Restraint in the Treatment of Eating Disorders,* which the Youth Advocate co-presented with a consumer, Shannon Calvert; and *The impact of restraint before hospital admission* by an Advocate who assists consumers in hospital within the South Metropolitan Health Service. A full list of the presentations is provided in appendix 11.

Quality assurance

The Advocacy Service is committed to continuous quality improvement in its service delivery and welcomes feedback of an informal and formal nature regarding its operations. Training and ongoing internal review is also undertaken.

Training

Thirteen new Advocates underwent an intensive four-day in-house training program, and had to complete a four-hour e-learning program on the Act and another e-learning program on aggression prevention training. They were then taken out by experienced Advocates to observe and be introduced to hospitals and hostels and a Mental Health Tribunal review hearing before being allocated to consumers. The Advocacy Service mantra is that Advocates should know the Act better than anyone else in mental health.

All Advocates are asked to attend Advocate quarterly meetings (AQMs) which are used for training and development of protocols, and preparation for inquiries. Regional Advocates attended three of the four AQMs by video-link. Advocates who attended other training were required to share the learning in a presentation at their team meetings. Monthly team meetings led by a Senior Advocate were also used for in-house, and occasionally external, training specific to the team, as well as for debriefing and raising systemic issues.

Appendix 12 provides a list of the training events attended by Advocates and Advocacy Services Officers during the year.

A newsletter was also sent out weekly with information and updates, and Advocates have regular communication with Senior Advocates for guidance and support.

Performance development conversations were also conducted with every Advocate by the Senior Advocates with a view to continuous improvement and to ascertain Advocate training needs.

Complaints

The Advocacy Service has a complaints protocol and process which is provided on its website.

There were four formal complaints about the Advocacy Service received during the year 2016-17. Three were from mental health service staff and one from a guardian. All were about the behaviour of an Advocate (different Advocates in each case) and all have been resolved. The Chief Advocate appointed an independent investigator for two of the complaints, and in each case the complaints were found to be unsubstantiated. In the third case, the complainant was satisfied with the answers to their questions, and in the fourth, the Advocate and complainant agreed to meet to discuss their respective issues.

From time to time, the Chief Advocate or one of the Senior Advocates receives an informal complaint about Advocates from mental health staff. In most cases, they reflect a lack of understanding about the way the Advocates work, and in particular the Advocacy Service approach to advocacy. Presentations for mental health services staff are usually offered, which help to provide better understanding. Advocates may also be counselled to reconsider their approach to staff.

APPENDICES

Appendix 1: Authorised mental health beds[27]

As at 30 June 2017.

Authorised Hospital Ward	No. of Beds	No. of Available Beds	No. of Inactive Beds
Albany Hospital	**16**	**16**	**-**
Mental Health Unit	16	16	-
Armadale Hospital	**41**	**41**	**-**
Banksia Ward	8	8	-
Karri Ward	8	8	-
Moodjar Open Ward	19	19	-
Yorgum High Dependency Unit	6	6	-
Bentley Adolescent Unit	**12**	**12**	-
Bentley Adolescent Unit	12	12	-
Bentley Hospital	**76**	**76**	-
Ward 10a, 10b, 10c	26	26	-
Ward Eight	19	19	-
Ward Seven	19	19	-
Ward Six	12	12	-
Broome Hospital	**13**	**13**	-
Mabu Liyan	13	13	-
Bunbury Hospital	**27**	**27**	-
Acute Psychiatric Unit	21	21	-
Psychiatric Intensive Care Unit	6	6	-
Fiona Stanley Hospital	**30**	**30**	-
Mother and Baby Unit	8	8	-
Mental Health Assessment Unit	8	8	-
Mental Health Youth Unit	14	14	-
Frankland Centre	**37**	**37**	-
Acacia Ward	8	8	-
Banksia Ward	12	12	-
Caesia Ward	10	10	-
Hutchison Ward	7	7	-
Fremantle Hospital	**64**	**64**	-
Ward 4.1 Secure	10	10	-
Ward 4.2 Unsecure	18	18	-
Ward 4.3 Psychogeriatric	16	16	-
Ward 5.1 Unsecure	20	20	-

27 Data was provided from 'Bedstate' by Mental Health Data Collections, DOH on 19 July 2017. Figures do not include Hospital in the Home Mental Health (MITH) ward.

Appendix 1: Authorised mental health beds *(cont.)*

As at 30 June 2017.

Authorised Hospital Ward	No. of Beds	No. of Available Beds	No. of Inactive Beds
Graylands Hospital	**121**	**121**	-
Dorrington Ward	18	18	-
Ellis Ward	14	14	-
Montgomery Ward	15	15	-
Murchison East Ward	22	22	-
Murchison West Ward	21	21	-
Smith Ward	15	15	-
Casson Ward	10	10	-
Pinch Ward	6	6	-
Joondalup Hospital	**47**	**47**	-
Open Unit	37	37	-
Psychiatric Intensive Care Unit	10	10	-
Kalgoorlie Hospital	**6**	**6**	-
A Ward	6	6	-
King Edward Memorial Hospital	**8**	**8**	-
Mother Baby Unit	8	8	-
Rockingham Hospital	**30**	**26**	**4**
Adult Closed Ward	4	4	-
Adult Open Ward	16	16	-
Elderly Closed[28]	4	0	4
Elderly Open Ward	6	6	-
St John of God, Mt Lawley Hospital	**12**	**12**	-
Ursula Frayne	12	12	-
St John of God, Midland Hospital	**56**	**56**	-
Ward 4A	25	25	-
Ward 4B	15	15	-
Ward 4C	16	16	-
Sir Charles Gairdner Hospital	**30**	**29**	**1**
Jurabi Ward (Psychiatric Intensive Care Unit)	6	6	-
Karijini Ward (Secure Unit)[29]	6	5	1
Tanami Ward (Open Unit)	18	18	-
Selby Hospital	**32**	**32**	-
Selby Acute	8	8	-
Selby Lodge	24	24	-
Total	**658**	**653**	**5**

28 There were four inactive beds at Rockingham Hospital due to demand as at 30 June 2017.
29 There was one inactive bed at Sir Charles Gardiner Hospital due to maintenance as at 30 June 2017.

Appendix 2: Private psychiatric hostels[30]

Licensee Hostel name	No. of Licensed Beds
AJH Nominees Pty Ltd	
Devenish Lodge	41
Albany Halfway House Association Inc	
Albany Community Supported Residential Units	11
Burswood Care Pty Ltd AFT Roshana Family Trust	
Burswood Care	31
Casson Homes Inc	
Casson House	92
Woodville House	25
Fusion Australia Ltd	
Ngurra Nganhungu Barndiyigu	14
Legal Accounting and Medical Syndicate Pty Ltd and Calder Properties Pty Ltd	
Salisbury Home	35
Life Without Barriers	
Ngatti, Fremantle Supported Accommodation for Homeless Youth	16
Mediwest Pty Ltd	
Romily House	70
Meski International Pty Ltd	
Franciscan House	75
Neami Ltd	
Joondalup Mental Health Sub-Acute Service[31]	
Pu-Fam Pty Ltd	
St. Jude's Hostel	52
East St Lodge	10
Richmond Wellbeing Inc	
Bunbury Community Supported Residential Units	15
Busselton Community Supported Residential Units	10
Kelmscott Community Options	8
Mann Way	12
Ngulla Mia	34
Queens Park Service	10
Westminster Service	6

30 Private psychiatric hostels include group homes, Community Supported Residential Units, and Community Options homes. Bed numbers are as at 30 June 2017.

31 The licence for the Joondalup Mental Health Sub-Acute Service expired on 1 July 2016. The facility had 22 beds and remains open but does not need to be licensed.

Appendix 2: Private psychiatric hostels *(cont.)*

Licensee Hostel name	No. of Licensed Beds
Roshana Pty Ltd	
BP Luxury Care	44
Honey Brook Lodge	35
Southern Cross Care (WA) Inc	
Bentley House	7
Mount Claremont House	7
Stirling House	8
St Bartholomew's House Inc	
Arnott Villas	22
Bentley Villas	25
Cannington Accommodation Unit	6
Medina Accommodation Unit	6
Midland Accommodation Unit	6
Sunflower Villas	25
Swan Villas	25
St Vincent de Paul Society (WA) Inc	
Vincentcare Bayswater House	6
Vincentcare Duncraig House	4
Vincentcare South Lakes House	3
Vincentcare Swan View House	4
Vincentcare Warwick House	4
Vincentcare Vincentian Village	28
TOTAL NUMBER OF LICENSED BEDS	**832**

Appendix 3A: Involuntary treatment orders[32] and number of consumers[33]

Forms 5A, 6A and 6B made during the seven months from 30 November 2015 to 30 June 2016 compared to the 12 months from 1 July 2016 to 30 June 2017. Total number of orders for adults and children are outside brackets (and numbers of orders for children are in brackets).

	30 Nov 2015 – 30 June 2016		1 July 2016 - 30 June 2017	
	No. of Orders (children)	No. of Consumers (children)	No. of Orders (children)	No. of Consumers (children)
Form 6A	1807 (21)	1518 (18)	3148 (37)	2417 (30)
Form 6B	47 (7)	39 (6)	97 (14)	86 (10)
Total Form 6A and 6B	**1854 (28)**	**1557 (24)**	**3245 (51)**	**2478 (40)**
Form 5A	470 (5)	401 (5)	796 (14)	656 (10)
Mentally impaired accused[34]	n/a	n/a	6 (0)	5 (0)
Total orders received[35]	**3627**	-	**7211**	-

Appendix 3B: Involuntary treatment orders – children

Forms 5A, 6A and 6B made from 1 July 2016 to 30 June 2017 for children (under 18 years).

Age	Form 5A	Form 6A	Form 6B
13	<5	<5	
14		5	<5
15	<5	<5	5
16		10	<5
17	10	18	<5
Total	**14**	**37**	**14**

32 Based on notifications by health services to the Advocacy Service as at 22 August 2017. Includes inpatient treatment orders and CTOs. Verification of ICMS data is ongoing and figures may be subject to change.
33 Some people were subject to more than one order during 2016-17.
34 These figures are based on 'Place of detention orders' made to an authorised hospital by the Mentally Impaired Accused Review Board.
35 Includes revocations, expired orders and invalid orders, as well as inpatient treatment orders, CTOs and mentally impaired accused 'place of custody' orders.

Appendix 4A: Involuntary inpatient treatment orders[36] by facility

Forms 6A and 6B (including children) made during the seven months from 30 November 2015 to 30 June 2016[37] compared to the 12 months from 1 July 2016 to 30 June 2017.

Facility	2015-16		2016-17		
	Form 6A	Form 6B	Form 6A	Form 6B	No. of Consumers[38]
Albany Hospital	56		74	<5	65
Armadale Hospital	121	<5	247	<5	207
Bentley Adolescent Unit	12		17	<5	16
Bentley Hospital	173		289		240
Broome Hospital	65		100	<5	81
Bunbury Hospital	98	<5	191		164
Fiona Stanley Hospital	80	<5	178	28	181
Frankland Centre	112		169		149
Fremantle Hospital	142		258	<5	211
Geraldton Hospital		<5		<5	<5
Graylands Hospital	348		580		486
Joondalup Hospital	126	<5	212	<5	172
Kalgoorlie Hospital	30		38		36
King Edward Memorial Hospital	6	<5	19	<5	21
Princess Margaret Hospital		5		11	8
Rockingham Hospital	92		135	<5	119
Royal Perth Hospital		13		15	14
Selby Hospital	20		29		27
Sir Charles Gairdner Hospital	116	15	241	20	244
St John of God, Midland Hospital	206	<5	357	5	297
St John of God, Mt Lawley Hospital	<5		14		13
Total	**1807**	**47**	**3148**	**97**	**N/A**

36 Based on notifications by health services to the Advocacy Service as at 22 August 2017. Verification of ICMS data is ongoing and figures may be subject to change.
37 Figures for 2015-16 are for the first seven months of the new Act.
38 If a consumer was admitted to one or more hospitals on a Form 6A or 6B during the financial year they are counted in the total of more than one hospital.

Appendix 4B: Involuntary inpatient treatment orders[39] – youth

Forms 6A and 6B made from 1 July 2016 to 30 June 2017 for youth (under 25 years).

Facility	Form 6A			Form 6B		
	≤15	16-17	18-24	≤15	16-17	18-24
Albany Hospital		<5	15			<5
Armadale Hospital		<5	34			
Bentley Adolescent Unit	9	8		<5		
Bentley Hospital			36			
Broome Hospital		<5	35			<5
Bunbury Hospital			20			
Fiona Stanley Hospital		15	46			<5
Frankland Centre			29			
Fremantle Hospital			34			
Graylands Hospital		<5	82			
Joondalup Hospital			51			
Kalgoorlie Hospital			8			
King Edward Memorial Hospital			<5			
Princess Margaret Hospital				6	5	
Rockingham Hospital			30			<5
Royal Perth Hospital						<5
Sir Charles Gairdner Hospital			44		<5	<5
St John of God, Midland Hospital			47			
Total	**9**	**28**	**513**	**7**	**7**	**11**

39 Based on notifications by health services to the Advocacy Service as at 22 August 2017. Verification of ICMS data is ongoing and figures may be subject to change.

Appendix 5: Community treatment orders by facility[40]

Forms 5A made from 1 July 2016 to 30 June 2017.

Service Responsible for the CTO	Form 5A
Albany Community Mental Health Service	11
Albany Hospital	<5
Armadale CAMHS	<5
Armadale Older Adult Community Mental Health Service	6
Armadale Hospital	<5
Bentley Adult Community Mental Health Service	49
Bridgetown Community Mental Health Service	7
Broome Community Mental Health Service	14
Bunbury Community Older Adult Mental Health Service	<5
Bunbury Community Mental Health Service	31
Bunbury Community OAMHS	<5
Busselton Community Mental Health Service	11
Carnarvon Community Mental Health Service	7
City East Community Mental Health Service	61
City East Community Mental Health Older Adult Service	<5
Clarkson Community Mental Health Service	9
Esperance Community Mental Health Service	<5
Eudoria Street Centre (Armadale)	80
Forensic Community Mental Health Service	6
Fremantle Adult Community Mental Health Service	67
Fremantle CAMHS	<5
Fremantle Older Adult Community Mental Health Service	<5
Geraldton Community Mental Health Service	26
Graylands Hospital	<5
Indian Ocean Territories Health Service	<5
Joondalup headspace	7
Joondalup Community Adult Mental Health Service	47
Joondalup Older Adult Clinic Mental Health Service	<5
Kalgoorlie Community Mental Health Service	5

40 Based on notifications by health services to the Advocacy Service as at 22 August 2017. Verification of ICMS data is ongoing and figures may be subject to change.

Appendix 5: Community treatment orders by facility *(cont.)*

Service Responsible for the CTO	Form 5A
Katanning Community Mental Health Service	<5
Kimberley Mental Health and Drug Service - Derby	<5
Kimberley Mental Health and Drug Service - Kununurra/East Kimberley	<5
Lower West Older Adult Mental Health Service	<5
Mead Centre (Armadale)	<5
Margaret River Community Mental Health Service	8
Midland Community Mental Health Service	45
Midland Headspace	<5
Midland Older Adult Community Mental Health Service	<5
Mirrabooka Community Adult Mental Health Service	33
Narrogin Community Mental Health Service	<5
Osborne Community Adult Clinic	64
Osborne Community Mental Health Service	5
Peel and Rockingham/Kwinana Older Adult Mental Health Service	<5
Peel CAMHS	<5
Peel Mental Health Service	33
Pilbara Mental Health and Drug Service - Hedland Health Campus, Community Mental Health Service	13
Pilbara Mental Health and Drug Service - Karratha Community Mental Health Service	<5
Princess Margaret Hospital	<5
Private psychiatrist	<5
Private psychiatrist	<5
Rockingham Adult Community Mental Health Service	42
Shenton CAMHS	<5
Specialist Aboriginal Mental Health Service	<5
Subiaco Community Mental Health Service	35
Warwick CAMHS	<5
Wheatbelt Community Mental Health Service - Gingin	<5
Wheatbelt Community Mental Health Service - Merredin	<5
Wheatbelt Community Mental Health Service - Northam	16
Youth Community Assessment and Treatment Team	<5
Total	**796**

Appendix 6: Notifications of orders[41] and Advocate contact times

Forms 5A, 6A and 6B made from 1 July 2016 to 30 June 2017.

	Time taken for a health service to notify the Advocacy Service Difference between date of order and the date received by the Advocacy Service[42]				Time taken for an Advocate to contact the consumer Difference between the date of order and the date contacted by an Advocate						
					Children			Adults			
Day	**Form 6A**	**Form 6B**	**Form 5A**	**All orders**	**Form 6A**	**Form 6B**	**Form 5A**	**Form 6A**	**Form 6B**	**Form 5A**	**All orders**
0	2014	49	575	**2638**	31	12	10	324	4	152	**533**
1	500	21	128	**649**				566	12	299	**877**
2	313	3	16	**332**				503	4	98	**605**
3	158	8	27	**193**				501	14	58	**573**
4	46	3	9	**58**				415	11	58	**484**
5	16		4	**20**				327	10	36	**373**
6	6	1	1	**8**				189	7	16	**212**
7	5	2	2	**9**				67	4	4	**75**
>7 days (adults) or >24 hours (children)	27	4	17	**48**	6	2	2	23	6	26	**65**
Order not received	63	6	17	**86**							
Not contacted							2	196	11	35	244
Total	**3148**	**97**	**796**	**4041**	**37**	**14**	**14**	**3111**	**83**	**782**	**4041**

Note: Pursuant to ss145 and 357 of the Act: adults to be contacted within seven days, children within 24 hours of an order being made.

41 Based on notifications by health services to the Advocacy Service as at 22 August 2017. Verification of ICMS data is ongoing and figures may be subject to change.

42 The date an order is received by the Advocacy Service is based on the time electronic orders are extracted from PSOLIS and the time transcribed orders are emailed or faxed. Orders are not extracted from PSOLIS on weekends or public holidays.

Appendix 7: Consumer issues[43]

1 July 2016 to 30 June 2017.

Issue Type	No. of Issues
Treatment	
1.1 Diagnosis	192
1.2 Care plans	237
1.3 Ground access and leave	354
1.4 Consultant psychiatrist or registrar	125
1.5 Nursing care	41
1.6 Physical health	295
1.7 Case management services	108
1.8 Social work services	90
1.9 Occupational therapy services	28
1.10 Psychological services	32
1.11 Transfer to another ward, hospital or clinic	305
1.12 Electroconvulsive therapy (ECT)	31
Treatment Total	**1838**
Medication	
2.1 Prescribing medication	333
2.2 Dispensing and administering medication	79
2.3 Side effects	200
2.4 Security and storage of medication	0
2.5 Other medication complaints	36
Medication Total	**648**
Consumer Rights	
3.1 Involuntary status	880
3.2 Further opinion	98
3.3 Access to communication	104
3.4 Forms	91
3.5 Rights not explained	38
3.6 Restraint	18
3.7 Seclusion	4
3.8 Confidentiality	16
3.9 Complaints	33
3.10 Medical records	43
Consumer Rights Total	**1325**
MHT Hearings	
4.1 Medical report	49
4.2 Attendance by psychiatrist or medical team	14
4.3 Other MHT	118
MHT Hearings Total	**181**
Admission, Discharge and Transport	
5.1 Admission	20
5.2 Transport	9
5.3 Discharge	245
5.4 Accommodation	257
Admission, Discharge and Transport Total	**531**

43 Raised by consumers and recorded by Advocates in ICMS as at 22 August 2017. Verification of ICMS data is ongoing and figures may be subject to change.

Appendix 7: Consumer issues *(cont.)*

1 July 2016 to 30 June 2017.

Issue Type	No. of Issues
Access/Appropriateness	
6.1 Smoking	133
6.2 Food and beverages	60
6.3 Clothing	56
6.4 Toiletries	14
6.5 Personal possessions	132
6.6 Welfare services	199
6.7 Guardianship orders	44
6.8 Administration orders	112
6.9 Financial issues	145
6.10 Interpreter	8
6.11 Access to courtyards, facilities and recreation	42
6.12 Access to consumer	12
6.13 Consultation	46
6.14 Regional and remote issues	4
Access/Appropriateness Total	1007
Safety, Dignity and Privacy	
7.1 Safety	71
7.2 Rough treatment	5
7.3 Conflicts	61
7.4 Cultural competency	9
7.5 Inattention to Aboriginality	9
7.6 Privacy	33
7.7 Special needs not accommodated	25
7.8 Serious Issue	46
Safety, Dignity and Privacy Total	**259**
Environment/Management of Facility	
8.1 Indoor furnishings	13
8.2 Courtyard and garden	3
8.3 Building	8
8.4 Temperature	2
8.5 Design and layout	2
8.6 Lighting	2
8.7 Cleanliness and hygiene	9
8.8 Posters and brochures	1
Environment/Management of Facility Total	**40**
Legal	
9.1 MIA Act and MIAR Board	48
9.2 Other legal matters	161
Legal Total	209
Total	**6038**

Appendix 8: State Records Commission compliance requirements

Section 19 of the *State Records Act 2000* requires all agencies to have an approved "Record Keeping Plan" that must be complied with by the organisation and its officers. The Advocacy Service is continuing to work in accordance with the Council of Official Visitor's Record Keeping Plan which was established in 2004 while a new Plan is developed.

State Records Commission Standard 2, Principle 6 requires government organisations to ensure their employees comply with the Record Keeping Plan. The following compliance information is provided.

1. The efficiency and effectiveness of the organisation's record-keeping systems is evaluated not less than once every five years.

   An evaluation of the Council of Official Visitor's Record Keeping Plan was completed in 2011–2012 and the Advocacy Service is in the process of developing a new Plan due for completion in August 2017.

2. The organisation conducts a record-keeping training program.

   Training regarding recordkeeping practices is provided for new Advocacy Services Officers and Advocates as part of the induction process. An online record-keeping awareness training program is also completed by Advocacy Services Officers every three years.

   A draft Procedures Manual covers record-keeping requirements and training is provided on an ongoing basis.

3. The efficiency and effectiveness of the record-keeping training program is reviewed from time to time.

   The training program is reviewed annually to ensure its adequacy.

4. The organisation's induction program addresses employee roles and responsibilities in regard to their compliance with the organisation's record-keeping plan.

   The Code of Conduct Policy includes the roles and responsibilities of Advocacy Services Officers and Advocates regarding laws and policies. Advocates' induction training includes their record-keeping responsibilities.

Appendix 9: Advocate functions and powers

Who the Advocates can help – s348 of the Act

The functions of the Advocates and the Advocacy Service are limited to those people defined under s348 of the Act as an "*identified person*" who is:

- referred under the Act for a compulsory examination by a psychiatrist, who may or may not be detained and who may be in an Emergency Department or a ward in hospital or elsewhere, including prison
- a voluntary inpatient in an authorised hospital under an order for assessment (which may lead to a referral for a compulsory examination by a psychiatrist)
- an involuntary inpatient, who has been examined by a psychiatrist and an order made which means they are being detained under the Act in an authorised hospital or a general hospital
- subject to a Community Treatment Order
- under a hospital order made under s5(2) of the MIA Act
- a mentally impaired accused required under the MIA Act to be detained at an authorised hospital
- a mentally impaired accused who has been released under a release order made under the MIA Act on a condition imposed under section 35(4)(a) of that Act that the mentally impaired accused undergo treatment as defined in section 4 of this Act
- a resident of a private psychiatric hostel as defined by the *Hospitals and Health Services Act 1927*
- being provided with treatment or care by a body or organisation that is prescribed by the regulations[44] for this paragraph and has or may have a mental illness (although no regulations are current)
- a voluntary patient who is in a class that the Minister directs under s354 is a class of identified person. Directions were issued by the Minister for Mental Health[45] which made the following classes of voluntary patient an "identified person" under the Act:
  - a child who is being treated, or who is seeking admission or is proposed to be provided treatment, by or in:
    - a public hospital as defined by the *Health Services Act 2016;* or
    - an authorised hospital.
  - a child who has been assisted in the previous six months by a mental health advocate while:
    - a voluntary patient in accordance with this direction; or
    - an involuntary inpatient
    - and is being treated, or is proposed to be provided treatment, by or in a community mental health service;
  - a person who is a voluntary patient but who, while an identified person, was being assisted by a Mental Health Advocate in relation to a complaint or issue that remains unresolved and where some further action can reasonably be taken to resolve the complaint or issue.

44 No regulations were in place as at 30 June 2017.
45 The Classes of Voluntary Patient Direction 2016 commenced operation on 1 January 2017.

Appendix 9: Advocate functions and powers *(cont.)*

Functions of the Chief Advocate - ss351 and 377 of the Act

Apart from engaging the Advocates, the functions of the Chief Advocate are:

- ensuring that "identified persons" are visited or otherwise contacted in accordance with the Act – this includes a requirement that every person who is made involuntary must be contacted within seven days and children within 24 hours of being made involuntary; to assist with this the Chief Advocate must be notified by mental health services of all involuntary orders
- promoting compliance with the Charter of Mental Health Care Principles by mental health services
- preparing and publishing information about, and promoting, the role of Advocates and how to contact the Chief Advocate
- developing standards and protocols for the performance by Advocates of their functions under the Act
- ensuring that Advocates receive adequate training in relation to the performance of their functions under the Act
- providing advice, assistance, control and direction to Advocates engaged under section 350(1) of the Act in relation to the performance of their functions under the Act
- ensuring compliance with any directions given by the Minister under section 354(1) or the Chief Advocate under paragraph (f)
- any other functions conferred on the Chief Advocate by the Act or another written law
- within 3 months after 30 June each year, prepare and give to the Minister a report on the general activities of the Advocates (which the Minister must cause to be laid before Parliament).

Functions of Advocates - s352 of the Act

The functions of the Advocates are:

- visiting or otherwise contacting identified persons in accordance with the Act which requires that every person who is made involuntary and Custody Order patients detained in an authorised hospital must be contacted within seven days and children within 24 hours of being made involuntary or detained; people who are awaiting assessment by a psychiatrist who request contact must be contacted with three days and other requests for contact by identified persons must be responded to 'as soon as practicable' or within seven days, and in the case of certain classes of children, within 24 hours (see s357 of the Act)
- inquiring into or investigating any matter relating to the conditions of mental health services that is adversely affecting, or is likely to adversely affect, the health, safety or wellbeing of identified persons
- inquiring into or investigating the extent to which identified persons have been informed by mental health services of their rights under this Act and the extent to which those rights have been observed
- inquiring into and seeking to resolve complaints made to mental health advocates about the detention of identified persons at, or the treatment or care that is being provided to identified persons by, mental health services (a complaint can be made by any person who has a sufficient interest in the identified person)
- referring any issues arising out of the performance of a function under paragraph (b), (c) or (d) to the appropriate persons or bodies to deal with those issues, including to the Chief Advocate and includes assisting the person to make a complaint to the mental health service and HaDSCO

Appendix 9: Advocate functions and powers *(cont.)*

- assisting identified persons to protect and enforce their rights under the Act which includes assisting the person with, and representing them in, any proceedings under the Act before the Mental Health Tribunal or SAT
- assisting identified persons to access legal services
- in consultation with the medical practitioners and mental health practitioners responsible for their treatment and care, advocating for and facilitating access by identified persons to other services
- any other functions conferred on an Advocate by the Act or another written law.

Advocates' powers - ss359 and 353 of the Act

Section 359:

(1) The powers of a mental health advocate include these powers -

(a) visiting, at any time and for as long as the Advocate considers appropriate, a mental health service at which one or more identified persons are being detained or that is providing treatment or care to one or more identified persons;

(b) inspecting any part of a mental health service that the Advocate visits

(c) seeing and speaking with an identified person unless the identified person objects to the Advocate doing so

(d) making inquiries about any of these things —

(i) the admission or reception of an identified person by a mental health service or other place

(ii) the referral of an identified person for an examination to be conducted by a psychiatrist at a mental health service or other place

(iii) the detention of an identified person at a mental health service or other place

(iv) the provision of treatment or care to an identified person by a mental health service or other place

(e) requiring a staff member of a mental health service or other place to do any of these things —

(i) answer questions or provide information in response to any inquiry made about a matter referred to in paragraph (d)(i) to (iv)

(ii) make available any document that the mental health advocate may inspect, or take a copy of, under paragraph (f) or (g)

(iii) give reasonable assistance to the Advocate in the exercise of a power under this subsection

(f) inspecting and taking a copy of the whole or any part of the medical record of, or any other document about, an identified person that is held by the mental health service unless the identified person objects to the Advocate doing so

(g) inspecting and taking a copy of the whole or any part of any document, or any document in a class of document, that is held by the mental health service and is prescribed by the regulations; and

Section 353:

...advocate may do anything necessary or convenient for the performance of the functions conferred on the mental health advocate by this Act or another written law.

Appendix 10: Committees and submissions

Committees

- Working Group addressing Recommendations 13 and 16 from the Review of the MIA Act
- Private Mental Health Regulation Reference Committee (PMHRRC) – regarding amending LARU standards
- Private Hostel Agencies Committee (PHAC) – comprising also the OCP, LARU and MHC
- Accommodation and Support Strategy Committee by the MHC
- Compulsory Alcohol and Drug Treatment Steering Committee by the MHC
- Mental Health Partnership Agreement Committee (hosted by HaDSCO)
- Hostel Investigation Working Party
- MHC workshops to develop the Statewide Consumer, Family, Carer Engagement Framework
- National Visitor and Advocacy bodies – various teleconferences and submission for symposium at the TheMHS conference in August 2017
- CAHS Review of Inpatient Care for Children and Young People with Eating Disorders: Service Improvement Project Team.

Submissions

- Inquiry by the Senate Community Affairs References Committee into Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia
- National Statement of Principles Relating to Persons Unfit to Plead or Not Guilty by Reason of Cognitive or Mental Health Impairment drafted by a cross-jurisdictional Working Group established under the Law, Crime and Community Safety Council in November 2015.
- Accommodation and Support Strategy Committee regarding people with high support needs
- Amendments to the Act to the MHC for submission to the Minister
- Post Implementation Review of the Act
- Compulsory Alcohol and Drug Treatment proposed legislation.

Appendix 11: Advocacy Service presentations

- Psychiatric Liaison and ED nurses at Joondalup Hospital – Senior Advocate
- Consumers on Hutchison Ward, Frankland Centre – Senior Advocate
- Joondalup Mental Health Unit nursing staff – Senior Advocate
- Autism Association of WA – Senior Advocate
- Chief Psychiatrist's Forums (twice) on capacity – Chief Advocate
- Mental Health Tribunal on hearings for children – Youth Advocate
- Mental Health Tribunal on TSD Plans – Chief Advocate
- Presentation on TSD Plans to Graylands Hospital medical and senior nursing staff – Chief Advocate
- Various presentations by Advocates to ward staff on TSD Plans
- Intellectual Disability and Complex Needs Roundtable – hosted by Developmental Disability WA on people with intellectual disability and complex needs and the role of the NDIS
- Presentations (two) at the Lorikeet Centre on the Role of the Advocacy Service – Senior Advocate
- Bunbury Hospital mental health unit and community staff (twice) – Chief Advocate
- Kalgoorlie Hospital – Senior Advocate
- CPFS – Youth Advocate
- Bentley CAMHS – Senior Advocate
- St John of God, Midland Hospital – Senior Advocate
- Joondalup headspace – Senior Advocate
- Medical staff at SCGH – Senior Advocate
- Osborne Park headspace – Senior Advocate
- Residents of Vincentian Village – Senior Advocate
- Towards Elimination of Restrictive Practice National Forum – 2 papers.

Appendix 12: Training, seminars, forums and conferences

August AQM: Training on coding for ICMS, Annual Report data, presentations by the Youth Advocate on Eating Disorders and by the Aboriginal Advocate on issues relating to Aboriginal consumers.

November AQM: Karen Farley, Appeals Consultant, Legal Aid WA, talking about custody order patients and the criminal law process; Advocate Helen Taplin on NDIS progress and experience in hostels; Reflections on the first year of the Act - the good, the bad, and the ugly. Launch of the Advocacy Service intranet.

February AQM:

- NDIS update by Adrian Munroe, Executive Manager of Operations, Richmond Wellbeing; Aimee Sinclair from Consumers of Mental Health WA on 'Assisted Decision Making – from a mad perspective', drawing on her experience as an Individualised Community Living Strategy Peer Coordinator and giving another approach to advocacy from a peer perspective
- Treatment, Support and Discharge Plans training session:
  - Senior Advocate, Michelle D'Silva, on ss186-188 of the Act
  - PSOLIS on TSD and other Plans, by David Ward, Women's Health Information Manager and a PSOLIS Administrator
  - 'The OCP Perspective of TSD Plans' by Tim Rolfe, Principal Officer, Statutory Education, and Peta Gallaway, Clinical Consultant, from the Office of the Chief Psychiatrist
  - Chief Psychiatrist, Nathan Gibson, on 'Getting Care Plans Done'
  - TSD Plans Inquiry by Advocates and introducing the Advocacy Service TSD Plan Prompt Sheet for getting compliance with ss186-188 of the Act (based on the results of consultation with stakeholders), including one consumer's experience
- Workshop on how Advocates are to do the TSD Plan Inquiry

May AQM (day-long event with regional Advocates attending in Perth):

- Presentation and discussion for planning on proposed hospital inquiry on sexual safety; presentation and discussion on Advocate document access and draft Consumer Records and Information Protocol; draft (amended) Notifiable Events and Serious Issues Protocol, draft (amended) Use of Interpreters Policy
- Presentations on 'Supporting family members and friends in a caring role for a person who is an involuntary Patient', by Donna Turner, from Helping Minds; and 'Capacity from a Guardianship and Administration Perspective', by Michael Bowyer from the Public Trustee Office.
- Session on Post-Implementation Review of the Act, led by Angie Rabbitt from the MHC.

Appendix 12: Training, seminars, forums and conferences *(cont.)*

Other training, seminars, forums and conferences attended:

- Introduction to Eating Disorders: Identification and Assessment (part 1) and Management and Treatment Approaches (part 2), CAMHS, 15-16 August 2016, attended by the Youth Advocate
- 'The overlap between the *Guardianship and Administration Act 1990 (WA)* and the *Mental Health Act 2014 (WA),* with regard to statutory advance health directives, by the MHLC
- Enhancing your Resilience, Centrecare, 14 September 2017, attended by Advocacy Services Officers
- Mental Health Tribunal Professional Development day on ECT hearings
- 'How to deal with difficult consumers on the phone', by Laurie Coffey, of Mental Health Emergency Response Line (MHERL), for staff and regional Advocates
- MHLC Law Week presentation on the Specialist Treatment And Referral Team (START Court)
- National Indigenous Mental Health and Wellbeing Forum, attended by the Aboriginal Advocate
- International Initiative for Mental Health Leadership (IIMHL) Leadership Exchange 2017 in Sydney 2-3 March 2017, attended by a Senior Advocate
- Empathy use it or lose it, Centrecare, 15 March 2017, attended by Advocacy Services Officers
- People with Intellectual Disability and Complex Needs in the WA National Disability Insurance Scheme Cross Sector Round Table, attended by a Senior Advocate
- Towards Elimination of Restrictive Practices national forum in Perth, 4-5 May 2017, attended by an Advocate, the Youth Advocate and the Chief Advocate
- De-escalation Techniques, Western Australian Association for Mental Health (WAAMH), 17 May 2017, attended by an Advocate
- Connecting the Dots: Making Sense of Eating Disorders, 19-20 May 2017, attended by the Youth Advocate
- Record-keeping training for all Advocacy Services Officers, Senior Advocates and Chief Advocate
- Online refresher training in record-keeping awareness, and Accountable and Ethical Decision Making, for Advocacy Services Officers
- The Advocacy Service Manager took part in the Government of Western Australian Interagency Mentoring Program
- Building and Leading High Performance Teams through Institute of Public Administration Australia (IPAA) WA, attended by the Advocacy Service Manager.

GLOSSARY OF ACRONYMNS AND TERMS

Act	*Mental Health Act 2014*
Advocacy Service	Mental Health Advocacy Service
Advocate	Mental Health Advocate
AQM	Advocate quarterly meetings
ALO	Aboriginal liaison officer
BAU	Bentley Adolescent Unit
Chief Advocate	Chief Mental Health Advocate
CAHS	Child and Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Service
Consumer	An 'identified person' as defined by s348 of the Act who can be assisted by an Advocate, but excluding hostel residents
CPFS	Child Protection and Family Support Division of the Department of Communities
CTO	Community treatment order
DOH	Department of Health
ECT	Electroconvulsive therapy
ED	Emergency department
Form 5A	Community treatment order, and a type of involuntary treatment order
Form 6A	Involuntary inpatient treatment order made in an authorised hospital, and a type of involuntary treatment order
Form 6B	Involuntary inpatient treatment order made in a general hospital (by a psychiatrist), and a type of involuntary treatment order
HaDSCO	Health and Disability Services Complaints Office
HCC	Health Consumers' Council
Hostel	Private psychiatric hostel as defined in the Act
ICMS	Integrated Case Management System, database used by the Advocacy Service

KDT	Kimberley Dental Team
LARU	Licensing and Accreditation Regulatory Unit
LARU standards	Licensing Standards for the Arrangements for Management, Staffing and Equipment - Private Psychiatric Hostels 2006
MHC	Mental Health Commission
MHLC	Mental Health Law Centre
NDIS	National Disability Insurance Scheme
MIA Act	*Criminal Law (Mentally Impaired Accused) Act 1996*
Minister	Minister for Mental Health
OCP	Office of the Chief Psychiatrist
PCH	Perth Children's Hospital
PMH	Princess Margaret Hospital
PSOLIS	DOH database for people in mental health wards which records the status of people under the Act
SAT	State Administrative Tribunal
TSD plan	Treatment, support and discharge plan

MHAS

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