

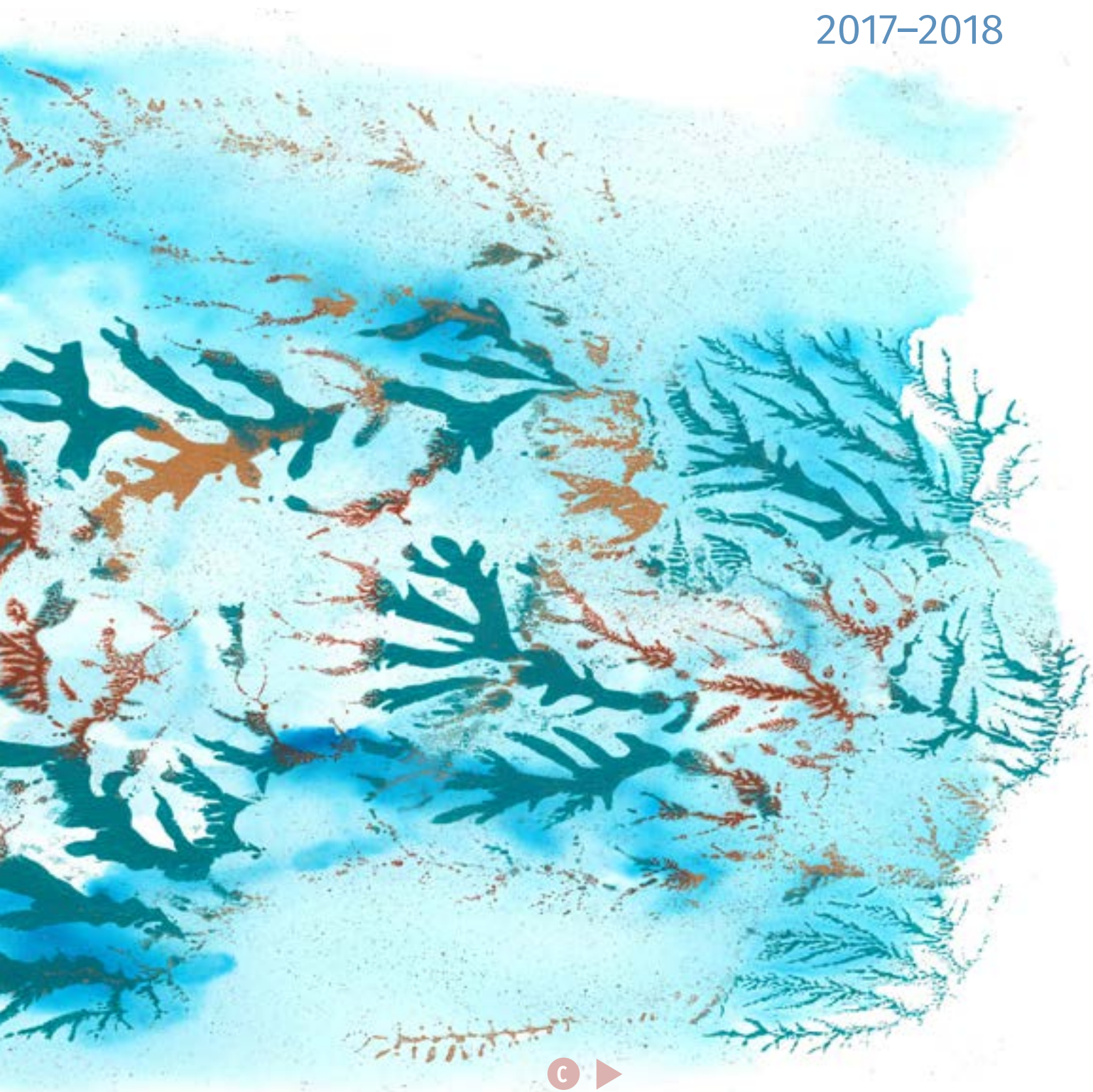


MHAS

MENTAL HEALTH ADVOCACY SERVICE

Annual Report

2017–2018





Artwork

The artwork on the front cover and throughout the Annual Report is titled 'Tranquillity' by artist donelle toussaint¹ from the Creative Expression Centre for Arts Therapy. It gives donelle a feeling of serenity, the sense of freedom and being without restriction.

This piece was a result of an afternoon of playing and experimentation by donelle. The end result has a balance of bold and solid colour, and intricate and fragile sections. The variation in the pattern enables the viewer to identify shapes, (like finding pictures in clouds), to give their own meaning to the image.

This mono print was created by painting acrylic paint on a piece of glass and pressing a second piece of glass on top. When the panes of glass are lifted away from each other, it produces ridges and peaks of paint. The print is made by gently laying paper over the paint, and peeling it off. When it dries, donelle works back into it by hand with acrylic and watercolour paints, until she is satisfied with the final image.

This artwork has been reproduced with donelle toussaint's kind permission.

¹ The artist expresses her name in all lower case.

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 2018.

As well as recording the operations of the Advocacy Service for the 2017-18 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 ADVOCATE

September 2018

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Foreword by the Chief Advocate

Welcome to the 2017-18 Annual Report of the Mental Health Advocacy Service which is framed around the Charter of Mental Health Care Principles. The Charter is a schedule to the Mental Health Act 2014 and it is one of my functions under the Act to promote compliance with the Charter.

It is hoped that the activities of the Mental Health Advocates and issues raised in this report will draw attention to the need for much better compliance as there are some major concerns particularly in relation to Principle 4 of the Charter which requires easily accessible and safe care.

An Executive Summary of the issues raised in the report is provided at (page v).

The report also contains analysis and presentation of data collected by the Mental Health Advocacy Service or provided to it by other agencies. It should be noted that some numbers may change after the report has been published and some numbers have been rounded.

As foreshadowed in last year's annual report, capacity and resourcing were major challenges, and some Mental Health Advocacy Service work had to be curtailed. It is a credit to the Mental Health Advocates, including the Senior Advocates, and the Advocacy Services Officers who form the service, that so much was achieved and that the integrity and reliability of the service is continuing as it is. I thank them all for their unwavering commitment to putting protecting consumers' rights and ensuring their voices are heard.

The following quotes from a consumer and a carer say it all:

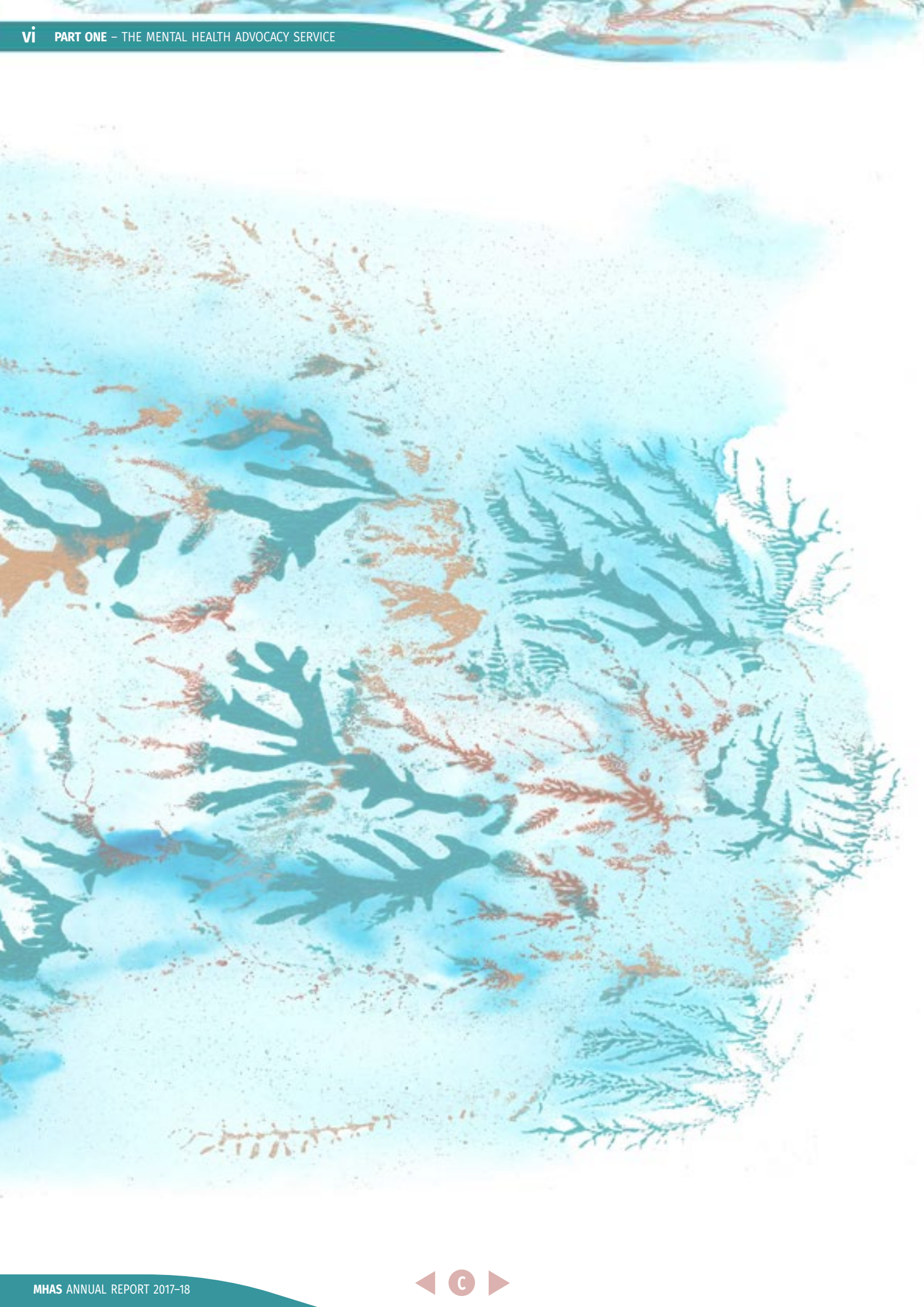
- *I wouldn't be here today if not for the help, guidance and advice my Advocate provided. It helped me through a difficult time in my life. Thank you from the bottom of my heart.*
- *I feel so full of gratitude for the Advocate that I had to put my feelings in writing. Her professionalism, her compassion and her unrelenting efforts in trying to make life in hospital bearable for my daughter are just incredible. She not only calms situations in difficult meetings but comes up with other ideas for consideration by the doctors to allow our daughter more freedoms or autonomy. She has provided hope where our daughter has only seen darkness and despair.*

Debora Colvin

CHIEF ADVOCATE

Executive summary of issues

- Bed shortages regularly resulted in children and adults spending days in emergency departments, some physically or chemically restrained, or with security guards, to reduce risk to themselves and others (page 7).
- Children were failed by the mental health system as the number of children subject to involuntary treatment orders under the Act increased by 35.4% to 88 and:
 - othey were increasingly held on adult wards, an inappropriate environment which exposes them to unacceptable risk (page 10)
 - o some were detained on locked wards for too long and/or discharged into unsafe homes because of a lack of supported accommodation (page 12)
 - o the access of 16 and 17 year olds at the Banksia Hill Detention Centre to inpatient mental health care was limited to the high-security adult forensic ward with some being held for days and, in one case, a month at Banksia Hill's isolation unit (page 12)
 - o some children were sedated in regional hospitals due to lack of available adolescent beds in Perth and the rescheduling of Royal Flying Doctor Service flights (page 10).
- The shortage of alternatives for people with serious and complex mental health conditions led to delayed hospital discharge, delaying admission for others who needed treatment, and to discharges into inappropriate care, increasing risks to consumers and others (page 13).
- Advocates dealt with 81 allegations of physical and sexual abuse and harm of which 21 concerned staff abuse of a consumer and 60 were between consumers (page 17).
- The lack of a female-only ward, meant female patients who have significant objections to being on a mixed ward – often due to past trauma or for cultural reasons – were left distressed and potentially at risk impeding their treatment and recovery (page 20).
- The number of Mental Health Tribunal hearings attended by Advocates increased but the overall rate of representation and support for consumers in hearings fell by 1.0% (page 24).
- Treatment, support and discharge planning across hospitals continues to be poor with few hospitals fully complying with the *Mental Health Act 2014* (page 31).
- Advocacy Service workload continued to increase with the number of people placed on involuntary inpatient orders up 3.1%, the number of people requesting contact up 9.3% and the number of issues up 22.1%. Since the new Act began on 30 November 2015, the number of inpatient treatment orders has increased by 4.9% (page 47).
- The Advocacy Service has been forced to scale back its efforts to protect rights of the thousands of vulnerable Western Australians subject to the *Mental Health Act 2014* and in psychiatric hostels because of budgetary constraints (page 51).



Part One – Overview of how the Mental Health Advocacy Service works

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 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 residents². To distinguish the people who Mental Health Advocates (Advocates) can assist from other patients, they are referred to in this annual report as consumers.

The Act requires that the Chief Advocate be notified of every person who is made involuntary so that Advocates can comply with the Act and contact every adult who is made involuntary in Western Australia (WA) within seven days of being made involuntary, and every child within 24 hours³. 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 Advocates under contracts for services. They must include a specialist Youth Advocate. Public service officers must also be appointed or made available to assist the Chief Advocate. Together they form the Mental Health Advocacy Service (the Advocacy Service).

Advocates’ functions

The Advocates’ functions⁴ 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.

Advocates are also required to inquire into or investigate conditions of mental health services, which include psychiatric hostels, that do, or are likely to, adversely affect the health, safety or wellbeing of consumers.⁵ Specific inquiries and regular visits may be conducted under this inquiry function.

² See s248 of the Act and appendix 9 for further details.

³ See s357 of the Act.

⁴ See s352 of the Act and appendix 9 for further details.

⁵ See s352(1)(b) of the Act.

Advocates' powers

Advocates have considerable powers⁶ of inquiry and right of attendance, including to:

- attend wards and psychiatric hostels at 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.

Advocacy Service structure

As at 30 June 2018, the Advocacy Service comprised the Chief Advocate, two Senior Advocates, two Youth Advocates, an Aboriginal Advocate, 30⁷ Advocates (in the metropolitan area, Bunbury, Albany, Kalgoorlie and Broome) and six Advocacy Service Officers who are public servants, including a Manager.

The Senior Advocates carry out delegated duties of the Chief Advocate⁸ providing advice, assistance, control and direction to the Advocates, ensuring identified persons are contacted, and Advocates are adequately trained, developing standards and protocols, and assisting with the annual report to Parliament. Senior Advocates and Advocacy Service Officers work closely to coordinate Advocates' responses to notifications and requests for assistance.

An executive group, comprising the Chief Advocate, two Senior Advocates and Manager (the Executive Group), acts as the advice and decision-making body.

'Pure advocacy' approach

The Advocacy Service Code of Conduct⁹ requires a 'pure advocacy' approach to individual advocacy, acting on the wishes of the consumer and as their voice. The exception to this is children, as the Act requires best interests advocacy for people under 18 years old.

Following Advocacy Service protocol, the Advocate tells the consumer their rights and options, as well as consequences, (the ROC principle) of taking particular actions 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'.

⁶ See s359 of the Act and appendix 9 for further details.

⁷ Another three Advocates were not active but still under contract.

⁸ See s374 of the Act.

⁹ Available on the Advocacy Service website: www.mhas.wa.gov.au.

Dealing with complaints and issues

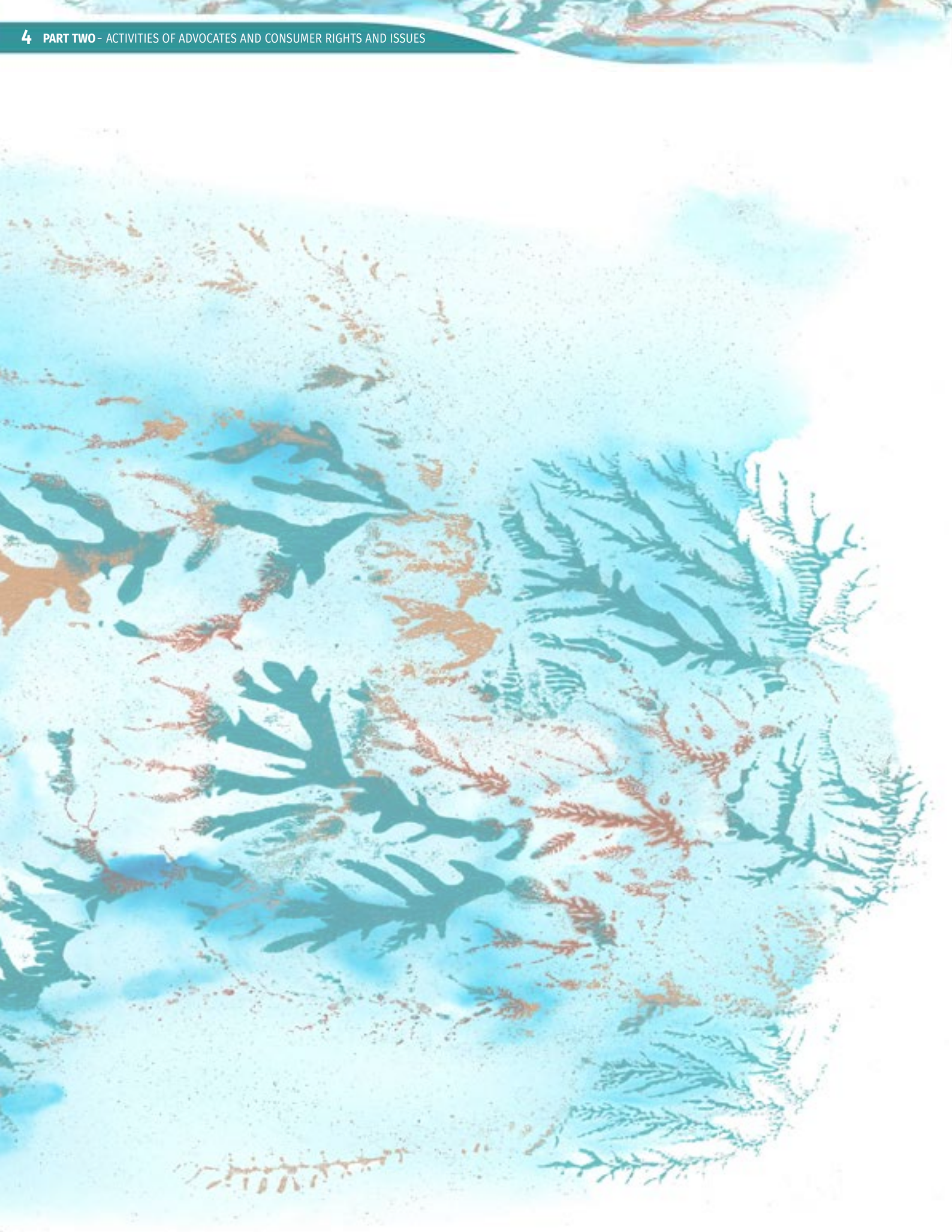
Advocates may attempt to resolve any issues by dealing directly with staff members, or refer the issue to the Chief Advocate if they cannot resolve the issue or consider it appropriate¹⁰. The Chief Advocate may provide reports about any issues raised to the person in charge of the relevant mental health 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 Advocate or Chief Advocate may meet with the licensee or raise issues with other bodies involved in the oversight of psychiatric hostels.

The Chief Advocate also meets with or contacts the Minister, the Mental Health Commissioner, the management teams of each of the authorised hospitals and related mental health services, the Chief Psychiatrist, the Chief Executives of North Metropolitan, South Metropolitan, East Metropolitan, WA Country and Child and Adolescent Health Services, the President of the Mental Health Tribunal and others from government and non-government sectors involved in the protection of consumer rights and the provision of mental health services in the state. 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.

¹⁰ See s363 of the Act.



Part Two - Activities of Advocates, and consumer rights and issues

The information and cases in part 2 of the report illustrate the activities of the Advocates and Advocacy Service in 2017-18:

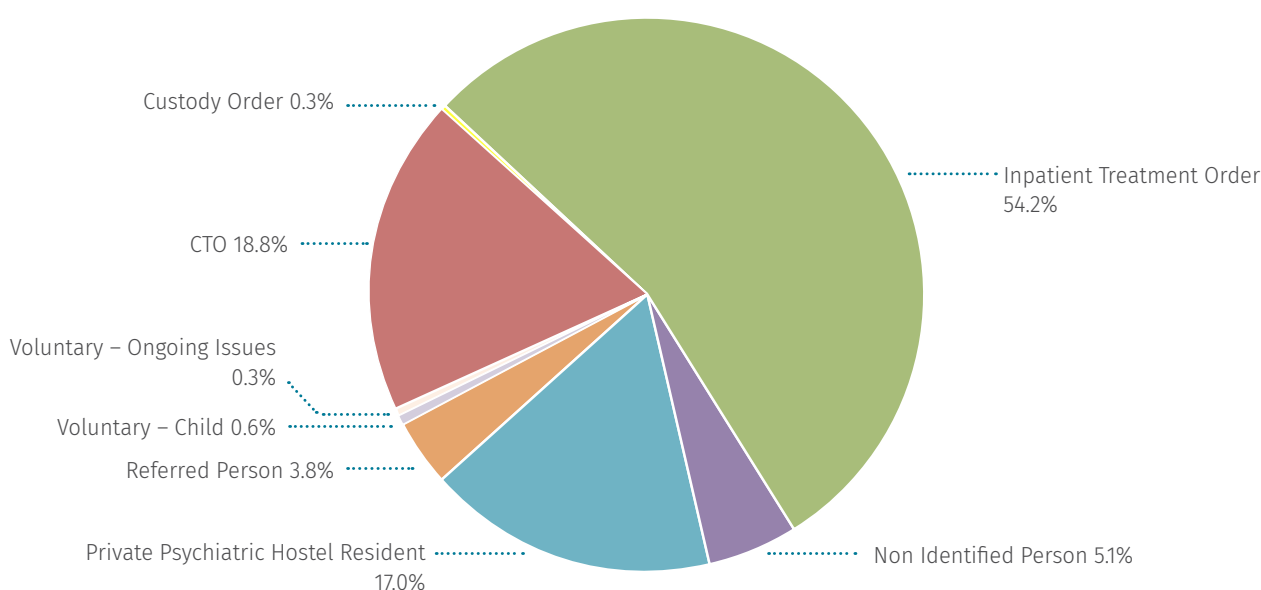
- contacting and supporting consumers to make sure their voice is heard and their rights observed
- carrying out functions under the Act regarding conditions in mental health services
- promoting compliance with the Charter of Mental Health Care Principles in Schedule 2 of the Act.

In 2017-18, 2522 people were detained on 3337 inpatient treatment orders (forms 6A and 6B) and 661 people were put on 817 CTOs (form 5A). Some people were subject to multiple orders in the year. See appendix 3. This included:

- 39 children on 48 form 6A inpatient treatment orders
- 22 children on 27 form 6B inpatient treatment orders, which means they were inpatients on a general ward rather than a mental health ward.

There were also 7567 requests for contact¹¹ made by 1438 consumers, with Advocates recording 22,280 consumer contacts. The majority of people requesting contact were on inpatient treatment orders, followed by people on CTOs, psychiatric hostel residents and referred persons. See graph 1, which also reflects requests from voluntary patients who are referred on to other advocacy agencies (non-identified persons).

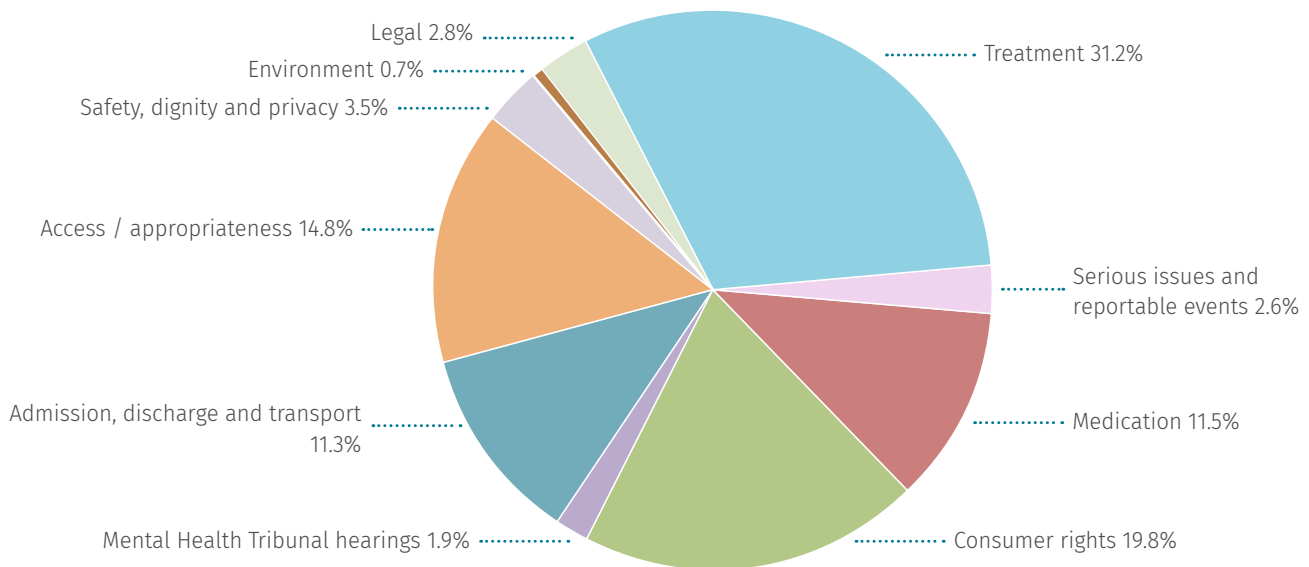
Graph 1: Individuals who requested contact by identified person category



¹¹ A Request for Contact (RFC) is a request to contact a consumer and may be received from the consumer or someone on behalf of the consumer. Most requests are received by phone but may also be received by post, email, or Advocates being approached while visiting a ward. RFC are recorded in the ICMS database. Occasionally, an unusually high number of calls are received from a consumer within a short period of time. When a person calls more than six times in a day, any additional calls are collated and entered as a single RFC.

During the year, Advocates assisted consumers with 7373 issues or complaints. See graph 2 for a breakdown of the type of issues and complaints being raised by consumers.

Graph 2: Issues recorded by Advocates as raised by consumers



The activities and examples of Advocate activity are set out by reference to consumer rights and the Charter of Mental Health Care Principles. The Charter is a rights-based set of principles that mental health services must make every effort to comply with in providing treatment, care and support to people experiencing mental illness.

Right to accessible treatment, care and support

Principle 4 of the Charter of Mental Health Care Principles:

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

Access to quality care in a timely manner is a key right of consumers. Without access to care, people turn up at emergency departments (EDs), have multiple admissions to hospital as revolving door patients, and some end up in the prison system.

Issues during the year dealt with by Advocates included:

- assisting people stuck in an ED for days while waiting for admission to hospital
- advocating for people stuck in a hospital bed because there was no suitable community support for them to be discharged to
- people being discharged without proper supports, resulting in either re-admission or risk to themselves and others.

Consumers who are referred for compulsory examination by a psychiatrist or being detained (on a form 1A or form 3, otherwise known as referral orders) in an ED are entitled to help and support from an Advocate, as are all children seeking admission to a mental health unit. In 2017-18:

- 175 people on referral orders requested Advocate assistance during the year, as well as a number of voluntary children, which was a 37.8% increase on the previous year and reflected increased stress in the mental health system
- many of the requests related to being stuck in an ED waiting for access to care and wanting to know their rights.

At the other end of the patient journey, Advocates dealt with 377 complaints and issues raised by consumers relating to discharge and 414 about accommodation. This was 61.1% higher than the previous year - again reflecting increased stress in the mental health system (see appendix 7). Complaints about social work services also increased by 73.3%, and many of these would have related to discharge and accommodation. Together they form the two biggest increases in complaints and issues raised by consumers.

Being stuck in emergency departments for days

Waiting several days in an ED or associated mental health observation unit is not an occasional or unusual event for a mental health patient – it is a regular occurrence. It includes children. Some are there voluntarily, many are being detained, either shackled or chemically restrained, or in the presence of security guards. It is unpleasant and highly distressing for the person and their family, and due to the levels of sedation given can be risky for the patient.

There are often more than 20 people waiting every morning in EDs for a bed, many of whom are being detained. A 'code yellow' is called when there are 15 or more people on referral orders across metropolitan hospital EDs requesting secure beds and there are no beds available or allocated. It is stood down when it gets below 10 people.

Multiple code yellows were called during the year and continue to be called. Mental health care is clearly not easily accessible or delivered in a timely way to people who are experiencing the most serious mental health conditions.

The reasons for the lack of accessible mental health care include:

- not enough 'beds' for the demand – be they hospital beds or alternative high level community supported care beds or other services. See the results of the hostel snap-shot survey. People stuck in a hospital bed unable to be discharged because there is no suitable supported accommodation in the community. See the results of the hospital snap-shot survey.
- people being discharged before they are ready or without appropriate community care, resulting in re-admission. The re-admission rate for January 2017 to December 2017 for involuntary patients was 17.6%, which is well above the Australian national target¹² of 12.0% for acute mental health inpatient facilities. The re-admission rate for voluntary patients was even higher, at 18.5%.¹³
- failure of the five area health services to agree on a state-wide bed flow management process between their respective authorised hospitals
- lack of agreed clinical pathways for a number of groups of people with specialised needs, such as forensic youth and people with an eating disorder.

The Advocate assists the consumer by trying to find out what is causing the delay and what the options are, as well as making sure they know their rights while waiting for admission. In some cases Advocates have negotiated discharge, in others they have added to various pressures being brought to find a bed for the person so they can get out of the ED and start treatment.

The impact of these delays goes beyond the person waiting for a bed. Below is an extract from one Advocate's report on a consumer who had been in the ED for 66 hours:

The psychiatric liaison nurse (PLN), advised that she had just taken the consumer down to the mental health ward for a 'break'. This was because they had been in the ED for 66 hours and they couldn't be sedated for too much longer due to the risk that the airways collapse. Despite the levels of sedation given, they were still being highly intrusive to other patients because they were still so elevated. This was being worsened by the noise and light on the ward.

The PLN explained that, in general, ED nursing staff are not mental health trained, although they do try to source trained staff for 1:1 specialising where possible, although these are regularly in short supply. There is an increasing number of assaults on staff, and complaints from other patients due to mental health patients being so difficult to manage in the ED environment. Mental health patients often require restraints, which is traumatic for them, staff and other patients in the ED. Due to their high level of needs, there are immense demands on staff, but when a medical emergency comes in (e.g. heart attack etc.) the mental health patient's needs tend to get put to the bottom of the list.

¹² Mental Health Commission 2016-17 Annual Report at page 110.

¹³ DOH data extracted 9 July 2018.

After this, I attended the mental health ward where the consumer had been taken and was confronted with angry ward staff members saying it was a breach of the Act and the patient still couldn't be treated because they weren't admitted. The ward was forced to 'shuffle' other patients so that they could officially admit the consumer, which resulted in another involuntary patient who was still highly unwell having to sleep on the open ward at night with a nursing 1:1 special, a voluntary patient being moved to a facilitated discharge, and the ward being 'over-census'.

Bed flow management – lack of agreed process

Since the devolution of the health services into boards and separate health service providers (health services), a new bed flow management plan has been needed. One health service may have no beds and have people waiting in their EDs, while another has vacant beds. The previous assertive patient flow plan was reviewed and recommendations made in April 2017 but the Chief Executives of the health services failed to agree. As at 30 June 2018, there was still no detailed agreement announced.

The result of this has been Advocates experiencing situations where the consumer is caught between mental health services arguing over who should take them. There is no agreed authorised and informed decision maker, so consumers languish in the EDs.

During the year the Chief Advocate:

- had meetings with Chief Executives of the health services and others, raising concerns about the delays and risks being caused by lack of agreement on patient flow
- in November 2017, wrote to the Director General of the DOH as 'system manager', asking him to intervene. He wrote back saying that: 'As a matter of priority, the Chief Executives have agreed to establish a working group in order to progress the assertive patient flow discussions and develop principles that will overcome the issues that are currently faced on a daily basis and as such, I would appreciate your patience whilst the best model for mental health patient flow is determined.'
- on 26 February 2018, when there were 34 people waiting in EDs for a mental health bed, five of them adults who had been waiting for two to four days, and four children who had been waiting for two to six days, wrote to the Chairs and Chief Executives of the health services, the Mental Health Commissioner and the Director General of the DOH asking for urgent action. The letter was put on the Advocacy Service website with the replies from each health service and the Mental Health Commissioner.

The Minister was copied into this correspondence and the issue has been raised in various meetings with the Parliamentary Secretary to the Minister, Alanna Clohesy.

In February 2018, the Sustainable Health Review Interim Report also raised both the bed flow issue and governance amongst the health services, DOH and Mental Health Commission (MHC) in two of its nine recommendations for immediate action.

In May 2018, in response to further follow-up attempts, the Chief Advocate was advised that the Chief Executives and medical directors of the mental health services had met:

‘That group has agreed the option of local responsibility with state-wide flexibility when needed for mental health assertive patient flow. We all feel that this provides the most responsive service to consumers. Everyone has recognised that to implement this change well it will need dedicated resource(s). We are currently working that through. Part of implementing the changes will of course be a communications plan and MHAS and other agencies will be part of that plan. We envisage that the changes will be implemented 6 months from the appointment of a project manager.’

In June 2018, the Chief Advocate wrote to the Minister, the Mental Health Commissioner and the Director General of the DOH, noting there had been eight code yellow days in 11 weeks. While there were numerous stories of distress, the Chief Advocate advised that in one case an Advocate had been told by hospital staff that a patient who had been waiting four days for a bed was put in the intensive care unit of the hospital to keep them safe, as a result of which surgeries had to be cancelled. The impact was extending beyond mental health patients.

Rural and regional consumers – chemical restraint

For people in regional hospitals, the problem of lack of beds is compounded by Royal Flying Doctor Service (RFDS) delays and the requirement that a person be allocated a bed in Perth before they are moved. Small regional hospitals are often not designed, well-equipped or staffed to care for people who are acutely unwell. Sedation is often used (in regional and metropolitan hospitals) while the person waits for a hospital bed, but prolonged sedation carries risks and, again, regional hospitals are not always well-equipped to handle those risks.

The issue has affected children and adults. The Advocacy Service conducted an inquiry into two cases involving children where ketamine was used for sedation. Both experienced significant delay (three and four days) in being able to access specialist inpatient care due to no adolescent beds being available and the rescheduling of RFDS flights.

WA Country Health Services (WACHS) responded in detail and acknowledged many of the concerns raised by the Advocacy Service. Lack of available child and adolescent hospital beds was a major issue. This led to further training of staff and a forum of senior stakeholders to review the evidence base for the use of ketamine in children. Further discussions were also underway with the RFDS.

Children on adult wards and waiting days in EDs

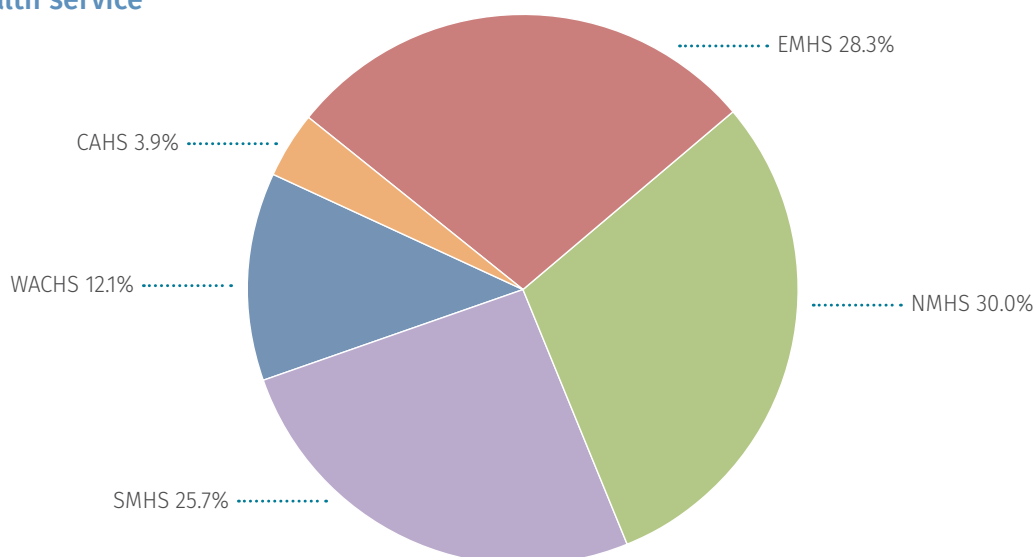
The issue of a specific lack of hospital beds for 16 and 17 year olds, as highlighted in last year’s annual report worsened during the year, with the Perth Children’s Hospital (PCH) and new Eastern Metropolitan Youth Unit (EMYU) only opening in mid-June 2018. The result was children inappropriately placed on adult wards or left in EDs for days:

- in November and December 2017, 22 children were stuck in an ED or inappropriate ward for two or more days, as advised to the Minister, Chairs and Chief Executives of the health services, the Director General of the DOH and Mental Health Commissioner in February 2018

- of the 75 inpatient treatment orders made for children (aged under 18), 60 orders were for 16 and 17 year olds.
- 10 children were detained under form 6A orders in adult mental health wards in Albany, Armadale, Broome, Graylands and Frankland hospitals. Another 18 children were detained on general medical wards (on a form 6B) in Royal Perth, Joondalup, Sir Charles Gairdner, Fiona Stanley and Albany hospitals. This marked a significant increase from the previous year, when a total of seven children were detained in adult wards – both general and mental health – on forms 6A and 6B.
- some of those admissions on adult wards 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
- an additional 23 children were detained on the Fiona Stanley Mental Health Youth Unit on a form 6A which, while restricted to 16 to 24 year olds, is still an adult ward.

Advocacy Service data shows that 30.0% of youth made involuntary in 2017-18 were in the North Metropolitan Health Service (NMHS) catchment, and this excluded those who were admitted to the Bentley Adolescent Unit (BAU) and the Fiona Stanley Hospital Youth Unit. See graph 3.

Graph 3: Forms 6A & 6B (involuntary inpatient treatment orders) for youth (16-24 years) by health service¹⁴



Although there are now more youth beds for people aged 16 to 24 years old, children in the NMHS remain without a dedicated child or youth ward. The Advocacy Service has been told that two beds will be made available for these children in the EMYU but there are no details as to how this will operate, and the assertive patient flow agreement will be crucial. The Chief Advocate has written to the Minister and the Chief Executive of the NMHS about this issue and will continue to watch the situation closely throughout 2018-19.

¹⁴ CAHS is Child & Adolescent Health Service; EMHS is East Metropolitan Health Service; SMHS is South Metropolitan Health Service.

Children with nowhere to go

There is only one mental health supported accommodation facility in WA for young people, and there are restrictions on who it will take. The result is children on a locked ward for several months and/or being discharged into a home which is not safe for them. In some cases family will not take the child home because their needs are too high for the family to cope with. The step-up step-down (SUSD) facilities will not take people without a fixed address for discharge and will only take people under 18 years on a case by case basis, so they are generally not eligible for these relatively new facilities either.

The Youth Advocates are regularly involved in complex meetings and email chains with multiple government departments trying to negotiate a package of care. This is a lengthy and time consuming process. The delays are stressful for the young person, and delay recovery at a time which is crucial to their long-term mental health. Children with difficulties regulating their behaviour need intensive care and support, not ad hoc programs and unstable accommodation, and their families need wrap-around support as well. The Youth Advocates have received feedback that community mental health services inconsistently meet the needs of these young people, resulting in frequent readmissions.

An option sometimes offered is the Kath French Secure Care Centre, which is a locked detention unit, but there are concerns about these placements. There is no independent oversight of this unit, despite it being used to lock up children. It is also only an option for children under the care of the Department of Communities and for a limited time.

The Chief Advocate and Youth Advocates met during the year with the Chief Executive of the Child and Adolescent Health Service (CAHS) about the lack of discharge options for children after it was raised by CAHS as a contributor to an incident on the BAU.

Forensic Youth – breaches of the Act and lack of a pathway to care

The Advocacy Service devoted considerable effort to improving conditions for young prisoners with mental illness.

There were several cases of 16 and 17 year old children waiting days for a hospital bed and/or being admitted to the adult forensic mental health ward, the Frankland Centre. Unwell children are held (in one case for a month) in an isolation unit at Banksia Hill which is similar to a seclusion room in a hospital. There are no specifically funded or allocated state-wide forensic mental health beds for young people in WA, despite MHC attempts to fund such beds.

The Advocacy Service considers the admission of young people to the Frankland Centre to be a breach of s303 of the Act because they cannot provide the child with treatment, care and support that is appropriate or in a part of the mental health service that is separate from any in which adults are provided with treatment and care.

The Advocacy Service wrote to, and organised a meeting with, the Commissioner for Children and Young People, the Inspector of Custodial Services and the Ombudsman to raise concerns.

The Chief Advocate then organised and facilitated a meeting, held at Banksia Hill, to seek solutions. It was attended by representatives from Corrective Services, each of the metropolitan health services, the MHC and the Chief Psychiatrist.

The discussion at the meeting reinforced that mental health service access for youth at Banksia Hill was below acceptable general community standards. There was a significant amount of good-will among the agencies at the meeting to look at existing resources that might support Banksia Hill, but it was recognised that there was no clinical coordination of this process and it was urgently needed.

Apart from improved communication and a better understanding across all parties, an outcome from the meeting was the need to map out the pathways to care using existing resources of the health services as an interim measure. Because it is a state-wide service issue, it was agreed to write to the Director General of the DOH as the system manager, inviting him to collaborate on the project. The three health services were willing to work together with Corrective Services staff on the mapping, but a secretariat support role was requested. The Director General of the DOH has since agreed to the request.

People living with an eating disorder

As with forensic youth, there is no specialist service and therefore no clinical pathway for people (adults and children) diagnosed with an eating disorder, and a lack of community mental health service options. The high number of hospital re-admissions will have been contributed to by people with this diagnosis. For 16 and 17 year olds, in particular, there is no funded eating disorder outpatient program. The only options are private services which are unaffordable for many, or CAHS community mental health services which don't specialise in the treatment of this condition.

People stuck on wards - hospital and hostel survey results

There is a major shortage of supported accommodation in the community for adults and young people who are experiencing serious and complex mental health conditions with long-term needs. The result is a gridlocked system of delayed discharge and delayed admissions or, people discharged into inappropriate care, resulting in re-admissions (adding to the gridlock) and/or raising risks to them and their families.

On 30 June 2018, there were 134 people in hospital who could not be discharged due to lack of suitable accommodation, and 62 empty psychiatric hostel beds¹⁵. The problem is that the available psychiatric hostel beds are not suitable or won't accept referrals from the people waiting in hospital, who generally require higher level long-term care.

The figures are from an annual snapshot survey conducted by the Advocacy Service of authorised hospitals and psychiatric hostels¹⁶.

¹⁵ Psychiatric hostels are defined as private premises in which three or more persons who: (a) are socially dependent because of mental illness, and (b) are not members of the family of the proprietor of the premises, reside and are treated or cared for.

¹⁶ The predecessor to the Advocacy Service, the Council of Official Visitors, started the 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 30 June 2017. See previous annual reports.

Hospital snap-shot survey results – 134 people stuck in hospital

Seventeen of the 18 authorised hospitals responded to the survey, which asked for the number of patients in the hospital on 30 June 2018, their length of stay and how many of the patients were still in hospital due to accommodation issues, either because there was no accommodation available, or no suitable accommodation.

Of the 606 patients reported in an authorised hospital bed on 30 June 2018, 134 people or 22.1% could not be discharged due to lack of accommodation options. See table 1.

Table 1: Summary of number of people on 30 June 2018 in 17 out of 18 authorised hospitals with delayed discharge due to lack of suitable accommodation

Time in hospital	No. of pts. 30 June 2016. 15 hospitals, 567 beds ¹⁷	No. of pts. 30 June 2017. 18 hospitals, 653 beds	No. of pts. 30 June 2018. 17 hospitals, 691 beds ¹⁸	No. of pts. whose discharge was delayed as at 30 June 2018 due to lack of suitable accommodation
Less than 30 days	NA	NA	396	20
30 to 90 days	177	115	109	41
90 days to 6 months	95	43	34	22
6 months to 1 year	58	25	19	12
1 to 2 years	50	20	15	11
2 years and over	43	39	33	28
			606	134

The number of people in hospital for very long periods of time appears to have improved from 2016 but has possibly stalled in the past year, though it is difficult to compare because of inconsistencies in responses to the surveys. It remains that there were 48 people who had been in hospital for more than a year, and 39 of those were there because there was nowhere else.

Comments from mental health services about the difficulties of discharging people included the following:

- no suitable high needs placements currently available
- limited options due to entry criteria excluding people with any forensic, verbal aggression or substance misuse history, and restrictions on smoking
- limited options due to lack of sufficient care packages
- complaints about the time taken to arrange guardianship and administrator applications
- difficulties getting aged care assessments (ACAT)
- many patients suffering cognitive impairment

¹⁷ Fifteen out of 18 hospitals responded to the 2016 survey.

¹⁸ Authorised beds only are counted and the survey did not include: the 12 bed St John of God Mt Lawley ward; the eight bed Hutchinson ward which was officially closed on 30 June 2018 although the consumers did not move until two days later; or six beds on the newly opened 12 bed EMYU ward which were not open on 30 June 2018.

- long-term homelessness leading to behavioural issues and care complications
- lack of 'crisis accommodation'
- extensive wait times for referrals to be processed and eligibility tested
- comments about how the National Disability Insurance Scheme (NDIS) might be an option but not available in the area, and issues navigating between NDIS and aged care
- families deciding at the last minute that they couldn't take the person home
- difficulty getting collaboration between multiple government departments.

Hospital bed numbers

There were officially 671 authorised hospital beds on 30 June 2018, but only 653 were open that day because 10 beds at Joondalup were closed due to maintenance issues and an influenza outbreak, and only six beds had been opened at the new EMYU (which was previously the 12 bed BAU. See appendix 1.

On the same day a year earlier, there were 658 authorised beds, with 653 open. The additional beds were from the PCH which opened in June 2018. Eight State Forensic Mental Health Services (SFMHS) beds in Hutchinson ward on the Graylands campus were closed on 30 June 2018. While there are now 13 extra authorised mental health beds, they include seven CAHS mental health beds which previously existed but were not authorised.

The overall increase in authorised mental health hospital beds from the previous year is therefore six.

Hostel snap-shot survey results – 62 unused beds

Licensees of 36 psychiatric hostels (as defined under the Act¹⁹) responded to the survey, representing 758 licensed psychiatric hostel beds and 748 active psychiatric hostel beds²⁰. The survey asked for the number of beds and vacancies on 30 June 2018, the average occupancy rate during the year, and the type of demand and issues. The results reflect ongoing shortages of high-care and long-term supported accommodation. See table 2.

Table 2: Psychiatric hostel bed vacancies on 30 June 2018 and occupancy rates for years June 2016 to June 2018²¹

30 June 2016 820 hostel beds ²¹		30 June 2017 832 hostel beds		30 June 2018 748 hostel beds	
No. beds vacant on 30 June	% average occupancy during the year	No. beds vacant on 30 June	% average occupancy during the year	No. beds vacant on 30 June	% average occupancy during the year
78	90.5%	96	88.5%	62	91.7%

¹⁹ The Act uses the same definition as in s26P of the *Private Hospitals and Health Services Act 1927*. The definition therefore does not include short-stay accommodation such as the Joondalup and Rockingham SUSD facilities or MHC funded homes with less than three people socially dependent due to mental illness.

²⁰ One six bed service was in the process of being decommissioned and four beds in two other facilities were not being funded or used by agreement with the MHC.

²¹ Not all licensees responded to the survey.

The 62 unused beds comprised:

- 23 beds from two psychiatric hostels with the same licensee. This licensee has consistently advised over the three years of the survey that it has a high vacancy rate and it considers 86.0% of the beds to be its maximum occupancy so these beds should not be counted
- 23 beds which would be classified as lower-level care (where residents do their own cooking and shopping, for example)
- 16 beds which would be classified as higher-level care (though the funding for these facilities varies widely).

Licensees' comments mirrored that of hospitals, saying the main reasons for vacancies or refusing referrals were:

- the needs of patients being referred were too high
- they required 24-hour support which could not be provided
- and/or they had drug and alcohol or forensic backgrounds.

Other reasons included being in the wrong location and balancing male to female resident numbers, with lower demand for beds by women.

The number of available psychiatric hostel beds²² has fallen because a large 75 bed hostel, Franciscan House, closed in December 2017, a six bed hostel is in the process of being decommissioned, and four beds were not being funded in two facilities by agreement with the MHC. This means that there has been a decrease in the high-care and long-term bed numbers, which is where there is the greatest need for consumers assisted by the Advocacy Service. Some of the Franciscan House residents were moved into non-psychiatric hostel accommodation, and a lower level care facility was given more MHC funding so that it would admit Franciscan House residents with higher level needs. See more under 'Hostels - residents' rights and issues'.

Need for review of supported accommodation funding

The only new supported accommodation facilities which have been announced are short-term SUSD in regional areas. These are based on the 22 bed Joondalup and 10 bed Rockingham SUSD units. They do not meet the definition of a psychiatric hostel because they are short stay.

The MHC Accommodation and Support Strategy also remains unannounced.

Following the closure of Franciscan House, the Chief Advocate raised concerns with both the Mental Health Commissioner and the Minister about the lack of appropriate supported accommodation for people who need higher levels of support. She called for a review of the supported accommodation sector aimed at ensuring the limited funding available was being spent where it was most needed.

²² A full list of the hostels and bed numbers is set out in appendix 2.

Right to safe treatment, care and support

Principle 4 of the Charter of Mental Health Care Principles: Delivery of treatment, care and support

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

One of the criteria for detaining a person under the Act 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 and/or not being safe on the ward are therefore clearly breaches of the Act, Principle 4 of the Charter of Mental Health Care Principles, and human rights in general.

Advocates dealt with 81 allegations of physical and sexual abuse and harm across 14 hospitals, seven psychiatric hostels and one community mental health service. Of the 81 allegations, 21 concerned staff abuse of a consumer and 60 were between consumers.

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 many of these cases the consumer chose not to make a complaint, or later withdrew the complaint when one was made. In a few cases, it was not possible to follow up on serious issues due to a consumer being discharged.

Complaints of abuse by staff

Of the 21 allegations about staff, 18 were about nursing staff, two were about doctors and one was about a psychiatric hostel worker:

- 13 complaints were made by consumers or family members
- 7 consumers did not want to complain
- 1 was not followed up by the Advocate
- of the 13 complaints made:
 - 6 were investigated and determined to be unsubstantiated
 - 3 of the outcomes are unknown
 - 1 resulted in a verbal apology
 - 1 resulted in a one-on-one female nurse 'special'
 - 1 resulted in the patient being transferred at their request
 - 1 resulted in a staff member admitting to an allegation of inappropriate touching and stating it was accidental.

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

Complaints about assaults in wards

The data collected regarding consumers reporting assaults on mental health wards is very concerning:

- of 60 allegations of consumer on consumer abuse:
 - 50 related to physical assaults
 - 7 related to sexual assaults
 - 3 related to bullying
- it would appear from the data that larger secure wards create a higher risk of physical assaults between consumers with one large secure ward having 24.0% of all patient-to-patient assaults recorded by the Advocacy Service. The Advocacy Service is in the process of investigating this further with the hospital concerned.

One consumer complained to a hospital with the help of an Advocate after being assaulted by another patient in the courtyard of the ward, saying there should have been staff in the courtyard, that staff in the nurses' station did not come to their aid after the incident, and they had to come through the ward while trying to fend off the attack and 'thump' on the nurses' station window to get attention.

The hospital investigated and apologised to the consumer, confirming that nursing staff were not in the courtyard, despite supervision guidelines requiring this, and had not immediately come to the consumer's aid. Staff were apparently 'counselled in relation to not adhering to the guidelines' and were given 'further training'. A 'comprehensive clinical review' to look at 'further service improvements' was also being undertaken, which would include reviewing and updating ward courtyard guidelines and developing nursing practice guidelines. The Advocacy Service is also monitoring safety of the courtyard.

Restraint and seclusion complaints

Advocates check that the relevant forms have been completed in relation to seclusion and restraints, 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 fear it may delay their release.

Seclusion

There were 11 issues raised about seclusion:

- the main concern with 10 of the 11 was that the seclusion was inappropriate/excessive
- 1 related to forms being completed incorrectly
- of those who felt seclusion was inappropriate/excessive, two made complaints, two complained but later withdrew their complaints, and six did not want to complain.

Restraint

There were 28 issues raised about restraint, eight of which involved children:

- 26 alleged that excessive force was used during restraint and they were left injured or in pain
- 1 was about forms not being completed
- 1 was that parents were not informed about restraint of a child
- of the 28 issues raised:
 - 14 complaints were made
 - 8 consumers didn't want to complain
 - 3 complaints were made and later withdrawn
 - 2 could not be followed up because the consumer was discharged
 - in one case, the Advocate did not follow up.

Police restraints

Of the 26 complaints that restraint had been excessive, four related to treatment by police, including one person who suffered heavy bruising and a broken bone after being tasered and hit with a baton. This person has lodged a complaint and the response is pending. In other cases:

- police were seen to be holding up taser guns when responding to an incident on a children's ward
- the Advocacy Service was informed when responding to an incident involving an 82 year old at an older adult ward that police had been prepared to use taser guns and bean bag rounds before hospital staff informed them this was not appropriate.

Access to toilets during restraint and seclusion

Included in the above examples of issues about seclusion and restraint were four complaints about no access to bathroom facilities:

- not being able to access the toilet due to issues with seclusion intercom systems were raised as issues in three hospitals. One hospital replaced its intercom system following the complaint, and two are looking into this
- one consumer complained that they soiled themselves after being refused access to a bathroom during a restraint lasting 24 hours. A catheter was also fitted without the consumer's consent. They complained and received an apology, with the hospital noting there was no safe alternative available at the time
- one consumer complained about lack of toilet paper and soap and received an apology.

Trauma-informed care

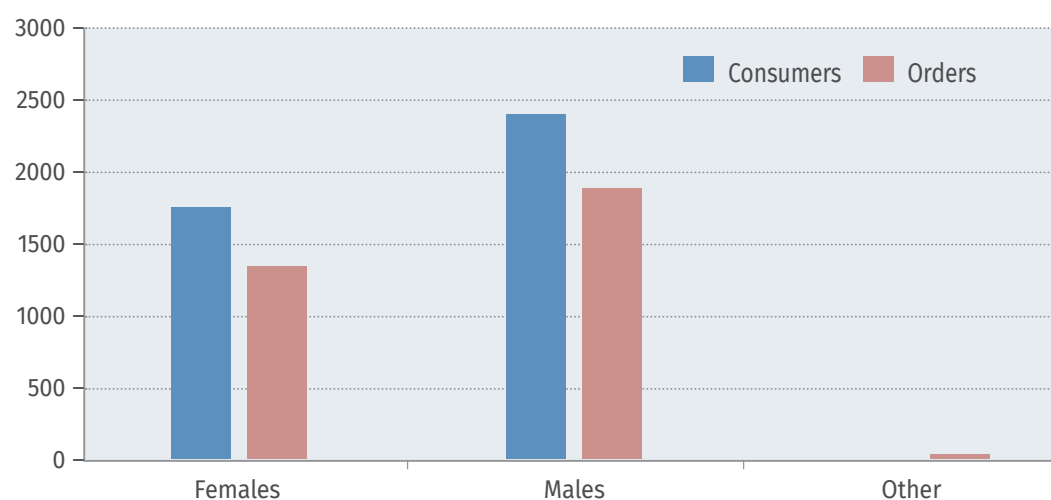
The Advocacy Service notes the importance of trauma-informed care when it comes to involuntary treatment, restraint and seclusion. The use of safety gowns²³ can also be re-traumatising for those with a history of sexual abuse and self-harm:

- one consumer told an Advocate that the compulsory wearing of the safety gown resulted in an unavoidable exposure of their heavily scarred arms. The Advocacy Service gave this feedback to the ward and asked for a long sleeve option in two hospitals but was told this was not possible
- another consumer told the Advocacy Service that a compulsory element of their management plan was sleeping in a safety gown without underwear or a comfort blanket. This was a terrifying prospect for this consumer in the context of a history of extensive childhood sexual abuse. The Advocate was able to assist the consumer to negotiate the terms of their management plan so that they could wear underwear and have the comfort blanket.

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 in WA. 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. Males comprised 57.8% of all involuntary orders in 2017-18 as can be seen in graph 4.

Graph 4: Involuntary orders by gender²⁴



Women on forensic wards are often the only female there at the time and they consistently tell the Advocacy Service that they do not feel sexually safe. The issues were raised with the Director of the SFMHS and were being drawn to the attention of the Mental Health Commissioner.

²³ Garments designed to prevent patients harming themselves.

²⁴ Consumers are referred to under their preferred gender based on information made known to Advocates, other refers to individuals with diverse genders.

Cases in which Advocates have been involved pertaining to sexual safety included the following:

- a female consumer became distressed by a male consumer entering her room at night as she slept. She felt her sexual safety was at risk but it resulted in her being transferred to a locked ward
- a male consumer was approached by a female consumer in their room as he slept and attempted to instigate sexual contact. He approached staff as he did not feel sex was appropriate on the ward and he was fearful of being accused of rape
- a male consumer attempted to guide a female consumer into his bedroom. She stated that she did not feel sexually safe on the ward as she could not lock her bedroom door
- two consumers had sexual intercourse while they were on heightened observations due to sexual vulnerability. One of them later alerted staff to this as they were concerned they had contracted a sexually transmitted disease
- a female consumer told her Advocate that she had extensive history of being raped while homeless. She was convinced she would be raped again and was the only woman on the ward. These intrusive thoughts disrupted her ability to receive treatment.

An Advocacy Service inquiry into sexual safety was planned for the second half of 2017-18, but could not go ahead due to funding constraints. This will be reviewed again in the second half of 2018-19.

The Advocacy Service is currently contributing to the Chief Psychiatrist's Standards and Guidelines Reference Group pertaining to sexual safety, and continues to raise the above concerns.

Gender diversity

The Advocacy Service notes the need for same-gender spaces on wards, while also recognising the importance of allowing for self-definition of gender in order to avoid trauma for those with diverse genders, who are known to be over-represented in mental health services.

The Advocacy Service is changing the way it collects data to allow for self-definition of gender and in order to monitor how many gender-diverse individuals it works with.

Right to have the law and standards followed

Principle 2 of the Charter of Mental Health Care Principles: Human rights

A mental health service must protect and uphold the fundamental human rights of people experiencing mental illness and act in accordance with the national and international standards that apply to mental health services.

It perhaps goes without saying that the Act must be followed. A person cannot be made involuntary, for example, unless the criteria and procedures set out in the Act are met and complied with. The Act also contains a number of consumer protections, including:

- right to a further opinion
- Mental Health Tribunal review
- freedom of lawful communication.

Right to a further opinion not being met

One of the most important protections under the Act for involuntary patients is the right to request a further opinion²⁵. It continues to be the case that the Act and a mandatory operational directive by the Director General of the DOH regarding the provision of further opinions are not being complied with.

In June 2017, the Advocacy Service sent a survey of Advocates to the Minister, Director General of the DOH, the Mental Health Commissioner, and Chief Executives of the health services pointing out the lack of compliance and making a number of recommendations. The main concerns were the inability to get an independent opinion from someone outside the hospital where the consumer was being detained, and not providing the consumer with a copy of the opinion.

In April 2018, the Advocacy Service received a copy of a 'Further Opinions Impact Study Report' (Impact Study Report) from the Director General of the DOH. The report made five recommendations, including further consideration of the four recommendations previously made by the Advocacy Service in June 2017 following a compliance survey (Compliance Survey), for which, see page 16 of the 2016-17 Annual Report.

Disappointingly, the Impact Study Report was indicative of a lack of willingness by the health services to be proactive around the issue of compliance with the Act. Despite requesting data over a three month period and giving hospitals time to collect the data, the DOH could not get enough data from the hospitals to come up with any conclusions, other than that the health services appeared to be not complying with the mandatory operational directive. To quote the executive summary of the report:

'The MHU's ability to conduct meaningful analysis and produce insights has been constrained by data quality issues as a result of inconsistent recording of data by health services. This has made it difficult to confirm or dismiss the criticism made by MHAS. For this reason, some of the specific objectives of the impact study were not achieved.'

²⁵ See s182 of the Act.

The Impact Study Report confirmed it appeared it was ‘uncommon’ for a further opinion to be provided by someone outside the health service, and that health services were ‘non-compliant’ with the mandatory operational directive. One of the recommendations of the report was that the views of the health services, Chief Psychiatrist and the MHC be sought about the Advocacy Service’s Compliance Survey recommendations.

The number of further opinion requests

Between 1 July 2017 and 30 June 2018, according to Advocacy Service data, Advocates were involved in making requests for 349 further opinions, or about 29 a month. This was 45 (or 14.8%) more than in 2016-17. This figure only relates to the requests for a further opinion in which an Advocate was involved.

The largest number of requests from consumers on inpatient treatment orders came from those hospitals which also had the largest number of people on involuntary orders – Graylands and Midland hospitals. There were also 15 further opinions sought for people on CTOs.

Further opinion outcomes

A further opinion can help promote the consumer’s trust in the treating team and also lead to changed treatment and improved outcomes for the consumer. Two examples are set out below.

- The consumer was concerned about their medication being increased because previously there had been negative side effects. Their psychiatrist in the community agreed with the increased medications so they wanted an opinion from someone outside the health service. A private psychiatrist was identified by the consumer but it would take time. The treating psychiatrist was persuaded to hold off administering the higher dose but only until the end of the week. The option for the consumer was to take a further opinion from another doctor at the hospital or wait for the independent private psychiatrist. They chose the latter. In the ensuing discussions the treating psychiatrist reconsidered and offered the consumer an alternative in the form of a new oral medication instead of the increase of depot (injection of slow release medication). This was a double win for the consumer as they found depot injections unpleasant.
- The consumer was involuntary on a locked ward, having recently been on a CTO. The further opinion concluded that the consumer should be discharged as a voluntary outpatient on oral medication. The further opinion psychiatrist said the consumer had a mental illness but still had capacity to make treatment decisions and therefore could not be kept involuntary as this is an essential criteria under the Act. The consumer was discharged home that day.

Right to review by a tribunal

The only way that a person can challenge a psychiatrist's decision to detain them as an involuntary patient or put them on a CTO (which usually requires them to take medication and attend a community mental health service), is via a review by the Mental Health Tribunal (Tribunal).

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

Every involuntary patient must be reviewed by the Tribunal within 35 days of being made involuntary and, thereafter, every three months while they remain involuntary.²⁶ Review hearings for children must be held within 10 days and, thereafter, every 28 days.

Representation in Tribunal hearings

The Advocacy Service aims to ensure that every consumer who wants it has representation or support in a Tribunal hearing. Advocates are provided with the Tribunal review hearing schedule two weeks in advance, and every effort is made to speak to consumers to make sure they know their rights in relation to the hearing, what to expect and that they can have legal or Advocacy Service support and representation.

The number of hearings attended by both Advocates and Mental Health Law Centre (MHLC) staff increased this year but the rate of representation and support fell by 1.0%²⁷. See table 3²⁸. The reduction in the rate of representation will have been impacted by a 6.9% increase in the number of hearings and Advocacy Service budget cut requirements from 1 January 2018 requiring Advocates try to refer consumers to the MHLC rather than attend the hearing themselves.

Table 3: Tribunal Representation

Year	No. of completed hearings	No. and % of hearings involving Advocates	No. and % of hearings involving the MHLC	% represented by MHLC and Advocates
2016-17	2101	749 / 35.6%	175 / 8.3%	924 / 44.0%
2018-19	2247	766 / 34.1%	199 / 8.6%	965 / 43.0%

The number of reviews where the person was made voluntary by a Tribunal decision was 60, or in 2.7% of reviews. The number of hearings where an involuntary inpatient (on a form 6A or 6B) was put on a CTO by a Tribunal decision was 16.

²⁶ Which includes people on a CTO up to 12 months, after which time it becomes every six months.

²⁷ Any discrepancies in the data generated by MHAS and the Mental Health Tribunal may be attributable to the different case management systems used by the agencies. The President of the Tribunal comments on the limitations of the Tribunal's current case management system and its recording of data in the Tribunal's Annual Report 2017-18.

²⁸ Data supplied by the Mental Health Tribunal as at 31 July 2018.

The number of reviews where the Tribunal changed the consumer's status was therefore 76, or 3.4%. This data has not been available in recent years, but in the years between 2012 and 2014 the number of consumers made voluntary at hearings (by the then Mental Health Review Board) was 4.2%, most of whom had been on a CTO.

Advocates made 283 referrals to the MHLC, which is 21.5% more than the referrals recorded in 2016-17. The reasons for the increase included that:

- from 1 January 2018 Advocates were required to try to persuade people to use the MHLC due to budget constraints on the Advocacy Service
- the MHLC had better capacity this year, though it fluctuated. Advocates do not attend with a MHLC lawyer unless in exceptional circumstances and only after approval by a Senior Advocate
- Advocates were recording the referrals more consistently.

Tribunal hearing applications and outcomes

While the main outcomes of a Tribunal hearing are focussed on whether or not to keep the person involuntary, there are other outcomes which consumers value, such as transfer to an open ward, ground access and getting a proper treatment, support and discharge plan (TSD Plan) which complies with the Act. The Tribunal is required by the Act²⁹ to have regard to TSD Plans. Below are some examples of Tribunal hearings in which Advocates were involved.

- **Transfer to an open ward**

The consumer was on the acute locked ward and wanted to be on the open ward. They said it was distressing and loud on the locked ward and had not slept. They also wanted to be able to engage in groups which were only available on the open ward. They could be managed with a nurse special (where the patient is monitored constantly or very frequently) on the open side to reduce risk but the request had been denied by hospital management due to funding constraints. These issues were all raised in the Tribunal hearing and the psychiatrist said they supported the request. After the Tribunal hearing the Advocate approached the ward management, highlighting this was what the psychiatrist wanted from a clinical perspective and it was supported by the Tribunal. The consumer got the transfer.

- **TSD Plans**

The consumer did not attend the Tribunal hearing but the Advocate met with them and a family member and took into the hearing their wishes. The family member said they did not feel included in the consumer's treatment and was desperately worried about the consumer. The doctor stated that the family member had been included. There was a client management plan on the medical file purporting to be a TSD Plan and to include their views but it was three months old and had not been signed by either the consumer or their family member, nor had they been given a copy as required by the Act. The involuntary treatment order was maintained but the Tribunal recommended that a TSD Plan be completed, including the consumer, their family member and the Advocate.

In other cases, preliminary to issuing a compliance notice³⁰, the Tribunal has referred the lack of a TSD Plan to the Director General of the DOH and Chief Psychiatrist, which has resulted in compliance with the Act.

²⁹ See s394 of the Act.

³⁰ See s423 of the Act.

- **Incorrect statements in medical report to Tribunal**

The consumer had a long history on involuntary treatment orders. Their medical report referred to them ‘manufacturing recreational polysubstances’ in the past. The consumer strongly denied this and there was no other evidence on the file. The medical report provided to the Tribunal referred to this, citing it as a potential risk. The Advocate asked for evidence, arguing that there was nothing else on the file and it was an unsubstantiated claim that was prejudicial. The treating team doctor, who knew the consumer from previous admissions, acknowledged that it was only hearsay and that it just kept getting transferred through subsequent admissions without being confirmed.

- **Being made voluntary**

The Advocate and the consumer argued that the risk was not significant, and indeed was very low. An essential criterion for making and keeping a person involuntary is that there is a ‘significant’ risk. The patient was getting unescorted leave from hospital, going out on public transport to find their own accommodation, was compliant with medications and there was evidence of capacity to make treatment decisions (another essential criteria). Prior to the hearing, the psychiatrist had been adamant that the consumer needed to stay involuntary and that when discharged would need to be on a CTO. During the hearing, having heard the arguments put by the Advocate and consumer, the psychiatrist changed their opinion, saying that the team could work with the consumer as a voluntary patient. The consumer was made voluntary by the Tribunal.

- **Electroconvulsive Therapy (ECT) urgent hearings**

ECT hearings are often heard with very short notice, and sometimes the consumer is catatonic and unable to let the Advocate know their wishes. The Advocacy Service protocol on uninstructed advocacy in ECT hearings requires the Advocate to ensure that the Act is followed and to endeavour where possible to find out what the consumer’s wishes might have been. In one case the consumer’s family was not notified until the Advocate intervened to ensure they could attend the hearing to express the consumer’s wishes.

Reviews of Tribunal hearings

Advocates also support people in State Administrative Tribunal (SAT) hearings which review decisions of the Tribunal. The SAT hearing is not an appeal as such but looks at the facts afresh as at the time of the SAT hearing. The Advocate will endeavour to get an MHLC lawyer to attend these hearings as they can lead to an appeal to the Supreme Court and precedent decisions.

Such reviews 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 person can also take their chance on another Tribunal hearing with a different Tribunal membership 28 days after the first hearing, which can be quicker than waiting for the SAT hearing.

Advocates were involved in three applications to SAT. In two of the cases the person was on a CTO in the community by the time of the hearing and either not willing to attend the hearing or couldn’t be contacted. The applicant was unsuccessful in the third case.

SAT decisions under the *Guardianship and Administration Act 1990*

Consumers regularly have a guardian or administrator appointed while they are involuntary and detained in hospital. Hospital social workers initiate the application usually, with a view to having someone appointed to decide where the consumer is to live on discharge from hospital and to control their finances. The orders made therefore result in a significant loss of rights and decision-making control.

Advocates reported assisting consumers in 25 hearings for either guardianship or administration orders (or both). In many more cases, Advocates explained to consumers their rights, and arranged for legal representation.

The number of people represented by Advocates is fewer than last year because budget cuts which took effect from 1 January 2018 required Advocates to pass all requests for guardianship and administration applications on to the MHLC. This was discussed with the MHLC prior to making the change. This cost-cutting measure was a regrettable decision because Advocates often know the consumer well, the MHLC is not always able to represent the person, which means they may be unrepresented in the hearing, and often the consumer is not present in person but has to attend by video link. This cost-cutting measure is continuing in 2018-19, though some exceptions will be made where there is no other representation and the Advocate has concerns about the patient's rights under the Act being impacted if the guardianship or administration order is made.

Right to lawful communication

The Act states that a patient has the right of freedom of lawful communication, including uncensored communications in reasonable privacy, by receiving visits, making and receiving telephone calls, and sending and receiving mail and electronic communications.

Mobile phones are used to keep in touch with people, pay bills, read books, listen to music, keep up with news events, apply for jobs and find accommodation. Taking away a person's mobile phone is cutting them off from the world and a breach of the Act unless a psychiatrist makes a form 12C order.

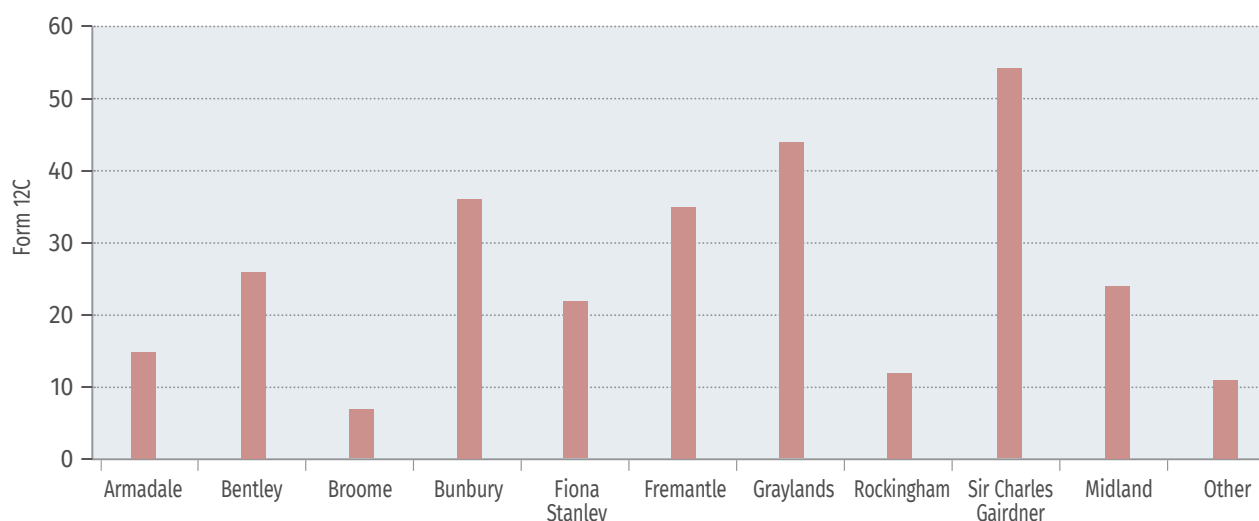
An Advocate survey in February 2018 showed good compliance with the Act except for:

- Selby Lodge, an older adult facility, where the main issue was that patients who didn't have their own mobile phones had to sit at the nurses' station to take and make calls, which meant it was not in reasonable privacy. When raised with the hospital, they took immediate action to organise additional phone lines and cordless phones.
- the locked ward at Sir Charles Gardiner Hospital, where it has been a blanket practice to only allow patients on the locked ward to have access to their mobile phones for 15 minutes a day on request and they had to be watched by the nurse while using the phone. This practice in breach of the Act was continuing as at 30 June 2018. The Advocacy Service has raised the issue, including taking legal advice from the State Solicitor's Office to persuade the hospital to change the practice, and is hopeful that changes will be made soon.

The patient's right to lawful communication, which includes having visitors, can be overridden by a psychiatrist when they consider that it is not in the patient's best interest to have that right (including voluntary patients). The psychiatrist must make an order (a form 12C) to override the right, and notify the Chief Advocate within 24 hours. Notification of 286 orders restricting communication and/or visitors were made for 201 consumers. Some consumers were placed on a form 12C multiple times and/or in different facilities.

Hospitals with higher numbers of involuntary patients might be expected to have higher numbers of 12C forms, but this was not the case. The hospital which issued the most such restriction orders was Sir Charles Gairdner, which only had 5.5% of involuntary inpatient orders³¹ and already restricted access to mobile phones as a blanket policy on the locked ward. The issue has been raised with the hospital. See graph 5.

Graph 5: Form 12C notifications by hospital – restriction of freedom of communication³²



³¹ See appendix 4.

³² 'Other' is the total of the Form 12C - Restriction of communication' forms received by health services where less than five.

Right to complain, and complaint handling

Principle 15 of the Charter of Mental Health Care Principles: Accountability and improvement

A mental health service must be accountable, committed to continuous improvement and open to solving problems in partnership with all people involved in the treatment, care and support of people experiencing mental illness, including their family members, carers and other personal and professional support persons.

It is a function of Advocates to inquire into and seek to resolve complaints by consumers³³. Advocates assist consumers in a number of ways, including raising the issue with ward staff, helping the consumer to write their own letter of complaint, and writing a letter of complaint to go from the Advocacy Service. There may be meetings attended and in some cases the complaint may be escalated to an inquiry by the Advocacy Service, raising concerns about rights not being observed or ward conditions adversely impacting on the health, safety or welfare of consumers.

Poor health service complaint handling

The Charter of Mental Health Care Principles refers to a mental health service being accountable, and the Act requires that each service have a procedure for investigating any complaint made, that it be reviewed regularly and be made readily available.³⁴

The health services all handle complaints differently, with some having more robust complaints procedures than others. The Advocacy Service continually raises issues with health services about the need for complaints to be investigated:

- by someone independent of staff on the ward or facility where the alleged incident took place if the allegation is about staff
- thoroughly and not just relying on the medical file notes – the consumer needs to be spoken to along with other witnesses, and CCTV footage should be examined where available.

In one case, the Advocacy Service conducted an inquiry into a situation which had ended with staff calling police to the ward. Information was given and sought from the health service as part of the inquiry. The Advocacy Service was not satisfied with the responses from the health service, which indicated that staff had done everything correctly and ignored the statements of the consumers involved, provided by the Advocacy Service. It called for a viewing of the CCTV footage, which contradicted the health service account, and raised the issue with the Chief Executive and other senior management. The health service wrote back apologising for sending ‘incorrect advice’, saying:

- having now looked at the CCTV footage, it agreed there were some significant issues with how the incident was managed by ward staff
- its response had relied on an investigation by ward staff, which it recognised was an error, especially given the seriousness of the concerns raised by the Advocacy Service.

³³ See s352(1)(d) of the Act.

³⁴ See s308 of the Act.

In another case, the Advocacy Service and the consumer's personal support person (PSP) wrote separately raising multiple issues of concern about the consumer's care on a ward. The Advocacy Service asked for an investigator from outside the health service. The first response by the health service to the PSP was a short letter generally dismissing the PSPs complaints, while failing to address many of them and containing errors of fact. The investigator was not identified and had made no attempt to contact any witnesses, which included the PSP and the Advocate. The Chief Executive of the health service was contacted and independent investigators appointed. The result was an apology by the Chief Executive for the substandard care of the consumer, and 14 recommendations for improvement by the health service.

HaDSCO complaints

The Act states that a person may complain to the service provider or the Health and Disability Services Complaints Office (HaDSCO) but, in practice, HaDSCO usually requires that the person complain to the service first. The process to get to HaDSCO can be complicated and lengthy. In most cases the Advocate assists the consumer to resolve the complaint or the consumer gives up. Advocates recorded only one complaint this year going to HaDSCO, in comparison to four last year. However, two complaints were ongoing, with one resolved during 2017-18. The resolved complaint began in January 2016 and was not resolved until September 2017.

Right to person-centred care and recovery approach

Principle 3.1 of the Charter of Mental Health Care Principles: Person-centred approach

A mental health service must uphold a person-centred focus with a view to obtaining the best possible outcomes for people experiencing mental illness, including by recognising life experiences, needs, preferences, aspirations, values and skills, while delivering goal oriented treatment, care and support.

Principle 14 of the Charter of Mental Health Care Principles: Involvement of other people

A mental health service must take a collaborative approach to decision making, including respecting and facilitating the right of people experiencing mental illness to involve their family members, carers and other personal support persons in planning, undertaking, evaluating and improving their treatment, care and support.

Person-centred care is a central theme of the Act as reflected in principles 3, 5, 8, 9 and 14 of the Charter of Mental Health Care Principles, and numerous provisions of the Act requiring clinicians to have regard to the patient's wishes. Sections 185-188 of the Act set up the practical implementation of this, requiring that:

- all treatment care and support provided to involuntary patients³⁵ **must** be governed by a TSD Plan
- the patient and any PSPs **must** be involved in the preparation and review of the TSD Plan
- the patient and any PSP **must** be given a copy of the TSD Plan
- the TSD Plan **must** be prepared, reviewed and revised having regard to the Chief Psychiatrist's Guidelines.

The patient's psychiatrist is the person required by the Act³⁶ to ensure that the TSD Plan requirements are met and the Tribunal must have regard to the involuntary patient's TSD Plan when considering a patient's involuntary status³⁷.

TSD Plan Inquiry

As indicated in last year's annual report, from March 2017 to 30 September 2017 Advocates conducted an inquiry into TSD Plans to promote compliance with the Act (the Inquiry). The Inquiry was finalised and results sent out to all health services in March 2018 (the Inquiry Report). A copy of the Inquiry Report was posted on the Advocacy Service website along with responses from each of the health services³⁸.

Details of the preparation for, and the conduct of, the Inquiry is set out in annexure 2 of the Inquiry Report, including the information sent to health services before the Inquiry began and the reporting requirements of the Advocates. Community mental health services were not included in the Inquiry, only hospitals. It was not an audit, as it was generally accepted that most health services were not complying fully with the Act.

³⁵ This includes people on CTO and mentally impaired accused in an authorised hospital.

³⁶ See s187 of the Act.

³⁷ Pursuant to s394 of the Act.

³⁸ Go to <https://mhas.wa.gov.au>

The outcome sought was to educate mental health services and consumers through a process of having each Advocate facilitate the production of a TSD Plan for three consumers which complied with the Act.

Outcomes of the TSD Plan Inquiry

The outcome was not achieved in that the Advocates were not able to produce three TSD Plans each that fully complied with the Act, even after extending the period of the Inquiry from 30 June 2017 to 30 September 2017.

There were a number of contributing reasons for this, but the main reasons were that:

- no health services were fully compliant with the Act, and many were not compliant at all, so the task was more difficult than anticipated
- clinicians, including many psychiatrists, were unaware of the requirements of the Act and their responsibilities
- clinicians did not have a process established to help them comply with the Act
- Advocates either could not get staff co-operation or found themselves having to educate staff at a level that included suggesting ways of engaging with consumers and carers and other practical aspects of compliance.

Findings and recommendations of the TSD Plan Inquiry - why the Act is not being complied with

Common themes across all health services included the following:

1. issues around the documentation (what document to use and how to use it) seemed to be an insurmountable hurdle for some mental health services, despite a mandatory operational directive requiring that the clinical management plan document on the mental health database (PSOLIS) be used
2. lack of acknowledgement by psychiatrists that TSD Plans are clearly stated to be their responsibility under the Act, that they should take the lead, and that the Act requires that all treatment, care and support be 'governed' by the TSD Plan
3. lack of a process for involving the consumer or PSPs in the development or review of the TSD Plan
4. lack of appreciation by clinicians of the therapeutic benefits and improved outcomes which can result from compliant TSD Plans
5. a belief by some clinicians that consumers should not see certain information, or would react badly if they did, or that they were too unwell to be able to add anything meaningful, and a (false) belief in some cases that there was a discretion which gave them the right to not comply with the Act
6. no leadership or involvement at health service level
7. lack of understanding or skills in recovery focussed and patient-centred language and the type of matters to be discussed and included in a TSD Plan
8. limitations on access to PSOLIS
9. continual turn-over of staff.

The Inquiry Report called for leadership from the health services, and made a number of recommendations to them, the Director General of the DOH, the Chief Psychiatrist, the President of the Tribunal and the Australian and New Zealand College of Psychiatrists. The full list of recommendations is set out in appendix 13.

Written responses have been received from all parties except Joondalup Hospital, and these can be read on the Advocacy Service website. The findings were either accepted in full or not refuted. Clarity was also given around agreement that PSOLIS be used, though as at 30 June 2018 some hospitals were continuing to try to use paper based documents. Issues with these included illegible handwriting and failure to update.

Despite the disappointing initial results, the TSD Plan Inquiry:

- ✓ resulted in education across the sector about the requirements of the Act
- ✓ has caused a shift towards compliance, or at least most hospitals have started to think about the changes they need to make to comply with the Act
- ✓ led to pockets of good work being done by some, including at Rockingham, Bentley and Graylands hospitals
- ✓ resulted in sharing of information across and within health services about what others were doing to comply, which avoids ‘re-inventing the wheel’ and proved to some sceptics that it can be done and there are benefits all round.

Update on TSD Plans

More work is needed and the Advocacy Service would like to do a follow-up inquiry but this will be subject to budget. In the meantime, Advocates continue to raise the issue with treating teams and the Tribunal. There have been many conversations between Advocates and staff, and several dedicated nursing staff and a few psychiatrists have championed the cause.

Anecdotally, there has been an improvement in the development of TSD Plans in most hospitals. Some are now doing regular updates, while others do updates sporadically. The quality of the plans and updates are works in progress for the majority of the facilities.

As noted above, the Tribunal has also started asking about TSD Plans in review hearings, and has referred some cases to the Director General of the DOH and Chief Psychiatrist preliminary to issuing a compliance notice. This was one of the recommendations of the Inquiry Report.

Right to culturally appropriate treatment, care and support

Principle 6 of the Charter of Mental Health Care Principles: Diversity

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.

Principle 7 of the Charter of Mental Health Care Principles: People of Aboriginal or Torres Strait Islander descent

A mental health service must provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities, including elders and traditional healers, and Aboriginal or Torres Strait Islander mental health workers.

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 of Mental Health Care Principles, and to ask if they would like to speak to the Advocacy Service's Aboriginal Advocate.

Aboriginal and Torres Strait Islander consumers

Advocacy Service data records that 5.8% of all consumers put on involuntary orders identified themselves to the Advocate as Aboriginal or Torres Strait Islander, and 7.6% of all involuntary orders were for Aboriginal consumers. See table 4. This is a significant over-representation of Aboriginal and Torres Strait Islanders, who form 3.1% of the state's population (based on 2016 ABS figures). They are significantly under-represented in the form 6B orders, where people were detained on general medical wards due to medical issues.

Table 4: Orders for Aboriginal consumers 2017-18

Order	Orders for Aboriginal consumers	Orders for all consumers	Orders for Aboriginal consumers	Individual Aboriginal consumers on orders	Total Individual consumers on orders	Consumers on orders who are Aboriginal
Form 5A	73	817	8.9%	55	661	8.3%
Form 6A	240	3203	7.5%	145	2432	5.9%
Form 6B	<5	134	1.5%	<5	115	1.7%
Total	315	4154	7.6%	153³⁹	2644⁴⁰	5.8%⁴¹

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

Need for inquiry

The Advocacy Service intended to inquire into the extent to which the provisions of the Act relating to Aboriginal and Torres Strait Islander people were being complied with but budget cuts from January 2018 meant this had to be put on hold. An aim of the inquiry was to include developing a list of all Aboriginal mental health workers and/or services available at, or to each, authorised hospital. Advocates would be able to use the list to facilitate compliance and access to such services⁴².

The need arose from Advocate feedback that the Act was not always being complied with and, in some cases, the Aboriginal Advocate was the person ‘filling in’. In one case, the matter was part of an investigation complaint made to HaDSCO. HaDSCO concluded that because the mental health service did not employ an Aboriginal or Torres Strait Islander mental health worker, ‘the application of section 50 of the Act was not practicable and appropriate in the circumstances’.

Subsequently, the ‘Post-Implementation Review of the Mental Health Act 2014’⁴³ conducted by the MHC recommended that the Advocacy Service conduct an inquiry into and prepare a report on services available to assist in the assessment, examination and treatment of Aboriginal people, in accordance with the requirements in the Act.

³⁹ The number of Aboriginal consumers on orders was 153, some consumers were placed on more than one type of order and are therefore counted more than once in the table. The number of Aboriginal consumers may be an under-representation as it relies on the Advocate to have identified the person as Aboriginal.

⁴⁰ The number of consumers on orders was 2644, some consumers were placed on more than one type of order and are therefore counted more than once in the table.

⁴¹ The percentage was calculated based on 153 individual Aboriginal consumers placed on orders compared to a total of 2644 non-Aboriginal consumers placed on an involuntary order.

⁴² See Advocate functions pursuant to s352(1)(c), (f) and (h) of the Act.

⁴³ March 2018, see <https://www.mhc.wa.gov.au>

Cases and support provided by Advocates

Below are some examples of work by Advocates relating to culturally appropriate treatment and care.

- The treating team reported in a Tribunal hearing that an Aboriginal woman was not engaging with staff and other consumers, which was a sign that she was still unwell. The consumer was the only female patient on the ward at the time and told the Advocate that as an Aboriginal woman she was culturally barred from engaging with non-Aboriginal men, which was why she was spending nearly all of her time away from the other consumers. The treating team had not considered this possibility until it was raised by the Advocate.
- A consumer from another country who had given birth only a short time before being made involuntary was allowed by the treating team to be interviewed by both child protection and immigration department officers, even though as an involuntary patient, by definition under the Act she lacked capacity to make treatment decisions. The Advocate intervened and arranged for specialist legal assistance. The Chief Psychiatrist and head of the mental health service were contacted about the fact that this had been allowed to happen.
- Issues arose during the year regarding the jurisdiction of the Act in relation to people in an immigration detention centre. Occasionally, they are sent to an authorised hospital and then made an involuntary patient. There were questions regarding the ability to put a person in a detention centre on a CTO or referral order and regarding the Chief Psychiatrist's and Advocate's powers and functions. The Chief Psychiatrist asked the MHC to obtain legal advice on these and other related issues.

Right to be treated with dignity and without discrimination

Principle 1 of the Charter of Mental Health Care Principles: Attitude towards people experiencing mental illness

A mental health service must treat people experiencing mental illness with dignity, equality, courtesy and compassion and must not discriminate against or stigmatise them.

The first principle of the Charter of Mental Health Care Principles requires mental health services and their staff to treat people with dignity, equality, courtesy and compassion. Advocates reported 46 complaints and issues in breach of this principle. Often the cases related to poor staff attitude and comments. The culture of staff on a ward can make a very big difference to a person's recovery and easing their distress at being detained.

Case examples

- As was widely reported in the media, one such case was the transport of a female prisoner naked from prison to the authorised hospital. As the consumer was on a form 1A, they were a referred person and within the Advocacy Service jurisdiction. A complaint was immediately made by the Chief Advocate to the Acting Director General of the Department of Justice. The Acting Commissioner of Corrective Services responded directly to the Chief Advocate, advising immediate investigations were underway into the 'totally unacceptable' treatment. The Inspector of Custodial Services was then asked to conduct an external review titled 'Transport of people in custody to secure mental health facilities'. The findings are expected to be reported publicly in September 2018.
- A second, not dissimilar, case involving the transport of a child was also raised with the Director General of the Department of Justice and the Inspector of Custodial Services.
- An inquiry is underway by the Advocacy Service into the reasons and the manner in which a consumer was referred for examination by a psychiatrist on a form 1A and placed on a transport order (form 4A) under the Act. The consumer was forcibly detained by police at their home during the family evening meal, and held in four-point restraints on arrival at the ED until the following morning, yet were given overnight leave and made voluntary in less than a week.
- In another case, the treatment by nursing staff accompanying the consumer to a court hearing was of serious concern, and subsequent derogatory comments were made by ward staff to the Advocate that the consumer deserved to be in prison. This was part of a major inquiry raising multiple complaints. The Inquiry continues to be followed up by the Advocacy Service but resulted in 14 recommendations being made for improvements to the mental health service.

Ward conditions

Ward conditions are also 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. Below are examples of issues raised by Advocates during the year.

- A ward was segregated to accommodate the needs of a very unwell consumer. An Advocate complained about the impact on the other consumers and highlighted how improvements to the outdoor space of that ward would help. This resulted in a courtyard action plan being implemented across all mental health wards in that hospital with the aim of improving all outdoor spaces.
- A consumer made a complaint about access to a toilet following changes to a ward which caused some consumers to urinate in the garden. The Advocate attended the ward and sighted the same. Complaining about this resulted in the hospital communicating toilet access arrangements to all consumers and providing education around this to staff.
- Concerns were raised by consumers and Advocates following changes and a reduction in cleaning across a hospital ward. Bathrooms were found to be in a squalid condition. A letter of complaint resulted in immediate reinstatement of the original cleaning schedule.
- A complaint from consumers regarding the occupational therapy room being closed over weekends resulted in it being opened up so that patients could use it to relieve boredom.
- A lack of shower doors in a communal bathroom on a hospital ward resulted in an unacceptable lack of privacy, dignity and safety. This was raised with the management team, which agreed to have it rectified. The Advocacy Service awaits a further response.
- Water damage, mould and loose tiles were noted in bathrooms on a hospital ward. This was rectified following a complaint from the Advocacy Service.
- Complaints were raised by the Advocacy Service regarding dirty carpets, poor ventilation, a broken television and worn furniture at another mental health unit. This resulted in the matters being rectified.

Right to contact by Advocates

An important pillar of protection under the Act is that adult consumers are contacted by an Advocate within seven days of their involuntary order being made and children within 24 hours. The timing is important, not only because it is an obligation under the Act but because the first few days and hours of being detained on a locked ward can be very frightening and distressing. Knowing there is someone independent who is there just for them can make a very big difference.

The Advocacy Service counts every case where a person is not contacted within seven days as a 'breach' even where it was not notified in time to comply with the Act:

- for 93.6% of all involuntary orders made, the Advocates contacted the consumer within the time required by the Act
- of the 265 orders where the person was not contacted within the time required:
 - 50.6% were because the order was revoked within seven days and before the Advocate got to contact the person
 - 10.6% were because the order was not notified to the Advocacy Service within the time limit
- in every breach involving a child, the Advocacy Service was not notified within 24 hours but the child was contacted as soon as the Advocacy Service became aware of them.

Details of the reasons and number of people not contacted within the legislated time frames are in appendix 6:

- The number of breaches is less than last year despite there being more orders. The change last year to involuntary orders being put on to PSOLIS and notifying the Advocacy Service via access to that health service database assisted.
- The number of people not contacted would have been higher but for Advocacy Service protocols requiring Advocates to check for new consumers when on the wards, which overcame the delayed notifications in many cases.
- More work needs to be done to ensure timely notification of children made involuntary, with 16 children not being contacted within the 24 hour time frame, though all but one were contacted very shortly afterwards. The Advocacy Service runs a phone roster to check for children made involuntary on a weekend but this will not pick up a child put on a form 6B on a general medical ward.

Mentally impaired accused issues and rights

Under the Act, people who are a mentally impaired accused under the *Criminal Law (Mentally Impaired Accused) Act 1996* (CLMIA Act) and who are required under that act to be detained in an authorised hospital, are also identified persons. 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 must be contacted by an Advocate within seven days of being detained in the authorised hospital (24 hours for children). There were less than five such people in 2017-18. They are usually detained in the Frankland Centre which is run by the SFMHS.

If they have been given a conditional release order allowing them to live in the community but on condition that they receive mental health services, they can also request advocacy.

Support and assistance was provided during the year to these consumers, including making submissions to the Mentally Impaired Accused Review Board (MIARB) when cases were reviewed.

Beds closed

One issue which arose was the closing of an eight-bed open ward on the Graylands campus which had been used by SFMHS for longer term rehabilitation patients who did not need to be in the highly secure Frankland Centre, most of whom were mentally impaired accused people. Five beds in another Graylands ward were made available to these patients so there was a net loss of three SFMHS beds and five (Graylands) rehabilitation beds.

The Advocacy Service has raised its concerns about the loss of these beds with the Minister and the MHC, as well as the NMHS which runs the SFMHS.

Need to amend the CLMIA Act

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 continues to raise concerns about this legislation.

A declared place – the Bennett Brook Disability Justice Centre

Part 10 of the *Declared Places (Mentally Impaired Accused) Act 2015* (Declared Places Act) establishes advocacy services for residents of a declared place, including a Chief Advocate and Advocates. The *Declared Places (Mentally Impaired Accused) Regulations 2015* to the Declared Places Act prescribe that the Chief Advocate and Advocates as defined in the *Mental Health Act 2014* are the Chief Advocate and Advocates for the Declared Places Act. A separate annual report is provided to the Minister for Disability Services about this work, for which there is separate funding.

Voluntary patient issues and rights

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 all older adult, child and youth wards have locked doors. 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.

Classes of Voluntary Patient Direction

In 2016 a Ministerial Direction was made⁴⁴ declaring certain classes of voluntary children and adults to be identified persons under the Act so that they could be supported by Advocates. The full wording of the Direction is in appendix 9.

A total of 47 voluntary children and 53 voluntary adults (who had been involuntary but who had ongoing issues) were assisted pursuant to the Direction in 2017-18.

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 33 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 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. The 30 June 2018 hospital snapshot survey shows that at least seven people on older adults wards had been there for six months or longer. It also means Advocates do not visit these wards regularly.

The Advocacy Service refers voluntary patients to the Health Consumers' Council (HCC) or Helping Minds, and sometimes the MHLC. There were 40 referrals to the HCC recorded by Advocates (other referrals are not noted and many referrals are likely to have been made without them being recorded by Advocates).

During the year the Chief Advocate met with the Executive Director of the HCC to discuss concerns about the ongoing workload of the HCC and its difficulties dealing with the increased number of voluntary patients seeking advocacy.

⁴⁴ Pursuant to s248(j) and 254 of the Act.

Hostel residents' issues and rights

Private psychiatric hostels⁴⁵ (hereafter called hostels) are defined in Part 20 of the Act as mental health services, which means they are within the jurisdiction of the Advocacy Service. Hostel residents are 'identified persons' under the Act so can request contact by an Advocate. Hostels are a form of supported accommodation and the style and standard of hostels, as well as their MHC funding, varies widely.

Hostel residents' rights derive from:

- the residents' agreement, which all hostels are required to have
- MHC funding contractual terms, which include the National Standards for Mental Health Services, and MHC evaluators visit hostels every three years to check on this
- licensing standards set by the Licensing and Accreditation Regulatory Unit (LARU), and LARU visits the hostels annually and sets conditions on licences
- the overview of treatment and care by the Chief Psychiatrist.

Notifiable incidents occurring in hostels must be reported to the Chief Psychiatrist, LARU and the MHC. These three agencies and the Advocacy Service meet on a quarterly basis to share information about hostels.

Due to the shortage of beds and other reasons, hostel residents can be very vulnerable. The Advocacy Service would like to do a lot more visits and inquiries at hostels but budget cuts have prevented this.

Issues during the year included the closure of one large hostel, evictions, staffing and NDIS matters. Requests for contact were made by 118 hostel residents. There were 1895 contacts, with Advocates noting 530 issues, seven of which were classified as serious issues across seven hostels. All but one of the serious issues were resident-on-resident allegations.

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

Hostel closure

On 1 September 2017, the licensee of the 75 bed Franciscan House hostel advised it would be closing on 31 December 2017. At the time, the hostel had 70 residents, many of whom had lived there for many years, (some for more than 20 years) and there were more hostel residents needing accommodation than hostel beds available in WA.

All residents were relocated before the hostel closure date. The interagency collaboration and co-operation which occurred at both the strategic and operational level was both notable and instrumental in ensuring this. As one of the Advocates wrote in an email to the people she had been working with on the project:

'Just want to say that this has been the most challenging, heart wrenching yet gratifying projects I have been involved with. The collaboration among teams has been astounding and shows what is possible when people with a common goal pull together.'

⁴⁵ 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.

More importantly, overall there were positive outcomes for most of the residents, who gained improvements in their living situations, mental and physical health, and their aspirations for recovery. Advocates described the joy of seeing some of the former residents for the first time walking around smiling and talking, taking an interest in everything.

The process

On receipt of notice of the closure, the 'Private Psychiatric Hostels – Hostel Closure Strategy 2016' was activated, led by East Metropolitan Health Service (EMHS) as the hostel was within its catchment area. To deliver the strategy, the Chief Executive of the EMHS, along with representatives from the DOH, MHC, Office of the Chief Psychiatrist (OCP), and the Advocacy Service initiated a project with the objective of relocating all Franciscan House residents to suitable alternative long-term accommodation by 15 December 2017.

A project team was formed of EMHS employees, including representatives from psychiatry, social work, nursing, and occupational therapy, which was responsible for undertaking resident assessments and finding new accommodation. Project support was also put in place for activity coordination, risk management and reporting. The team was funded by the MHC and the DOH.

The Advocacy Service:

- took part in the Executive Committee chaired by the Chief Executive, EMHS
- was on the Working Group chaired by the Interim Director of Corporate and Nursing Services, Mental Health, Royal Perth Bentley Group
- created a team of three Advocates to visit and support every resident as they were presented with relocation options. This included liaising with families and guardians, and ensuring residents were involved in the planning and decision-making process regarding alternative accommodation. This information was utilised by the project team to organise successful relocations.

Outcome

Sixty-eight residents were placed in alternative long-term accommodation by 19 December 2017. This included residents being:

- interviewed and assessed
- matched to suitable accommodation
- escorted to visit relocation options
- transported to and settled into their new accommodation.

Additional funding was made available by the MHC to open up more supported accommodation places at the level required, and some residents moved to aged care facilities.

Some placements have not worked out and the MHC is conducting an evaluation of the closure, and assessment and relocation of the Franciscan House residents.

The final report on the closure project by the Executive Committee highlighted a number of issues, including the need:

- to better monitor the mental health, physical health and psychosocial requirements of hostel residents
- for better systems and processes for monitoring hostels to support early intervention and preventative action when issues arise, and to allow advanced planning for responding to the closure of a hostel to avoid lead agencies operating in a crisis mode.

While it was noted that there were a number of strategies to monitor and improve the safety and quality of hostels already being implemented or in development (such as the MHC's quality evaluation for community managed organisations program and the updating of the 'Licensing Standards for the Arrangements for Management, Staffing and Equipment for Private Psychiatric Hostels' by LARU), a number of further recommendations were made in the final report which are still to be followed up.

Advocates continue to work with some of the residents whose placements have not worked out.

NDIS and hostel residents

For some years the Advocacy Service has been told that the way to better care and to improve recovery prospects for hostel residents is through the NDIS. The delay in WA deciding which model to use has meant that a lot of hostel residents have not been able to access NDIS. This particularly applies to the larger for-profit hostels in the eastern corridor, where NDIS is not due to start until July 2019.

Request to Minister for Disability Services

The Chief Advocate met with and wrote to the Minister for Disability Services in July 2017, raising concerns about these hostel residents and noting that MHC funding for these hostels was already lower than many other hostels. The Minister for Disability Services was asked whether some special arrangements could be made for this group. The Chief Advocate also commended the lessons learned from the approach which had been taken to hostel residents in the Perth Hills NDIS trial site. The trial site project was successful in engaging more than 110 hostel residents with the NDIS⁴⁶.

The Minister for Disability Services replied that there was no scope to bring these residents into the NDIS ahead of the scheduled transition date.

Hostels Clinical and ACAT Assessment Project

This 12 week project was initiated and funded by the MHC following the Franciscan House closure and after the Mental Health Commissioner met with hostel licensees in February 2018. It covered hostels in the EMHS catchment area and was aimed at:

- completing clinical assessments for hostel residents not currently accessing the NDIS support to prepare them for the roll-out in July 2019 in the cities of Victoria Park and Gosnells
- initiating the opportunity for ACAT assessments for elderly residents who might be suitable for transition to aged care services.

Advocates talked to residents about the project to allay their fears and encourage their participation.

⁴⁶ Information about the original National Disability Insurance Agency trial project in the form of a project report and three videos have been widely disseminated and available on the NDIS website WA page - <https://www.ndis.gov.au/about-us/our-sites/WA>.

Hostel Resident Support Committee

As a result of agreement between the MHC and the National Disability Insurance Agency (NDIA), an initiative similar to the psychiatric hostels project undertaken at the Perth Hills NDIS trial site was established in June 2018. A Collaboration Steering Committee is to oversee the project, with representatives from key stakeholder groups including the Advocacy Service.

Hostel evictions

Advocates continue to work with hostel residents who are threatened with eviction. In some cases, the person is taken to hospital (or an ED) and then told they cannot return to what was their home. Some evictions have been averted, which may include getting more support for the resident and staff from the community mental health service or just helping the resident to articulate their needs and concerns so that hostel staff can better understand and support the resident.

An inquiry by an Advocate into the eviction of one resident (referred to below as BA) who was taken to hospital and told they could not return home, identified the following systemic issues:

- There is a lack of suitable community accommodation options for people like BA with complex needs. Although the Community Supported Residential Units⁴⁷ get paid much more than the for-profit hostels, they would not consider someone like BA. As it stands, the for-profit hostels that are paid less have fewer resources in terms of numbers and competencies but are expected to take the more complex cases.
- There are only four Community Options⁴⁸ houses which offer the level of support needed for a person with very complex needs, but people can only move into one of them after a stint in Graylands Hospital.
- Graylands Hospital will not accept a referral from the community and a patient has to have been in hospital for 90 days before a referral can be made.
- The only way to get a person with complex needs to long-term rehabilitation, therefore, is by a 90 day admission to hospital. This is a costly exercise and not always in the best interests of the consumer.
- Facilities should be expected to have exit plans for all residents and the first port of call should not be the hospital. An admission to hospital should not count as an exit plan.

These issues were common to several other cases. The Advocacy Service also dealt with proposed and actual evictions from Community Options houses. In one case, the consumer stayed many months in hospital after the eviction. Attempts were made to find other accommodation, including at other hostels which get considerably less funding than the Community Options houses. Eventually the consumer was discharged into the community on a CTO.

⁴⁷ Community Supported Residential Units or CSRUs are a psychiatric hostel funded by the MHC. They are usually clusters of villas managed and staffed by a not-for-profit, non-government agency. The funding per bed for the CSRUs is usually about double that of beds in for-profit hostels.

⁴⁸ Community Options houses are the highest-funded psychiatric hostels by the MHC. They usually comprise two houses on the same site, staffed 24 hours a day by a not-for-profit non-government agency.



Part Three - Operational matters

Advocacy Service workload

The Advocacy Service's workload continued to increase in 2017-18 with the number of people placed on involuntary inpatient orders up 3.1%, the number of people requesting contact up 9.3% and the number of issues up 22.1%, the latter probably reflecting increased complexity of cases, as also evidenced by increases in the number of further opinions and Tribunal hearings.

Since the new Act began on 30 November 2015, the number of inpatient treatment orders (6As and 6Bs) has increased by 4.9% and the number of involuntary orders overall by 4.2%. The average number of people put on a 6A or 6B per month (as notified to the Advocacy Service) in the first seven months of the new Act was 265, increasing to 270 a month in 2016-17 and 278 a month in 2017-18.

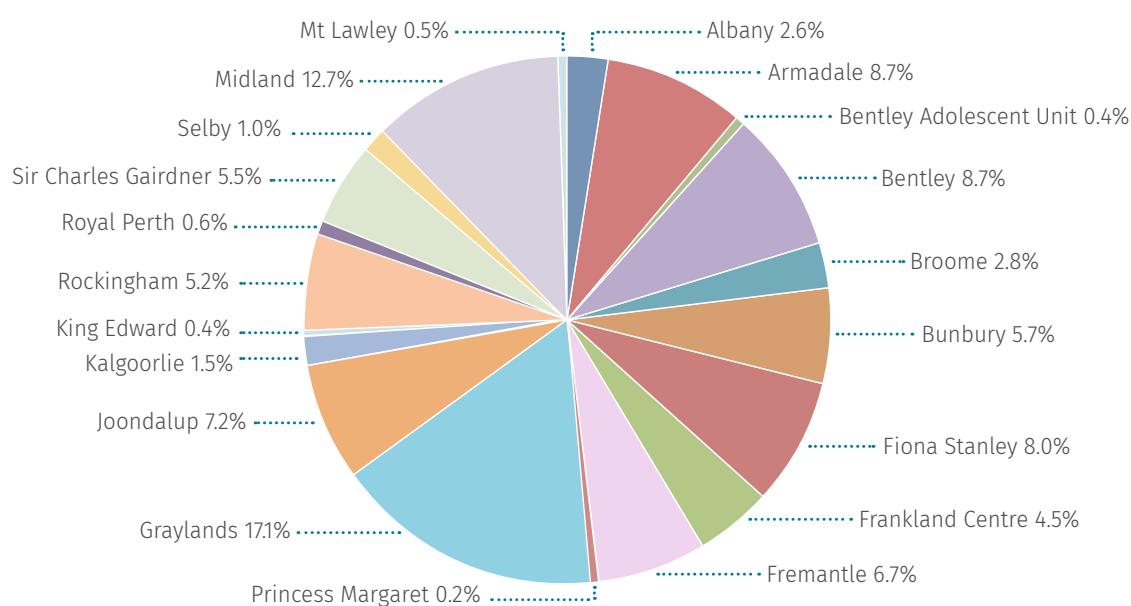
Increased involuntary orders

The number of inpatient treatment orders (forms 6A and 6B) in 2017-18 increased by 3.1% over the previous year while the number of CTOs increased by 2.6%⁴⁹, comprising:

- 2522 people detained as involuntary inpatients on 3337 inpatient treatment orders (forms 6A and 6B)
- 661 people on 817 CTOs (form 5A)
- 39 children detained as involuntary inpatients on 48 form 6A inpatient orders – an increase of 29.7%
- 22 children detained as involuntary inpatients on 27 form 6B orders, which means they were detained on a general ward and not a mental health ward – an increase of 92.9%

The highest number of involuntary patients was in Graylands Hospital, with 17.1% of all inpatient treatment orders, followed by Midland on 12.7%, and Armadale and Bentley, each on 8.7%. See graph 6.

Graph 6: form 6A & 6B (inpatient treatment orders) by hospital



⁴⁹ See appendix 3.

There were significant changes in the number of orders made in hospitals when compared to the 2016-17 Advocacy Service data. The number of involuntary inpatient treatment orders:

- increased by 12.3% in EMHS, due mostly to increases in the number of orders from Armadale (17.7%) and Midland (17.4%) hospitals
- decreased by 6.6% in NMHS, due mostly to a decrease in orders received from Sir Charles Gairdner Hospital (30.3%) and Frankland Centre (11.2%)
- increased by 9.4% in the South Metropolitan Health Service (SMHS), due to increases at Fiona Stanley (29.6%) and Rockingham (23.7%) hospitals but decreased at Fremantle hospital by 14.2%.

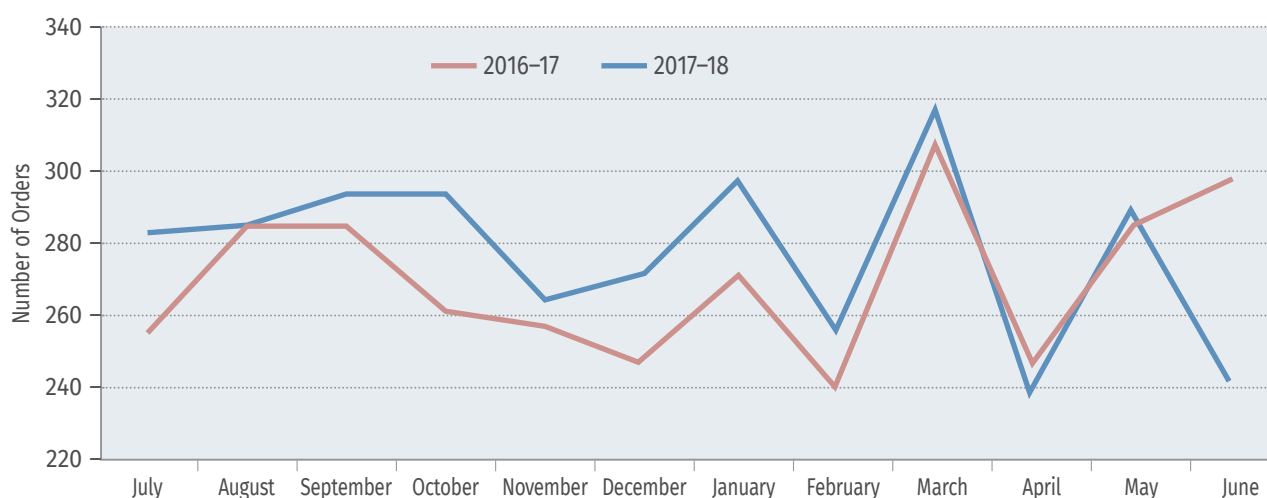
Across the health services, the biggest number of consumer orders were made in NMHS (35.6%), followed by EMHS (31.3%), SMHS (19.8%), WACHS (12.6%) and CAHS (0.7%).

The number of orders made each month, and where they were made, fluctuated significantly over the year. The number of orders made in the first half of the year (July to December 2017) was considerably higher at 282 orders per month, than the second half of the year, at 274 per month.

Movements like this impact on the Advocacy Service workload and expenditure as most Advocates are allocated to hospitals near to where they live. Advocates are not guaranteed minimum hours of work and need to be flexible to meet the ups and downs of demand. The number of involuntary orders also impacts on other activity such as further opinions, Tribunal hearings and requests for contact, which makes workload and budget difficult to predict and manage.

Comparing this year's orders with last year, as can be seen in graph 7, shows the increased orders and suggests peaks in January and March but there is no obvious reason for this.

Graph 7: Form 6A & 6B (inpatient treatment orders) by month – a comparison of 1 July 2016 to 30 June 2017 with 1 July 2017 to 30 June 2018



Increased number of people requesting contact

The number of people who requested contact increased by 9.3%, from 1316 people last year to 1438 in 2017-18⁵⁰. Most of the contacts were made by consumers on an inpatient treatment order (54.2%), followed by people on a CTO (18.8%) and hostel residents (17.0%). Not surprisingly, most requests were from consumers in hospitals with the largest number of involuntary orders. See graph 8.

Graph 8: Consumer requests for contact compared to percentage of 6A and 6B orders by hospital



The number of people requesting contact is also impacted by the Classes of Voluntary Patient Direction⁵¹ which applied from 1 January 2017. The Direction means that children who are voluntary inpatients, trying to get admission but not on referral forms, or who have been discharged into the community, are able to be assisted by the Youth Advocates. Although the numbers are relatively low, many of these cases are complex and time-consuming. This year 22 children were assisted under the Direction, in comparison to 10 children in the six months from 1 January 2017 to 30 June 2017.

Increased number of issues and other Advocate work

There was a 22.1% increase in the number of issues or complaints recorded by Advocates, rising from 6038 last year to 7373 in 2017-18. The number of issues recorded by Advocates probably reflects increased complexity of issues, although better recording practices by Advocates may have contributed.

Other increased workload came from:

- an increase in the number of Tribunal hearings attended by Advocates – up 2.3%. This equates to 64 hearings a month, in comparison with 62 per month last year and 40 per month in the first seven months of operation of the Advocacy Service. Tribunal hearings can take a lot of time in preparation, as well as the hearing and debriefing with the consumer afterwards
- an increase in the number of further opinions requested by Advocates – up by 14.8%
- two major pieces of work undertaken by Advocates:
 - the completion of the TSD Plan Inquiry
 - the closure of Franciscan House hostel.

⁵⁰ Note that people may request contact numerous times during the year and while in different classes of 'identified person'. These numbers reflect the actual number of people so do not count people more than once.

⁵¹ See appendix 9 for the full wording of the Direction.

Budget and resourcing

2017-18 expenditure

The Advocacy Service's budget for 2017-18 was \$2.627 million. The expenditure for the Advocacy Service was \$2,651,988⁵², which was \$24,988, or 1.0%, over the allocated budget. The cost of Advocates, including the Chief Advocate, comprised 70.4% of the expenditure. The remaining costs were for Advocacy Services Officers' salaries and office running costs.

The over-spend was considerably reduced as a result of major cost-saving measures implemented from 1 January 2018, which have impacted consumers. These measures meant not all Advocate functions were able to be carried out, and increased the risks that consumer rights were not protected, and that hospital and hostel conditions may adversely impact the health, safety and welfare of consumers.

While the Advocacy Service is funded by a separate administered appropriation pursuant to s60(1)(b) of the *Financial Management Act 2006*, it is an affiliated body of the MHC, as are the Tribunal and OCP. A number of corporate services are provided by the MHC to the Advocacy Service. The MHC must disclose in its annual financial statements the nature, and, where practicable, the amount or value of financial assistance provided.

There is currently no specific agreement around the provision of the services or any financial breakdown of the value of services provided, which include ICT, payroll and finance matters. The MHC records a note in its financial reports stating 'services provided free of charge to other agencies'. The amount stated for 2017-18 by the MHC is \$328,313. This sum is calculated based on employment costs and a proportion of the MHC corporate, executive and audit costs shared between the MHC, the Advocacy Service, the Tribunal and the OCP. The Advocacy Service's proportion of the cost is 6.3%.

In addition, the Advocacy Service received legal services from the State Solicitor's Office free of charge to the value of \$18,318. This was for advice about the Act, primarily in relation to consumer rights to possessions and lawful communication.

In separate funding agreed to by the Minister the previous financial year and outside the parameters of the 2017-18 budget process, the Advocacy Service was reimbursed \$74,616 by the MHC for costs incurred to develop a PSOLIS import function in the Advocacy Service database (ICMS). This work was completed in May 2018 and reduced significantly the amount of manual inputting required by Advocacy Services Officers of involuntary and other order notifications. The PSOLIS import function had been planned since the Advocacy Service began operations. An office review is expected to follow in 2018-19 now that this work has been completed.

⁵² As advised by the MHC.

As required under the *Electoral Act 1907*, s175ZE(1), the Advocacy Service recorded \$11,954 in expenditure related to the designated organisation types between 1 July 2017 and 30 June 2018, which is broken down as follows:

- a) advertising agencies: \$605 Seek Ltd, and \$5137 Whistling Moose Graphics
- b) media advertising organisations: \$5948 Adcorp Australia Ltd, and \$264 Ethical Jobs
- c) market research organisations: nil
- d) polling organisations: nil
- e) direct mail organisations: nil.

Cost-cutting measures

In August 2017, the Chief Advocate was advised by Treasury that the Advocacy Service budget had been cut by \$35,000 to \$2,627,000, or 1.3% on the previously advised budget for 2017-18, and \$75,000 less than the previous year's expenditure, in effect a cut of 2.3%. The Advocacy Service has complained about under-funding since its inception in November 2015.

A few months into 2017-18, it became clear that the Advocacy Service would considerably exceed budget if it did not get an injection of funds or make budget cuts. Significant and ongoing increases in demand for advocacy services were clearly evidenced by data for the July to November 2017 period, compared to the same period in 2016. There were significant increases in the number of involuntary inpatient orders being made (up 5.6% for July to November 2017 in comparison with the same period the previous year) and all other associated workload measures. As Advocates are paid on an hourly rate (because the Act requires that they be engaged on a contract for services), the monthly expenditure was rapidly increasing and over budget.

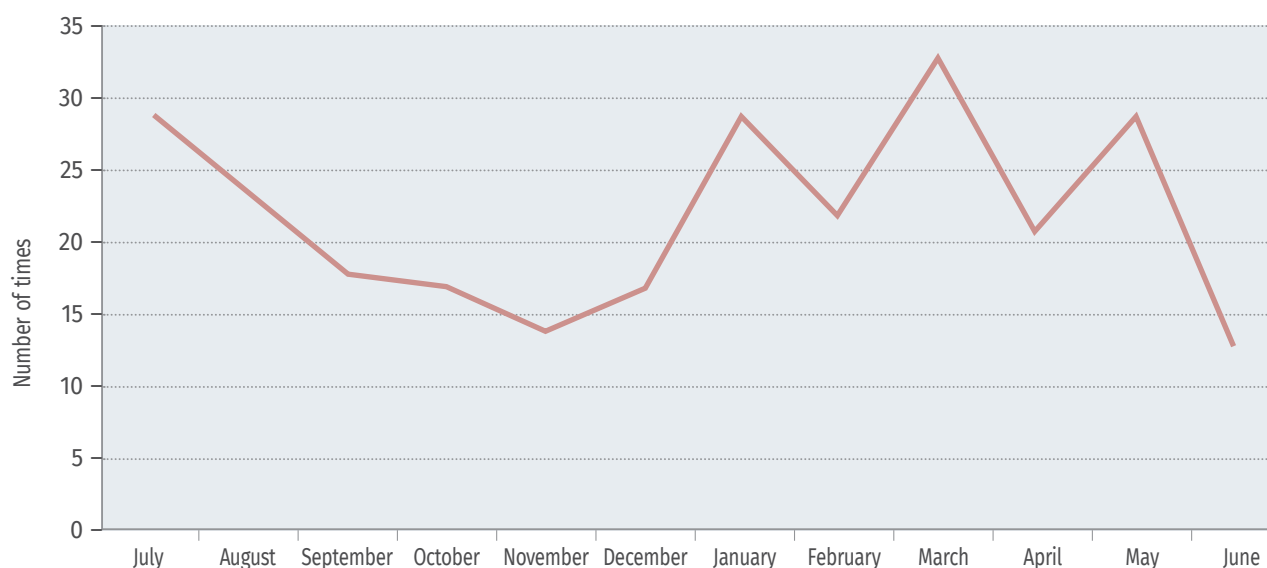
A mid-year review application to the Economic Review Committee (a sub-committee of Cabinet) seeking extra funding was therefore made but it was not accepted. As a result and following consultation with Advocates and Advocacy Services Officers, the Executive Group put a number of cost savings measures in place, most of which are continuing. A list of the measures can be found in appendix 14.

The cuts to services and continued under-funding of the Advocacy Service risk:

- people being wrongly detained in hospital, not knowing their rights or detained for longer than they otherwise would be
- patient rights under the Act being breached or breached for longer or without redress
- lack of representation before tribunals making decisions which impact on basic human rights
- vulnerable hostel residents not having access to advocacy, and associated increased risk of abuse
- systemic breaches of the Act going unchecked
- less oversight of hospital complaints management and outcomes
- decreased ability of the Government to protect people detained, or to be informed about and respond to concerns about the mental health sector
- ongoing inability of the Advocacy Service to meet budget
- damage to the reputation of the Advocacy Service
- Advocate recruitment and retention issues compounding other risks.

Apart from complaints about the cutting of the weekend phone roster service (which is being partially reinstated in 2018-19), the cost-cutting measures appear to have increased the number of times that the Act was breached by the Advocacy Service because a consumer was not contacted in the time required by the Act. The cost-cutting required Advocates to reduce the frequency with which they visited hospitals and to ‘cluster’ work. Advocacy Service data shows that the number of breaches of the Act as a percentage of the number of orders in the second half of the year was 9.0% in comparison to 6.9% in the first half. See graph 9.

Graph 9: Number of times that a consumer was not contacted in the time required by the Act during 2017-18



Advocate remuneration

Advocates (including the Chief Advocate) are entitled to remuneration as determined by the Minister⁵³. 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 any paid leave and must supply their own car and mobile phone. They can claim mileage but not parking, and in very limited circumstances some Advocates can claim travel time. A laptop is provided to maintain security of information.

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. In the same period, Advocacy Services Officers working for the Advocacy Service received three pay increases: 2.5% on 1 July 2016, and two pay increases of \$1000 (or pro rata equivalent) in July 2017 and 2018. This inequity was of concern to the Executive Group but there was insufficient funds in the 2017-18 budget to seek an increase in the rate.

⁵³ See ss365, 370 of the Act.

In May 2018, the Advocacy Service budget for 2018-19 was confirmed as \$2,668,000. This is an increase of \$41,000 over 2017-18. The Executive Group therefore agreed on 29 June 2018 to make a submission to the Minister for an increase in the Advocates' and Chief Advocate's rate of pay on equity grounds to apply from 30 November 2018. This will be three years since the Advocacy Service began operation and three years since the Advocates' rate of remuneration has been increased. The proposed new rate for Advocates is \$50.65 per hour and for Senior Advocates \$60.66 per hour (plus superannuation). This is a pro rata increase of \$1000 in line with the public sector wages policy. The Chief Advocate's pay increase would be \$1000 per annum.

Records management

In accordance with s19 of the State Records Act 2000, the Advocacy Service has a recordkeeping plan governing the management of all its records. At its meeting on 10 August 2018, the State Records Commission approved the Advocacy Service's updated Recordkeeping Plan.

An evaluation of the Advocacy Service's Recordkeeping Plan is scheduled for 2023 in accordance with the State Records Commission Standard 2, Principle 6. See appendix 8 for the statement of compliance.

Committees, submissions and presentations

The Advocacy Service is well-placed to sit on committees and make submissions reflecting the experience of consumers treated under the Act and in hostels. Such committees and submissions also provide an opportunity to seek systemic change and promote compliance with the Charter of Mental Health Care Principles.

The Chief Advocate or her proxy sat on 10 committees and provided a number of written submissions or took part in forums and face to face consultations as set out 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 occasionally by 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. 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. In its 2018-19 budget submission the Advocacy Service applied for \$25,000 funding to have an external party conduct an evaluation. Regrettably the funding was not granted.

The role of the Senior Advocates is an essential part of the Advocacy Service's quality assurance:

- they take calls and emails from Advocates, who work solely in the field, providing advice and assistance with complex issues and cases, and control and direction
- they finalise and approve letters of complaint and inquiry documents
- they may attend meetings with or on behalf of Advocates about consumer issues
- with the Chief Advocate, they set the agenda for and attend management meetings at hospitals and with hostel licensees, where they give and are given feedback on issues about the work done by Advocates
- as part of the pay claim process and at other times they conduct random checks on reports of consumer contacts written by Advocates
- all serious issues must be notified to them and they or the Chief Advocate take the lead role in the handling of such issues
- they provide feedback and debriefing to Advocates
- with the Chief Advocate, they take part in the development and presentation of Advocate training.

Advocate training and professional development

Previously, Advocates were asked to attend quarterly meetings which were used for training and development of protocols, and preparation for systemic inquiries. Regional Advocates attended three of the four meetings by video link. Due to budget constraints, only two meetings were planned for 2017-18. Due to budget cuts, this was reduced to one meeting held in November 2017, with regional Advocates attending by video-link.

The budget cuts also meant that monthly team meetings used for training more specific to individual teams had to be reduced to every second month from January 2018.

A weekly newsletter by the Chief Advocate, called 'Chattering Chief', also contains information updates and reminders aimed at keeping Advocates in touch with developments and raises issues of concern as they arise.

The Chief Advocate, Senior Advocates and some selected Advocates attended a number of external forums and seminars during the year with a view to passing on the information learned in internal training sessions. Appendix 12 provides a list of the training events attended.

Training of new Advocates

New Advocates undergo an intensive four-day in-house training program, complete a four-hour e-learning program on the Act and an e-learning program on aggression prevention training. They are then taken out by experienced Advocates to observe and be introduced to hospitals and hostels and a Tribunal review hearing before being allocated to consumers.

In 2017-18, there were two intakes of new Advocates in January and May 2018, which included a second Youth Advocate and primarily recruitment in the four regional areas. The low level of work available for Advocates in Broome, Albany and Kalgoorlie makes it very difficult to recruit and retain Advocates. Six new regional Advocates were engaged. A pool of applicants who would be suitable is maintained after every recruitment drive and two new Advocates were also engaged from the pool for the metropolitan area.

Complaints

The Advocacy Service has a complaints protocol and process which is provided on its website. There were six complaints about the Advocacy Service received during the year 2017-18. Three were from consumers:

- in two cases the consumer complained that the Advocate had not responded to them in a timely way. Both of these were resolved:
 - in one case an apology was sent because there had been an error by office staff allocating the task to an Advocate who was on leave at the time
 - in the second case the Advocate had a different perspective to the consumer and felt that they had attended the ward and provided assistance. The Senior Advocate spoke to the consumer and assisted them over the next few weeks. Ultimately arrangements were made for the Senior Advocate to discuss the consumer's concerns pertaining to their hospital admission with the Advocates as well as the management team of the hospital. The consumer said they were happy with the resolution of the complaint
- in the third complaint the consumer said the Advocate had not done enough to address the deplorable conditions on the ward. The Senior Advocate went to the ward and outlined the work already in progress by the Advocacy Service relating to the concerns. The Senior Advocate further escalated the consumer's concerns and assisted them to write their own letter of complaint. The hospital took steps to respond to the issues and is in the process of responding to the consumer's complaint.

One complaint was from a family member who complained about re-allocation of an Advocate. It was explained that there were issues personal to the Advocate and unrelated to the consumer which required the change.

Two complaints were by health service staff:

- in one case the complaint was about information given by the Advocate to the consumer, but the Advocate had been asked by another staff member to speak to the consumer. The Advocacy Service also had concerns about the way this issue arose and the lack of a patient-centred approach by the ward staff which were relayed back to them
- in the second case the complaint was that the Advocate asked them to arrange a further opinion and when the psychiatrist giving the further opinion turned up, the consumer was unable to, or refused to communicate with the doctor. The allegation was that the Advocate could not have been acting on the consumer's instructions. The Advocate denied this was the case. As was proven later, the consumer moved in and out of catatonia and at times was speaking quite lucidly.

Appendices

Appendix 1: Authorised mental health beds⁵⁴

As at 30 June 2018

Authorised Hospital Ward	No. of Beds	No. of Available Beds	No. of Inactive Beds
Albany Hospital	16	16	-
Mental Health Unit	16	16	-
Armada Hospital	41	41	-
Banksia Ward	8	8	-
Karri Ward	8	8	-
Moodjar Open Ward	19	19	-
Yorgum High Dependency Unit	6	6	-
Bentley Adolescent Unit⁵⁵	0	0	-
Bentley Hospital	88	82	6
East Metropolitan Youth Unit ⁵⁶	12	6	6
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	30	30	-
Acacia Ward	8	8	-
Banksia Ward	12	12	-
Caesia Ward	10	10	-
Hutchison Ward ⁵⁷	0	0	-
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	-

⁵⁴ Data was provided from 'Bedstate' by Mental Health Data Collections, DOH on 9 July 2018. Figures do not include Hospital in the Home Mental Health (HITH) ward.

⁵⁵ Bentley Adolescent Unit was closed on 13 June 2018.

⁵⁶ East Metro Youth Unit was authorised as a 12 bed unit and opened on 14 June 2018. As at 30 June 2018 six beds were open.

⁵⁷ Hutchison ward was an eight bed forensic ward which closed as at 30 June 2018.

Appendix 1: Authorised mental health beds (cont.)

As at 30 June 2018

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	37	10
Open Unit ⁵⁸	37	27	10
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	-
Perth Children's Hospital⁵⁹	20	20	-
Ward 5A Mental Health	20	20	-
Rockingham Hospital	30	30	-
Adult Closed Ward	4	4	-
Adult Open Ward	16	16	-
Elderly Closed	4	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	30	-
Jurabi Ward (Psychiatric Intensive Care Unit)	6	6	-
Karijini Ward (Secure Unit)	6	6	-
Tanami Ward (Open Unit)	18	18	-
Selby Hospital	32	32	-
Selby Acute	8	8	-
Selby Lodge	24	24	-
Total	671	655	16

⁵⁸ As at 30 June 2018 the Joondalup Open ward had 10 inactive beds. Four were closed due to maintenance and six were closed due to infection.

⁵⁹ Perth Children's Hospital, ward 5A opened on 13 June 2018 as a 20 bed unit.

Appendix 2: Private psychiatric hostels⁶⁰

As at 30 June 2018

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 Woodville House	92 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 ⁶¹	0
Pu-Fam Pty Ltd St. Jude's Hostel East St Lodge	52 10
Richmond Wellbeing Inc Bunbury Community Supported Residential Units Busselton Community Supported Residential Units Kelmscott Community Options Mann Way Ngulla Mia Queens Park Service Westminster Service ⁶²	15 10 8 12 34 10 6

⁶⁰ Private psychiatric hostels include group homes, Community Supported Residential Units, and Community Options homes. Bed numbers are as at 30 June 2017.

⁶¹ Franciscan House was a 75 bed licenced private psychiatric hostel that closed on 19 December 2017.

⁶² Richmond Wellbeing Westminster service was licenced for six beds and closed on 14 June 2018.

Appendix 2: Private psychiatric hostels (cont.)

As at 30 June 2018

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 Swan View House	4
Vincentcare South Lakes House ⁶³	0
Vincentcare Warwick House	4
Vincentcare Vincentian Village	28
Vincentcare Viveash House ⁶⁴	4
TOTAL NUMBER OF LICENSED BEDS	832

⁶³ Vincentcare South Lakes was licenced for three beds and did not renew their licence for 2018.

⁶⁴ Vincentcare Viveash House was licenced from 6 December 2017 as a four bed private psychiatric hostel.

Appendix 3: Involuntary treatment orders⁶⁵ and number of consumers⁶⁶

Forms 5A, 6A and 6B made from 1 July 2016 to 30 June 2017 compared to 1 July 2017 to 30 June 2018.

Orders	1 July 2016 –30 June 2017		1 July 2017 –30 June 2018		% of Orders Difference
	No. of Orders	No. of Consumers	No. of Orders	No. of Consumers	
Adults & Children					
Form 6A	3148	2417	3203	2432	1.7%
Form 6B	97	86	134	115	38.1%
Total Inpatient Treatment Orders / Consumers	3245	2478	3337	2522	3.1%
Form 5A	796	656	817	661	2.6%
Total Involuntary Orders / Consumers	4041	2618	4154	2644	2.8%

Forms for Children⁶⁷					
Form 6A	37	30	48	39	29.7%
Form 6B	14	10	27	22	92.9%
Form 5A	14	10	13	12	-7.1%
Total Orders / Consumers	65	50	88	61	35.4%

Total orders received⁶⁸	7211	-	7421	-	2.9%
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⁶⁵ Based on notifications by health services to the Advocacy Service as at 2 August 2018. Includes inpatient treatment orders and CTOs. Verification of ICMS data is ongoing and figures may be subject to change.

⁶⁶ Some people were subject to more than one order during 2017-18 and are only counted once against each form type in the 'number of consumers' columns.

⁶⁷ Children are consumers under 18 years of age.

⁶⁸ Includes revocations, expired orders and invalid orders, as well as inpatient treatment orders, CTOs and mentally impaired accused orders by the MIARB.

Appendix 4: Involuntary inpatient treatment orders⁶⁹

Forms 6A and 6B (including children) made from 1 July 2016 to 30 June 2017 compared to from 1 July 2017 to 30 June 2018.

Health Service Provider / Hospital	2016-17		2017-18		% Difference ⁷⁰	% of Orders ⁷¹
	Form 6A	Form 6B	Form 6A	Form 6B	Between 2016-17 and 2017-18	Health Service 2017-18
CAHS	17	12	14	9	-20.7%	0.7%
Bentley Adolescent Unit	17	<5	14		-22.2%	0.4%
Perth Children's Hospital				<5	100.0%	0.0%
Princess Margaret Hospital		11		8	-27.3%	0.2%
EMHS	907	22	1020	23	12.3%	31.3%
Armadale Health Service	247	<5	288	<5	17.7%	8.7%
Bentley Hospital	289		291		1.0%	8.7%
Royal Perth Hospital		15		20	33.3%	0.6%
East Metro Youth Unit			<5		100.0%	0.0%
SJOG Hospital, Midland	357	5	424	<5	17.4%	12.7%
SJOG, Mt Lawley	14		16		14.3%	0.5%
NMHS	1250	23	1147	42	-6.6%	35.6%
Frankland Centre	169		150		-11.2%	4.5%
Graylands Hospital	580		570		-1.7%	17.1%
Joondalup Health Campus	212	<5	229	10	12.2%	7.2%
King Edward Memorial Hospital	19	<5	10	5	-28.6%	0.4%
Selby Older Adult Mental Health	29		33		13.8%	1.0%
Sir Charles Gairdner Hospital	241	20	155	27	-30.3%	5.5%
SMHS	571	34	608	54	9.4%	19.8%
Fiona Stanley Health Service	178	28	224	43	29.6%	8.0%
Fremantle Hospital	258	<5	222	<5	-14.2%	6.7%
Rockingham Hospital	135	<5	162	10	23.7%	5.2%
WACHS	403	6	414	6	2.7%	12.6%
Albany Regional Hospital	74	<5	85	<5	11.7%	2.6%
Broome Health Campus	100	<5	94		-7.8%	2.8%
Bunbury Regional Hospital	191		189	<5	-0.5%	5.7%
Geraldton Hospital		<5			-100.0%	0.0%
Kalgoorlie Regional Hospital	38		46	<5	28.9%	1.5%
Nickol Bay Hospital				<5	100.0%	0.0%
Total	3148	97	3203	134	2.8%	100.0%

⁶⁹ Based on notifications by health services to the Advocacy Service as at 2 August 2018. Verification of ICMS data is ongoing and figures may be subject to change.

⁷⁰ Compares difference in orders received by each health service between 2016-17 and 2017-18.

⁷¹ Indicates percentage of orders for health service compared to the total form 6A and 6B orders.

Appendix 5: Community treatment orders⁷²

Forms 5A made from 1 July 2017 to 30 June 2018.

Form 5A by Service Responsible for CTO	Total
CAHS	13
Armada Child & Adolescent Mental Health Service (CAMHS)	<5
Bentley Family Clinic CAMHS	<5
Bunbury CAMHS	<5
Fremantle CAMHS	<5
Peel CAMHS	<5
Princess Margaret Hospital for Children	<5
Rockingham CAMHS	<5
EMHS	200
Armada Adult Community MHS	39
Armada Health Service	24
Armada Older Adult Community MHS	<5
Bentley Adult Community MHS	26
Bentley Hospital & Health Service	<5
Bentley Older Adult Community MHS	<5
City East Community Mental Health Service	51
City East Older Adult Community MHS	<5
Midland Community Clinic	44
Midland Older Adult Community Clinic	<5
NMHS	227
City East Community Mental Health Service	5
City Lower West Older Adult Community MHS	<5
Clarkson Adult Clinic	5
Forensic Community MHS	6
Hospital in the Home	<5
Joondalup Community Adult Clinic	43
Joondalup Older Adult Clinic	<5
Mirrabeeka Community Adult Clinic	41
Osborne Park Community Adult Clinic	63
Osborne Park Older Adult Clinic	<5
Selby Older Adult Mental Health Service	<5
Sir Charles Gairdner Hospital	<5
Specialist Aboriginal Mental Health Service Clinic	9
Subiaco Community Mental Health Clinic	51

⁷² Based on notifications by health services to the Advocacy Service as at 2 August 2017. Verification of ICMS data is ongoing and figures may be subject to change.

Appendix 5: Community treatment orders (cont.)

Forms 5A made from 1 July 2017 to 30 June 2018.

Form 5A by Service Responsible for CTO	Total
SMHS	154
Fremantle Adult Community MHS	74
Fremantle Hospital & Health Service	12
Fremantle Older Adult MHS Clinic	<5
Peel Adult Community MHS	28
Rockingham Adult Community MHS	36
Rockingham Older Adult Community MHS	<5
YCATT - Youth Community Assessment & Treatment Team	<5
WACHS	202
Albany Community MHS	13
Albany Regional Hospital	<5
Bridgetown Community MHS	<5
Bunbury Community MHS	37
Bunbury Regional Hospital	<5
Busselton Community MHS	13
Carnarvon Community MHS	9
Esperance Community MHS	<5
Geraldton Community MHS	42
Kalgoorlie Community MHS	7
Kalgoorlie Regional Hospital	<5
Katanning Community MHS	<5
KMHDS - Broome	11
KMHDS - Fitzroy Crossing	<5
KMHDS - Kununurra	<5
Margaret River Community MHS	10
Narrogin Community MHS	<5
PMHDS HHC Community MHS	17
PMHDS Karratha Community MHS	<5
Wheatbelt Community MHS - Gingin	<5
Wheatbelt Community MHS - Merredin	<5
Wheatbelt Community MHS - Northam	16
Other	21
Autism Association of Western Australia	<5
Joondalup Headspace	13
Melville Clinic (Private)	<5
Midland Headspace	<5
Osborne Park Headspace	<5
Private Psychiatrist	<5
Total	817

Appendix 6: Consumers not contacted in the statutory timeframe⁷³

1 July 2017 to 30 June 2018.

Reason for Breach	Form 5A	Form 6A	Form 6B	Total	%
Orders for children	1	7	8	16	6.0%
Advocacy Service administration error	2	3		5	1.9%
Other		3	2	5	1.9%
Inpatient Treatment Orders					
Order not received within 7 days of being made		10	3	13	4.9%
The notification was received in 7 days and:					
- contact was made after 7 days		25	1	26	9.8%
- the consumer was not contacted		13		13	4.9%
- the order was revoked within 7 days		126	8	134	50.6%
- subsequent order within 7 days ⁷⁴		7		7	2.6%
CTOs					
Order not received within 7 days of being made	15			15	5.7%
The notification was received in 7 days and:					
- the order was revoked in 7 days	2			2	0.8%
- no address available, unable to contact by phone	2			2	0.8%
- rights explained prior to order date/time	1			1	0.3%
- letter was returned, unable to contact by phone	26			26	9.8%
Total	49	194	22	265	100.0%

⁷³ Indicates percentage of orders for health service compared to the total form 6A and 6B orders.

⁷⁴ A subsequent order was made within seven days (e.g. the consumer initially placed on Form 6A followed by a Form 5A) and the consumer was not contacted by an Advocate in time for the initial order.

Appendix 7: Consumer issues⁷⁵

1 July 2017 to 30 June 2018.

Issue	Total
Treatment	
1.1 Diagnosis	248
1.2 Treatment, Support and Discharge Plans and Care Plans (in hostels)	296
1.3 Ground access and leave	472
1.4 Consultant psychiatrist or registrar - ss260, 253	121
1.5 Nursing care	99
1.6 Physical health - ss241, 252	380
1.7 Case management services	59
1.8 Social work services	156
1.9 Occupational therapy services	30
1.10 Psychological services	58
1.11 Transfer to another ward, hospital or clinic	349
1.12 Electroconvulsive therapy (ECT) - ss192, 200	29
Treatment Total	2297
Medication	
2.1 Prescribing medication	435
2.2 Dispensing and administering medication	115
2.3 Side effects	270
2.4 Security and storage of medication	1
2.5 Other medication complaints	27
Medication Total	848
Consumer Rights	
3.1 Involuntary status	932
3.2 Further opinion - ss182-184	116
3.3 Access to communication - ss261-262	126
3.4 Forms	130
3.5 Rights not explained - ss243-246	24
3.6 Carers and PSP rights - Part 17	19
3.7 Advanced Health Directive	1
3.8 Confidentiality - ss576-578	8
3.9 Complaints handling	35
3.10 Medical records - ss247-251	58
3.11 Children - ss303, 304	12
Consumer Rights Total	1461

⁷⁵ Raised by consumers and recorded by Advocates in ICMS as at 31 July 2018. Verification of ICMS data is ongoing and figures may be subject to change.

Appendix 7: Consumer issues (cont.)

1 July 2017 to 30 June 2018.

Issue	Total
Mental Health Tribunal (MHT) Hearings	
4.1 Medical report	47
4.2 Attendance by psychiatrist or medical team	8
4.3 Other MHT	84
MHT Hearings Total	139

Admission, Discharge & Transport	
5.1 Admission - ss255-257	33
5.2 Transport	10
5.3 Discharge	377
5.4 Accommodation	414
Admission, Discharge & Transport Total	834

Access/Appropriateness	
6.1 Smoking	108
6.2 Food and beverages	69
6.3 Clothing	62
6.4 Toiletries	22
6.5 Personal possessions	164
6.6 Welfare services	248
6.7 Guardianship orders	47
6.8 Administration orders	114
6.9 Financial issues	159
6.10 Interpreter	11
6.11 Access to courtyards, facilities and recreation	84
Access/Appropriateness Total	1088

Safety, Dignity & Privacy	
7.1 Safety	107
7.2 Dignity and Respect	46
7.3 Conflicts	58
7.4 Cultural competency	8
7.5 Inattention to Aboriginality	3
7.6 Privacy	20
7.7 Special needs not accommodated	14
Safety, Dignity & Privacy Total	256

Appendix 7: Consumer issues (cont.)

1 July 2017 to 30 June 2018.

Issue	Total
Environment/Management of Facility	
8.1 Indoor furnishings	14
8.2 Courtyard and garden	4
8.3 Building	7
8.4 Temperature	3
8.5 Design and layout	5
8.6 Lighting	3
8.7 Cleanliness and hygiene	14
Environment/Management of Facility Total	50

Legal	
9.1 Complaints re Criminal Law (MIA Act) and MIAR Board	14
9.2 Other legal matters	191
Legal Total	205

Serious Issues & Reportable Events	
10.1 Seclusion	11
10.2 Restraint	28
10.3 Alleged physical or sexual assault or harassment - Staff	17
10.4 Alleged physical or sexual assault - Patient/Patient or Resident/Resident	57
10.5 Alleged bullying or harassment	7
10.6 Reportable events	75
Serious Issues & Reportable Events Total	195

Total	7373
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Appendix 8: State Records Commission compliance requirements

Section 19 of the *State Records Act 2000* requires all agencies to have an approved 'Recordkeeping Plan' that must be complied with by the organisation and its officers. The Advocacy Service is working in accordance with our Recordkeeping Plan which was approved by the State Records Commission in August 2018.

State Records Commission Standard 2, Principle 6 requires government organisations to ensure their employees comply with the Recordkeeping 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.

The Advocacy Service submitted a newly developed Recordkeeping Plan to the State Records Commission, which was approved on 10 August 2018. An evaluation of the Advocacy Service Record Keeping Plan will be scheduled for 2023.

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.

The Recordkeeping 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. This policy was reviewed and approved by the Advocacy Services Executive Group in July 2018. 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 CLMIA Act
- a mentally impaired accused required under the CLMIA Act to be detained at an authorised hospital
- a mentally impaired accused who has been released under a release order made under the CLMIA 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 regulations⁷⁶ 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 Minister⁷⁷ 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.

⁷⁶ No regulations were in place as at 30 June 2018.

⁷⁷ 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 three 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).

Appendix 9: Advocate functions and powers (cont.)

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 mentally impaired accused 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
- 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 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.

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

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

Continuing:

- Accommodation and Support Strategy Committee by the MHC
- Hostel Investigation Working Group
- Private Mental Health Regulation Reference Committee (PMHRRC) – regarding amending LARU standards
- Private Hostel Agencies Committee (PHAC)
- National Visitor and Advocacy bodies

New:

- Accountability Agencies Review Working Group
- Closure Strategy for Franciscan Hostel – Executive Group
- Franciscan House Hostel Closure Working Group
- Hostel Recovery Support Project
- OCP Sexual Safety of Mental Health Consumers - Standards and Guidelines Reference Group

Submissions, forums and consultations

- Submission to the Australian Human Rights Commission in response to *OPCAT in Australia – Consultation Paper* regarding the implementation and ratification of the Optional Protocol to the Convention Against Torture, July 2017
- Hospital Transitions Pathway project undertaken by the WA Primary Health Alliance; Advocate attendance at focus group to discuss and review the transition pathways to, through and from hospital for people with a mental illness, July 2017.
- Review of the Disability Justice Centre, a declared place: interview by Alan Carter with the Chief Advocate, Senior Advocate and two Advocates, August 2017
- Youth Mental Health Consumer Centred Services Integration Project by the WA Association of Mental Health, funded by the Department of Finance: interview with the Youth Advocate and Senior Advocate, January 2018
- Justice Health Project – feedback on potential governance options for the management and commissioning of custodial health services, February 2018
- Governance Review of State Forensic Services – interview with the Chief Advocate and other Advocates, February 2018
- Response to HaDSO consultation paper on the implementation of the *National Code of Conduct for Health Care Workers in Western Australia*, February 2018

Appendix 10: Committees and submissions (cont.)

- Submissions and comments on the *Chief Psychiatrist's Draft Standards for Clinical Care*, April 2018
- Australian Human Rights Commission roundtable on violence against people with disability in institutional settings, consultation by teleconference, April 2018
- Written feedback on HaDSCO draft *Guidelines for Handling Complaints about Mental Health Services*, May 2018
- Response to the DOH on the Further Opinions Impact Study Report, May 2018
- Submission to Inquiry by the Senate Community Affairs References Committee into the accessibility and quality of mental health services in rural and remote Australia, May 2018
- WA Police Disability Access and Inclusion Plan – attendance by Senior Advocate at workshop, June 2018

Appendix 11: Advocacy Service presentations

- Bentley Community Mental Health Services, Senior Advocate
- Borderline Personality Disorder conference, Chief Advocate
- CAHS Board, Chief Advocate
- Fresh Start Recovery Program, Senior Advocate
- Fiona Stanley Hospital (clinicians) on Treatment Support and Discharge Plans, Senior Advocate
- Mental Health Advisory Council, Chief Advocate
- Mental Health Professionals Network Albany, regional Advocate
- Mental Health Matters 2 – *Using your voice for change: what works, what doesn't* – Panellist – Senior Advocate
- North Metropolitan TAFE, Leederville (Certificate IV Mental Health Peer Work students), Senior Advocate
- Richmond Wellbeing, Ngulla Mia, Senior Advocate
- Rockingham Hospital (new staff), Senior Advocate
- Rockingham Hospital (Registrars), Senior Advocate
- Selby Older Adult Mental Health Service, Senior Advocate
- The Mental Health Services (TheMHS) Conference, Sydney, Symposia, Chief Advocate
- WADJAK Northside Aboriginal Community Group, Advocate
- WA Mental Health Conference on 'I Don't Have a Mental Illness', Senior Advocate.

Appendix 12: Training, seminars and conferences

- Western Australian Association of Mental Health Conference, 13-14 July 2017 attended by some Advocates, the Senior Advocates and Chief Advocate
- The Mental Health Services (TheMHS) conference, Sydney, 30 August to 1 September 2017, attended by Chief Advocate and Advocacy Service Manager with a presentation by the Chief Advocate on the Advocacy Service.
- Australian Rotary Health on *Lifting the Lid – Mental Health and our Kids*, 13 September 2017, attended by Senior Advocate and Advocate.
- Borderline Personality Disorder Conference, 18 October 2017, attended by Senior Advocate and Advocate
- Rural and Remote Mental Health Conference, 24 October 2017, attended by Broome Advocates
- St Johns Ambulance Western Australia, first aid training, 10-11 October 2017, attended by an Advocacy Services Officer.
- MHC, Strong Spirit Strong Minds 24 October and 14 December 2017, attended by Advocacy Service Officers
- An Advocacy Services Officer took part in the Government of Western Australian Interagency Mentoring Program
- Record-keeping training for new Advocacy Services Officers and Acting Advocacy Service Manager, 12 July 2018
- Child Protection and Family Support Division presentation on how the Department of Communities works with children in care – attended by the Youth Advocate and other Advocates jointly with MHLC lawyers, 17 August 2018
- Youth and the Justice System – Law Week event by the MHLC attended by the Chief Advocate, 15 May 2018
- ShelterWA - *A forum of celebration and discovery* attended by the Chief Advocate, 6 June 2018
- *Many Voices, Big Impact: The Mental Health Review and Making Your Voice Heard* attended by the Chief Advocate, 28 June 2018

Appendix 13: Findings and recommendations from the TSD Plan Inquiry⁷⁸

Why ss185-188 of the Act were not being complied with:

1. **Issues around the documentation (what document to use and how to use it) seemed to be an insurmountable hurdle for some mental health services.** This is despite a mandatory operational directive⁷⁹ requiring that the Treatment, Support and Discharge Plan be completed on the mental health database (PSOLIS). The operational directive further notes that it is “currently on PSOLIS as Management Plan”. For inpatient services this is the client management plan (CMP) on PSOLIS. The issues were primarily as follows:

- 1.1. **Clinicians not being able to see how the CMP could be adapted for use as a TSD Plan.** CMPs were being used regularly by the treating teams, but for use solely by the clinicians. They generally contained medicalised/clinical language and instructions to nursing and other staff. As such they did not comply with ss186-188 of the Act as a TSD Plan and a lot of staff struggled to see how they could be adapted or were concerned about such documents being given to a patient. The letter from the Chief Advocate sent to all health services included a draft CMP to show how it could be used as a TSD Plan and there are some recent and welcome initiatives which show that it can be done:

- 1.1.1. Graylands Hospital has recently produced a Collaborative Care Plans FAQ Information guide for staff;
- 1.1.2. Rockingham Hospital has gone one step further and produced a CMP template with prompts for staff which is on PSOLIS; and
- 1.1.3. at Bentley Hospital, a training package has been produced.

See annexures 4 and 5 to the Report.

- 1.2. **Confusion over which document to use was exacerbated by the existence of a paper-based document titled “Treatment, Support and Discharge Plan”.** This was issued some years ago as part of a suite of Statewide Standardised Clinical Documents (SSCD) which are mandatory to use but it is not on PSOLIS. Some mental health services said they wanted to wait for this document to be put on PSOLIS but advice to MHAS was that there is no plan for this to happen. The problem in using a paper-based document is that it cannot be easily updated or added to by all members of the treating team or viewed when a person changes health service (for example on discharge to a community health service or on seeking re-admission at an emergency department). This is presumably why the operational directive instructs health services to use the CMP instead.

⁷⁸ See the full report on the Advocacy Service website <https://mhas.wa.gov.au>

⁷⁹ Operational Directive 0526/14 State-Wide Standardised Clinical Documentation for (SSCD) for Mental Health Services.

Appendix 13: Findings and recommendations from the TSD Plan Inquiry *(cont.)*

2. Lack of acknowledgement by psychiatrists that TSD Plans are clearly stated to be their responsibility under the Act, that they should take the lead, and that the Act requires that all treatment care and support be “governed” by the TSD Plan:

- 2.1. In many cases the psychiatrist did not seem to know their obligations or the patients’ rights under the Act. The Act is very clear – s187 says the patient’s psychiatrist is responsible for ensuring that the TSD Plan is prepared in accordance with the Act and the Chief Psychiatrist’s guidelines.
- 2.2. Even when told about their responsibilities, many psychiatrists seemed to think it was the job of nursing staff. In part this relates to the documenting of the TSD Plan but it included the process as well.
- 2.3. Where psychiatrists were not involved in the TSD Plan process it seems unlikely that the TSD Plan is governing the patients’ treatment care and support as required by s186. While it does mean more patient centred care by nursing staff and a shift in culture, it does not mean that the Act is complied with.
- 2.4. Overall most nursing staff embraced the need for change to comply with the Act as did most mental health senior management but some psychiatrists were far less enthusiastic.

3. Lack of a process for involving the consumer or personal support persons (PSPs) in the development or review of the TSD Plan. This stems in part from the lack of interest by some psychiatrists but also a general lack of process around the TSD Plan requirements:

- 3.1. A few hospitals invite consumers into the treating team weekly meetings but this is rare and in many cases not conducive to discussing the patient’s goals and wishes because of both time constraints and the large number of personnel who attend such meetings.
- 3.2. Some hospitals used other (paper) documents to be completed by the patient in order to discuss things which might go into a TSD Plan but mostly these did not make their way into the TSD Plan/CMP.
- 3.3. Some clinicians, particularly psychiatrists and registrars, would say they had spoken to the patient and the PSP, but if there were any notes to this effect, they were on the patient’s file where neither the patient nor PSP could see them nor add to them, and again they did not make their way into the TSD Plan/CMP.
- 3.4. Often it was left up to the nursing staff to speak to the patient and PSPs about the sorts of things which they might want included in a TSD Plan and to relay that back to the treating team. The problem with this is that the wishes of the patient and information provided by the PSPs was not always accurately conveyed and/or did not make its way into the TSD Plan/CMP.

Appendix 13: Findings and recommendations from the TSD Plan Inquiry *(cont.)*

4. **Lack of appreciation by clinicians of the therapeutic benefits and improved outcomes which can result from compliant TSD Plans. Apart from compliance with the Act, a good TSD Plan:**

- 4.1. encourages trust and a positive and engaging therapeutic relationship with the patient (as stated in the Chief Psychiatrist's Guidelines) as they feel their wishes are being heard and the process provides a forum for the clinician to get to know and understand the patient better;
- 4.2. is likely to mean a better discharge process particularly where PSPs are involved because the treating team has accurate and more fulsome information; and
- 4.3. acts as a prompt to holistic care, particularly where the Chief Psychiatrist's Standards and Guidelines in relation to TSD Plans are followed.

5. **A belief by some clinicians that patients should not see certain information, or would react badly if they did, or that they were too unwell to be able to add anything meaningful, and a (wrong) belief in some cases that there was a discretion which gave them the right to not comply with the Act. Each case will be different (and that is the point of patient-centred care) but:**

- 5.1. the MHAS experience is that the choice of words and showing respect for the patient is usually the way to avoid such issues – noting that Principle 1 of the Charter of Mental Health Care Principles in the Act requires that a mental health service must treat people experiencing mental illness with dignity, equality, courtesy and compassion;
- 5.2. the Act requires that psychiatrists have regard to the wishes of the patient so is it difficult to see how this is complied with if information is being withheld;
- 5.3. many clinicians expressed how even patients in the grip of delusions can still speak rationally about other issues such as housing and their physical health; and
- 5.4. there are no exceptions or discretions in the Act to compliance with the requirements of s186-188 of the Act.

6. **No leadership or involvement at health service level.** The mental health services in each hospital appear to have been left to their own devices to work out whether and how to comply with the Act. This means:

- 6.1. inconsistency between mental health services within the same health service;
- 6.2. re-inventing of the wheel and associated inefficiencies; and
- 6.3. changes in approach at individual mental health service level when managers/ psychiatrists change which leads to consumer and PSP confusion and dissatisfaction and increased likelihood of non-compliance.

Appendix 13: Findings and recommendations from the TSD Plan Inquiry *(cont.)*

7. **Lack of understanding or skills in recovery focussed and patient centred language and the type of matters to be discussed and included in a TSD Plan.** This varied according to the clinicians involved but:
 - 7.1. a prompt sheet developed by MHAS in consultation with patients and PSPs as part of the TSD Plan Inquiry was found to be useful by some health service staff; and
 - 7.2. the work done by Rockingham and Graylands hospitals addressed this issue.
8. **Limitations on access to PSOLIS.** The efficacy and usefulness of the TSD Plans is limited by restrictions on access to the mental health database (PSOLIS). MHAS was told, for example, that only senior hospital staff could access TSD Plans on PSOLIS prepared by community mental health services and vice versa. If better access was provided clinicians might better appreciate the value of a good TSD Plan because it can lead to better outcomes and efficiencies.
9. **Continual turn-over of staff** – this was mainly in regional areas but also applied in some metropolitan mental health services. It meant lack of leadership at the psychiatrist level in particular, but the impact was exacerbated by poor training and understanding of the requirements of the Act.

Recommendations

1. **Each health service to show leadership by:**
 - 1.1. asking their mental health services to immediately report on:
 - 1.1.1. the extent to which they are complying with ss186-188 of the Act including the extent to which all treatment, care and support is governed by the TSD Plans and the involvement of, and provision of copies to, consumers and PSPs;
 - 1.1.2. their process or procedure for involving patients and PSPs in the preparation and review of their TSD Plan as required by the Act;
 - 1.1.3. what they are doing to ensure and/or increase compliance with the Act;
 - 1.1.4. the hurdles they face, and what support they need to ensure compliance with the Act;
 - 1.1.5. whether they are complying with the operational directive requiring the TSD Plan to be on PSOLIS, and if not, why not;
 - 1.2. for those mental health services with a poor compliance rate, to require a plan of action and timetable to increase compliance;

Appendix 13: Findings and recommendations from the TSD Plan Inquiry *(cont.)*

- 1.3. requiring the psychiatrists in their mental health services to take a leadership role in the process to ensure all treatment, care and support is governed by the TSD Plans noting the obligation under the Act is on them;
- 1.4. encouraging their mental health services to work together on solutions so they are not re-inventing the wheel and there is a consistent approach for patients in the health service's catchment;
- 1.5. ensuring that there is regular training for all clinicians, especially at the time of induction/orientation of new staff, about the importance of the TSD Plan, the mandatory requirements under the Act and the Operational Directive;
- 1.6. providing the support which is identified as necessary to ensure compliance across all the mental health services;
- 1.7. reporting back to MHAS and the Chief Psychiatrist on this Report and outcome of the recommendations above.

2. The Director General of the Department of Health to:

- 2.1. clarify and amend the Operational Directive on State-Wide Standardised Clinical Documentation for Mental Health Services or consider issuing a new operational directive dealing only with TSD Plans making clear that the documentation is to be on PSOLIS and should not be paper based; and
- 2.2. consider changes to the accessibility to PSOLIS in relation to TSD Plans.

3. The Chief Psychiatrist to:

- 3.1. review and amend as appropriate the standards and guidelines relating to TSD Plans noting that the guidelines could provide more detail on the type of information which should go into a TSD Plan; and
- 3.2. provide training on TSD Plans including on engaging with patients and PSPs and the use of language in TSD Plans;

4. The Royal Australian and New Zealand College of Psychiatrists to:

- 4.1. promote compliance with the Act amongst its members;
- 4.2. include TSD Plans regularly in its continuing professional development program; and
- 4.3. ensure that sufficient training is given to psychiatry trainees about the responsibility of psychiatrists under s186-188 of the Act.

Appendix 13: Findings and recommendations from the TSD Plan Inquiry *(cont.)*

5. The Mental Health Tribunal to:

- 5.1. promote compliance with the Act by asking for copies of TSD Plans to be provided to the Tribunal for hearings; and
- 5.2. where there is no TSD Plan compliant with the Act, to consider an order under s423 of the Act to refer the matter to the CEO of the Health Department, the Chief Psychiatrist and/or the CEO under the Act (the Commissioner for Mental Health).

6. MHAS to follow up the TSD Plan Inquiry by:

- 6.1. Advocates continuing to raise the issues with patients and mental health service staff;
- 6.2. conducting a further Inquiry on TSD Plans in 2018-19; and
- 6.3. promoting the right of patients to seek orders from the Mental Health Tribunal where ss186 to 188 of the Act are not being complied with. The Act provides for the Mental Health Tribunal to either make a Compliance Order (and the subject of that order must be named in the Tribunal's Annual Report which is laid before Parliament) or the Tribunal can refer a case to the Director General of the Department of Health, the Commissioner for Mental Health, the Chief Psychiatrist and/or a registration board.

Appendix 14: Cost saving measures implemented January to July 2018

No	Item	Description, Impact and Risks
1	Inquiries - s352(1)(b) of the Mental Health Act 2014 (the Act)	Hospital inquiries on sexual safety and restrictive practices in 2017-18 will not be done. The risk is that wards will not be kept as safe, the protection and voice of consumers is compromised, and compliance with the objects of the Act is reduced because Advocates' function of investigating conditions which are or may be adversely impacting on patient health safety and welfare (as required by the Act) is impeded.
		No systemic inquiries at the 38 licensed private psychiatric hostels. This compromises the access of hostel residents to the advocacy service thereby increasing the risks to hostel residents by reducing the amount of oversight of these facilities.
		Advocates' investigations into serious issues as they arise will be limited to requesting mental health services to advise MHAS of the outcome of their own investigation. The risk is that wards will not be kept as safe, the protection and voice of consumers is compromised, and compliance with the objects of the Act is reduced because Advocates' function of investigating conditions which are or may be adversely impacting on patient health safety and welfare (as required by the Act) is impeded.
2	Hostel Strategy and Operational Plan	Bi-monthly visits to 10 "identified" hostels cancelled. This increases the risk of abuse to very vulnerable hostel residents as their access to the advocacy service is greatly reduced, as is the oversight of these facilities. Recent incidents have shown that hostel residents are extremely vulnerable to abuse and they do not phone for help.
3	More consumer contact work by phone	If the Advocate knows the identified person can talk on the phone even when they are acutely unwell (and it is more efficient) they should phone rather than visit. This will reduce mileage, but it is unknown if it will reduce the duration of the contact, however it is expected to reduce the overall number of requests for assistance as Advocates will be less accessible to patients. The impact on consumers will be less time on wards therefore reducing access to Advocates and protection of consumers' rights. There is also increased risk of Advocates' misunderstanding consumers' wishes over the phone and possible compromise of their ability to fully represent their views in Tribunal hearings and other meetings.

Appendix 14: Cost saving measures implemented January to July 2018 (cont.)

No	Item	Description, Impact and Risks
4	Extended timeframe to respond to requests for assistance	<p>The timeframe to respond to requests for assistance (excluding the initial request) has been extended from 48 hours to 72 hours. Section 357 of the Act requires contact as soon as possible and this is the maximum period to contact people who are referred for examination, detained for assessment, and detained as voluntary patients. This should reduce costs by allowing Advocates to 'cluster' work therefore also reducing mileage.</p> <p>The impact on consumers will be less time on wards so reducing access to Advocates and therefore protection of consumers' rights. Inquiries into ward conditions by Advocates are also likely to be reduced thereby reducing the number of issues raised and addressed, and reducing rights of consumers.</p>
5	Fewer visits to facilities	<p>By using strategies such as "clustering" the allocation of work to Advocates and strategies mentioned above, the visits to facilities should be reduced. This is likely to have a compounding effect of reducing the requests for assistance from identified persons.</p> <p>The impact on consumers will be less time on wards so reducing access to Advocates and therefore protection of consumers' rights. Inquiries into ward condition by Advocates are also likely to be reduced thereby reducing the number of issues raised and addressed, and reducing rights of consumers.</p>
6	Reduced calls to people on a Community Treatment Order (CTO)	<p>Advocates will no longer phone people transferred from hospital to a CTO where they have offered to explain to the person their rights, just a letter will be sent to reduce costs.</p> <p>This increases the risk that consumers do not know or understand their rights on a CTO. This includes the risk that letters will not reach the consumer in the time required, or at all, and the Act will be breached.</p>
7	Ward mailboxes to be removed	<p>Hospital wards have MHAS mail boxes where patients can write to an Advocate to make a complaint or request assistance without having to ask ward staff to post a letter or ask staff for access to their mobile or to phone MHAS for them.</p> <p>This reduces consumers' access to Advocates and their ability to raise complaints especially on older adult wards as there are few involuntary patients. Abuse of the elderly is a growing national concern.</p>
8	Team meetings	<p>Advocates work from home and seldom see other Advocates or their Senior Advocate except at monthly team meetings which will be halved to 1.25 hours for metropolitan Advocates and 45 minutes for regional Advocates.</p> <p>The risk to consumers is a lowering of the standards of advocacy and therefore potential compromise of their rights. Advocate burn-out is also a risk due to fewer opportunities to discuss difficult cases which in turn will increase costs of recruiting and training new Advocates.</p>

Appendix 14: Cost saving measures implemented January to July 2018 (cont.)

No	Item	Description, Impact and Risks
9	Training days	<p>The four-hour biannual training is cancelled for May 2018.</p> <p>This will significantly reduce the ongoing training of Advocates in turn reducing the quality of the advocacy services offered and potentially compromising the protection of consumer rights.</p>
10	More referrals to the Mental Health Law Centre (MHLC)	<p>Historically Advocates have assisted people at State Administrative Tribunal (SAT) hearings about guardianship and administration matters but this will cease. Instead identified persons will be referred to the Mental Health Law Centre (MHLC), which is funded by Legal Aid WA, to perform this function.</p> <p>The appointment of a guardian or administrator is a significant removal of human rights and is regularly applied to involuntary mental health consumers. This measure has been undertaken following a commitment by the MHLC to prioritise these hearings but is dependent on them having capacity.</p> <p>Advocates must refer reviews of Mental Health Tribunal decisions at SAT to the MHLC or seek approval to represent identified persons.</p> <p>The impact on consumers will be dependent on the capacity of MHLC lawyers to do these hearings.</p> <p>Advocates to try to reduce the number of Mental Health Tribunal hearings they attend by making referrals to the MHLC.</p> <p>The impact on consumers will be some loss of support due to Advocates' indepth knowledge of the consumer and ready statutory access to their medical files for use in hearings which the MHLC lawyers do not have. This cost-cutting measure will also depend on the capacity of the MHLC to increase the number of hearings it conducts.</p> <p>Advocates will not attend hearings where the identified person is not attending, unless they have approval from a Senior Advocate.</p> <p>The risk to consumers is not being represented in hearings and possibly losing the chance to be made voluntary or discharged on a CTO.</p>
11	No longer contact the Public Trustee on behalf of consumers	<p>Identified persons will be referred by Advocates to hospital social workers or to hostel staff for assistance to contact their Trust Manager. If there are concerns about the management of funds by the hostel, the Advocate may make inquiries of the Public Trustee.</p> <p>The impact on consumers may be delayed response time to getting access to money while in hospital which is a common issue. Hospital welfare officers are generally over-worked and have other priorities.</p>

Appendix 14: Cost saving measures implemented January to July 2018 (cont.)

No	Item	Description, Impact and Risks
12	Reduce hospital management meetings	<p>Meetings with hospital management to raise protracted, systemic and serious issues will be reduced.</p> <p>The current Chief Advocate and two Senior Advocates who attend these meetings have close working relationships with current hospital management but should personnel change, there will be an impact on systemic advocacy and resolution of serious issues. Such meetings also provide the Chief Advocate with a means to carry out her function, specified in the Act, of promoting compliance with the Charter of Mental Health Principles.</p> <p>Advocates will no longer accompany a Senior Advocate to management meetings. This applies when the Chief Advocate is not attending the meeting or there is a specific issue in which the Advocate has been involved.</p> <p>The impact is a potential compromise in the ability to advocate and negotiate issues and loss of ability to train and upskill Advocates including for succession planning.</p>
13	Bunbury Advocates to forgo call out fee	<p>Bunbury Advocates have agreed not to charge a call-out fee which is applicable for regional Advocates to compensate them for the time taken to travel in areas where there may be limited work.</p> <p>The impact is directly on the Bunbury Advocate who will earn less money.</p>
14	No pay rise	<p>Advocates, Senior Advocates and the Chief Mental Health Advocate's rates are frozen at 2015 rates and will not be increased.</p> <p>The impact is on the Advocates including the Chief Advocate whose pay rate has fallen to below that of a level 9 officer. The risk is loss of Advocates and recruitment difficulties particularly for a Chief Advocate and specialist and Senior Advocates. This in turn impacts on the service to consumers.</p>
15	Weekend phone service	<p>An Advocate checks answering machine messages over weekends, triages matters and deals with urgent matters. This service has been discontinued but calls will still be made to the three child and youth wards to ascertain whether any children have been made involuntary.</p> <p>There is a high risk of failing to protect a consumer's rights in a timely manner causing the person to be distressed for longer as they have to wait until a working day to speak to an Advocate. Feedback indicates this service is valued, and there is the risk that children may be made involuntary on an adult ward and an Advocate is not informed to make contact within 24 hours as per s357(2)(b) of the Act.</p>

Appendix 14: Cost saving measures implemented January to July 2018 (cont.)

No	Item	Description, Impact and Risks
16	No second Advocate in Kalgoorlie	<p>It has been MHAS' practice to engage at least two Advocates in each regional centre with an authorised hospital, so that there is at least one Advocate who can visit the facility. There are low numbers of involuntary orders made at Kalgoorlie Hospital and the existing Advocate has agreed to the workload. When she is unavailable, contact will be made by phone by another Advocate.</p> <p>The risk is a reduction in the protection of consumer rights when a person is made involuntary as phone contact at this stage in a consumer's journey is often impossible.</p>
17	Senior Advocates to reduce hours	<p>Both Senior Advocates will reduce their hours. This is possible as there will be no systemic inquiries and fewer meetings.</p> <p>The impact is likely to be increased workload for the Chief Advocate and there is a risk of reduced supervision of Advocates and therefore lowering of standards of advocacy services.</p>
18	Staff reductions	<p>A staff member has agreed to work a 9 day fortnight.</p> <p>This person works for the Chief and Senior Advocates so the impact will be on them as they will have reduced administrative support and potential increased workload (for which the Chief Advocate receives no extra remuneration). Ultimately the impact will be on consumers as the MHAS is reduced in its ability to advocate as effectively.</p> <p>Positions will not be back-filled when taking short leave and not fully back-filled for annual leave. As MHAS provides service directly to the public, tasks will need to be performed by higher level officers during period of high demand (which are not predictable).</p> <p>The risk is inefficiencies and staff burn-out. The impact will be on all MHAS staff including the Chief Advocate. Ultimately the impact will be on consumers as the MHAS is reduced in its ability to advocate as effectively.</p>
19	Other savings	<p>Staff will supply their own tea, coffee and milk.</p> <p>This is a small but nice gesture by staff.</p> <p>Office cleaning has been reduced to weekly with staff assisting.</p> <p>An MHAS pamphlet will not be enclosed with letters to people when they are put on a CTO.</p>

Glossary of acronymns and terms

Act	<i>Mental Health Act 2014</i>
ACAT	Aged care assessment team required for Commonwealth funded packages
Advocacy Service	Mental Health Advocacy Service
Advocate	Mental Health Advocate
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
CTO	Community treatment order
DOH	Department of Health
ECT	Electroconvulsive therapy
ED	Emergency department
EMHS	East Metropolitan Health Service
EMYU	East Metropolitan Youth Unit
Executive Group	Advocacy Service advice and decision making body comprising the Chief Mental Health Advocate, two Senior Advocates and Manager
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
Health service	Health Service Provider – comprising each of or collectively EMHS, NMHS, WACHS, CAHS and WACHS
ICMS	The Advocacy Service database
LARU	Licensing and Accreditation Regulatory Unit

MHC	Mental Health Commission
MHLC	Mental Health Law Centre
CLMIA Act	<i>Criminal Law (Mentally Impaired Accused) Act 1996</i>
Minister	Minister for Mental Health
NDIS	National Disability Insurance Scheme
NMHS	North Metropolitan Health Service
OCF	Office of the Chief Psychiatrist
PCH	Perth Children's Hospital
PLN	Psychiatric liaison nurse – usually in EDs
PSOLIS	DOH database for people in mental health wards which records the status of people under the Act
PSP	Personal support person as defined by the Act
SAT	State Administrative Tribunal
SFMHS	State Forensic Mental Health Service
SMHS	South Metropolitan Health Service
SUSD	Step-up step-down short term supported accommodation facility funded by the MHC
Tribunal	Mental Health Tribunal
TSD Plan	Treatment, support and discharge plan
WACHS	WA Country Health Service



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