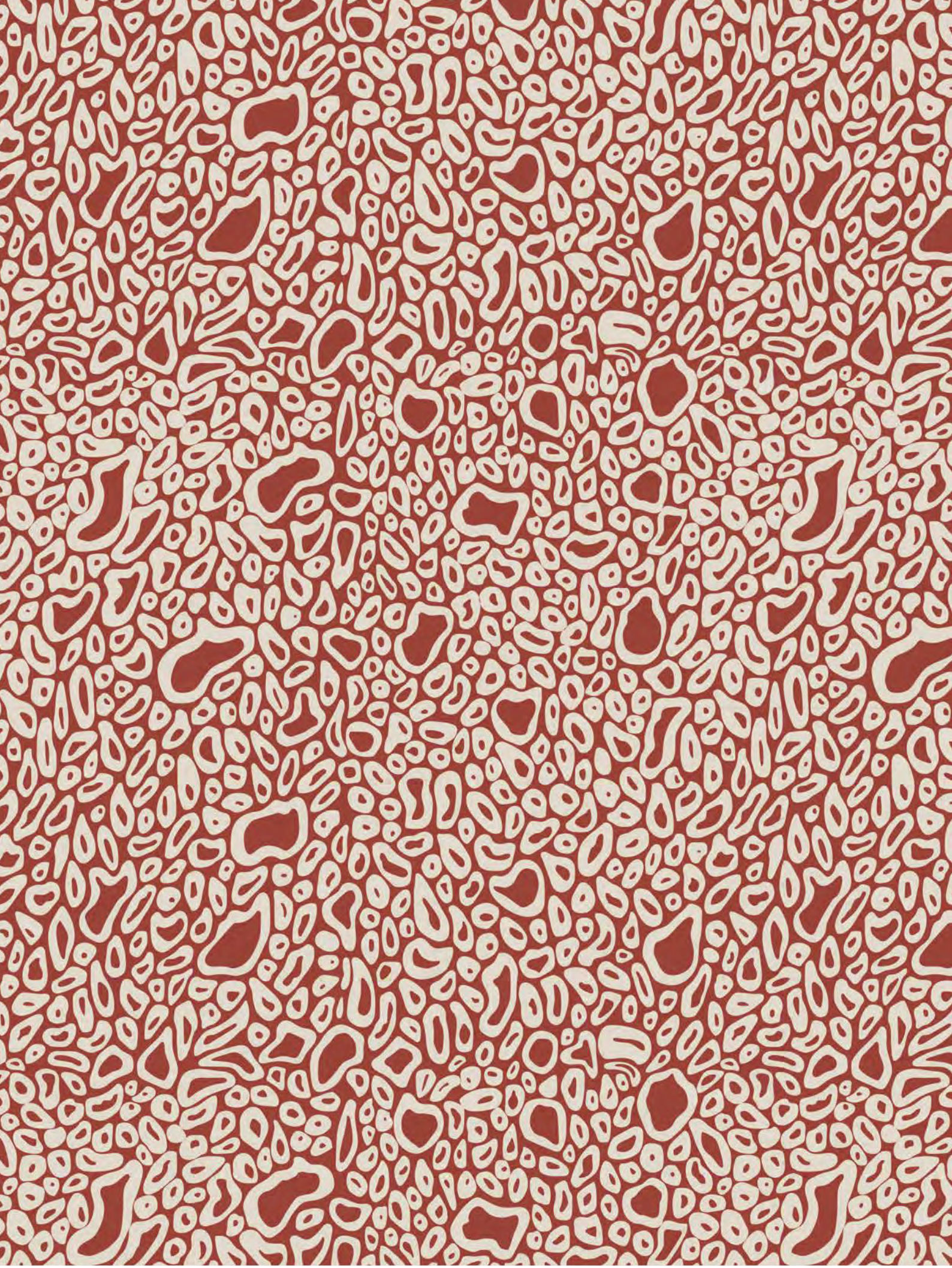
MHAS

MENTAL HEALTH
ADVOCACY SERVICE

2021-2022

Annual Report



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

We value the contribution made by those of us with a lived or living experience of mental ill-health and recovery and those who are or have been carers, family members and supporters. We progress when all voices have an equal say on what matters and what works.

We welcome people from all cultures, sexualities, genders, bodies, abilities, ages, spiritualities and backgrounds to our service.

Hon Amber-Jade Sanderson MLA
MINISTER FOR MENTAL HEALTH

In accordance with sections 377 and 378 of the *Mental Health Act 2014*, I submit for your information and presentation to Parliament the Annual Report of the Mental Health Advocacy Service for the financial year ending 30 June 2022.

As well as recording the operations of the Mental Health Advocacy Service for the 2021-22 year, the Annual Report reflects on a range of issues that continue to affect consumers of mental health services in Western Australia.

Dr Sarah Pollock
CHIEF MENTAL HEALTH ADVOCATE

September 2022

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Chief Advocate's foreward

Welcome to the seventh annual report for the Mental Health Advocacy Service. Our job is to make sure that every person who is identified under the *Mental Health Act 2014* can access their rights and gets their voice heard. We use what we learn from the people we support to advocate for services that will better meet their needs. The report outlines the activities of our Advocates and draws attention to issues in the mental health system. Although most of these issues are long-standing and well-known, the COVID pandemic has shone a light on the cracks in the system.

This has been a difficult year for everyone. I appreciate how difficult the conditions brought about by COVID have been for staff of mental health services. Every challenge they have encountered has also impacted on consumers. It is our job to focus on the impacts on consumers' experiences and access to their rights.

The report draws attention to parts of the system where resources are inadequate or not organised in ways that meet consumers' most pressing needs. It emphasises the need for collaboration at interfaces within and between services, and the gains that can be achieved when the consumer is placed at the centre of their treatment, care and support. Not all the changes that are required are difficult to achieve. Some are relatively straightforward. But they all require consumers to have a say in what needs to happen.

Our Advocates continue to press for what consumers want, and we continue to use what we learn from them to drive change in services and in our contributions to system development. We have done excellent work to protect the rights of consumers subject to seclusion and restraint, to make wards safer places and to advocate for proportionality in COVID restrictions. We continue to make significant contributions to the Statutory Review of the Mental Health Act, the Infant, Child and Adolescent Taskforce and the Graylands Reconfiguration and Forensic Taskforce. Always, we draw on what consumers tell us about what works for them.

I thank the Advocates, the Senior Advocates and the advocacy support staff at MHAS. Through an incredibly challenging year, you have stuck at it and put the consumers first. I am immensely proud of the work you do and the service that we offer to consumers across the state.

Dr Sarah Pollock
CHIEF MENTAL HEALTH ADVOCATE

Executive summary

Demand for advocacy remained high, driven by people on forms in medical wards (largely eating disorders), children and young people, consumers 'stuck' in hospital and/or on long-stay wards and increased contact from people in psychiatric hostels. The past year saw a shift in trends in involuntary orders, with a decrease in orders for authorised hospitals and an increase for general hospitals. Community treatment order numbers remained the same as last year.

In 2021-22 Advocates repeatedly reported the following:

- Concerns about consumer safety, with allegations of physical abuse and of staff misconduct accounting for many of the serious issues Advocates responded to.
- Complaints about treatment in seclusion, and excessive or heavy-handed use of restraints.
- Access to getting a further opinion appears to be getting more difficult.
- Consumers' access to their rights in relation to treatment, support and discharge plans are still patchy and there is still no effective system-wide implementation.
- First Nations consumers frequently are unable to access the additional and specific rights they have to involvement of family and community, and to traditional healers.
- The COVID pandemic impacts hit regional consumers particularly hard.
- The deficits in system capacity to meet the needs of young people, particularly 16-17 year-olds, is now critical.
- Emergency Department (ED) wait times for young people, people in regional EDs and older adults are unacceptable.
- The enhanced hostel visiting program has highlighted the number and range of issues that residents experience.
- The situation with the lack of forensic beds is also critical. Whilst there are plans to address this, something needs to be put in place in the interim. Basic rights for prisoners (amongst others) are being breached.
- The conduct of Mental Health Tribunal (Tribunal) hearings by VC and the quality and timing of medical reports impact on procedural fairness for consumers.
- The COVID pandemic has shone a light on the cracks in the system, placing it under great strain, with adverse impacts on consumers' experiences and rights.

The artwork used on the front cover of the Annual Report is called 'UNSINKABLE' and has been reproduced with the permission of the artist.

"Three (my favourite number) Tai Chi Balls, appear to be floating and an open vase-shaped cylinder, representing a cup three quarters full of emotion, as well as a horse-shoe open for good luck! The pebbles also appear to be floating out of the cylinder, suggesting the bubbles in sparkling wine!"

- Suzannah Lee Kolev, 22 August

About us

The Mental Health Advocacy Service (MHAS) exists to amplify the voices and protect the rights of people using, and seeking to use, mental health services.

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

The functions and powers are set down in Part 20 of the *Mental Health Act 2014* (the Act). This requires the Chief Mental Health Advocate (Chief Advocate) to ensure advocacy services are delivered to the above groups of people, called 'identified persons' in the Act and referred to as 'consumers' throughout this report. The Act requires the Chief Advocate to be notified by mental health services of every person made involuntary. Advocates must contact all adults within seven days after they have been made involuntary, and all children within 24 hours. Advocates also make contact at the request of consumers or others acting on their behalf.

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

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

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

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

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

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

The year in review

3,610
Consumers assisted

5,813
Phone requests for contact

7,226
Issues raised by consumers

7,116
Notifications of orders

158
Letters of inquiry, concern, or complaint

119
Stakeholder meetings attended

934[1]
Mental Health Tribunal hearings attended

177
Further opinions requested

175
Allegations of assault or abuse received

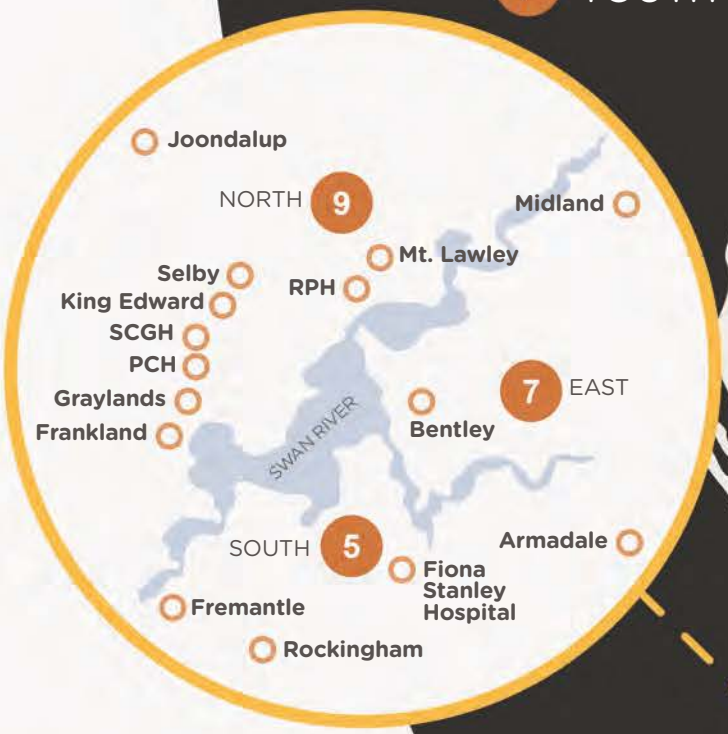
[1] Figure is based on MHAS data recorded by Advocates and is likely to under-represent the number of hearings attended. Prior to 2020-21, data was provided by the Mental Health Tribunal.

Distribution of Advocates and authorised hospitals

This figure represents the numbers of Advocates working across services on 30 June 2022 and does not equate to Full Time Equivalent (FTE) Advocate numbers. It excludes five Advocates who were unavailable for work on 30 June.

STATE-WIDE:

- 4 HOSTEL
- 0 ABORIGINAL
- 1 WEEKEND PHONES
- 7 YOUTH



1 BROOME

1 KALGOORLIE

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2 ALBANY

Number of active Advocates

Authorised hospitals

Advocacy service provision

The support we provide

In 2021-22, the Mental Health Advocacy Service (MHAS) assisted almost 3,500 consumers to ensure they were aware of and could access their rights. Advocates raised over 7,000 consumer issues; a decrease compared to the previous year (see table one). COVID was a significant factor on Advocate availability in the second half of the year, and there was a fall in the number of inpatient treatment orders in authorised mental health wards (where the majority of MHAS' advocacy occurs). On average, there were just over two issues raised per consumer. However, some consumers do not want assistance beyond an explanation of their rights. Issues were recorded against just over half the consumers assisted, taking the number of issues and complaints to just under four per consumer.

TABLE ONE - Number of identified persons assisted, and issues/complaints recorded by Advocates

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Total number of identified consumers[2]	N/A	3,132	3,141	3,427	3,605	3,454
Number of issues and complaints recorded by Advocates	6,038	6,038	7,373	5,081	8,970	7,226

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

Who we supported

Consumers on involuntary treatment orders

The number of involuntary treatment orders for inpatients decreased in 2021-22, however this was due to the decrease in form 6As (inpatient orders made in authorised hospitals) - a 13.0% decrease in the past two years (see table two, noting that because an individual may have been subject to more than one order type during the year, the total for involuntary consumers is not equivalent to the sum of the consumers for each order type). Orders made in authorised hospitals made up 92% of all inpatient orders and had a greater impact on overall trends. Although the decrease in the number of orders made on form 6A began in July 2021, the rate increased from December 2021 when COVID began to circulate in the WA community.

Conversely, orders made in general hospitals (form 6Bs) increased - 51.8% in the past two years. However, they are relatively few in relation to the total number of orders (255 form 6B orders made in 2021-22).

The advocacy for consumers in general hospitals is disproportionately higher than the number of orders as there are commonly more, and more complex issues involved for consumers. Additionally, staff in general hospitals are less familiar with the requirements of the Act, responsibilities and oversight of involuntary detention and involuntary treatment. Because staff generally have less familiarity with the legal implications of involuntary treatment and detention, there are greater risks in terms of rights protection for consumers treated in general wards.

The number of community treatment orders (CTO) was identical to the previous year (884). There continues to be an overall increasing trend in the number of CTOs, and a different trend since COVID compared to other types of orders. At the same time, the number of issues reported for consumers on CTOs decreased in 2021-22 compared to the previous year.

TABLE TWO - Number of involuntary orders[3] and number of consumers[4]

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

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

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

5 Because an individual may have been subject to more than one order type during the year, the total for involuntary consumers is not equivalent to the sum of consumers in each column.

Children and young people

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

The number of children assisted on any involuntary treatment order stabilised in 2021-22 after more than doubling in the five years prior (see table three).

The trends by type of order varied:

- As with adults, there continued to be an increase in inpatient orders made in general hospitals for children;
- There was a decrease in orders made in authorised hospitals. MHAS can only speculate about the reasons such as people not wanting to go to EDs and/or be admitted due to COVID, strategies to care for more people in the community, and/or resourcing issues; and
- The number of CTOs for children fell slightly. Overall numbers are small, so caution is recommended in interpreting this information.

The number of children admitted to authorised mental health hospitals (both voluntarily and subject to involuntary treatment orders) decreased by 14.6% in 2021-22[6]. However, the number of voluntary children assisted by an Advocate reduced 25.6%, reflecting the impact of COVID on the Advocacy workforce, as well as difficulty retaining Youth Advocates under contracts-for-service (see table four). MHAS does not receive notification of the voluntary admission of a child to an authorised mental health hospital. Therefore the need for advocacy is dependent on Advocate availability and presence on wards, necessary to establish a relationship with the child and/or their family. It should be noted that the decrease in voluntary children assisted is not necessarily due to a decrease in voluntary children treated in WA.

In many instances parents or guardians have consented to the child's admission and treatment[7]. Children are thus not always admitted or treated under their own volition. The Act requires the child's wishes are considered (to the extent to which those wishes can be ascertained) and the Advocate plays an important role in ensuring the child's wishes are raised. This is extremely important for the trust between the child and their treating team and nursing staff, and for the overall well-being of the child.

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

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

6 Data supplied by Department of Health on 30 August 2022. Source: Hospital Morbidity Data System.

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

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

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Voluntary children (<18 years) assisted	15	59	59	278	460	342[8]

There were fewer involuntary inpatient treatment orders made for people in regional WA[9] than each of the previous two years, whilst the number of community treatment orders remained consistent (see table ten). Most consumers do not want to be admitted as an involuntary patient. However, the decline in orders may represent a decline in access to appropriate services for people who are the most unwell.

Voluntary adult consumers

As of January 2017, MHAS has been able to continue to assist voluntary adult consumers to resolve issues that an Advocate was assisting them with while they were subject to an involuntary treatment order[10]. The Advocate must have been assisting the consumer while they were an 'identified person' and there must be further action that can be taken to resolve the issue or complaint.

There has been a consistent increase in voluntary adults assisted with ongoing issues since the commencement of MHAS in 2016 (see table five).

Consumers are typically assisted with an ongoing issue where their order has been revoked and they remain a voluntary patient of a mental health service, but we have not received a response, or a satisfactory response, to a letter of complaint. Anecdotally there has been an increase in the number of complaint letters sent compared to the previous year although our system is not sufficiently developed to enable comparisons.

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

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

8 Methodology for 2021-22 data for voluntary children assisted may differ slightly from previous years. Prior years' data is as published in previous Annual Reports.

9 This may not reflect the number of people from regional WA who are treated under involuntary inpatient orders, because they may be transferred to a metropolitan hospital before an order for involuntary treatment is made. This is likely to be the case for children aged 16 and 17 years, because of the lack of specialised beds for this age cohort outside of Perth.

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

11 Data is drawn from the MHAS ICMS database of notifications sent by facilities and work recorded by Advocates and extracted as at July 2022; data is subject to change. Consumers may be assisted in multiple categories during the financial year. MHAS started providing advocacy services to children and consumers with ongoing issues via a Ministerial Directive on 1 January 2017.

Referred persons

For most people, involuntary treatment begins with a referral for examination by a psychiatrist (form 1A). The referral is made by an authorised mental health practitioner[12] or a medical practitioner and is typically made in an emergency department. A referred person must be 'received' at the authorised hospital (or other place nominated on the form 1A) within 72 hours or the referral ceases to be in force.[13]

MHAS is not notified of referral orders and is therefore reliant on referred persons (or other parties including family, hospital staff, etc) requesting assistance. The exception is children, where MHAS receives a daily 'bed report' of the number waiting for admission.

Each day a Youth Advocate will make inquiries about children on the bed report. In some situations, an inpatient bed has been identified and the young person is waiting to be transferred. However, where a bed has not been secured an Advocate will make contact[14] to ensure they are aware of their rights and assist them if there is anything they need or have issues or complaints they want to raise.

There was a 9.3% reduction in the number of referred persons (adults and children) assisted by an Advocate in 2021-22 (see table six). This corresponds with the 9.8%[15] decrease in the number of referral orders made in 2021-22. The overall decreasing trend commenced in November 2020.

TABLE SIX - Six-monthly trend in the number of referral orders (form 1A): 2020-21 and 2021-22

	Average number of referral orders
July to December 2020	500.3
January to June 2021	491.7
July to December 2021	462.0
January to June 2022	432.5

Custody orders

The number of consumers subject to Custody Orders and detained in authorised hospitals has remained stable for the past two years (see table seven). The overall number of people subject to custody orders, and the number detained for mental health treatment has increased since 2017 when the government made a pre-election commitment to reform the *Criminal Law (Mentally Impaired Accused) Act 1996*.

TABLE SEVEN - Six-year trend in the number of custody orders as at 30 June each year[16]

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

[12] An authorised mental health practitioner must be a psychologist, nurse, occupational therapist or social worker with at least 3 years' experience in the management of a mental illness (s.538 of the Act) and the Chief Psychiatrist publishes their names.

[13] Referrals for examination may be extended if they were made outside the metropolitan area.

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

[15] Data supplied by Department of Health on 30 August 2022. Source: Mental Health Information Data Collection (MIND).

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

As detention orders are limited to the Frankland Centre (30 beds) or Murchison Ward East in Graylands Hospital (a further 4 beds) they are approaching the limits to the number of people who can be treated as inpatients due to bed capacity. The increase in the number of custody orders issued each year is no longer offset by the number of people discharged from the orders, with a net increase in the number of people needing to be treated, cared for and managed on custody orders (see table eight).

TABLE EIGHT - Six-year trend in the number of new and discharged custody orders[17]

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

Hostel residents

MHAS reintroduced a proactive hostel visiting program in January 2022 after progressive cuts in budget reduced our service for residents over previous years. Prior to December 2021 an Advocate only responded to requests for contact from residents (or from others on their behalf). Hostel residents rarely call (or email) MHAS to request assistance, due in part to high level psychosocial disability and in some cases intellectual and/or other cognitive impairments.

Residents are significantly more likely to discuss problems when Advocates are on site and develop relationships. A flow on effect occurs when other residents see Advocates resolving problems in a constructive way and then raise issues and complaints of their own.

The program of visits aimed to establish ongoing engagement between residents and Advocates, familiarise hostel staff with MHAS functions and powers under the Act and identify systemic issues that require further investigation.

In 2021-22 Advocates assisted 261 residents with 444 issues or complaints. The number of residents assisted increased 54.4% on 2020-21.

New consumers

The number of consumers new to MHAS decreased for the first time since we commenced operations (see table nine). This is probably linked to the overall decrease in the number of involuntary orders and reduced numbers of voluntary children assisted (obviously, most of whom would be new to our service). Another possible explanation is that fewer people who would have been subject to an involuntary order for the first time were treated involuntarily in 2021-22, although MHAS is not able to test this.

TABLE NINE - Six-year trend in the number of consumers new to MHAS

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

[17] Source: Mentally Impaired Accused Review Board annual reports. The number of MIA persons discharged is an assumption based on the net change in total custody orders between successive years, taking into account new orders made. The exception is 2021-22 data which is based on correspondence with the MIARB on 3 August and 5 September 2022.

[18] One mentally impaired accused person received 2 custody orders.

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

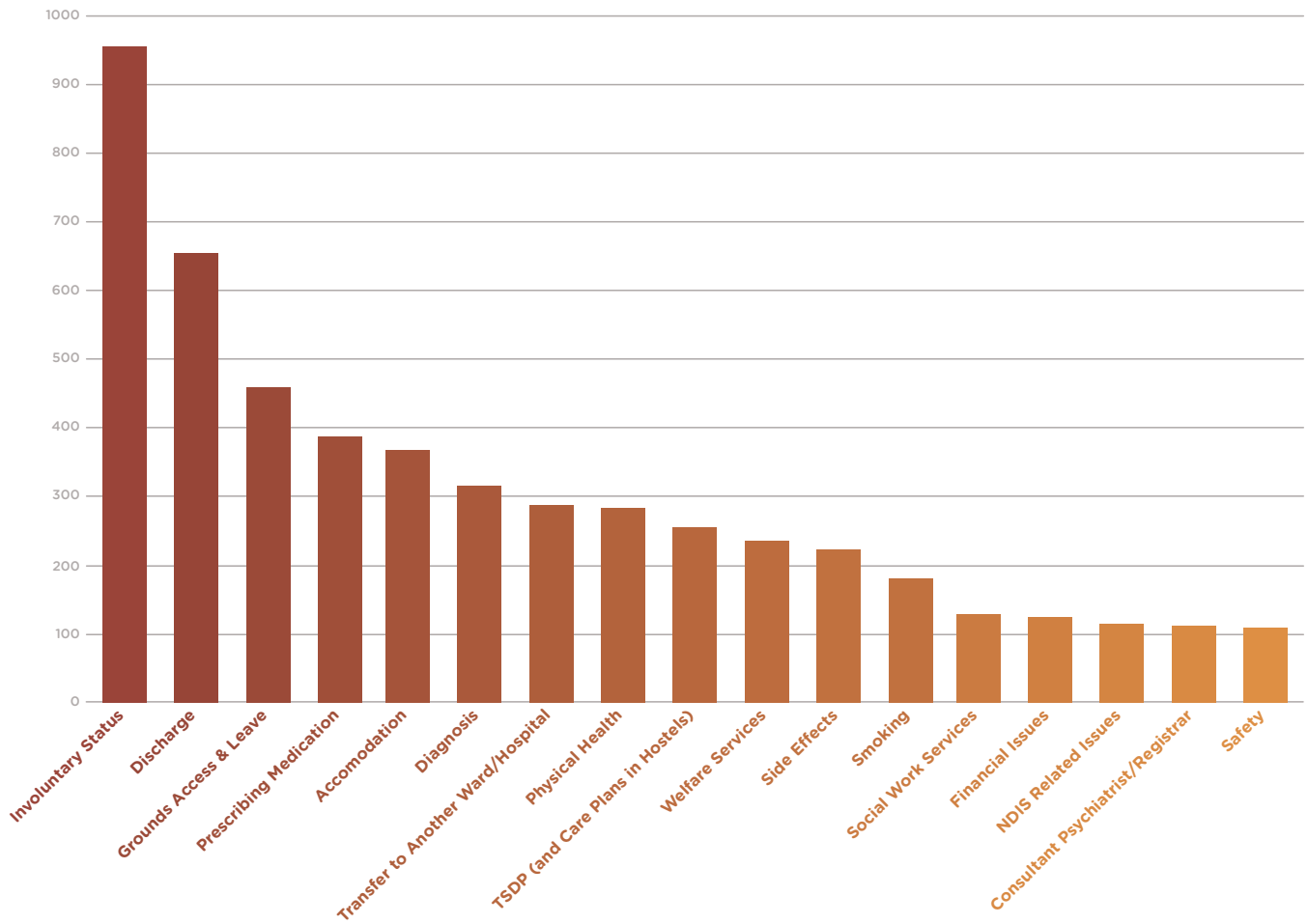
What consumers' concerns were

Advocates recorded 7,226 complaints and issues in 2021-22 with little change in the nature of the issues compared to the previous year (see table one). These are largely complaints that consumers would like Advocate assistance to resolve.

There are also matters Advocates must investigate, (even without a complaint from a consumer) where the conditions could adversely affect the health, safety or wellbeing of any consumer (refer to s352(1)(b) of the Act).

The complaints and issues data that we report is dependent on what Advocates enter into the MHAS integrated client management system (ICMS). There have been concerns in previous years about the consistency in coding across Advocates, and these concerns became greater in 2021-22. The training and ongoing support to Advocates in the use of the system has been largely impacted by stability in key staff positions and workload pressures as a result of COVID absences towards the end of the year. The data set is large enough to consider general trends, however caution is noted regarding specific complaints.

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



Two of the most commonly used complaint codes (involuntary status and discharge) relate to issues about being detained for treatment. Combined, these accounted for over a fifth of all issues. The other common issues relate to diagnosis and medication (including side-effects), which combined account for a further eighth of all issues.

Facilities we visit

During 2021-22, MHAS began visiting two new facilities:

1. On 14 June 2022 the new 12-bed authorised unit, Dabakarn Mental Health Unit, opened at Royal Perth Hospital. The ward has single bedrooms and ensuite bathrooms which is welcomed.

   MHAS commenced providing statutory advocacy services at the new ward but did not receive additional funding in 2021-22 (or for subsequent years). It is understood this may be because the unit was to be funded by the closure of ward 2K (a 20 bed, non-authorised unit that treats voluntary consumers who are not in scope for our advocacy) and ward 2K has been retained. MHAS has included requests for funding for the authorised beds as part of annual budget submissions for several years and is now in discussions with East Metropolitan Health Service and the Mental Health Commission (MHC) about funding our service.

   The funding of new or expanded facilities is a recurring problem for MHAS. For instance, MHAS was not funded for the Mental Health Emergency Centres (MHEC) or Mental Health Observation Areas (MHOA) at Royal Perth Hospital, Sir Charles Gardiner Hospital and Joondalup Health Campus, nor for expanded facilities such as additional beds at Joondalup Health Campus' mental health unit. This has added to the chronic, ongoing under-funding of our service.

2. Richmond Wellbeing opened an eight-bed facility, Momentum Queens Park in February 2022. It provides a 12-month residential program for youth who are homeless and have issues with mental health and/or alcohol and other drugs. This is licensed by the Licensing and Accreditation Regulatory Unit (LARU) of the Department of Health (DoH).

The total number of private psychiatric hostel beds licensed by LARU increased from 707 (30 June 2021) to 715[20] (30 June 2022). Residents of licensed psychiatric hostels are defined as 'identified persons' (see s.348 of the Act) and can request assistance from Advocates. Advocates must also investigate conditions at hostels that could adversely affect residents (see s.352(1)(b) of the Act).

There are growing inconsistencies in access to MHAS statutory advocacy services with the evolution of various residential service options. For example, a Community Care Unit (CCU) is proposed for people with severe and persistent mental illness and complex needs. As this facility will be operated by a private provider (in this case Richmond Wellbeing) it is intended that it will be licensed with LARU which means residents will have access to statutory advocacy and rights protections.

The proposed Transitional Care Unit in St James will accept very similar residents as the CCU, but as it will be operated by East Metropolitan Health Service it will not be licensed by LARU. The licensing is not an issue in itself; however, the consequence is residents of the Transitional Care Unit will not have access to assistance from MHAS Advocates. This is inequitable and a result of changes to government regulation not keeping pace with new models of care. MHAS raised this issue in submissions to:

- MHC's *Statutory Review of the Mental Health Act 2014* in March 2022.
- LARU's *Review of the Private Hospitals and Health Services Act 1927 Act and Private Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997* in February 2022.

[20] There were also two small changes to the number of licensed beds but they did not affect the overall number of licensed beds: Mt Claremont House (increased from 7 to 8 beds) and Swan View House (reduced from 4 to 3 beds).

Our weekend phone services

MHAS operates two weekend phone services including over public holidays:

- We monitor messages and determine the urgency of requests and will either contact consumers over the weekend for urgent matters or arrange for an Advocate to make contact within time periods determined by the Act (or MHAS protocol).
- We contact youth mental health wards to check whether orders for children have been made as an Advocate must make contact within 24 hours of the order being made.

Weekend phone messages

In 2021-22 MHAS received 363 phone messages on weekends and public holidays[21]. Most of the calls were received from consumers admitted to hospital, a few from consumers on CTOs and two from consumers in hostels[22]. There were also a few from consumers outside MHAS' jurisdiction and they were referred to other appropriate services.

A decline in the number of messages was observed in early 2022 and coincided with COVID starting to circulate in the WA community. A further decline occurred at the end of the financial year when a new phone system was introduced which did not operate as anticipated.

Calls were generally one of three types:

1. Those that required information about their rights as an involuntary treatment order has just been made (these are mostly consumers subject to form 1A, 3C or 6A).

2. Consumers already on involuntary treatment orders who need assistance with new issues that had arisen over the weekend such as leave being cancelled.

3. Requests for their Advocate to contact them, such as to attend a meeting with their psychiatrist for a review on the Monday (and didn't require advocacy on the weekend).

Issues are varied and may include problems with medication, wanting to make a complaint about their treatment, allegations of assault, or access to cigarettes and/or leave from the ward to smoke. Access to clothing is often raised and an example was, a consumer who had no shoes and was forced to walk around the ward in bare feet. When the Weekend Advocate made inquiries, they discovered the shoes were taken as the laces were a ligature risk. The Advocate negotiated for the laces to be removed so consumers could wear their shoes.

In another example, a consumer who had just been admitted needed the batteries for their hearing aids replaced. The Weekend Advocate arranged this and queried how the examination with the psychiatrist had been conducted and why this also wasn't identified when the physical examination was done on admission (as required under s.241 of the Act) as the consumer couldn't hear what people were saying to them. The Advocate arranged for the explanation of rights and orientation to the ward to be conducted again when the consumer could hear.

The Weekend Advocate also commonly assists consumers referred for examination by a psychiatrist who are often waiting in emergency departments (ED) on a form 1A and/or detained on a form 3C. In these situations, the Advocate can provide timely information about their rights to help the consumer better

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

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

understand the referral process and prepare for their examinations. Without the weekend service, consumers would have already been examined by a psychiatrist on Monday by the time an Advocate could make contact.

Advocates who provide the weekend service advise that many consumers are appreciative of the service and reassured by the information and assistance given.

Advocacy for children on weekends

The Weekend Advocate contacts Perth Children's Hospital and the two youth units every Saturday and Sunday to check if an involuntary inpatient treatment order has been made for a child, or if a child has been discharged on a CTO. The Advocate makes contact with the child as soon as possible. If this is not possible, for example if the child is too unwell, heavily sedated or doesn't want to talk on the phone, then a Youth Advocate will visit as soon as possible.

The Advocate also makes other inquiries when they phone youth wards. They query:

- If there are any children referred for examination and ensures staff have explained to the child that they can ask for an Advocate.
- Whether ward staff are aware of orders made in adult authorised wards, general hospitals or regional areas, or any child on a hospital order.
- The general safety on the ward, whether there have been any seclusions, restraints, emergency codes (such as for personal threats, medical emergency, high bed demand, etc) or any other issues that may affect consumers (such as COVID issues, bed closures, reduced staff numbers, etc) with follow up arranged as required.

Consumer rights and issues - adults

Safety, dignity and privacy

When a person is treated involuntarily, they have the right to feel safe, to be treated with dignity, courtesy and respect, and for their privacy and confidentiality to be maintained. Advocates play an important role in responding to consumer complaints about safety, dignity and privacy and work to bring about improvements to the way consumers are treated.

Advocates dealt with 134 serious issues involving adult consumers. Serious issues are incidents that require escalation to the Senior Advocate and further intervention. These comprised:

- 46 allegations of physical abuse.
- 40 incidents involving potential staff misconduct, wilful neglect or mistreatment.
- 25 allegations of psychological or verbal abuse.
- 15 allegations of violations of the consumer's sexual safety.
- 8 incidents involving another serious issue.

Following an allegation of assault, abuse or mistreatment by staff the Advocate's first response is to ensure that the consumer feels and is safe. The Advocate and Senior Advocate then develop an advocacy strategy to investigate the incident or allegation. Inquiries may include the period leading up to the incident, whether de-escalation strategies were used and were sufficient, what happened during the incident or allegation, what debriefing took place and what was put in place to make sure the incident was not repeated.

It is likely that serious issues are under-reported in the MHAS data system. Consumers' perceived lack of concern about what has happened to them combines with a tendency to conflate or overshadow the consumer's experience with their symptoms. During the past year, MHAS has undertaken practice development with Advocates to improve our response to serious issues and other matters that require escalation.

The following are examples from 2021-22 of advocacy for consumers whose safety, dignity or privacy had been breached.

Assault and conflict on wards

A consumer was assaulted whilst on a 3:1 'nursing special'. A nursing special allocates nursing staff to an individual consumer, often for their safety and/or the safety of other consumers on the ward. The Advocate wrote a complaint on behalf of the consumer, who had asked for acknowledgement of what had happened to them, and an apology.

While the facility's response to MHAS was thorough, the apology to the consumer was not commensurate with what had happened. The service has committed to amending the letter sent to the consumer and will work with us to improve their response to complaints.

Sexual safety

Sexual safety issues are compounded by mixed wards, bedrooms without lockable doors and workforce shortages that lead to, for instance, all male nursing teams on an overnight shift. Complaints and inquiries have covered the actions of specific staff members whose behaviour unintentionally or otherwise, left consumers feeling unsafe.

A consumer with a history of being sexually assaulted by male security guards woke up in the night to find several male security guards outside her bedroom. The guards were there to assist the person in the room next to her. The Advocate helped her to have her room changed to an area further away from the guards.

A consumer felt uncomfortable being observed while showering. The Advocate was able to arrange for a transfer to a low dependency ward with a different observation protocol that gave the person more privacy.

Last year we received several sexual safety complaints from consumers about staff members. These were escalated immediately and followed up to advocate for rigorous investigations and comprehensive service responses.

In addition to individual advocacy, we have liaised with the Office of the Chief Psychiatrist (OCP) on the implementation of the Sexual Safety Guidelines. Over the past year, Advocates have periodically checked to ensure that the OCP sexual safety posters are displayed in wards and have highlighted this with senior ward staff when they are missing. The posters have been effective in informing consumers of their rights.

A consumer used the poster in a discussion with their treating team, who wanted to move them to another ward where they hadn't felt sexually safe. Using the poster as leverage, the consumer prevented a transfer on this basis.

Allegations of staff misconduct

Some consumers feel persecuted by staff, but treating teams maintain the feelings of persecution, abuse and attack are part of the person's illness. In these cases, our advocacy focuses on ensuring that each allegation is taken seriously and investigated, and on what can be changed in the person's treatment plan to help them feel safer. In other cases, staff disrespect and poor practice is apparent.

A consumer made allegations of staff assaulting them on multiple occasions. The Advocate escalated this to their Senior, who raised with the head of service. Each allegation was investigated, and although none were upheld, it was clear the consumer did not feel safe. The head of service agreed that greater attention needed to be given to the consumer's feelings of safety. They changed roster to ensure that the nurses in question no longer came into contact with the consumer, and in doing so maintained the safety of all involved.

A consumer was injected in the buttock in the general area of the ward in full view of other consumers and staff. In response to our complaint letter, a senior member of staff met with the consumer, and their treatment plan was changed so that future injections would not be in the buttock. In addition, the service committed to investigating options to always ensure privacy on the ward, including advice to staff on how to create privacy in emergency situations.

A consumer complained that a staff member had responded to their expressions of distress with verbal abuse and profane name calling. We wrote a complaint on the consumer's behalf, including their request for an apology. The consumer received a response that did not deny the incident had happened, but nor did it make an apology. Following further intervention, the consumer received the apology they had asked for.

A nurse told a consumer that their 'drag' make-up was 'disgusting'. The Advocate assisted the consumer to write a complaint letter, and to raise this with senior staff in the facility. The senior staff circulated policies to all staff regarding the need for inclusive and consumer-centric practice.

Complaints do not need to extend to allegations of staff misconduct for there to be an element of inhumanity in the way a consumer has been treated and cared for. For people under an involuntary order, the fight to retain a dignified sense of self and exercise control and choice can be hard.

A consumer with extensive scarring from self-cutting on their limbs wanted to wear garments that meant the scarring was visible to others. The treating team prevented access to certain activities when the consumer was wearing these garments because of the potential impact on others. The Advocate and consumer wrote a complaint, and the limitations on clothing were removed from the consumer's treatment plan.

An Advocate visiting an older adult asked them why they were wearing newspaper stuffed into their shoes. The consumer said their feet were cold, and despite asking repeatedly for socks had not been given any. It took a further two weeks of the consumer and Advocate asking for socks before these were provided.

Unsafe infrastructure

In other cases, the hospital or clinic infrastructure creates unsafe conditions, or conditions that infringe consumers' right to privacy. We note that regional facilities appear to be more frequently impacted by infrastructure issues, likely reflecting difficulties in accessing the personnel and materials to undertake remedial works.

Two facilities have fences that do not meet the required height. Although there is a commitment to undertaking works to raise the fences, work has not yet happened. We have raised our concerns in various forums, including with senior service staff and with the OCP. This year, MHAS made an inquiry into events that occurred when a consumer scaled the wall in order to get out of the facility and was quite seriously injured at some point between climbing the wall and being returned by security guards.

We wrote two complaints and one letter of concern for consumers about conditions on one facility. The door from the courtyard into one ward had come off and not been replaced, allowing heat and flies to get into the ward and presenting a general health risk to consumers. The ward has since been closed while extensive remedial works take place.

A consumer complained about the acoustics on a ward where the air conditioning system made it possible to hear what they were saying in the adjacent ward. MHAS raised this matter with the service.

Seclusion and restraint

The continued use of restrictive practices contributes to consumers' experiences of treatment in a coercive, unsafe and undignified environment. The use of seclusion and restraint are both governed by the Act. It is recognised that restrictive practices generally have an adverse impact on recovery, and there is an express intention to reduce use of these. Because of their prominence in relation to rights and consumers' experiences, these practices are a focus of Advocate attention.

Following a restraint or an episode of seclusion, the Advocate checks that relevant forms have been completed and clinical notes are up to date. When a consumer raises an issue or complaint about a seclusion or restraint, the Advocate outlines the options the consumer has, raises issues with staff and lodges a complaint when required. Sometimes MHAS raises concerns independent of the consumer, depending on their potential impact on identified people as per the Act.

Complaints about seclusion have included:

- Nursing staff who undertake the required observations only by video and do not attend the seclusion room.
- Lack of access to a toilet, forcing the secluded consumer to use a bedpan with no privacy screen.
- A one-way intercom, so the secluded consumers had no way to gain the attention of nursing staff.
- Poor conditions, for instance insect infestations in the seclusion room.
- A seclusion room off the lounge area of the ward, not affording dignity to people who are placed in seclusion and potentially upsetting or traumatising consumers who may be using the lounge area of the ward.
- A consumer whose clothes were removed for a seclusion on the basis that they were a suicide risk, although this was not part of their clinical presentation. This happened twice to the same consumer and was the subject of an inquiry each time.

Advocate actions included escalation, complaints, and inquiries. The Senior and Chief Advocate regularly raised seclusion issues in facility meetings and sought staff commitment for resolution. Advocate action and escalation has largely been effective in bringing about change to practice and policy, although changes to infrastructure are harder to achieve. In some cases, Advocates were involved in the review and refinement of policy and paperwork to support better practice.

Following a commitment to make a change, Advocates then monitor for implementation and highlight where this is not happening or is lagging.

Complaints about restraint have included:

- Following a consumer complaint about being restrained, the Advocate discovered that the facility's restraint policy was not compliant with the OCP standards and allowed some restraints to take place without oversight. We wrote to the service and the OCP. The service contacted the consumer with an explanation and apology since the initial response to their complaint had indicated the Act had not been breached, when in fact it had been.
- Escalated this with the OCP who wrote to the service. The policy has been amended.
- A prolonged transfer to an authorised hospital in 'soft restraints', a form of handcuff, for a person not in police custody. We are awaiting a response to a complaint we lodged.
- A consumer who was taken from the ward into the seclusion room in handcuffs. We undertook an inquiry, and the issue has been resolved.

Other consumer rights

Further opinions

Consumers have the right to request a further opinion. Consumers often get a good outcome from a further opinion, even if their involuntary status continues. Changes to their medication, leave, communication rights can all have a positive impact on the consumer's recovery, as does the sense of empowerment that can come through exercise of this important right.

An operational directive covered the consumer's right to flexibility and choice in who would provide the further opinion, and the HSP's responsibility to provide this within a set timeframe was rescinded in June 2021.

After slight decreases in the number of consumers requesting Advocate assistance to access a further opinion since the Act came into operation, MHAS data indicates that the recorded number of requests dropped by 33.7% in the 2021-22 year. Although we have concerns about the overall accuracy of our data the trend is supported by anecdotal feedback from Advocates. Since a consumer can request a further opinion directly, the data does not equate to the number of requests made. Despite the lack of clear data on further opinions, we remain concerned that this important consumer right is being eroded.

Advocates report greater difficulties in finding a psychiatrist who could provide a further opinion. In one case, the Advocate made seven requests, none of which were successful. In another case, the Advocate made multiple requests within WA, Australia and eventually tried overseas but was unable to find a psychiatrist who could provide the further opinion.

COVID has undoubtedly had an impact on the availability of psychiatrists who can complete a further opinion. However, rescinding the operational directive and along with it the requirement that HSPs respond within a set timeframe, appears to have impacted the urgency with which services respond. During the past year, we had several discussions with the Chief Psychiatrist, exploring examples of good practice and options for the effective provision of a further opinion service. We anticipate that the issue will receive attention in the statutory review of the Act.

The right to communication

Consumers have the right to lawful communication in reasonable privacy, unless their psychiatrist decides that restriction of communication is in their best interests. Restrictions may be placed on the amount of time spent communicating, whom the consumer can communicate with, or both. The psychiatrist completes a form 12C outlining the nature of the restriction and a notification is sent to MHAS. The form 12C applies for a 24-hour period and must be renewed once this has elapsed.

Advocates follow up to ensure paperwork has been completed correctly, consumers are aware of and understand the restrictions, and can access their right to communication within the terms of the form 12C.

Communication restrictions have remained at relatively similar levels over the past three years, although there is fluctuation across authorised hospitals and HSPs. MHAS has routinely shared data on the number of orders and consumers whose communication is restricted at regular facility meetings, where we have also raised specific concerns about any increase in numbers.

During the past year, we have raised the following concerns:

- Seven facilities where the number of consumers placed on a form 12C proportionally more than the number of involuntary orders by at least 10%.

Treatment support and discharge plans

Involuntary consumers have the right to a comprehensive Treatment, Support and Discharge Plan (TSDP) that is intended to respond to their clinical, social and psychosocial needs. The right extends to their involvement in the development and ongoing review of the TSDP. The consumer may choose to have their nominated person, family or other unpaid carer involved in the consideration of the options for their treatment, care and support during an inpatient stay, including planning for what they need when they will leave hospital.

The TSDP provisions in the Act are largely good, but implementation has been poor. As a result, the consumer does not have the choice and self-determination that the Charter expects, and a key means of facilitating person-centred services is under-developed.

As reported in our submission to the statutory review of the Act, many consumers are not aware that they have a TSDP and have not been involved in its development. This can leave the consumer feeling disengaged from their treatment and care, which can reinforce the disempowerment that people feel when treated involuntarily.

During the past year, there was an 8% drop in the number of consumer issues relating to TSDPs recorded by Advocates. Periodically, Advocate teams were asked to review TSDPs for consumers they were working with. These reviews consistently revealed poor quality plans, some with little detail and/or blank or missing information. Others that focused only on clinical treatment. Involvement of consumers was often not evident in the plan.

Over the past year, concern about the quality of TSDPs was raised at many facility meetings. Staff turnover, the lack of a dedicated TSDP document as part of the Statewide Standardised Clinical Documentation (SSCD) set, inconsistent education and the lack of a centralised education program for clinical staff were all raised as factors impacting the quality of TSDPs. In one service who reported a near 100% result on a recent TSDP audit, the first two plans that MHAS asked to see were missing and blank respectively. In another service, a planned audit was delayed multiple times. It may be that audit processes are focused on 'tick box' compliance on the existence of the plan, and less able to critically examine the quality of the plans against the criteria in the Act.

Some services have done well and produce detailed plans with clear consumer involvement. This has occurred where there has been strong leadership from a senior member of the clinical team, ongoing education for new staff and the development of a customised TSDP plan template.

- Apparent administrative problems with 12C notifications from one facility.
- Difference of opinion about how to count the 24-hour period. MHAS sought clarification from the OCP on their interpretation, who advised the facility accordingly.
- An instance where a psychiatrist wanted to use the form 12C to restrict a consumer's access to a smart phone to stop them using it to listen to music late at night.
- Clarified the need to use a 12C to restrict communication access to people who were prisoners and were admitted to hospital on an involuntary order.

Positive outcomes for consumers

Our advocacy involves identifying potential breaches of consumer rights and instances where the services fall short of the expectations of the Charter for Mental Health Principles. Raising issues and concerns, complaining, investigating and inquiring are central functions.

Although these processes can be difficult and time-consuming and at times stretch the relationship between MHAS and services, they also deliver good outcomes for consumers:

- Changes that restore consumer rights in specific circumstances, for instance improved storage space for personal possessions, return of possessions from police, access to leave.
- Changes to practice and policy that improve the health, safety and wellbeing of all consumers.
- Apologies to consumers that validate their experiences.
- Changes to consumers' treatment plans to respond to their stated needs and preferences.
- Improvements to ward safety, sexual safety and restrictive practices.
- A shared concern about structural problems that limit access to services for some groups of people, and commitments to look for solutions.
- Improved relationships between MHAS and services.
- Improved complaint handing processes.

Consumer rights and issues - older adults

Last year's Annual Report focused for the first time on the experiences of older adults in authorised hospitals. Little has changed since we reported a year ago. Advocates reported multiple examples from this year where older adults were not able to access their rights or where their treatment, care and support did not match the standards set by the Charter.

There are not enough older adult beds across the state to meet demand, creating pressure on older wards everywhere. Older adults may wait for long periods, sometimes as much as a week, in emergency departments or on medical wards until they can access a bed. The closure of the older adult Hospital in the Home (HiTH) beds because of the lack of an older adult psychiatrist is concerning considering this.

Lack of safety, dignity and privacy

Listening to and trusting the consumer is important to their recovery. In the example below, the treating team was as pleased with the outcomes as the consumer - it just required them to listen really well to what the consumer was proposing.

An older adult was made voluntary prior to discharge but the consumer and their treating team disagreed where they should be discharged to. Liaison between the consumer, Advocate, doctors, social workers and welfare workers resulted in the consumer clearly expressing their preferences and the treating team eventually agreeing with their proposed plan.

The environmental conditions on older adult wards are no worse (and in some cases, better) than on adult wards, and impact on older adults' health, safety and wellbeing in similar ways. Wards that have bedrooms, bathrooms and toilets without lockable doors present a safety issue and fail to afford older adults the dignity that should be a norm in a contemporary health system.

Given that older adults are more likely to require assistance with personal care activities, this is a concern. Advocates addressed instances where older adults were washed, changed or were assisted with toileting with doors left open so they were in view of others on the ward. They reported occasions when older adults were not asked about the gender of the nurse assigned to assist them with these intimate activities.

In such instances, Advocates raised consumers' concerns and facilitated changes to their treatment and care that better protected their safety, dignity and/or privacy.

For an older adult, being able to have some belongings in their room can be a source of comfort, helping them feel safe during their admission. Advocates reported occasions where older adults' rooms were cleaned without telling the occupant, and their belongings were moved. In these instances, the confusion and distress this caused could have been avoided by better communication between staff and consumer.

Older adults who are bedbound and admitted on a 6B are particularly vulnerable, especially when they are placed in shared rooms. Unable to leave the room to access consultation spaces elsewhere, private and confidential conversations with their treating teams must take place in their bedroom, regardless of the other occupant being there.

Lockable bedroom, bathroom and toilet doors would go a long way to addressing concerns that some older adult consumers raised with their Advocate. Education for all staff on how to communicate with older people, particularly at a time of stress and distress in their lives, might address some of the confusion that older adults experience in an environment that they have little control over. This is especially true for older adults who are experiencing their first involuntary admission and for those who have been living independently in their own home before their admission.

Ineffective communication

The right to communication in a language and form that the consumer understands is enshrined in the Act and included in the Charter in the principle on diversity. Over the past year, Advocates reported instances of ineffective communication in inpatient and community clinic settings.

Many older adults require some accommodation to be able to communicate effectively: hearing impairment, language, culture and possibly cognitive decline can all impede an older adult's ability to understand information and express their views and preferences. Communication may also take more time. Unfortunately, Advocates reported instances where insufficient effort had been put into supporting the older adult to express their views about what they want to get out of their hospital stay, their medication preferences and/or the supports they will need to return home safely. Sometimes, older adults simply are not asked.

An Advocate assisted a socially isolated consumer who was to be discharged to a residential care facility that they had not chosen. A lack of confidence in speaking English, no contact from their guardian and a busy treating team had made it hard for the consumer to get their preferences heard. The Advocate brought the parties together and supported the consumer to express their distress about the situation and their preference for where they wanted to live. The discharge was successfully completed, and at a Tribunal hearing shortly after, their Community Treatment Order was revoked - an excellent outcome for the consumer.

For those older adults whose first language is not English, an interpreter service is available. However, the decision about the necessity of using an interpreter lies with the treating psychiatrist. Advocates reported instances where the older adult asked for an interpreter, but the psychiatrist did not agree on the basis that the person was able to speak English. In other cases, Advocates encountered a family member used as a substitute interpreter, also not compliant with the provisions in the Act.

An Advocate made sure that an interpreter was arranged for a consumer who, although they could speak English, felt more comfortable communicating in their first language. The interpreter attended prior to the consumer's Tribunal hearing to take them through the medical report and attended the hearing.

A great deal of the work in supporting older adults is about getting their voices heard in what can be crowded spaces with many, much more powerful voices - families, treating teams, Guardians. Advocates reported issues with older adult TSDPs that appeared to not meet all requirements of the Act. These included plans written in language that omitted or obscured the older adult's voice, those that focused narrowly on their clinical and medical needs, and issues raised by older adults about TSDP discussions that left them feeling disempowered and lacking control over their lives.

This is a lost opportunity to support recovery in a person-focused way. As well as training in communicating with older adults, a TSDP written in language that the older adult understands, reflecting their words, preferences and hopes would enhance dignity and safety for older adults across inpatient and community clinic settings.

There is also an opportunity for clear policy on the use of accredited interpreters, centring the older adult's wishes in this regard. Family or staff should not be a substitute.

Tricky family dynamics and relationships with treating teams

Advocates often find themselves working within the complicated dynamics between the older adult, their family and their treating team. The older adult may also have a publicly appointed or family guardian. Advocates are guided by the older adult's preferences, and report that they may work within vested interests that do not align to the older adult's best interests. Advocates have noted a tendency for treating teams to trust the family guardian over the older adult. This can make it extremely hard to amplify the older adult's voice, even with strong advocacy, and is compounded by TSDPs that do not meet the requirements of the Act.

Discharge is particularly contentious. Advocates have observed occasions where older adults are moved out of their homes and into supported accommodation or aged care without, in the Advocate's view, sufficient interrogation of the full range of circumstances. The over-reliance on the family view, the failure to fully hear the older adult's voice and the risk lens combine to remove independence from people who, with appropriate supports, could return to a meaningful life in the community.

Better access to their right to a TSDP that responds to the full range of their needs and has been developed with their involvement, vigilance over the communication and relationship context, and consideration of what happened to the older adult leading up to their admission, would help to ensure that this does not happen without good reason. Greater scrutiny of the intentions of family guardians and a preparedness to challenge State Administrative Tribunal decisions or application for the appointment of a public guardian where the treating team has concerns about the family's interests might better protect the older adult's interests.

Rights of voluntary older adults

Last year, we raised concerns about voluntary older adults who are admitted to locked wards. In these wards the older adult may by subject to restrictive practices but do not have access to an Advocate.

A door to a garden was kept locked to restrict the movements of a couple of consumers, however, it meant restriction for everyone on the ward. The Advocate sent an email to the social workers about the unacceptability of the situation, who forwarded the email to facility management. The door was permanently unlocked the same day and the change in ward policy was attributed to the MHAS intervention.

As reported last year, MHAS has advocated to the MHC for the provision of funded advocacy to voluntary older adults in authorised hospitals. There is provision for the Minister to make a Direction under s.348(j) of the Act to assist certain voluntary consumers (which is published in the WA Government Gazette and tabled in Parliament). We have received widespread support for this, including from the then Minister who encouraged us to seek a direction. The service would also need to be funded. The Chief Advocate raised this with the Commissioner in September 2021, and then again in February 2022. There was no commitment to additional funding at that point: we were assured that there was still an intention to facilitate a workshop with Department of Communities, first proposed in December 2020, to explore how to strengthen individual advocacy for voluntary older adults. In June 2022, the Chief Advocate wrote to the Commissioner to ask for an update on the progress on plans for the workshop. A response had not been received at the close of the financial year.

As an outcome of discussions with the Commissioner, the Chief Advocate presented to the Mental Health Leads Sub-Committee of the Mental Health Executive Committee on the issues faced by older adult consumers in June 2022 (and described in this section). She proposed options that could be implemented with relatively little cost and time. The Chief Advocate was invited back to the August 2022 meeting to further discuss the options and possible actions.

The MHAS submission to the Statutory Review of the Mental Health Act also raised the issue of rights of voluntary older adults. Any potential legislative change is some time away. In the meantime, voluntary older adults remain vulnerable to having their rights restricted with limited oversight and no access to advocacy.

Consumer rights and issues - children and young people

System capacity

Last year we reported that mental health care for children and young people was in crisis. This remains the case. The lack of bed capacity for acute inpatient care for youth aged 16-24 years is a major concern, with some groups of young people particularly disadvantaged:

- 16-17 year-olds.
- Complex support needs related to, for instance, learning disabilities, neurological conditions, in the care of Child Protection and Family Services.
- Diagnosed with eating disorders, or complex trauma or both.
- Living in regional Western Australia, and especially First Nations young people.
- In the youth justice system.

We are hopeful that the reforms identified through the Infant, Child and Adolescent Taskforce will, over time, alleviate the current demand for acute inpatient care but remain concerned about what will happen in the interim. Delays in accessing acute beds can result in prolonged transfers of care between services involving restraints and heavy sedation, increased lengths of stay in hospital, greater use of restrictive practices whilst admitted, more code blacks and increased involvement of security guards in aspects of treatment and care. A great deal of MHAS advocacy for children and young people relates to addressing these impacts of bed scarcity, and ensuring their rights are upheld in difficult circumstances.

One of the tasks MHAS undertakes is a review of the daily bed report to identify and monitor children and young people in emergency departments, medical wards or in the community who are referred or waiting for an admission. The review of the bed report creates a pathway for MHAS intervention with services, and for consumers as required. When the Advocate can get a bed allocated and transport arranged, this may remove the need for an Advocate to visit the child or young person while they are waiting. As well as general bed availability problems, advocacy also identifies facility issues - for instance, staffing, acuity, and differing levels of risk tolerance - and gaps in community services. It highlights patterns and trends in the response to different presenting needs and the inequitable access to treatment experienced by certain groups.

Advocates ensure that children and young people can access their rights, provide reassurance to them and their families so they know they do not have to navigate the system by themselves, liaise with services to remove barriers to admission, and facilitate prompt transfers to authorised hospitals where required. We undertook an analysis of the bed report data for children and young people for the fourth quarter of 2021-22[23]. This indicates the nature of the demand for beds:

[23] We estimate that numbers are under-reported by about 10% because the bed-report Advocate was away for a brief period in mid-April.

- 99 individual children and young people presented to emergency departments or were in medical wards seeking admission to a mental health bed; the youngest was 11 years old and the oldest was aged 22.
- 73 were voluntary children, and 60 of these were ages 16-17 years.
- 26 were children or young people on involuntary orders.
- Most regional referrals came from Broome, Busselton, and Bunbury (9). Most metropolitan referrals came from Sir Charles Gairdner Hospital (SCGH), Royal Perth Hospital (RPH), Joondalup Health Campus and Fiona Stanley Hospital.
- Advocates visited 33 children or young people in EDs or MHOAs.
- The longest wait in ED/MHOA that MHAS was aware of was 11 days (two consumers), and a further six consumers waited for five days or longer.
- There were some significant delays in accessing a mental health bed for consumers on medical wards, once they were medically stabilised, including a delay of 18 days and another of nine days.
- Extensive escalation was required for 12 consumers.

In addition to individual advocacy and escalation during the past year, the Chief Advocate raised concerns about youth bedflow and access with the Chief Medical Officer - Mental Health, the Chief Executive of EMHS (responsible for the youth bedflow project), the Mental Health Commissioner and the Minister for Mental Health. Some improvements to the bedflow process are evident, but these do not and cannot fix the capacity problem.

Consumer issues for children and young people

Youth Advocates recorded 888 issues for the children and young people they worked with over the past year. The highest number was recorded for treatment, followed by admission, discharge and transport, and then consumer rights. These figures are reflective of the difficulties in accessing inpatient services and treatment, trying to get appropriate services in place to enable discharge, problems with safety for those with eating disorders and/or complex trauma, and the high levels of self-harm and suicide attempts seen during child and youth admissions.

During the year, 38 serious issues were recorded for children and young people. The greatest number were classified as 'other' where the child or young person had seriously self-harmed or tried to abscond (12). Sexual safety and physical abuse were ranked second (eight each), and psychological/ verbal abuse third (six). The remaining four issues related to staff misconduct.

Self-harm on child, youth and medical wards is concerning. Advocates report that self-harm is a regular occurrence and does not always constitute a serious issue under the MHAS protocol. The Advocate generally completes follow up action at the ward level, and no further escalation is required. Nevertheless, the frequency with which children and young people hurt themselves whilst in hospital is alarming.

Serious issues may result in a complaint being made or an inquiry conducted. Correspondence may also be written in relation to an intractable or systemic issue. Over the past year there were three inquiries, 10 complaint letters, two letters of concern and one giving feedback. There were consistent themes across the correspondence:

- The care of children and young people with eating disorders and excessive or heavy-handed use of mechanical restraints on medical wards.
- Communication and the involvement of families in discharge planning.
- Delays to discharge because of CPFS and NDIS accommodation and support issues.

With one exception, where the inquiry response is outstanding, all issues raised in inquiries or complaints have been resolved. The initial complaint response was unsatisfactory in four cases and required further liaison with the facility to re-examine the issue and produce a satisfactory response. MHAS has undertaken work to improve complaint-handling with facilities, with good results being achieved.

During the year we had some good outcomes from serious issue follow up, and through liaison with facilities involving the Senior and Chief Advocate meeting with co-directors and senior staff.

Some examples include:

- Roll out of a model for involving young people in TSDPs as part of a new complete care package at East Metropolitan Youth Unit (EMyU), and agreement that Advocates would report instances of 'copy and paste' across TSDPs to the Nurse Unit Manager (NUM).
- The response to care for young people being treated for eating disorders on medical wards at Fiona Stanley Hospital.
- Agreement to change how security guards are deployed at Perth Children's Hospital (PCH), and how restraints take place on medical wards.
- The incorporation of culturally responsive elements into the treatment, care and support for First Nations young people, for instance on-country leave and use of smoking ceremonies.
- Increased resourcing for psychology and re-instatement of occupational therapy groups at EMyU.
- Collaboration between CPFS, a presenting ED and a receiving youth unit to develop a plan for a young person with complex support needs to expediate future presentations and thus to avoid excessive waits in ED.

Each of these examples of changes that facilities have made to enhance consumers' access to their rights could be adopted by other services and facilities

Advocacy on systemic issues for children and young people

In addition to the issues presented above, MHAS has undertaken advocacy on key systemic issues.

Young people on medical wards

The care provided to young people being treated for eating disorders on medical wards has been a focus of our individual advocacy and indicates systemic concerns. Medical wards are not authorised, and do not have the same clinical oversight as mental health units. Treating teams and nursing staff may lack an understanding of the mental health dimensions of a young person's condition, and this can result in complaints from consumers about the lack of compassion they experience. Nursing staff frequently approach Advocates seeking a better understanding of the mental health issues that are impacting the young person they are caring for, and express that they do not always feel equipped to de-escalate a young person who has become distressed.

Following complaints from three separate consumers, MHAS undertook an inquiry into the care of young people with eating disorders admitted to medical wards at Fiona Stanley Hospital. Driven in part by the inquiry, Fiona Stanley Hospital have made or committed to several changes to improve the care given to people with eating disorders. These include, better recording and documentation of the use of mechanical restraints, training for staff in de-escalation, restraints to be nursing-led and the incorporation into practice of a consumer-directed tool to identify individual triggers.

Gaps and misalignments at the child protection, mental health and NDIS interface

Interface issues impact access to services and timely and effective discharge. During the past year, the Senior and Chief Advocate have built a relationship with the DoH long-stay project team and with the project officer allocated from the MHC. This has improved our ability to escalate specific cases where children and young people are stuck in hospital beyond the point when they are ready to be discharged because of NDIS and CPFS issues. However problems remain, compounded by a lack of expertise in dual disability (learning disability and mental health issues) in mental health services across the state.

A great deal of Youth Advocate time is taken up liaising with multiple services involved in the treatment, care and support for young people with complex support needs. An inquiry into the discharge arrangements for such a young person demonstrated the impact of the lack of collaboration between mental health, CPFS and NDIS services on their discharge. Following the inquiry the Senior and Chief Advocate met with the Executive Director for Service Delivery of the Department of Communities. This meeting led to an improved understanding of the structure and escalation pathways within CPFS, and more effective advocacy for young people who have got 'stuck' trying to access or leave inpatient mental health care.

Advocates spend time in developing relationships with non-mental health stakeholders involved in the care and support of young people with complex support needs, including Young People with Exceptional and Complex Needs initiative (YPECN) and Youth Justice Services. These relationships provide an effective way for us to advocate for consumers with complex needs and have been instrumental in facilitating their access to their rights.

Over the past year there have been at least three instances where Youth Advocates have been involved in supporting young people with a disability in EDs, experiencing extreme distress and/or with suicidal ideation and self-harm. In each case, the mental health service determined that the young person's presentation was driven by their disability and an admission to a mental health unit was not required. At the same time, their community support provider was equally clear that they were unable to support them because of their mental distress. Although each of the three young people were eventually admitted, each spent several days in an ED whilst the Advocate liaised between services, guardians and families.

Access to inpatient mental health care for young people at Banksia Hill Detention Centre

Effective advocacy relies in large part on relationships between MHAS and services at every level. This year we have started to build our relationship with staff at Banksia Hill Detention Centre (BHDC) and more broadly in the Department of Justice to improve our advocacy to detainees who are identified under the Act. This followed individual advocacy for a detainee who was an identified person, was very unwell and required an admission to a youth unit. MHAS now has a regular meeting with BHDC staff to raise and resolve issues experienced by young people who are identified under the Act.

We also liaise regularly with the Office of the Inspector for Custodial Services, the Commissioner for Children and Young People and the OCP on the provision of and access to in-reach and inpatient mental health services for detainees.

Consumer rights and issues - regional consumers

This section reports on the experiences of consumers in regional WA and highlights how these can be shaped by location. Although many of the issues are similar across the state, regionality and distance play a role. Availability of appropriately skilled staff, accessibility of services, and access to resources present challenges for services and impact on consumers' access to their rights.

These are not new problems, but the COVID pandemic has made the cracks in the system and the impact on consumers more visible.

Involuntary consumers in regional WA

The composition of involuntary admissions in regional WA is different to metropolitan hospitals. The vast majority are admissions into an authorised hospital, rather than to a general hospital (form 6B). The steep increase in admissions to general hospitals in the Perth hospitals has not been replicated in the regions. Regional consumers who need an involuntary admission to a medical bed are more likely to be transferred to a hospital a long way from their home and family than their metropolitan counterparts.

Although the number of orders has fallen, Advocate hours across regional WA have increased by 15%. This is encouraging and reflects the regional advocacy team's focus on the quality and depth of advocacy, ensuring that issues are followed up and escalated where necessary. Consequently, the past year saw an increase in complaint and inquiry letters and improved resolution of issues raised by consumers.

TABLE TEN - Number of involuntary treatment orders for consumers in WACHS

	2019-20	2020-21	2021-22
Adult inpatient orders (18+)	480	495	450
Inpatient orders for children (0-17)	2	10	4
Adult community treatment orders (18+)	213	222	222
Community treatment orders for children (0-17)	2	8	8

Workforce shortages and scarce resources

Staffing shortages have impacted the system but have been particularly acute in some regional locations. We acknowledge impact on staff and how hard they have worked to provide consumers with treatment, care and support. However, MHAS is obliged to draw attention to the impact these shortages have had and continue to have on consumers and on the ways in which they restrict consumers' access to their rights.

Advocates report that where a service relies on locums, consumers may experience inconsistency in how their treatment and care is planned and managed. Consumers often have no choice of psychiatrist and for some this can impact on their recovery outcomes.

A consumer complained about a psychiatrist and forcefully expressed their opposition to their treatment plan. The opposition had jeopardised discharge which the consumer very much wanted. The Advocate helped the consumer understand their rights in relation to treatment, and the consequences of refusing treatment. The consumer was able to make an informed decision about how they engaged with their treatment and shortly after was discharged successfully.

A family did not want to complain about COVID restrictions on visiting hours which meant they were not able to visit their child because they were worried this would compromise the chances of getting an eating disorder bed in Perth. The Advocate represented the family's concerns and was able to negotiate leave and visiting arrangements that suited the child and family.

Regional Advocates have reported that it can take a long time to get problems addressed. The scarcity of resources within health services is compounded by a scarcity of resources in communities, exacerbated further by the demand for labour from a booming mining sector. A case in point is the work required on the fence at Kalgoorlie, and the difficulty the service has had in securing a contractor who can meet the requirements of a government contract. The scarcity of resources particularly impacts children and young people who may need to be transferred to Perth to access the specialist help they need. It can be particularly difficult when there are disagreements between the family and the treating team over what is in the child's best interests.

Advocates also report poor access to services and supports including specialist support co-ordination for people with NDIS plans. This was identified as a major inequity for people with psychosocial disability living in regional WA in the MHAS-MHC NDIS project. In the context of the growing shortages of affordable and appropriate accommodation, Advocates more frequently find themselves liaising with hospital social workers to try to address accommodation issues that are preventing a consumer from being discharged.

Transfers to intensive and high care facilities

Accessing prompt transfers to facilities for consumers who need intensive or specialised treatment and care than is available locally can be problematic for regional consumers. The temporary closure of the Broome High Dependency Unit has resulted in some prolonged transfers and delays for consumers in accessing treatment, particularly those living in regions north of Perth. Consumers may wait for many hours or even days in emergency departments for a flight, a bed or the alignment of both. Advocate work comprises liaising with emergency department staff to ensure the consumer has what they need to be as comfortable as possible, monitoring the progress of transfer arrangements and advocating for escalation where appropriate.

A consumer in Geraldton was sedated whilst waiting for transfer, and during this time started their menstrual cycle. No sanitary protection was provided, and the consumer was transferred in blood-stained clothing. MHAS is undertaking an inquiry into this.

A consumer who needed high acuity treatment and care was transferred from a regional facility to Perth by the Royal Flying Doctor Service (RFDS), and then to another regional facility by road ambulance. The consumer was kept in handcuffs for the duration of the transfer, which took over eight hours. The Advocate wrote a letter of complaint; we are awaiting the response.

Licensed private psychiatric hostels

Last year, we reported on insufficient access to advocacy and rights protection for people who live in licensed private psychiatric hostels. Hostel residents are a marginalised group whose voices are easy to ignore, and who are at high risk of neglect, abuse and exploitation. Advocates can respond to requests for contact from residents, but without an assertive approach to Advocate presence in hostels, many residents lack the confidence, initiative or wherewithal to make contact themselves. Our individual advocacy has made clear that many hostel residents are not aware of their rights, and there have been many occasions where their right to dignity and respect has been breached.

The enhanced hostel visiting program

The Chief Advocate raised her concerns about this situation with the Mental Health Commissioner at a meeting at the end of the 20-21 financial year. In response, she was asked to provide an outline and costing for an enhanced hostel visiting program. In September 2021, the Commissioner agreed to provide funding to support an enhanced hostel visiting program that would facilitate access to advocacy for residents and develop risk mitigation strategies until such time as WA transitions to a contemporary model of accommodation and support for people with complex psychosocial disabilities.

Since the program of regular visits commenced in January 2022, Advocates have made 140 visits to 24 hostels, and seen 424 residents[24].

Advocates have recorded 305 issues and 146 actions to resolve them. To date, 41 of the issues raised have been resolved. Actions may include discussions and email correspondence with hostel management and staff, education sessions for staff on resident rights, advising residents themselves of their rights, and attending residents' meetings to address issues when residents lack the confidence to speak up or fear retribution if they do. Advocates have been invited to attend resident meetings on a regular basis at some facilities.

Issues that are raised frequently across multiple hostels indicate systemic flaws and opportunities to improve support provided to residents. Last year, Advocates reported poor attention to maintaining care plans,

24 These figures are likely to be under-reported; data collection practices within the Hostel Advocate Team are currently being addressed.

inattention to supporting residents' goals and aspirations, and lack of support to attend their community mental health clinic appointments. Advocates reported undignified and disrespectful environmental conditions, and residents who told them they were afraid to complain in case they were evicted.

One resident was afraid that if they asked for vegan food they would be evicted for "being difficult". The resident told their Advocate that staff stood over them until they ate everything on their plate and was told that they would be 'punished' by having 'privileges withdrawn' if they refused to eat the food provided.

On more than one occasion, Advocates reported that they visited residents who were dressed in clothes that were ill-fitting, or not appropriate for the season. When Advocates inquired, the residents said they were given no choice over the clothes provided despite their board payment being inclusive of clothing.

An Advocate raised this issue with the management at one hostel, who said, 'we get the cleaners to check the wardrobes and tell us what they need, then we go and get it.' Following our advocacy, the hostel management started to ask people what clothing they wanted, and vouchers were provided for new clothing.

Physical health was also a recurrent theme in the hostel Advocates' work over the past year. Many residents experience relatively poor physical health, and Advocates remain vigilant to unaddressed physical health needs, including dental health, intervening to ensure these are attended to.

An Advocate noticed a resident who had a visible bleeding sore. Hostel staff told the Advocate that they had tried to make a specialist appointment, but none was available for three months. The Advocate called the specialist clinic and was able to get an appointment for the resident within two weeks. When the Advocate visited again, the resident had been seen by their doctor and the sore was much better.

A resident had been unable to get a medical review from their community mental health clinic, despite asking several times. The Advocate raised the matter with the community clinic and at first the doctor tried to do a review without seeing the resident. The Senior Advocate escalated the matter to the Health Service Provider. After further action from the Senior Advocate, the resident got a face-to-face review.

FIGURE FOUR: Overview of issues raised and resolved through the hostel visiting program

ENVIRONMENT PHYSICAL

RESOLVED: Unsuitable mattress; broken water dispenser; residents unable to access building; no towels for hand drying; weather blinds; lockable cupboards.

PARTIALLY RESOLVED: Broken furniture; cleanliness; mould.

ONGOING: Flimsy flyscreens; suitability, orientation and timeframe for new [hostel] facility; dirty tables and outside areas; lack of locks on bedroom doors; lack of air-conditioning; overgrown gardens, damaged fencing; door safety; toaster; bathroom plug; clothes dryer; lighting.

ACCESS TO APPROPRIATE SUPPORTS

RESOLVED: GP visits; poor telehealth appointments; financial abuse (by other resident); entertainment in isolation; potential eviction; timing of wellness checks; COVID health directives; whole of facility lockdown.

PARTIALLY RESOLVED: Poor food choices; boredom due to lack of NDIS; food supply, NDIS support; payment for tea and coffee; empty water dispenser.

ONGOING: Lack of activities; food quality including lack of food with afternoon tea; no resident meetings; early breakfast times; poor provision of NDIS supports; clothes smelling on return from laundry; access to financial statements; lack of toilet paper in bathroom; need for protective covers for devices; access to money; undisclosed rent increases; transport; access to activities; safety hazard (hoarding); accommodation changes; resident arrest; retrospective pharmacy bills; information about length of stay; providing cigarettes on credit; TV streaming services; clothing inadequate and ill fitting; public trustee issues; concerns over how the MHC COVID activities funding has been utilised.

SAFETY AND DIGNITY

RESOLVED: Shower opening from outside; privacy of mail; shower safety (non-slip mats); predatory resident; coercion to have rapid antigen test; behaviour management of resident.

PARTIALLY RESOLVED: Boredom due to suspension of NDIS; food supply; timing of wellness checks; NDIS support; access to clinical staff at night; administration of medication during COVID isolation.

ONGOING: Lack of privacy in rooms and bathrooms (locks on doors); fear of eviction; refused return after hospital stay; hygiene and food preparation; night safety; safety from intruders; dignity - including disposing of consumers' belongings; vegan forced to finish food (despite not being vegan food); lack of COVID isolation plans; lack of COVID education; exclusion, eviction and breach policies; security of belongings (lockers too small); Clozapine and COVID interactions; COVID response planning.

STAFFING

RESOLVED: Gender diversity of staff.

PARTIALLY RESOLVED: Access to night staff; staff leaving residents in charge.

ONGOING: Student supervision; lack of staffing; night-time staffing; staff engagement with residents; handover to and proper orientation to facility to agency staff.

ADVOCACY

RESOLVED: Lack of MHAS posters and brochures; reception familiarity with MHAS; provision of information about rights.

ONGOING: Fear of getting into trouble for talking with Advocates.

Accessing the NDIS

Accessing the NDIS and establishing or re-establishing supports is a growing aspect of what hostel residents have asked their Advocate for assistance with. In some circumstances Advocates can assist identified persons access other services. Under the enhanced hostel visiting program, this has extended to assisting hostel residents to access the NDIS. Advocates report the value of this work because of the outcomes for the residents. However, the extent to which Advocates can assist is limited, and there is a clear need for hostel residents to be able to access independent support in relation to NDIS matters.

Advocates continue to monitor and follow up NDIS provisions for hostel residents. Advocates have addressed instances where NDIS support workers have not turned up for a planned support visit without informing the resident, failed to address the resident's individual needs or under-utilised funding in other ways. We also remain concerned that there are residents who are likely to be eligible for the NDIS but whose eligibility has not been tested because hostel staff have not progressed the person's application. In one case, a resident with significant social anxiety was unable to leave the hostel. Although they had commenced an NDIS application, it was only progressed when the Advocate wrote to hostel management. The resident now has an NDIS package and has supports to access the community.

The following are examples of what has been achieved during the last year.

A resident told their Advocate that they wanted NDIS support and kept mentioning that a lady had visited them and said they would return, but never did. The Advocate contacted the NDIS, and eventually established that the Access Request had been commenced during a hospital stay in 2020 and re-commenced in 2021 with a plan approved later that year. The Advocate contacted the Office of the Public Advocate and the NDIS support provider to find out what had happened. A meeting was arranged with the various parties and with the Advocate's support the resident's supports were recommenced.

An Advocate noticed that a resident had stopped engaging in NDIS supported activities outside the hostel and made inquiries with the hostel staff who confirmed that supports had ceased, but they did not know why. When the Advocate investigated, they found that the resident had asked for the supports to be stopped because they were being provided on a day that didn't suit the resident. The Advocate arranged for the supports to recommence on a day and time that suited the resident. Additionally, the resident was awaiting the approval of Supported Independent Living (SIL) funding with a shared accommodation place that had been held for over twelve months. The Advocate helped the resident voice their preferences and secure their preferred accommodation. The Advocate liaised with the resident, their recently appointed Guardian, support co-ordinator and SIL provider to implement the NDIS plan.

At present, hostel providers can also register to be an NDIS support provider for the residents in their care. Whilst this may be an opportunity to extend hostel provider capability, it presents a duality of interest where both accommodation and NDIS supports come from the same provider. Given the culture of fear noted above, MHAS is concerned about the possible limiting impact on control and choice that this may have for some residents. A strong care plan and proactive engagement with a community mental health clinic case manager might provide an opportunity to ensure oversight of a resident's care and support outside of the accommodation and support environment, but this is not available for every resident.

Advocacy on the response to COVID in hostels

A co-ordinated approach to the response to the removal of the WA hard border, led by the DoH, commenced in January 2022. The Chief Advocate and Project Co-ordinator[25] for the enhanced hostel visiting program attended the outbreak and scenario planning meetings that took place in January and February.

From March to June, they attended weekly meetings led by the MHC to ensure provisioning for hostel residents during the outbreak phases of the pandemic.

MHAS was also involved in the MHC activities related to hostels. The Project Co-ordinator assisted with the provision of communication devices (tablets and smart phones) to hostels and provided input into a MHC health promotion campaign to support people in isolation in hostels. The MHC provided funding for each hostel so they could provide activities for residents who were isolating due to COVID. Advocates ran information sessions for residents of hostels and spoke to many individually to ensure that funding was spent in accordance with their wishes and needs. Where this appeared not to be the case, MHAS raised the matter with the MHC.

The Project Co-ordinator also successfully advocated with EMHS to ensure continued provision of community clinic staff visits to residents in hostels in that HSP.

The COVID outbreaks impacted on Advocates' ability to visit hostels, but all consumer contact requests and follow-ups were addressed.

Advocates consistently followed up with hostels regarding COVID protocols and safety measures in place to limit the spread of COVID within hostels - particularly those with shared bedrooms and bathrooms. They worked to ensure that hostel residents had the same freedoms of movement as people in the general community and successfully advocated against 'whole hostel' lockdowns. They negotiated with hostel management to ensure provision of appropriate resources for residents during isolation and lockdowns. Each week, MHAS provided feedback to the MHC's COVID Communication and Co-ordination Centre meeting regarding reporting inconsistencies, unaddressed resident needs and some hostels' overly restrictive practices.

[25] The Project Co-ordinator position was turned into a temporary Senior Advocate for hostels in April. This arrangement has been extended for the 22-23 financial year.

The rights of First Nations people

The Act provides specific, additional rights for Aboriginal and Torres Strait Islander[26] consumers that recognise the holistic concept of mental health for First Nations people. Sections 50, 81 and 189 of the Act seek to involve significant members of a First Nations consumer's community including Elders, traditional healers, or Aboriginal Mental Health Workers, to the extent that it is possible. These are important rights, intended to respond to the cultural and spiritual beliefs and practices of First Nations people and their ways of knowing about what works to restore social and emotional wellbeing during times of mental distress.

Unfortunately, we do not see general compliance with these requirements. Yet again, there has been little evidence of system change and the resources required to meet the terms of the Act have remained scarce. However, as this section demonstrates, when Advocates have been able to work with First Nations consumers to amplify their voices and support them to access their rights, the outcomes can be good. However, we have a long way to go before we have a mental health system that is truly responsive to our First Nations people.

Individual advocacy with First Nations consumers

Too often Advocates are trying to work with hospital staff to address the impacts of being off-country and advocating for visits, contact with family, and ability to participate in cultural ceremonies and events. While it is not always possible for consumers to return to country, there are options that help ameliorate the impacts. Examples of advocacy for First Nations consumers during 2021-22 included:

- A young consumer had been cleared for discharge but this was delayed due to a lack of accommodation. The consumer was constantly asking to go home which was a very long way away. The Advocate talked to staff about the consumer's wishes and was able to negotiate an extended leave of absence so they could return to country. The family organised a smoking ceremony during the trip and the consumer returned to the hospital willingly. The feedback indicated the leave and ceremony improved the therapeutic relationship with the treating team which had been damaged by the unnecessarily prolonged admission.
- A consumer did not feel safe being outside of their culture and had brought a weapon into the hospital for protection. This adversely impacted their risk assessment and the Advocate organised for the consumer to see an Aboriginal Liaison Officer to assist with their safety concerns.
- A consumer was admitted to hospital off-country and wanted to return home. The consumer explained to the Advocate that their treatment was not helping, and their distress was a result of evil spirits. The Advocate liaised with an Aboriginal Mental Health Worker and over a couple of weeks options were explored for an Elder from the consumer's community to be transported to the hospital to provide tradition healing. Eventually other traditional healing was arranged, and the consumer reported they were "fixed". A couple of days later they were discharged on a community treatment order. That order was revoked a few weeks later at a Tribunal hearing and the psychiatrist agreed the consumer had experienced a cultural phenomenon.

[26] Consumers of Aboriginal and Torres Strait Islander descent are referred to as 'First Nations' in this report.

- A consumer was referred for examination (form 1A) to a hospital that was off country and did not want to leave country. The Advocate explained the impact of the transfer for the consumer to the psychiatrist, and the consumer was able to be treated on a community treatment order instead so they could remain on-country.

MHAS has been concerned about access to Aboriginal Mental Health Workers and Aboriginal Liaison Officers since state-wide services were reduced. Advocates have been liaising with cultural services at individual hospital sites to progress requests from consumers and raise awareness of their needs. Advocates widely acknowledge the positive difference of having Aboriginal Liaison Officers available at mental health units.

Examples of how Advocates can assist with culturally responsive treatment include:

- A consumer appeared uncomfortable in a clinical review when delicate matters were raised, so the Advocate asked to stop the review to talk to the consumer. They found the consumer was feeling shamed and the people in the room of another gender were compounding an already difficult situation. The Advocate asked for other people to leave and the review continued.

- Advocates report that when interpreters are used there is typically no or limited time for yarning to build trust. The conversations can be rushed, and staff tend to want to jump in and are not comfortable with silence. Advocates assist by asking what the consumer would like, and with things like time to allow the consumer to respond during conversations with the treating team, or an opportunity for the consumer to speak their own language with the interpreter.

Advocates report that too often First Nations consumers do not want to complain. Although not confined to First Nations consumers, this can be compounded by previous experiences with white people in positions of authority, and/or a lack of hope that things will change. There are other examples where Advocates did not provide assistance but were told by consumers for example, that they would have gone voluntarily for treatment had they been told what was happening, or where no explanation was provided, and the matter resulted in a restraint.

MHAS' inquiry into Aboriginal and Torres Strait Islander consumer rights

In 2019-20 MHAS undertook an inquiry into the rights of First Nations people under the Act[27]. While the recommendations were accepted in principle by the key system leaders including the then Minister, it has proven very difficult to get progress on the development and implementation of an action plan. Some recommendations required investment and planning. Other recommendations were more straightforward and involve amendments to forms or templates specific for First Nations consumers.

In September 2020, Minister Cook referred MHAS' 15 recommendations to Mental Health Executive Committee (MHEC) to develop an action plan to address the findings of the inquiry and report back in 12 months and for the Director General of Health and the Mental Health Commissioner to provide a proposal to the Minister to resolve funding issues. MHAS therefore followed up in October 2021 about the plan and funding proposal with the then Minister.

In November 2021 Minister Dawson acknowledged the delay and advised that the MHEC and Mental Health Leads Sub-Committee (MHLS; a working group of MHEC) were discussing the recommendations to identify the lead agencies to address the recommendations and finalise the approach. He noted that several recommendations did not reside with the MHC as it was not the system manager, and this would be resolved through MHEC and MHLS, and the MHC would liaise directly with the MHAS to ensure timely updates in the future[28].

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

[28] MHAS was advised on 10 August 2022 (and outside the reporting period) that the Mental Health Unit of the Clinical Excellence Division, WA Department of Health, will be submitting a paper for the September 2022 meeting of MHEC for consideration and approval of recommended approaches/responses to MHAS' recommendations, including proposed acceptance/non-acceptance of recommendations, and recommended leads, actions, target completion dates and reporting process for the accepted recommendations.

The MHEC meeting communique from November 2021 stated, 'the MHC, DoH and Health Service Providers are committed to progressing the recommendations in the report through leadership, collaboration and coordination of roles.' However, there was no further communication between the MHC and MHAS. The Chief Advocate raised the apparent lack of progress with the Commissioner in a meeting in February, and then wrote asking for a progress update in June 2022. She received a response at the start of July[29].

This explained that, following MHEC deliberations in November 2021, an agency stakeholder meeting had been held in March 2022 where it was decided that the DoH Mental Health Unit (MHU) would be the lead agency, and lead agencies proposed for each recommendation. Specifically, the MHU would co-ordinate updates on progress against specific recommendations and develop indicators to monitor progress against each recommendation.

Cultural safety project

MHAS also has a responsibility to develop our cultural responsiveness. We are partnering with the OCP on a two-year project with the Looking Forward Project based at the Curtin School of Allied Health that is based in building relationships with Elders and community members, storying and working together to develop culturally safe and sustainable practices. We hope to build our capacity as individuals and as a service to respond flexibly, confidently and competently in our work with First Nations people, families and communities across WA.

Forensic consumers' access to treatment and care

The definition in the Act (s.348) of the 'identified persons' that Advocates can support includes:

- Consumers subject to a hospital order made by the courts for examination by a psychiatrist at an authorised hospital.
- Consumers subject to a custody order (ie unfit to stand trial or not guilty due to unsound mind) and detained at an authorised hospital.
- Consumers subject to a custody order and released subject to a condition that they undergo treatment for a mental illness.

Advocates may also assist prisoners who are subject to an involuntary treatment order. In practice this is almost exclusively consumers detained through a form 6A to the Frankland Centre. MHAS could assist prisoners in gaol who are subject to a community treatment order, however in practice these orders are not made in prisons.

29 Although marginally outside the reporting period, details are included for the sake of continuity and because the work referred to in the correspondence took place within the 2021-22 reporting period.

Custody orders

The number of beds available to forensic consumers reduced from 38 beds in 2018 to 34 beds: the difference being four open beds that were part of a rehabilitation pathway. Since 2018 the number of consumers subject to custody orders who are detained at the Frankland Centre (by order of the Mentally Impaired Accused Review Board) has increased three-fold, from nine to 28 consumers. This has severely impacted consumers' ability to demonstrate functional capacity and progress toward less restrictive options due to the lack of access to rehabilitation beds at Graylands Hospital (along with access to things like kitchen facilities and OT services).

In 2018 MHAS made inquiries of North Metropolitan Health Service (NMHS) about the reduction in forensic bed numbers. In response, NMHS stated there were no patients waitlisted for rehabilitation care but when future needs arise step-down care would be considered based on the individual's needs. MHAS was also assured those forensic consumers in the rehabilitation ward would continue to have access to kitchen facilities and OT support.

MHAS once again raised concerns about the treatment pathways available through the Frankland Centre for people on custody orders in June 2022, writing to the Chief Executive of NMHS to seek a review of processes. MHAS queried the apparent substantial blockages in access to support for forensic consumers in general, and specifically for people subject to custody orders. There are consumers at the Frankland Centre whose place of custody has been changed to Graylands Hospital by the Mentally Impaired Accused Review Board but have not moved as beds are not available. MHAS also raised significant inequity in access to services for females. MHAS noted that changes from the Graylands Reconfiguration and Forensic Taskforce and the reforms to the *Criminal Law (Mentally Impaired Accused) Act 1996* are likely to be years away.

The response from NMHS[30] advised the matters are being considered by the Graylands Reconfiguration and Forensic Taskforce (GRAFT). The Taskforce has prioritised the significant undersupply of forensic mental health beds: funding was allocated in the 2022 State Budget over two years to continue planning, including developing business cases. NMHS advised the impact of interim, small-scale measures would be minimal, however, they agreed to investigate all possible options for the use of rehabilitation beds at Graylands, and to explore options for individuals mentioned. MHAS will continue to advocate for increased rehabilitation pathways for all forensic consumers, so they have access to services and opportunities to reintegrate into the community.

Hospital orders

Hospital orders are made by courts where they suspect an accused person has a mental illness, does not have capacity to consent to treatment, and there is significant risk either to the health and safety, or of serious harm, of the person or another person (refer to s.5 of the *Criminal Law (Mentally Impaired Accused) Act 1996*). Hospital orders are akin to referral orders made under the (Mental Health) Act and provide for detention at an authorised hospital, except they may be in effect for up to seven days. In practice, people are seldom at the Frankland Centre on a hospital order for a week before returning to court. Either an involuntary inpatient treatment order is made, and the consumer is on the ward for treatment, or the person does not meet the criteria for an involuntary inpatient treatment order and is returned to prison.

The number of hospital orders made to the Frankland Centre has significantly decreased since 2019. This coincided with the increase in the number of people subject to custody orders being detained to the Frankland Centre (table seven shows the number increased from 11 as of 30 June 2019 to 22 as at 30 June 2020).

[30] The response was received on 17 July 2022, which is outside the reporting period, but a summary has been included to enable the right of reply.

During 2021-22 MHAS assisted two people subject to hospital orders. This is partly attributed to the fact MHAS is not advised when a hospital order is made. MHAS must make contact following a request from the consumer or someone on their behalf. However, unlike referral orders made under the (Mental Health) Act, there is no similar requirement for the person who makes the order to 'ensure that the person has the opportunity and the means to contact [...] the Chief Mental Health Advocate' to request assistance' (s.53(3) of the Act). Hospital staff can of course inform the consumer they can access an Advocate, but there is no requirement for them to do so.

Other forensic related advocacy

There are occasions when an Advocate becomes aware that Police will be interviewing a consumer, charges have been laid and/or a matter is proceeding to court. In such situations Advocates talk with consumers about accessing legal representation and in consultation with the consumer assist them to access that representation. Advocates also find the focus can be on a forensic history from years or even decades past and they work with the parties to ensure a balanced view.

The client management plan for a consumer was focused on the forensic history of over ten years ago and even when the Advocate entered a ward, they were advised by hospital staff that a consumer had been in prison. The ongoing reminder of prison was a trigger for the consumer who would end up crying. The Advocate worked with staff to help them understand the impact of the reminders on the consumer and about using trauma-informed language.

A consumer's forensic history from over twenty years ago was constantly referenced and this impacted their access to services and accommodation. The incident referred to had occurred when their child was removed by child protection workers, and they assaulted the worker. The Advocate assisted the consumer to present the conviction in its context and highlight that there had been no other history of offending.

CLMIA reforms

MHAS continues to be funded for a project management resource for the reforms of the *Criminal Law (Mentally Impaired Accused) Act 1996* to participate in cross-agency preparations to develop operating models and service requirements and document agency requirements. During 2021-22, MHAS provided updated budget submissions for pre-implementation resourcing and input into a project management framework. MHAS representatives participated in the inaugural meeting of the Implementation Steering Committee in November 2021 and various working and project groups convened by Department of Justice and MHC between July 2021 and February 2022. MHAS also finalised a review of literature and evidence to support the development of advocacy services for people in the criminal justice system with intellectual and/or mental impairment. This included exploring the drivers for contact with the criminal justice system and their support needs.

MHAS hopes the reforms will provide a more contemporary pathway for the safe reintegration into the community for accused persons.

Mental Health Tribunal hearings

Mental Health Tribunal (Tribunal) hearings are the only mechanism for a consumer to challenge a psychiatrist's decision to detain them and require them to take medication (or in the case of a CTO, require their attendance at a community mental health service for treatment). Tribunal hearings are therefore one of the three pillars or rights protection for involuntary consumers along with access to a second/further opinion and statutory advocacy.

Processes that enable consumers' participation in hearings and access to legal representation and/or non-legal advocacy are fundamental to support procedural fairness at hearings. This includes access to the psychiatrist's report ahead of the hearing, and opportunity for the consumers (and/or their representative) to ask the psychiatrist questions at the hearing.

Advocates attended 934 Tribunal hearings in 2021-22 either with, or at the request of, consumers to support and assist them at their hearing: that is about 18 hearings per week. Advocates assisted many more consumers to prepare for their hearings which either did not go ahead or that was all the consumer wanted from their Advocate.

Representation at Tribunal hearings

MHAS would like to see representation at hearings significantly higher, if not closer to 100% subject to consumer's wishes. The number of hearings attended by Advocates shows an overall increase over the past six years of operation of the Act (see table eleven). The proportion of hearings attended (compared to hearings conducted) increased by 34% over the previous two years.

Table eleven includes the number of all hearings listed by the Tribunal; Advocates commonly assist consumers to prepare for hearings that then do not go ahead, or are not completed. Based on the proportion of conducted hearings that Advocates attend (ie 34%), it is estimated that Advocates assisted a further 450 consumers to prepare for scheduled hearings in 2020-21 that did not go ahead (note the Tribunal's statistics for 2021-22 are not available). In these cases, hearings were cancelled as the involuntary order was revoked or expired but in 2021-22, cancellations were also occurring due to COVID.

Preparation commonly includes providing information about the role of the Tribunal, what happens at hearings, who attends, discussion of the content of the report prepared/approved by the psychiatrist and possible outcomes of Tribunal hearings. Advocates can assist consumers prepare their responses to the points made in the psychiatrist's report, and they help the consumer work out if they want to talk during the hearing and if not, what they want their Advocate to say on their behalf. Advocates also typically follow up when medical reports have not been made available.

TABLE ELEVEN - Six-year trend in representation at Tribunal hearings[31]

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Number of hearings listed	3,320	3,446	3,618	4,253	4,007	NA
Number of hearings conducted	2,103	2,247	2,320	2,627	2,659	NA
Number (and percentage) of hearings attended by MHAS[32]	680 (32%)	693 (31%)	692 (30%)	906 (34%)	916 (34%)	934
Number of hearings attended by the MHLC	8%	9%	9%	8%	11%	NA

Hearings conducted by video conference

MHAS raised the impact of hearings conducted by video conference (VC) on procedural fairness in the 2020-21 annual report in considerable detail. Following widespread community transmission of COVID when the borders opened up in March 2022 restrictions started to ease, and we are pleased to report an increase in the number of face-to-face hearings. In-person hearings have a very positive impact on consumers being able to participate in hearings. However, we remain concerned about the detrimental impact that hearings still conducted by VC have on the consumer and their access to their rights. Issues include availability or quality of equipment and VC facilities, software issues and poor-quality connections. Most people have experienced the general difficulties of VC meetings such as audio problems, connection dropping out etc. This can be much more stressful when the purpose of the conference is to determine whether the consumer will continue to be detained and/or treated against their will.

For some consumers the use of VC is not consistent with principle 3 of the Charter of Mental Health Principles (person-centred approach). As explained in MHAS' 2020-21 annual report, VC can be highly unsuitable for people experiencing psychosis or who are experiencing sedation from medication, confused, anxious and for those not familiar with technology. The perception of apparently disembodied heads on screens can be alarming, or when audio is out of sync with the video people can be confused where the voices are coming from. Often there are people participating who are not in a narrow camera view (and thus can only be heard, not seen) and for those not familiar with technology this is confusing.

Many older adults have great difficulty participating in their Tribunal hearing due to their unmet age-related support needs. Advocates have experiences of being crowded around a laptop trying to hear and communicate with the Tribunal members. Insufficient consideration appears to be given to the consumer's communication supports in Tribunal hearings, beyond the use of interpreters.

[31] Data is based on information published in Mental Health Tribunal's annual reports from 2017 onwards with the exception of Advocate attendance which is based on MHAS data.

[32] Advocate attendance at Tribunal hearings is based on data recorded by Advocates and is historically lower than the numbers recorded by the Mental Health Tribunal. As a comparison the Tribunal recorded Advocates attending 40% of conducted hearings in 2019-20 and 2021-22. MHAS data on representation is used, as Tribunal data on Advocate attendance in 2021-22 is not available until after this annual report is finalised.

An older adult attended a hearing by VC. They were unable to hear or follow the proceedings, which were on a small screen. The sound quality was extremely poor, and there was no social distancing with chairs pushed together in front of the computer. The Tribunal members were all wearing masks, muffling their voices further and preventing lip reading (often used by older adults with hearing loss). The Tribunal stopped proceedings three times, trying to improve the sound. The consumer opted to continue as they were hoping to be discharged and did not want to wait for an adjournment. MHAS raised concerns with the facility management who have now installed a large screen in the MHT room for times when VC is unavoidable. MHAS also advocated with the MHT for the return of face-to-face hearings, particularly for older adults. These have now re-commenced.

During the height of community transmission of COVID from March 2022 some hearings were held in rooms on the ward converted for hearings by VC to reduce the movement of people. At one site student nurses and doctors continued to seek permission to attend the hearings in person. Most consumers if asked will consent. However, Advocates were finding the rooms were far too small for more than a couple of people, and consumers wanted to leave during the hearing as they became uncomfortable or claustrophobic.

In one example, an Advocate had attended a number of hearings in a crowded room. In the end, the Advocate raised this as not only a safety issue but also lacking a person-centred approach, and suggested student nurses and doctors could attend by VC. The consultants agreed and made alternative arrangements at that site.

Given the ongoing use of VC, better facilities, equipment and etiquette/capability in using VC are needed for consumers. MHAS lobbied to have video equipment reviewed and replaced at three hospital sites where there have been problems and we are pleased to report progress and success:

1. In one hospital the equipment has already been upgraded.

2. In the second hospital, MHAS provided information about equipment that was working well at another site. The hospital has agreed to upgrade their system and had commenced the procurement process.

3. At the third hospital, they agreed to switch from Avaya to Microsoft Teams which has improved quality. Multiple requests to review the equipment (verbal and then via email) were not acted upon therefore MHAS sent a formal request. The service has committed to review the equipment and make the required changes. We await the outcome and will continue to follow up.

Improvements are still required at various other sites. MHAS will continue to make the point that Tribunal hearings are held for the consumer, and all parties should uphold a person-centred focus.

Production of medical reports and psychiatrist attendance at hearings

MHAS would like to recognise those psychiatrists who provide comprehensive reports that are considerate of how the information will be received by the consumer. A comprehensive report addresses essential points such as each of the criteria for involuntary treatment, the circumstances of the current admission and the treatment, support and discharge plans. The result of such reports is that the Tribunal often has few questions of the treating team, and the consumer understands their situation and more easily accepts the Tribunal's decision, even if it is not what they hoped for. Unfortunately, the provision of comprehensive and accessible reports happens less frequently than it should.

Ideally the psychiatrist provides a copy of the report three days prior to the hearing and goes through it with the consumer before the hearing. Too often this does not occur, and reports are made available to the consumer minutes before or during a hearing. From March 2022 the availability of reports was severely impacted by community transmission of COVID, and has not improved substantially since.

If an Advocate is attending, then in consultation with the consumer they can request a break at the start of the hearing for the consumer to have time to absorb the content of the report. Reports can contain details of what lead up to previous and/or the current admission and

other confronting information and medical opinions, some of which the consumer may be hearing for the first time. This can be distressing for the consumer, and it can be hard for them to compose themselves in the few minutes before the start of the hearing. Reports may also contain details of incidents from years ago that continue to be raised, regardless of the consumer's recovery. Advocates (and Tribunal members) have queried reports which are identical to past reports prepared for the Tribunal.

It appears to have become accepted practice that there will be a break at the start of a hearing as the alternative to the medical report being available beforehand. This is far from ideal as it disrupts the flow of the hearing. Too often consumers feel under pressure to review the report as the panel, doctors and others in attendance are waiting for them. At times the parties in attendance express annoyance at the break. Advocates have observed the difference for individual consumers when they have the reports ahead of time and have had time to work through the details with an Advocate, as opposed to the difficulty they experience engaging with the content when they are rushed.

An Advocate was so concerned at the tone and language of a medical report and the impact it would have on the consumer reading summaries of so many difficult things that had happened in their life that they queried the content with the consultant, who agreed. The report was quickly re-written, and the consumer was not distressed when reading the report.

Another report included detailed descriptions of the effects of smoking on the consumer's appearance. The Advocate queries the relevance of this to the involuntary treatment order. The psychiatrist apologised to the consumer when it was brought to their attention.

Ideally the psychiatrist should attend the hearing, but it may be another member of the treating team who knows the consumer such as the psychiatric registrar who can answer questions about the need for an ongoing involuntary treatment order. Adjournment of hearings so that the treating team can be in attendance (as well as adjournments due to sickness of key parties due to COVID) continues to impact on the rights of consumers to have Tribunal hearings, including within statutory timeframes.

The impact of well conducted hearings

Advocates witness the benefits for consumers' recovery and wellbeing of Tribunal hearings where there is effective and respectful communication. The leadership and sensitivity shown by the presiding Tribunal member (the legal representative) is also very important in hearings.

For example, an Advocate reported how good a consumer felt when the Tribunal congratulated the consumer on their progress.

Advocates report the different experiences of consumers when the Tribunal approach and the process are explained during a hearing. Advocates also explain this to consumers beforehand, but it makes a difference when this is explained in the hearing and members take the time to check that the consumer has understood. Explanations of what it means for an independent body to review and assess the involuntary order are particularly impactful for consumers.

Delayed discharge and the NDIS interface

The growth in Advocate involvement in consumers' NDIS issues noted in last year's annual report continued throughout this year. The inclusion of coding in our ICMS database in 2021-22 indicates that problems with NDIS ranked 15 out of 61 codable issues, with Advocates recording 115 issues for 95 consumers. Advocates were most likely to assist consumers with NDIS issues if they were young people with complex support needs, or adult consumers in the Hospital Extended Care Service (HECS).

This section reports on MHAS; work at the NDIS interface for children, young people and adults in inpatient settings. The NDIS interface for hostel residents is considered separately in the section on hostels.

Over the past year Advocates worked with inpatient consumers to resolve issues with:

- Obtaining hospital social worker involvement in initiating an NDIS application process.
- Advocacy to treating teams and other parties to provide relevant evidence to support a consumer's application.
- The consumer's voice and preferences not being articulated in planning processes.
- Getting someone to explain their plan and funding to the consumer.
- Consumers who have active NDIS plans, but whose support providers have not made contact or effectively engaged with the consumer.
- Inadequate plans, or reduction in plan amounts without a change in the consumer's situation that require application to the Administrative Appeals Tribunal and other NDIA processes.
- Accessing supported independent living (SIL) services and/or other supported accommodation.

Advocates have written letters in support of applications for four consumers and advocated to the NDIA for one person to have a higher level of support than provided in the plan. The following are examples of this work.

A consumer who had been hospitalised for many years had been discharged successfully onto a Community Treatment Order with support provided by an NDIS package. A review reduced the plan by around a third, and it was no longer possible for the consumer to live safely in the community. The Advocate supported the consumer's family and guardian to successfully appeal, retain the supports from the original plan and remain safely in the community.

A young consumer with complex support needs was stuck in hospital because of difficulties getting adequate funding and a support provider with required capabilities. The Advocate made requests for use of plan funds while the consumer remained in hospital so they could engage in activities they enjoyed. The Advocate remained involved during the consumer's transmission to living in the community. A focus was access to culturally appropriate supports and ensuring restrictive practices in community were approved and in keeping with the consumer's rights.

NDIS access project

During the past financial year the MHC funded a program of work so that people with psychosocial disability who wanted to test their eligibility to NDIS could do so. The program included funding for non-government organisations (NGO) to assist people to prepare their NDIS applications, and to Consumers of Mental Health Western Australia (CoMHWA) to provide peer support workers to people going through the application process. The MHC funded MHAS to deliver information about the NDIS to identified persons, and to refer interested people to the MHC, so they could be linked to the available support for making an application.

Twelve Advocates nominated to be part of a team working across the metropolitan authorised hospitals that implemented the access project. Advocates liaised with treating teams to identify consumers who might have been eligible for NDIS support. They provided NDIS information to 117 consumers, made 22 referrals to the MHC for NGO assistance, and assisted 11 consumers to commence an NDIS application with the hospital social worker. Of the 22 referrals to MHC, one did not progress because the consumer already had an NDIS package but did not realise, and another referral was declined because of lack of NGO capacity to take on further referrals.

Advocates recorded reasons why consumers elected not to progress with a referral through the access project. Some already had an NDIS package (26%), some had an existing application underway through the hospital or clinic (21%). Others were not interested (26%). Other reasons were, concerns that having an NDIS might affect their accommodation (11%), unlikely to meet eligibility criteria (11%), or did not understand the information provided (5%).

Advocates also asked consumers whether they had considered making an NDIS application previously and if not, why they had not. Many had not heard of the NDIS before (40%), and some were aware of the Scheme but did not know how to apply (24%). Other reasons were, concern that it would affect Centrelink benefits (12%), low motivation due to being unwell (12%), and a lack of understanding of what the NDIS might offer them (12%).

These results suggest that accessible information about the benefits of the Scheme, its relationship with other forms of social support and the need for assistance in completing an application are all important to maximise Scheme engagement.

Feedback gathered from Advocates at the end of the project add to this picture. Facilities appeared to prioritise NDIS applications for long-stay consumers whose discharge was dependent on getting support, and in some cases, accommodation, through the NDIS. Advocates noted that there were other consumers on shorter stays who were likely eligible but for whom no application was started unless the Advocate, consumer or family member or guardian asked about it. While this is likely to be related to how to best use available resources, it is possible that there are consumers who are discharged unaware that they might be eligible for NDIS supports.

Advocate feedback highlights the opportunity to increase NDIS participation through the provision of education and/or information for inpatient and clinic staff on NDIS eligibility and benefits for people with psychosocial disability. The same applies to consumers; NDIS information sessions could be incorporated into ward group programs.

It was clear during the conduct of the project that some facilities had strong processes and practices in place to initiating and progressing NDIS applications for consumers and helping them with plan reviews. One facility had a proactive approach to initiating applications for consumers who were likely to be eligible. Another was working with the Local Area Co-ordinator to provide on-site information and advice sessions to staff who were working with consumers who might want to apply for the NDIS.

However, there were other facilities where staff were hesitant or at times resistant to consideration of how clinical interventions might be complemented by psychosocial supports. Education on the benefits of NDIS to supporting and sustaining recovery would be an advantage in these settings.

Regional Advocates noted the scarcity of services able to provide supports to people with psychosocial disability. The Chief Advocate discussed the possibility of an extension of the project to people in regional WA with the Commissioner in June.

The impact of delayed discharge on consumers

This year there has been increased system attention on the relationship between the NDIS and delayed discharge from inpatient services. The DoH established a 'long-stay' project to facilitate transition out of hospital and back into community living for people who were stuck in hospital despite being clinically cleared for discharge, generally because of a lack of support, accommodation, or both. Over the past year, the Chief Advocate and Senior Advocates met regularly with the team at DoH and the MHC project officer to share information and build an understanding of each other's work.

In most cases where Advocates have supported a consumer stuck in hospital past the point at which they have been clinically cleared for discharge, the block has been related to NDIS supports not being in place or being insufficient to sustain a successful return to community. Advocates report the adverse impacts these protracted admissions have on consumers: loss of functional capacity, loss of social networks, adverse impact on physical health (especially weight gain), rising frustration related to living in a restricted environment, increase in self-harm, and increase in expressions of frustration that result in code blacks, seclusions and other restrictions being placed on the consumer.

Ultimately, these system failures produce an institutionalised individual who leads an unnecessarily diminished life and requires more support for longer.

Over the past year Advocates have addressed these issues in the following ways:

- Advocating for access to activities and other allied health interventions that might slow down the loss of functional capacity that comes with living in a restricted environment.
- Ensuring consumers' physical health care is attended to.
- Asking questions about the conduct of seclusions and other restrictive practices to see whether less restrictive alternatives could or should have been used.

There are opportunities for improvement. The TSDP is an excellent vehicle for integrated planning that could include clinical and psychosocial services that could support the consumer once they were discharged. A TSDP developed with input from the consumer, their treating team and NDIS support providers would provide an integrated approach to care planning, continuity of care and collaboration to resolve barriers to discharge. For those consumers who need ongoing support related to psychosocial disability, ensuring that NDIS supports are in place as part of the TSDP is likely to decrease the chances of failed discharge.

The impact of COVID

Community transmission of COVID has had a significant impact on frontline staff and management in mental health services. The work to keep services safe for consumers has presented unprecedented problems and has required ingenuity, collaboration, and dedication. We acknowledge the risks that frontline staff have confronted daily, and their hard work in providing treatment, care and support to consumers during this difficult time.

In the early months of community transmission, advocacy focussed on ensuring that consumers were not unnecessarily restricted and a reasonable balance between public health requirements and consumer rights was achieved. Each day brought unique and unexpected challenges and our work took place in a rapidly changing environment. After the first few months, protocols were well embedded, and facilities had become practised at responding to outbreaks on wards. However, this came at a cost to many staff and to the workforce in general, and this showed in consumers' access to treatment, their rights and sometimes on the quality of care and support they received.

Safe and effective advocacy during widespread community transmission

Advocates continued to deliver services to consumers through the red alert phase of the WA Government's System Alert and Response (SAR) Framework, implemented to manage the risks posed at different levels of community transmission. Some work took place via phone or video conference (for instance, family meetings, case conferences and Tribunal hearings). HSPs were notified that Advocate powers and functions under the Act remained, and Advocates would abide by any public health directions or ward arrangements. In the early weeks of the red alert phase, the Chief Advocate liaised with the Chief Executive of the COVID Response to ensure that the guidelines for the implementation of the SAR referred to Advocates. This regular contact helped facilitate access to wards and consumers.

Advocates were given the choice to visit consumers in wards and hostels. We were able to manage allocations so that every consumer who wanted a face-to-face visit from an Advocate got one. Advocates became accustomed to facility protocols, taking RATs on arrival at the hospital, getting fit-tested for masks and wearing full Personal Protective Equipment (PPE) when required. In a few cases, and through discussion with the Senior and Chief, Advocates visited people who were COVID positive.

At the start of March, we established a COVID co-ordination process to ensure that consumer and facility issues were promptly responded to and escalated where necessary. An Advocate who was unable to undertake face-to-face work became the co-ordinator for all COVID-related information. When an issue arose, the ward/hostel Advocate reported to the COVID co-ordinator and together they would triage the matter, escalating to the Senior Advocate where necessary. The COVID co-ordinator prepared a daily report for the Chief and Seniors, who also had a brief daily stand-up meeting to ensure oversight at HSP and system levels. This worked as an effective escalation process and the Chief Advocate was able to feed issues of systemic concern into the weekly HSP COVID co-ordination meeting.

As the weeks passed the number of unique issues diminished and services became better at predicting and responding to issues as they arose. Our daily COVID meetings shifted to weekly, and most issues were able to be resolved at ward or facility levels. By the end of the financial year, we were in the process of considering winding up the co-ordination function.

Protecting rights during the red alert phase of SAR Framework

From March onwards, Advocates dealt with the following issues:

- A decline in environmental conditions at the start of the red alert phase as services tried to cope with the sudden and unprecedented impact of community transmission: unemptied bins, a lack of hot food options for days, bed linen not changed.
- Blanket bans on leave across facilities regardless of whether there was anyone with COVID on the ward.
- Bans on visitors, limited visitor hours, and time taken to complete COVID protocols included in the limited time available for visits.
- Impact on quality of treatment and care for people with communication support needs: deaf and hearing-impaired consumers struggling to communicate with staff in masks, limited access to the interpreter service.
- General impact of trying to engage with staff in full PPE, especially for consumers new to the facility or mental health system.
- Tribunals being conducted by video conference. Advocates reported many instances where the VC facilities were inadequate, impacting on consumers' experiences and on procedural fairness. In some cases, Advocates reported the quality of the technology available for the hearing had an adverse impact on the treatment outcomes for the consumer. Note, many hearings are returning to be held in-person (see also the section on Tribunal hearings).
- HSPs struggling to meet the conditions of people's CTOs, increasing Advocates' work to make sure reviews took place within the timeframes of the Act.

Staffing shortages became more acute over the months from March to June as staff were also impacted by COVID or were close contacts and thus not able to attend work. Fewer staff meant many of the issues consumers were raising with Advocates were exacerbated. There were fewer staff to take people on escorted leave, engage them in activities on the ward or help them manage the impact of restrictions. Advocates reported noticeable stress and exhaustion amongst ward staff translating in some cases to poor treatment from staff and a punishment/reward dynamic to the granting of some consumer rights.

By the end of June, facilities had become practiced in responding to consumers who tested positive on wards or in hostels. However, the impact of COVID on the health workforce - and on the Advocate workforce - was taking a significant toll, with a range of negative impacts on consumers noted throughout this report

Resourcing, data and disclosures

Budget and expenditure

2021-22 Budget and expenditure

In 2021-22 MHAS' total allocated budget was $4,996,000 which comprised:

- $3,670,405 under direct control of the Chief Advocate for statutory advocacy services.
- $936,000 for planning and policy development activities to prepare for implementation of the Criminal Law (Mental Impairment) Bill.
- $389,595 (9.4% of the total budget) covering the cost of corporate services provided by the MHC[33].

MHAS aimed to work to its allocated budget. Expenditure for MHAS statutory advocacy services and Mental Health Commission's corporate support services was $4,129,100[34], which was $69,100 or 1.7% over budget.

MHAS was also allocated $936,000[35] to prepare for the implementation of the Criminal Law (Mental Impairment) Bill. MHAS incurred $105,975 costs during the year to fund a project management position, however cross-agency consultation to develop models of service was delayed. The unspent funds allocated by the Department of Justice ($803,329) were returned to the Department and they gave in-principle approval to roll-over funding for project and planning activities for July to December 2022.

TABLE TWELVE - MHAS allocated budget and expenditure 2016-17 to 2021-2022[36]

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

[33] MHAS pays a proportion of the cost of the Mental Health Commission's corporate, audit and executive salaries as estimated by the Mental Health Commission. Services include payroll and human resources support for staff, invoice processing and financial services, and IT infrastructure, some of which is provided by Health Support Services.

[34] MHAS' expenditure may be adjusted as the audit had not been completed.

[35] The funds were partly approved by the Expenditure Review Committee ($133,000) and largely from a re-prioritisation of funds by the Department of Justice ($803,329).

[36] Excludes funding provided for the Criminal Law (Mental Impairment) Bill.

TABLE THIRTEEN - Cost of resources received free of charge 2021-22

Agency	Resources received free of charge	Amount
Mental Health Commission	Corporate support services	$389,595.00
State Solicitor's Office	Legal services	$8,890.00
Department of Finance	Leasing services	$8,614.75
TOTAL		**$407,099.75**

The cost of Advocates, including payments to the Chief and Senior Advocates, comprised 62.4% of MHAS' expenditure. Costs of salaries for advocacy support services (including agency staff and payroll services for Advocates) comprised a further 17.1% of the total expenditure. Other goods and services accounted for 11.1% of the MHAS budget. This included Advocate training, the building lease, the Chief's fleet vehicle, investment in business improvement projects and a three-year project being undertaken in partnership with OCP and Curtin University to improve cultural responsiveness within each agency and system-wide. The remainder of MHAS costs (9.4%) are for corporate support services provided by the MHC.

Investment in business improvement projects within the 2021-22 budget comprised commencing a project for a new records classification system, initiating stage one (of three stages) of an upgrade to the phone system, preparatory work for the migration of MHAS' client management system (ICMS) and relocation of the MHAS website to the wa.gov.au platform.

These projects were identified through the strategic planning process with the aim of increasing MHAS' system capability and sustainability. Work will continue into 2022-23 to complete these initiatives.

Remuneration

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

Advocate remuneration

The Advocates and Senior Advocates are paid an hourly rate plus superannuation and can claim mileage (and, in limited circumstances, some Advocates can claim travel time). They have no entitlement to paid leave because they are engaged on contracts for service. They must also supply their own car and mobile phone. Laptops are provided to maintain security of information.

In October 2018, the Minister approved pay increases for Advocates and Senior Advocates in line with the salary increases under the government's Public Sector Wages Policy. In the 2021-22 year, rates rose from:

- Senior Advocates' rate: $61.95 to $62.20/hour.
- Advocates' rate: $51.95 to $52.60/hour.

Resourcing

Recruitment and induction of new Advocates

Advocates work on a casual contract renewed by mutual agreement for a maximum of three years. Advocates may declare themselves unavailable for work, including for long periods of time. Upon resignation Advocates' contracts are terminated. They can be removed from office in the case of mental or physical incapacity, incompetence, neglect of duty or misconduct.

In 2021-22 seven Advocates resigned or their contracts were not renewed, and seventeen new Advocates were engaged. Of the Advocates on current contracts five were not available for Advocacy work for an extended period through the year. As of 30 June 2022, there were ten more active Advocates than at the same time in the previous year.

A Senior Advocate retired effective 30 June 2022, although at this point both the retiring and new incumbent were contracted to a Senior Advocate role because they were completing a handover. However, only one Senior Advocate is counted in the figures reported for 30 June 2022. Another Senior Advocate responsible for Youth Advocates resigned during the year and on 30 June 2022 the role was filled on a temporary basis in a job share arrangement. In addition, two temporary part-time positions were created for Senior Advocates, one covering regional facilities and the other leading the Enhanced Hostel Visiting Program. Those appointed to temporary Senior Advocate positions continued to perform functions as an Advocate. As of 30 June 2022, there was a 4.0FTE Senior Advocate allocation.

As of 30 June 2022, the Advocacy service comprised:

- The Chief Advocate.
- Six Senior Advocates (including those in temporary part-time and/or job share arrangements).
- Forty-five Advocates (including four people in combined Senior/Advocate roles):
    - Twenty-one general Advocates in metropolitan Perth;
    - Seven general Advocates across Albany, Broome, Bunbury and Kalgoorlie;
    - One Advocate providing a weekend phone service (youth and general);
    - Seven Youth Advocates;
    - Four hostel Advocates (including the person holding the temporary Senior position);
    - Five Advocates on contract but unavailable (including one Aboriginal Mental Health Advocate).
- Ten public servant Advocacy Services Officers (7.8 FTE) including the Principal Project Manager (CLMI) reform.

There was an 11.2% increase in Advocate hours worked from 28,431 hours in 2020-21 to 31,601 in 2021-22. This was largely accounted for by an increased investment in Advocate training and support.

Attraction and retention of Advocates continues to be challenging. The Act requires that Advocates are engaged on a contract for service basis. The majority are engaged on zero hours contracts without guaranteed hours or leave entitlements. The lack of income certainty is offset by the flexibility that the arrangement offers but can result in unreasonable demands on their availability. Advocates continue to cite their employment conditions and MHAS' laborious payroll process as a major disincentive in exit interviews. It was also identified as a major barrier to retention in the survey undertaken during 2021-22 as part of the strategic planning process.

New Advocates complete the clinicians' e-learning module on the Act. In addition, MHAS delivers an intensive five-day, in-house induction program interspersed with observation days in facilities. New Advocates are mentored by experienced Advocates. Mentoring runs for several weeks and includes a variety of key advocacy tasks including attending at least one Tribunal hearing. Inductees are assessed against a checklist, and once this is complete, they work alone with consumers under the general guidance of their Senior Advocate.

Advocate training and development

The Chief Advocate is committed to improving Advocate safety and retention by focussing on improving Advocate support. MHAS made a significant financial investment in 2021-22 in Advocate training.

In 2021-22 MHAS hosted two events. The first, held in October, comprised a day-long workshop on trauma-informed care. The second, in June, ran over two days and comprised a follow-up workshop on compassionate care, and sessions on working with people from LGBTIQA+ communities and lived experience engagement.

Additionally, we increased the frequency of Advocate team meetings and introduced a range of practice-focused sessions for teams, including peer reflective practice and guided practice development.

Advocacy services staff

The Advocacy support service officers assist the Chief Advocate to perform functions under the Act. It comprises a small team that undertakes a variety of policy, executive support, data management and system support, administration and consumer liaison functions. The full-time equivalent (FTE) of staff has increased to 6.8 FTE, not including the temporary Principal Project Manager (CLMI) and the Website Project Officer[37].

Since the restructure in 2018, MHAS has experienced ongoing turnover in support service roles. Together with the need to resource the CLMIA reform project, over the past year MHAS relied on temporary staff on fixed term contracts and from agencies. The use of temporary staff met immediate needs, but the loss of corporate knowledge impacted critical business systems and resulted in a significant reduction in the quantity and quality of support. During the past year an increasing number of administrative tasks were performed by senior staff, including the Chief Advocate.

The composition of support services does not match the needs of the organisation; however a complete staffing review has been delayed until MHAS has clarity about the impact of the CLMIA reforms on resourcing requirements. As an interim measure, an internal review of the reporting relationships and level of resourcing of some administrative and technical roles was completed in December 2021. This identified a shortfall in high level executive support functions with an overall net shortfall across advocacy support functions. A realignment of some reporting arrangements and creation of new positions is being implemented to meet this shortfall.

Business systems

Under-resourcing from 2015 to 2021 negatively impacted multiple business systems. The increase in base funding in 2021-22 provided opportunity to start to address some of the core and fundamental system problems.

MHAS strategic plan

In August 2021, we commenced the development of a five-year strategic plan. The process included a survey of Advocates and advocacy support staff to gain their input on priority areas for attention, and a series of facilitated workshops with the MHAS Leadership Team.

A draft strategy and implementation plan is in the final stages of completion.

[37] From July 2021 MHAS received 12 months funding via a Treasurer's Delegated Authority for a 0.8FTE Principal Project Manager to prepare for CLMIA Act reforms and scope the database requirements.

Integrated Client Management System upgrade and migration

The integrated client management system (ICMS) is 2013 Microsoft Dynamic Customer Relationship Management software and requires an urgent upgrade. The MHC has not had a support contract in place since 2019, significantly hampering system maintenance, creating security risks and making all but the smallest improvements impossible.

Data quality is of increasing concern. Report production capability has always been limited and resource intensive, commonly requiring manual data extraction and manipulation. Over the past year, report production often exceeded 60 hours per month and produced a limited range of reports. The limited reporting and data of dubious quality impacts both our ability to monitor our performance and limits our capacity to understand systemic issues. We are no longer able to report with confidence on the extent to which key consumer rights are being upheld.

Migration of the ICMS system was initiated to a cloud-based platform. The project was commenced in August 2021 and was originally scheduled for completion in March 2022. Technical issues with the establishment of a tenancy for the new cloud-based system have delayed the project. MHAS awaits a revised date from the MHC for the establishment of the tenancy.

A major drawback is the inability to automate the Advocate payroll process. This involves at least 18 hours per fortnight of administrative time, significant time required for each Advocate to complete their pay sheets, and a laborious audit process. Automation of the payroll process is a priority efficiency project for 2022-23 once the ICMS migration is completed.

MHAS phone system

Advocates are required to use their personal mobile phones for their advocacy work and may not disclose their personal phone number to consumers (as per the Advocate Code of Conduct). It is not possible for Advocates to text/SMS consumers without disclosing their personal phone number, preventing them from using what is now a widely accepted and expected mode of communication.

The existing MHAS office phone system relied on an office-based liaison officer transferring calls to Advocates' personal mobile phones, creating inefficiency and potentially requiring the consumer to tell their story twice. An upgrade to the phone system was initiated to help facilitate timely contact between Advocates and consumers.

A project was planned over three-stages. It is intended to deliver a system that will enable information-protected calls between Advocates' personal mobiles and consumers, removing the liaison officer as a conduit. However, it is also reliant on the completion of the ICMS migration and upgrade.

The first stage was the introduction of a contemporary voice over internet protocol (VOIP) phone system, introduced in June 2021. Unfortunately, there are ongoing technical and functional problems with the VOIP system which have yet to be resolved.

Website and intranet redevelopment

MHAS' website had fundamental stability and access problems and it did not meet accessibility standards. The service level agreement for ongoing website maintenance was ceased in 2017 due to budget pressures, and external support was purchased on an as needs basis. In November 2021, the provider notified us that the private hosting platform was closing. Consequently, we decided to move the website to the wa.gov.au in March 2022. This improved disability and community access and audit standards. A second phase of the project is required to improve its acceptability to consumers, young people and First Nations people.

The MHAS website had also provided a portal for Advocates to access resources. To replace this, a SharePoint site was created for Advocates and staff and implemented in March 2022. This site requires further work to reach its full potential.

Records management

In accordance with section 19 of the *State Records Act 2000*, MHAS has a record-keeping plan governing the management of all its records. The plan required MHAS finalise its Record-keeping Procedures Manual and classification system of functional keywords by mid-2018. The Procedures Manual was completed in July 2018, and a project commenced in late 2021-22 to revise the classification system.

An evaluation of MHAS' Record-keeping Plan is scheduled for 2023 in accordance with the State Records Commission Standard 2, Principle 6.

Electoral Act requirements

As required under the Electoral Act 1907, section 175ZE (1), MHAS recorded $4,930 in expenditure related to the designated organisation types between 1 July 2021 and 30 June 2022, which is broken down as follows:

- Advertising agencies: Bigwig Advertising Pty Ltd - $4,930.
- Media advertising organisations - nil.
- Market research organisations - nil.
- Polling organisations - nil.
- Direct mail organisations - nil

Quality assurance

We are committed to continuous quality improvement on our service delivery, and we welcome feedback of an informal and formal nature regarding our operations.

Complaints

In 2021-22 we received 11 complaints about our service, each of which was handled according to the MHAS complaints protocol. Ten complaints have been resolved, and one remains in process. The complaint process is published on the MHAS website.

The apparent increase in complaints is largely due to under-reporting in 2020-21 (four complaints) because of the difficulties in retrieving information from the records management system.

MHAS breaches of the Act

The Act requires Advocates to contact consumers within seven days of an involuntary treatment order being made for an adult, and within 24 hours of an order being made for a child. Consumers were contacted by an Advocate within the statutory timeframes for 96.4% of involuntary treatment orders. This is an improvement on the previous year when 95.6% of consumers were contacted within the statutory period.

The most common reason for a breach was due to the order being revoked within that timeframe (68.3% of all breaches). In addition, 30.3% of breaches were due to orders being revoked within two days[38]. Revocations within a few days of an order being made are a concern; they raise questions whether a form 3C should have been used to enable further examination by a psychiatrist with the possible outcome of avoiding the need for an involuntary order.

All but one child was contacted following an involuntary order being made. Contact was achieved within statutory timeframes for 96.3% of children (six out of 164 orders). This is an improvement on the previous year when 87.2% of children were contacted in time (21 children). Five out of the six breaches were because the Health Service Provider did not notify MHAS within two hours (as agreed), or within 24 hours of the order being made

Ministerial directions

The Minister for Mental Health may issue written directions to the Chief Advocate about the general policy to be followed by the Chief Advocate, and the Chief Advocate may request the Minister issue directions (under s354 of the Act). During 2021-22 no directions were issued, nor did the Chief Advocate request directions.

Similarly, the Minister for Mental Health may request the Chief Advocate report on the provision of care by a mental health service or ensure that a service is visited (see s355 of the Act). There were no directions issued during 2021-22.

Committees, submissions and presentations

The Chief Advocate, or their proxy, was a member on 11 committees. She took part in nine consultations or provided written submissions, as set out in the appendix.

The Chief Advocate and Senior Advocates regularly give presentations to facility staff and other stakeholders on the role of MHAS and consumer rights.

The presentations are an important means of helping to protect consumers' rights and improving understanding of the role of MHAS. This work was significantly curtailed due to the impact of COVID on the MHAS workforce and on services.

[38] The actual number of orders revoked within the first few days is higher, because Advocates may make contact with consumers soon after the order is made.

Appendix - committees, forums and submissions

Continuing committees

1. Private Hostel Agencies Committee (oversight agencies' committee)
2. Accountability Agencies Collaborative Forum
3. Mental Health Network Executive Advisory Group - MHC
4. Mental Health Act 2014 Statutory Review Steering Group - MHC
5. Criminal Law Mental Impairment Reform Implementation Steering Committee - MHC

New committees in 2021-22

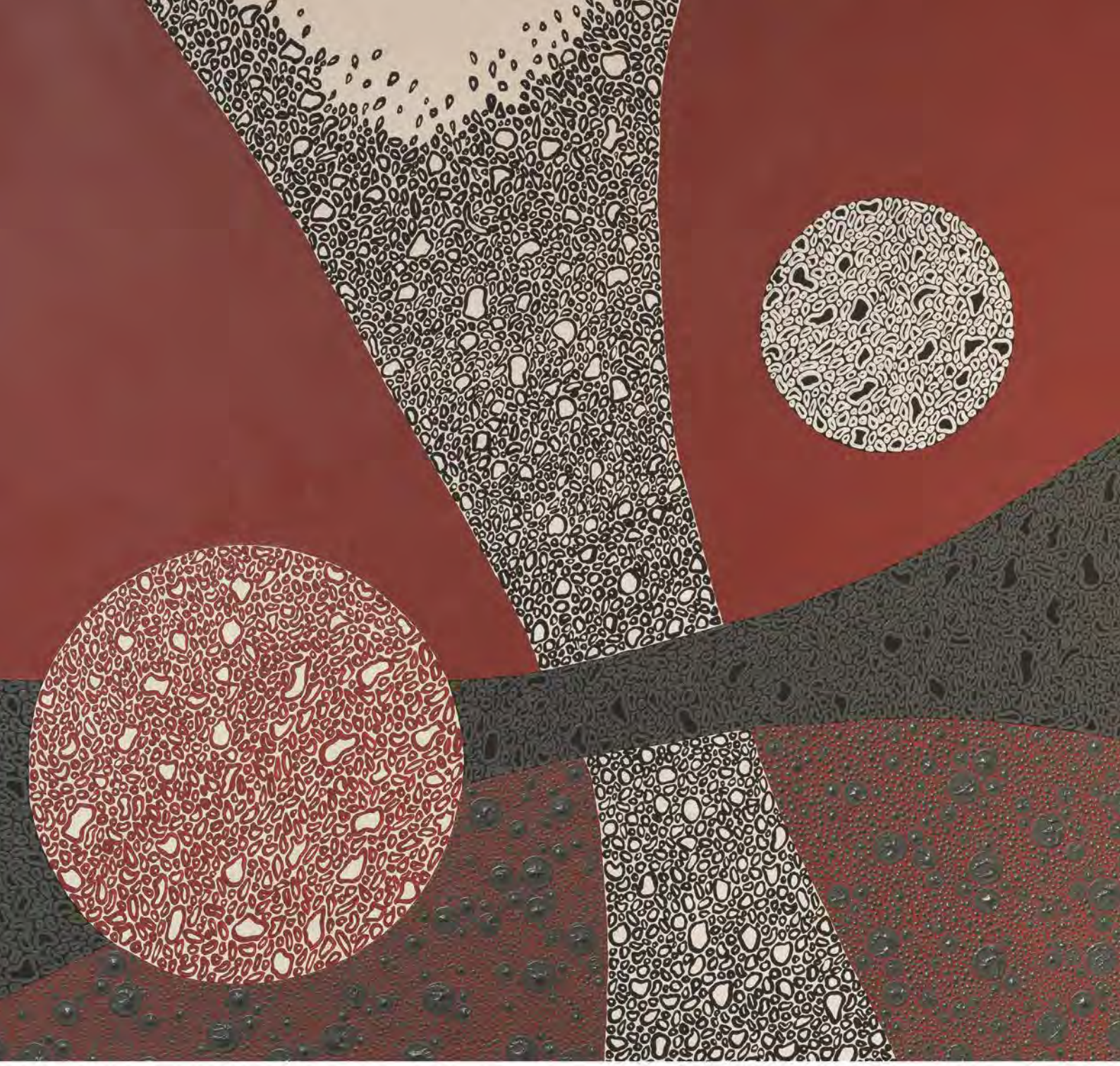
1. Infant Child and Adolescent Taskforce - Expert Advisory Group - Ministerial
2. Graylands Reconfiguration and Forensic Taskforce Clinical Advisory Group - MHC
3. Optional Protocol on the Convention against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment Advisory Group - Ombudsman Western Australia
4. Reducing Structural Stigma and Discrimination Technical Advisory Group - National MHC
5. Forensic Model of Care Working Group of the Graylands Reconfiguration and Forensic Taskforce Clinical Advisory Group - MHC
6. Criminal Law Mental Impairment Reform Interagency Implementation Steering Committee - Department of Justice

Submissions, forums and consultations

1. Australian Housing and Urban Research institute Inquiry Panel - Enhancing the co-ordination of housing supports for individuals leaving institutional settings - consultation - June 2021
2. Victorian Mental Health and Wellbeing Act Update and engagement Paper - submission - August 2021
3. Mental Health, Alcohol and other Drugs Forum - Building Momentum Together - October 2021
4. Review of Private Hospitals and Health Services Act 1927 and the Hospitals (Licensing and Conduct of Private Hospitals) Regulations 1987 - submission - DoH - February 2022
5. Statutory Review Mental Health Act 2014 - submission - March 2022
6. Good Mental Health Care in Emergency Departments - submission - March 2022
7. Mental Health Workforce Action Plan Meeting - consultation - March 2022
8. Reportable Conduct Bill - submission - October 2022
9. Community Treatment and Emergency Response Roadmap - consultation - October 2021

Glossary

Act	Mental Health Act 2014
Advocate	Mental Health Advocate
CAHS	Child and Adolescent Health Service
Chief Advocate	Chief Mental Health Advocate
CPFS	A division of the Department of Communities, known as Child Protection and Family Support
CLMIA Act	Criminal Law (Mentally Impaired Accused) Act 1996
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, also called a form 5A
DOH	Department of Health
ED	Emergency department
EMHS	East Metropolitan Health Service
EMYU	East Metropolitan Youth Unit
Form 1A	Referral order for a compulsory examination by a psychiatrist who decides whether the person should be made involuntary and put on a form 5A, 6A or 6B
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
Hostel	Private psychiatric hostel as defined in the Act
HSP	Health Service Provider - comprising each of or collectively EMHS, NMHS, SMHS, CAHS and WACHS
Involuntary treatment orders	Collectively include community treatment orders (form 5As), involuntary inpatient treatment orders on an authorised mental health ward (form 6As) and involuntary inpatient treatment orders on a general medical ward (form 6Bs)
LARU	Licensing and Accreditation Regulatory Unit
MHAS	Mental Health Advocacy Service
MHC	Mental Health Commission
MHLC	Mental Health Law Centre
MIARB	Mentally Impaired Accused Review Board
Minister	Minister for Mental Health
NDIS	National Disability Insurance Scheme
NMHS	North Metropolitan Health Service
OCP	Office of the Chief Psychiatrist
PCH	Perth Children's Hospital
PPE	Personal Protective Equipment
PSOLIS	DOH database for people in mental health wards which records the status of people under the Act
RPH	Royal Perth Hospital
SCGH	Sir Charles Gardiner Hospital
SMHS	South Metropolitan Health Service
Tribunal	Mental Health Tribunal
TSDP	Treatment, support and discharge plan
WACHS	WA Country Health Service



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MENTAL HEALTH
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