Annual Report 2019-20

MHAS

MENTAL HEALTH ADVOCACY SERVICE

The artwork on the front cover and throughout the Annual Report is by Janice Oliver and called 'Spring into life.' The work represents the joy she feels from discovering art. It brings her healing, energy, and new connections with family and friends. This artwork has been reproduced with the artist's kind permission.

Hon Roger Cook MLA

MINISTER FOR MENTAL HEALTH

In accordance with sections 377 and 378 of the *Mental Health Act 2014*, I submit for your information and presentation to Parliament the Annual Report of the Mental Health Advocacy Service for the financial year ending 30 June 2020.

As well as recording the operations of the Advocacy Service for the 2019-20 year, the Annual Report reflects on a number and range of issues that continue to affect consumers of mental health services in Western Australia.

Debora Colvin
CHIEF MENTAL HEALTH ADVOCATE

September 2020

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Foreword by the Chief Advocate

This is my fifth and final annual report in the role of the Chief Mental Health Advocate as I will be stepping down from the position at the end of the year. It has been my honour and privilege to be the inaugural WA Chief Mental Health Advocate and before that, since April 2008, the Head of the Council of Official Visitors under the *Mental Health Act 1996*.

The *Mental Health Act 2014* (the Act) considerably expanded the functions of the Advocates (previously the Official Visitors). The expansion of that role, requiring every person in Western Australia who is made an involuntary patient to be contacted by an Advocate, has in my view been the single biggest change and improvement for consumers from the new Act. It has meant every consumer has someone standing next to them to make sure their rights are observed and their voice is heard – it leads to better decision-making and outcomes - and clinicians on many mental health wards now appreciate the role as much as the consumers. The Advocates are empowered which empowers the consumers and helps to make the experience of being locked up less traumatising.

In the role of the Chief Advocate there is a tendency to only focus on the negative because these are the issues which are escalated by the Advocates. It is also true that, despite the promise of the Mental Health Commission being able to 'steer the ship' that is mental health services towards more community-based services and less reliance on hospital beds, this has not happened. As this and previous annual reports attest, there are many gaps in services; the result is that ill-equipped emergency departments (EDs) are used as the gateway for help by desperate consumers and their families. But the ED leads only to hospital admission – and consumers regularly wait days for a bed, which is just not acceptable health care – or being sent home to wait for appointments to over-subscribed and limited community services. Meanwhile, others languish on expensive acute mental health wards because there is no suitable service for them in the community. The facts are well known and proven – what is missing is the funding to make changes.

The situation with children and young people particularly concerns me, as the number and seriousness of the issues Advocates are dealing with seems to be getting worse and the age of the children affected, getting younger. I ask could we have helped these children earlier so that they never need hospital admission or our advocacy?

The plight for people in prison also concerns me as they are already so disadvantaged in life, and the delays in inpatient treatment compromises their recovery prospects. Hostel residents are another highly vulnerable group which the Mental Health Advocacy Service has not been able to fully protect and support due to lack of funding.

Looking back over the past 12 years, though, there has been a shift towards person-centred care, which was a major aim of the new Act. It is patchy and more work needs to be done. Compliance with the Act in relation to treatment, support and discharge plans would greatly enhance that. There has also been a reduction in seclusion and some of the punitive-style approaches to consumers that we used to see. Having to fill-out a lot more forms when a person is secluded may have contributed to that, but hopefully it is a cultural shift and the result of better de-escalation training and trauma informed care. There have also been improvements such as respecting consumers' right to keep their mobile phones – which many had said would have terrible consequences ..... but it hasn't. And changes at the Mental Health Tribunal have led to more procedural fairness in hearings.

There are many good people working in mental health services but the power imbalance is pervasive and hospitals, where Advocates do most of their work, continue to be largely medication and detention based – which is why oversight and strong advocacy is always going to be needed. The Productivity Commission recognised this is in its draft report on mental health, referring to the Mental Health Advocacy Service in WA and recommending that all State and Territory governments should ensure non-legal advocacy services are available for all involuntary patients.

Over the years I have worked with, and been supported by, some extraordinary, hard-working, diligent, generous and compassionate people, both amongst the office staff and in the field as Advocates, many of whom were also involved in the Council of Official Visitors. The Mental Health Advocacy Service has respect and influence because of their work. The job of an Advocate is not simple - it requires intelligence, empathy, exceptional communication skills and resilience, and the support of a committed administration staff. Words cannot express well enough my gratitude to everyone who has worked with me over the years.

I also want to acknowledge the many other advocates for mental health rights and quality care who are working hard both inside and external to mental health services, and the amazing consumers and carers who keep fighting for change. Systemic advocacy is not achieved by one person alone but by working together. I encourage you all to keep 'chip, chip, chipping away' at it.

Debora Colvin
CHIEF MENTAL HEALTH ADVOCATE

Executive Summary

- Advocacy Service workload continued to rise, with dramatic increases in the numbers of children (both voluntary and involuntary) and people in emergency departments (EDs) wanting support
- Advocates recorded more than 30,000 contacts in supporting nearly 3,500 consumers
- Children and adults waiting days in EDs due to bed shortages in mental health units
- Bottlenecks in mental health wards as beds are occupied by people who no longer need to be there, but who require community care …which is not available
- Children, particularly those aged 16 and 17, face significant gaps in care
- Children presenting at EDs after self-harming increased 319% in the past nine years
- Prisoners' inpatient treatment routinely delayed or denied due to hospital bed shortages
- Aboriginal people detained under mental health orders at more than twice the rate of other Western Australians
- Families and carers not being notified of loved ones made involuntary as required by the Mental Health Act
- Reduced support and oversight for vulnerable hostel residents due to Advocacy Service budgetary constraints
- The Advocacy Service maintained support for consumers throughout COVID-19 restrictions
- The Advocacy Service operations severely impeded by budgetary constraints.

About Us

The Mental Health Advocacy Service (the Advocacy Service) assists all patients on involuntary treatment orders, as well as psychiatric hostel residents, people referred for psychiatric assessment, people subject to custody orders and required to undergo treatment, and some voluntary patients.

Its functions and powers are set down in Part 20 of the *Mental Health Act 2014* (the Act), which requires the Chief Mental Health Advocate (Chief Advocate) to ensure advocacy services are delivered to the above groups of people – who are called 'identified persons' in the Act and referred to as 'consumers' throughout this report.

[The Chief Advocate is also required to provide advocacy services to residents of the Disability Justice Centre under the *Declared Places (Mentally Impaired Accused) Act 2015,* for which there is a separate annual report.]

The Act requires the Chief Advocate to be notified by mental health services of every person made involuntary, and Mental Health Advocates must contact all adults within seven days of them being made involuntary, and all children within 24 hours. Advocates also make contact at the request of consumers or others acting on their behalf. Involuntary treatment orders comprise community treatment orders (form 5As, also called CTOs), involuntary inpatient treatment orders on an authorised mental health ward (form 6As) and involuntary inpatient treatment orders on a general medical ward (form 6Bs).

The Advocates' functions include ensuring consumers are aware of their involuntary status, and their rights under the Act, and assisting consumers in protecting and exercising those rights. Advocates also seek to resolve complaints by consumers, facilitate their access to other services, and assist them in Mental Health Tribunal and State Administrative Tribunal hearings.

The Act confers considerable powers on Advocates, who may do 'anything necessary or convenient' for the performance of their functions. These include the powers to:

- investigate conditions at mental health services which do, or may, adversely affect consumers
- attend wards and hostels any time the Advocate considers appropriate
- see and speak with consumers, unless consumers object
- make inquiries about any stage of a consumer's time in the mental health system, with staff required to assist (and subject to penalties if they fail to assist)
- view and copy a consumer's medical file and any other documents about them, unless the consumer objects.

During the year there was a team and Senior Advocate restructure to try to balance the continually increasing workloads. An extra Senior Advocate was appointed to lead the youth and Aboriginal advocacy teams. Another Senior Advocate was appointed for the Disability Justice Centre (see above). The total Senior Advocate FTE for the Advocacy Service is now 2.4 (increased by 0.4FTE) with one FTE Senior responsible for Advocates working in hospitals and hostels within the South and East Metropolitan health services; a 0.9FTE Senior responsible for Advocates covering North Metropolitan and WA Country health services; and a 0.5FTE Senior responsible for the Youth and Aboriginal Advocates.

At 30 June 2020, the Advocacy Service comprised:[1]

- the Chief Advocate
- three Senior Advocates
- four Youth Advocates
- two Aboriginal Advocates
- 9 Advocates in regional areas (in Albany, Broome, Bunbury and Kalgoorlie)
- 18 Advocates in the metropolitan area
- two Advocates[2] covering weekend phones
- eight Advocacy Services Officers (6.0FTE), who are public servants and include a Manager.

The Chief Advocate, who is appointed by the Minister for Mental Health, works with the Senior Advocates and Advocacy Services Officers to coordinate the Advocates' responses to notifications received from mental health services and requests for contact, as well as setting protocols, delivering both internal and external training, ensuring compliance with the Act, reporting to Parliament and engaging in systemic advocacy.

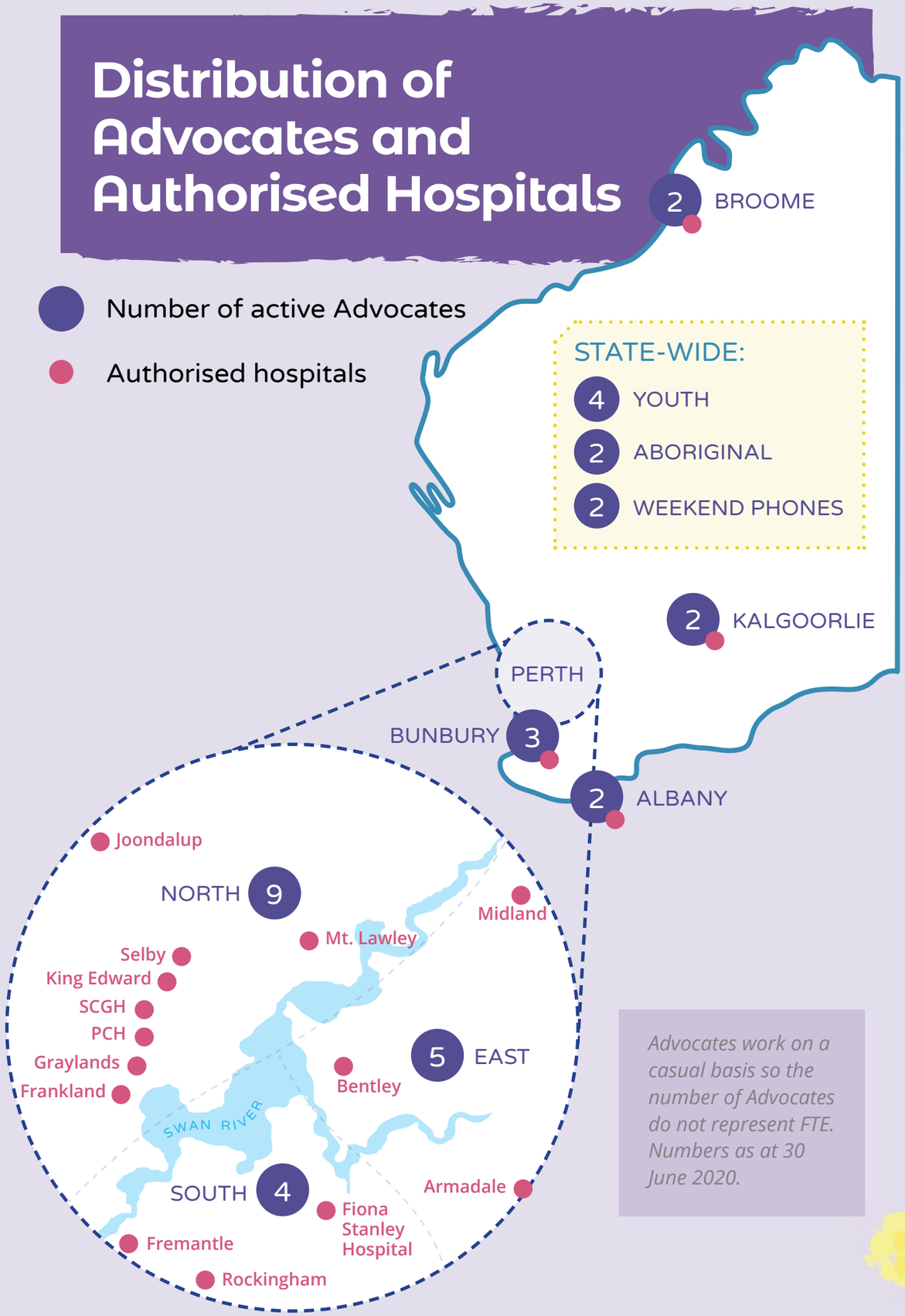
Advocates deliver pure advocacy, also called representational advocacy, which means they serve as a mouthpiece for the consumer, are partial to the consumer, and act according to the wishes of the consumer. Children are an exception, as the Act requires best interests advocacy for them. Advocates may undertake 'non-instructed advocacy' in cases where a consumer cannot express their wishes and where the advocate is concerned the consumer's rights may be infringed.

Advocates may attempt to resolve issues directly with staff members or refer matters to the Chief Advocate if they cannot be resolved or if they are of a serious or systemic nature. The Chief Advocate and Senior Advocates may then contact management of the facility, the Chief Psychiatrist, the Mental Health Commissioner, the Director General of the Department of Health (as the 'system manager'), or the Minister for Mental Health to seek resolution.

[1] The Advocates, including the Senior Advocates, are engaged on a contract for services at an hourly rate; with one exception (a Senior Advocate) they do not work full-time hours, are generally not guaranteed work, do not have any leave entitlements and can make themselves unavailable at any time.

[2] One Advocate supports consumers in Geraldton by phone.

Distribution of Advocates and Authorised Hospitals



Advocates work on a casual basis so the number of Advocates do not represent FTE. Numbers as at 30 June 2020.

The Year in Review

provided services to 3,427 consumers

received 5,901 phone requests for contact

attended 1,041 Mental Health Tribunal hearings

noted 8,970 issues raised by customers

responded to 7,793 notifications of orders

finalised a major inquiry on the rights of Aborginal and Torres Strait Islander people

requested 270 further opinions

maintained advocacy services during COVID-19 restrictions

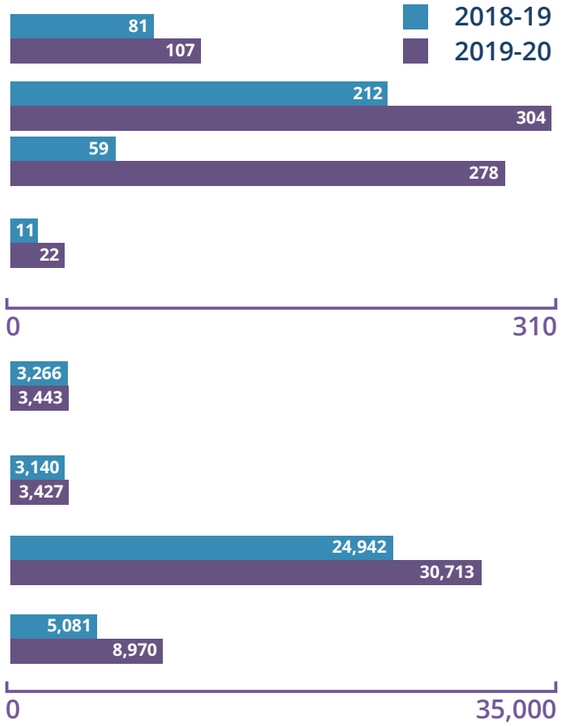
Demand, Gaps and Lack of Access to Care

Demand for advocacy continued to grow in 2019-20 as more people were made involuntary, more people waited in emergency departments (EDs) for too long, more children were detained and the overall cases and issues became more complex.

The data tells the story in part, with increases in the number of:

- people involuntarily detained on wards - up 5.4%
- children involuntarily detained on wards - up 32.1%
- people on referral orders awaiting a compulsory psychiatric examination, often detained in EDs, requesting Advocate contact – up 43.4%
- voluntary children (or their families and guardians) seeking help - four-fold increase - up 371.2%
- mentally impaired accused on Custody Orders – up 100%
- consumers provided with advocacy services as required by the Act – up 5.3%
- contacts with consumers by Advocates (reflecting increased case issues and complexity, and Mental Health Tribunal hearings) – up 23.1%

Increases in Advocacy Service workload



Increases
+ 32.1%
+ 43.4%
+ 371.2%
+ 100%
+ 5.4%
+ 9.1%
+ 23.1%
+ 76.5%

Access to appropriate care is the single biggest issue for the consumers who Advocates help. The extent of the issue varies but particularly impacts on:

- children and young people
- people in prison
- people with eating disorders
- people who self-harm and/or who suffer suicidal ideation
- those who have severe mental health issues, or intellectual impairment and challenging behaviours.

There are gaps and shortages across the system, as the following stories based on Advocate activities attest.

Adult access to care

The unacceptable wait times for adults (18 years and over) in EDs continued in 2019-20. One of the worst cases was a consumer who waited six days for a bed, but many others waited several days. The number of adults in EDs and the periods they waited there eased from mid-March to mid-May due to COVID-19 restrictions, but people continued to be made involuntary (see page 27 COVID-19 Impacts).

The 43.4% increase in advocacy support to people on referral orders (who are generally in EDs) reflects this continued and increasing demand and the gap in the mental health system.

The Auditor-General's report '*Access to State Managed Adult Mental Health Services*' published in August 2019 told us what we already knew - there is an over reliance on costly hospital beds and a lack of community alternatives that allow people to be treated and stay in the least restrictive care setting. As the report noted, 10% of people use 90% of the hospital care, and almost 50% of ED and community treatment services. Those comprising the 10% are the people who Advocates typically work with and include many who are stuck on hospital wards because there are no suitable alternatives. It was hoped that the Auditor General's report would provide further impetus and significant data to lead to some specific funding commitments, but then COVID-19 intervened.

Some Government announcements have been made which are welcome - in particular, an adult community care unit, but it will only be 20 beds. We know that about 25% of hospital beds are occupied by people who could be discharged if there was somewhere for them to go,[3] so that means over 160 people[4] could be discharged if there were appropriate community care facilities for them. That hasn't changed, and there are now 16 fewer psychiatric hostel beds due to bed closures announced by one hostel in June 2020.

A mental health emergency care unit (MHEC) opened at Royal Perth Hospital (RPH) in October was designed to take some of the pressure off EDs and help people avoid hospital admission. While this is also welcome, the MHEC was funded by closing eight voluntary beds on a non-authorised mental health ward at RPH, which just put pressure back on the system. Plans for a 'safe haven' café as another alternative to EDs are also underway and more hospital beds were announced during the year for Fremantle Hospital, but they won't be open until 2024.

[3] See last year's annual report, page 11 and reference to the Mental Health Commission's snapshot survey in April 2019.

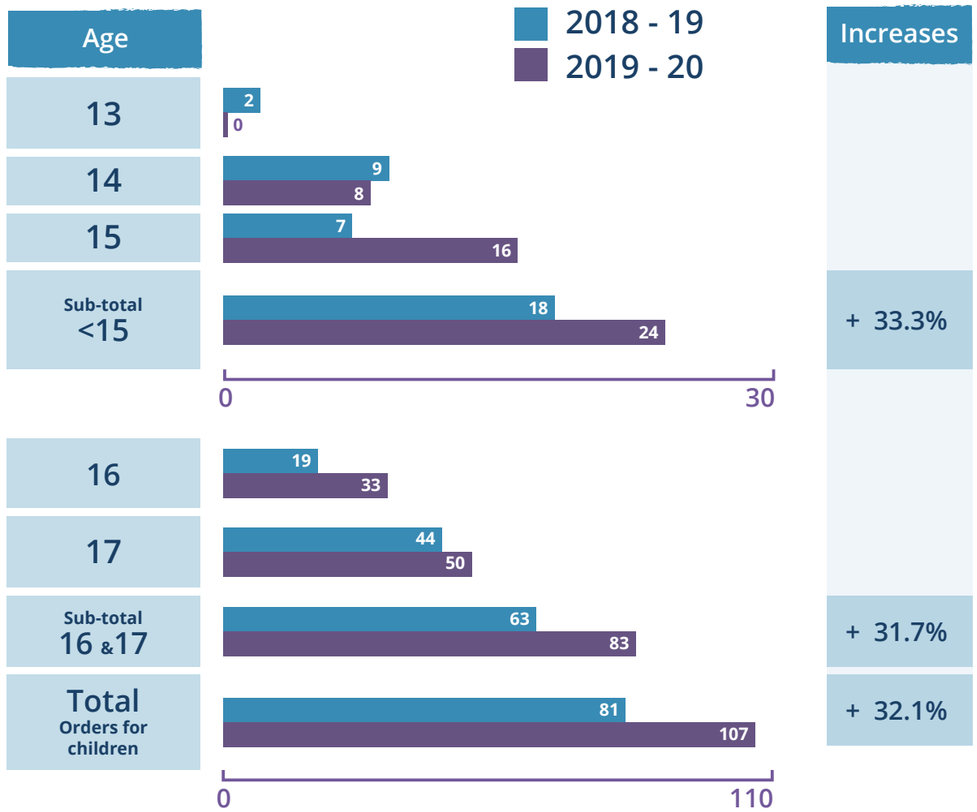
[4] As at 30 June there were 674 authorised mental health beds.

New MHEC at RPH opened on 16 October 2019.

Children and young people – tragic gaps

There are some tragic gaps in mental health care for Western Australian children. More and more children are being made involuntary - with the number increasing by 32.1% this year. Many more are on locked mental health wards under the authority of parents and guardians. Youth Advocates' work with voluntary children on mental health wards increased four-fold and that work was usually as complex as for involuntary children.

Increases in involuntary inpatient orders for children by age



The EDs and the three acute mental health wards that can take children attempt to fill in the gaps but support services in the community have been lacking or failing these children and their families. Public community mental health services have long delays for referrals (over six weeks) and are limited in scope, hours of operation and ability to provide the intensity of care required for children the Advocacy Service assists. Headspace youth mental health programs do not deal with the more serious mental health issues. The result is that EDs are the only place left but there are never enough hospital beds, resulting in long wait times in EDs, distraught families, tension with treating teams, compromised care and recovery prospects, and sometimes, tragically, a child dies.

The situation is exacerbated because three of the five government health service providers (HSPs) in WA have mental health wards for children, but one only takes up to age 15, two HSPs have no wards at all and there is no single HSP responsible for all children and young people. The Child and Adolescent Health Service (CAHS) which manages Perth Children's Hospital (PCH) does not accept children aged 16 and 17 years as inpatients and they can only be admitted to one of the two youth wards (which take people aged 16 to 24):

- East Metropolitan Youth Unit (EMYU) managed by East Metropolitan Health Service (EMHS)
- Fiona Stanley Hospital Youth Unit (FSH Youth Unit) managed by South Metro politan Health Service (SMHS).

However, on discharge, 16 and 17 year olds must go to a different HSP - CAHS - for community care. Although 'developmentally appropriate' 16 year olds are meant to be admitted to PCH, the Advocacy Service has had little success advocating for admission for these young people.

Added to the mix are young people with conditions such as autism and foetal alcohol spectrum disorder (FASD) being detained on mental health wards and long delays in accessing National Disability Insurance Scheme (NDIS) funding to provide alternative care (and often places to live), plus complications with child protection services. This is a major gap in care which goes beyond mental health services and requires a multi-departmental approach.

Trying to get into hospital - nowhere else to go

Prolonged stays in EDs continue for children. Beds on the two youth wards are constantly in demand and they rarely have vacancies. Even during the tightest COVID-19 restrictions when adult mental health patient attendance at EDs dropped off significantly, this was not the case for children.

It is not uncommon for referrals to be rejected, and for there to be differing clinical opinions about the need for admission between the clinicians in the ED and the inpatient unit. Meanwhile, the child and their family or guardian wait, in some cases for days. Issues raised can include ward acuity, and whether the child is exhibiting mental health issues or something else, such as autism or FASD, in which case the referral can be rejected as not a mental health issue.

Sometimes the child and family give up waiting in the ED - because the ED is a distressing and, in some cases, unsafe place – and the child remains on a waitlist but concerns for the safety of the child remain.

Requests for contact by Advocates come from families and ED clinicians. The Youth Advocates have the advantage of understanding the overall mental health system for children, which helps in explaining to the young person and families what is going on. The role of the Advocates is to ensure the child and their family or guardian know their rights, while also facilitating and

advocating for access to inpatient services or appropriate support in the community. Youth Advocates work with the child, the parents or guardians, and the clinicians in the ED to ensure all relevant information is obtained and shared, which can assist in the decision whether to admit the child. Some rejected referrals have gone ahead after the Advocate provided further information from the child and/or family.

The Advocacy Service also keeps a close watch on the Monday to Friday daily bed demand report, which shows the number of people on mental health orders waiting in EDs, and Advocates follow up where there appear to be delays.

Children in regional areas are particularly vulnerable, even more so if they are seeking voluntary admission as they may not be prioritised for Royal Flying Doctor Service transport. They can wait for days in a regional ED or hospital and, despite being voluntary, may still be under the supervision of security guards and quite unwell. Similarly, 16 and 17 year olds with eating disorders can be delayed admission because the wards where they are treated restrict how many people they can take with this mental health issue.

A snapshot of the year in EDs and cases Advocates were involved in is set out below.

- July / August / September – Five or six children waiting and only one bed available on at least two occasions; a 17 year old rejected by a youth ward was waiting longer than 24 hours; a child with intellectual disability in an ED for over 40 hours.
- October - Three children were stuck in an ED, two of them for over 20 hours, and one went missing (AWOL) while waiting. In another ED a young child was shackled to a bed. In a fifth case, a child was held in a regional ED with security guards for over 24 hours and not admitted for another two days.
- November/December – Critical shortages of beds lasting days on two occasions - one child waited 56 hours, two children waited three days, a third waited five days before going home without admission; a child waited in a regional hospital for a week before being transferred to Perth; a child with an intellectual disability waited over 24 hours; two other children also waited over 24 hours.
- January / February /March – A child with an eating disorder was on multiple referral orders (form 1As) for a month waiting for admission; 14 youths waitlisted for one youth ward; young people waiting in the community for weeks for admission; one child spent a day on a Graylands Hospital adult ward.
- April – Four children waiting and only one bed available and then EMYU announced late on Thursday 9 April, just before the Easter long weekend, that it had closed four beds on its acute ward to be used in case a COVID-19 positive adult, who was also an involuntary mental health patient, needed to be isolated.

  The Advocacy Service immediately raised concerns about the impact on children as demand for beds had not fallen away in this group. By 16 April there were children waiting in several EDs for beds.

The Advocacy Service sought answers from EMHS as to why an arrangement could not be made with another HSP, especially as demand for adult beds had fallen. Answers were received on 21 April, but the Advocacy Service was not satisfied and wrote back, copying in all HSPs as the EMYU bed closure affected the whole state.

The Chief Advocate wrote:

'We are already aware of young people being held up in EDs due to the lack of beds. Worryingly some eventually chose to go home and wait which, for a young person susceptible to impulsive behaviour, can be a very dangerous time. There are delays with access to Community CAMHS in ordinary times so that is another concern for us. It would be a really terrible outcome if we lost a young person this way while 4 beds remained closed just in case a COVID-19 involuntary adult emerged .... '

On 22 April it was announced that the EMYU secure beds would re-open as a 'collaborative solution' had been found, with North Metropolitan Health Service (NMHS) agreeing to accept any involuntary mental health adult patients from Royal Perth Hospital (RPH) and Bentley Hospital who required quarantine due to COVID-19.

- May/June – A child waiting for four days gave up and went home; a child waited in a regional hospital for 12 days; a child with an eating disorder was delayed admission because there were already two patients with eating disorders on the ward; concerns were raised by clinicians about a child in an ED referred to PCH but with no guarantee of when a bed would be available, saying they had 'proactively explored all possibilities' to get the child off the ED which they were sharing with adults with drug and alcohol issues. In the end, the child was transferred via ambulance to Perth Children's Hospital (PCH) ED.

With the help of some young people on the youth mental health wards the Advocacy Service designed and launched new brochures for voluntary and involuntary children and young people during Mental Health Week in October 2019.

One of the Youth Advocates at the launch of the new pamphlets for voluntary and involuntary children and young people during Mental Health Week in October 2019.

Trying to stay in hospital – nowhere else to go

When young people do get a bed in hospital, they, or their parents or guardians can be resistant to discharge because they do not feel safe, the discharge plan is inadequate and/or there is nowhere safe to be discharged to, as the following work of the Advocates illustrates.

Suicidal young people

Youth Advocates regularly deal with parents and guardians who want children admitted and to stay in hospital to keep them safe because the child is acutely suicidal. The Advocacy Service is advised that the average age of these children presenting to PCH is now 13-14 years and over the past nine years there has been a 319% increase in the number of children (under 18) presenting to an ED following self-harm (from 934 in 2009-10 to 3,914 in 2018-19). Hospital stays over the same period associated with self-harm for children aged under 18 increased by 88%.

Clinicians advise, however, that acute hospital ward admission can be detrimental and the result is that such children and young people (and, indeed, often adults) have multiple, short, crisis admissions because there are no (or not enough) suitable services in the community.

The Youth Advocates work closely with the treating team to make sure clinicians hear the child's voice, as well as that of the parent or guardian, and explore all options. Often the Youth Advocate becomes the liaison between the two as tensions rise. Exhausted parents and guardians are expected to take home their still suicidal child and keep them safe while waiting for a community mental health appointment at some time in the future.

Eating disorders

Cases involving children with eating disorders are also fraught as there is no public rehabilitation service for such young people who could benefit from a medium-term admission with specialist care. Mental health wards limit the number of children with an eating disorder on the ward at the same time. The situation is no better for people over 18 years. Most of these consumers are female and treatment often includes feeding by nasogastric tube, which may involve restraining the consumer. This is done on a medical ward and security officers are generally used to detain the consumer. Advocates have argued for more female security officers, to avoid trauma. There are ongoing issues with stigma, lack of training for staff and understanding of this very serious mental illness which can end in loss of life.

"Having been through both the child and youth hospital systems for anorexia nervosa inpatient and outpatient treatment, I have seen both the positive and negative aspects of eating disorder treatment in Perth. While the child system deals well with younger patients, I feel there is a lack of availability of these services and a gap after the age of 16, as the children's service is not appropriate, yet the youth system can be frightening and daunting.

Although there is a team of compassionate, experienced nurses at the Perth Children's Hospital eating disorders program, it is suited for much younger patients, rather than adolescents.

The youth system at Fiona Stanley Hospital is a major jump from the children's services and was extremely overwhelming. Both the medical and mental health services had positive and negative aspects that affected my wellbeing at the time, and still impact in my mental health today.

The medical department was extremely daunting and lacked a sense of coordination. Both my family and myself felt lost in a big system that we did not understand, with no guidance other than that provided through advocacy. The nurses on the medical ward had good intentions, though it was clear they lacked experience and insight into eating disorders. And the AINs (assistants in nursing) lacked any understanding, compassion and kindness needed to support a patient. AINs made some of the most distressing, inappropriate comments that have ever been said to me, including complimenting my weight loss and asking for weight loss tips!

The mental health youth unit was extremely inconsistent, with some days being extremely distressing and unhelpful while others were quite beneficial. It was glaringly obvious which nurses had experience and understanding regarding eating disorders and which did not, and this made all the difference. Mental Health Advocacy services at Perth Children's Hospital were extremely lacking.

But at Fiona Stanley Hospital, I had the fortune of meeting the most amazing, compassionate and helpful Advocate, who supported both my family and myself through the most stressful period of my life. In a system that was so overwhelming and frightening, she provided direction, comfort and allowed my voice to be heard. I have nothing negative to say about the Mental Health Advocacy service at FSH. I will forever be thankful of this amazing service.

While the health system is improving for eating disorder treatment, I feel that it is extremely underdeveloped in this area, and no matter how many adjustments are made, there will always be a major flaw in our system until we establish specialised eating-disorder services. This is something I believe is very important in our modern world - and something with a growing demand - and something that I hope to see in my lifetime."

- Becky

No safe home and nowhere else to go

Sometimes the young person does not have a home to go to or is not safe to go home but staying on an acute mental health ward is delaying and potentially jeopardising their recovery. There is nowhere else for them to go because child protection and family services within the Department of Communities does not have capacity to support their high level needs and there is only one mental health supported accommodation service in WA for young people.

In June, the Minister announced an additional $25 million had been invested to develop a 16-bed youth mental health and alcohol and other drug homelessness service in the metropolitan area to provide stable transitional supported accommodation for young people aged 16 to 24 years. This is welcome but will take some time to establish.

Whose problem is it anyway????

In too many cases, Youth Advocates find themselves as the voice for the child amid a battle between mental health and child protection services5 and/or disability services and NDIS:

- The mental health service says the child needs to be discharged somewhere safe with high levels of care and staying on an acute ward is not conducive to recovery. Child protection services say that they can't provide the level of care/supervision required and it is the responsibility of mental health services. In some cases, there are family members available to help but they need support, and that support has been denied to them by child protection services because they are a family member.

- Last year, the Advocacy Service reported mental health wards were being used as a place of respite and there were long delays in discharge of children and young people with disability and co-occurring mental health diagnoses. This did not change in 2019-20, with Youth Advocates continuing to be the voice of the young person.

- Some successes were achieved during the year, albeit after the consumers spent many months living on acute wards. The Youth Advocates worked tirelessly on the cases in collaboration with the treating teams - in particular, the social workers. The Department of Communities also advised in November that it had established nine Regional Intensive Support Co-ordinator positions to be the 'go-to' people in such cases in the future. The idea is that this team can have capacity to suddenly pick up a complex case and work on it to prevent discharge delays. In one case, the Department of Communities also agreed to guarantee interim funding while NDIS processes were being completed to get discharge happening sooner.

During the year the Chief Advocate:

- wrote to the three Ministers involved - Community Services, Disability Services and Mental Health - about the discharge delays being experienced by young people with disability and co-occurring mental health diagnoses. It was acknowledged that, in the transition to an Australia-wide NDIS, delays in discharge from hospital had emerged as a significant and challenging issue. Reference was made to a Disability Reform Council National Hospital Discharge Delay Action Plan and that service coordination was a priority for the Department of Communities.

- met with the newly appointed NDIA State Manager to raise the issues.

5. Child protection services and disability services come within the Department of Communities though with separate Ministers. In this annual report they are referred to separately. Mental health services could be any of the three HSPs that admit children.

"My son Gavin was diagnosed with autism at the age of three, and schizophrenia at 15.

This illness was a completely different ballgame, and things he used to be able to do he could no longer manage, such as go to a cafe, the local swimming pool or public library. He was extremely distressed, delusional, ranting, volatile and even violent.

Over a period of around six months, Gavin presented to ED approximately six times due to psychotic episodes. Each time, until the last time, he was discharged with the view from the treating teams that there was nothing untoward, that he simply had a disability of autism and required behavioural management.

This began a very distressing battle to get him some help and treatment. More distressing than the actual episodes was the bouncing through departments, with him not fitting into any of them, and the wild goose chases we went on to try find a solution. Being under 18 years of age, disability saw him under child protection, child protection saw him under disability, police saw him under mental health, mental health saw him under disability and so on. Each phone call would take me down a track to another phone call somewhere else and we just got nowhere. And because nobody was in the same room as anybody else, anybody could say the solution is not here it is over there, and I would follow it up over there, relaying the same information over and over again, only to get to the same result at the end of having to go to a different place and repeat the same process again and again.

Over this time, Gavin's life unravelled, he couldn't complete Year 12 and became more and more at risk, as did the community.

The last episode Gavin had saw him back in ED, but this time transferred to a mental health unit, where he was recognised as being quite ill and ended up staying for around one month to stabilise. He was given medication and discharged back to the community under the mental health team, and his existing supports – but with poor coordination and communication between the different services.

About six months later, Gavin's CTO lapsed and he ceased taking his medication, which lead to a relapse and another stay in the mental health unit for nearly a month. At this stage I was nearly ready to give up and was totally exhausted on every level. Fortunately, Gavin's mental health advocate proposed better communication and a team approach going forward for a greater chance of success. I felt her strength and recommendation of this shared communication and teamwork held considerably more value coming from her than from me, and that it probably wouldn't have happened had it only been myself advocating for it. This turned out to be a pivotal point and the start of much more positive change for my son's health and quality of life.

Gavin has now started engaging in the community again and has many great prospects on the horizon, and our relationship is the best it has ever been."

- Kathy

Prisoners' human rights

Inpatient bed crisis

There is a dire shortage of beds in WA's only secure mental health inpatient facility where people in prison are treated, the Frankland Centre. In September 2018 it was reported[6] that one third of prisoners who were referred on a form 1A for inpatient care to the Frankland Centre, never got there, and 61% of all referrals lapsed without a hospital placement.

The situation remains at crisis point. The Advocacy Service is aware of a young person who waited while extremely unwell for over two months. Admission was obtained shortly after the Advocacy Service raised the issue. The longer a person remains untreated, the longer it takes to recover, and the more suffering they endure.

In the past year there has been an increasing number of people put on Custody Orders by WA Courts under the *Criminal Law (Mentally Impaired Accused) Act 1996* (CLMIA Act) who have been admitted to the Frankland Centre under Place of Custody Orders by the Mentally Impaired Accused Review Board (MIARB). This means they remain at the Frankland Centre rather than in prison. Seventeen of the 30 available beds are currently filled on a semi-permanent basis by people on Custody Orders. It is expected that if this trend continues, by March next year there will be no beds left for people in prison needing inpatient care.

The Chief Advocate wrote on 19 June 2020 to the Ministers for Corrective Services and Mental Health and the Attorney-General (responsible for people on Custody Orders), asking: 'What is the plan? As at 30 June 2020, responses had not been received.

Shortly after this, the Advocacy Service became aware of Frankland consumers being returned to prison while still on involuntary orders - their psychiatrist refused to revoke the orders because the consumers still required inpatient care and the only reason for their return to prison was a lack of beds in the Frankland Centre. The Chief Advocate raised the issues with the Chief Psychiatrist and Inspector of Custodial Services (who checked on the welfare of the prisoners) and briefed the Minister for Mental Health and Acting Mental Health Commissioner.

National and international standards state that mental health care in prisons should be equivalent to care in the community. The Chief Psychiatrist and Chief Mental Health Advocate have both repeatedly raised concerns with various Ministers, the Mental Health Commissioner and the Director General of WA Health. Multiple historical business cases and presentations on the data have been put to successive governments and Ministers. In late 2019, several crisis meetings about forensic mental health were held at the most senior agency levels but nothing had been announced by 30 June 2020.

Custody Order issues

People on a Custody Order have been found not guilty by reason of unsound mind or not fit to stand trial. Those detained at an authorised hospital or who are in the community but must undergo mental health treatment are identified persons under the Act.

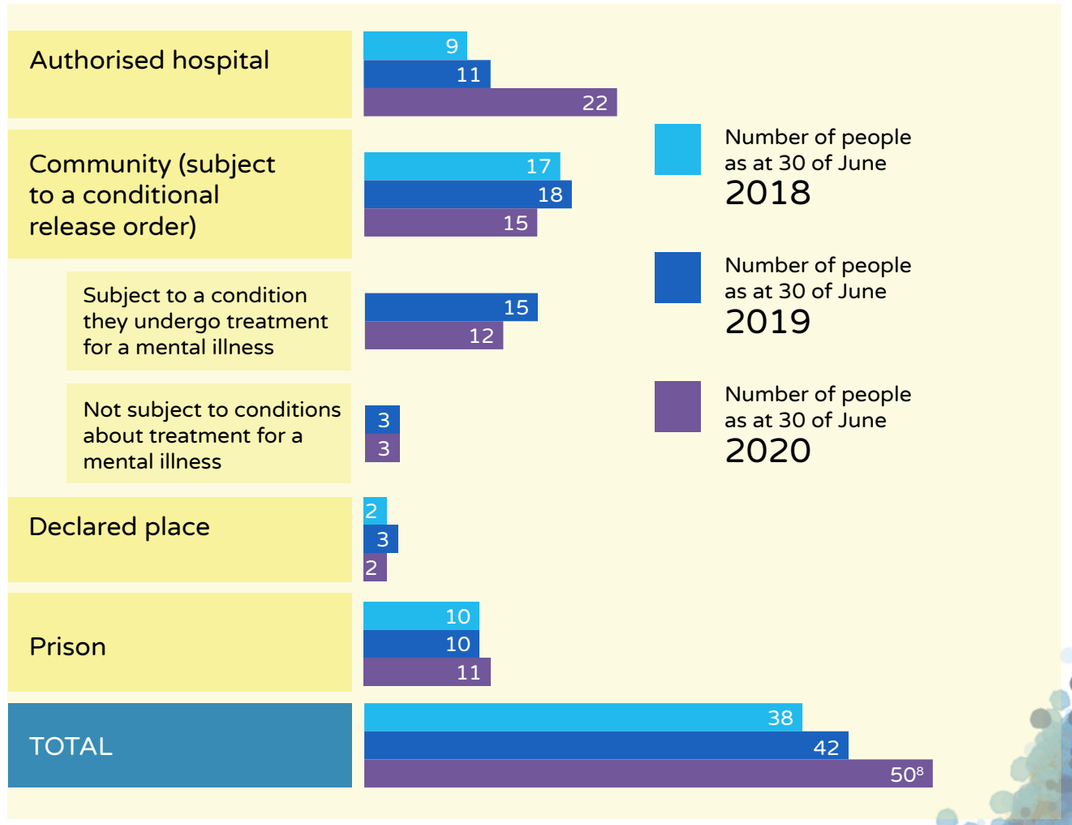
The Custody Order has no end date and the person is subject to the CLMIA Act, which means their care is governed by recommendations of the MIARB, which must be approved by the Governor. There were delays in the granting of leave of absence orders recommended by the MIARB during the year. This meant that some people on Custody Orders in the Frankland Centre could not access routine medical treatment. While emergency health procedures are allowed, a leave of absence order is needed so the person can leave the Frankland Centre for any other treatment. The MIARB comprises experts, including a psychiatrist, and regularly makes standard leave of absence orders to allow the person to attend medical appointments. The leave of absence order must be approved by the Governor - which means it must go via the Attorney-General's office before it can be put on the agenda for approval by the Governor.

The Chief Advocate wrote in June 2020 to the Attorney General and Ministers for Mental Health and Corrective Services raising the delays and associated risk to the people affected.

Long awaited amendments to the CLIMIA Act were also delayed during the year, in part due to COVID-19. This was a Government pre-election commitment which now looks unlikely to be met.

In the meantime, the number of people on Custody Orders continues to grow, as does the number of people whose Place of Custody is in the Frankland Centre, rising from 11 last year to 22.

Mentally Impaired Accused Persons Place of Custody Orders[7]



[6] Inspector of Custodial Services, 'Prisoner Access to Secure Mental Health Treatment', September 2018.

[7] Data provided by the MIARB on 11 August 2020.

[8] Two orders were for the same person so there were 49 people on 50 Custody Orders.

Need for declared places

For those people on a Custody Order with mental health as their prime disability, there is no place for them except at the Frankland Centre or prison. The CLMIA Act allows for the possibility of a 'declared place' which is neither a prison nor an acute hospital ward but the only declared place in WA is the Bennett Hill Disability Justice Centre (DJC)[9] which can only take people who have intellectual impairment as their prime disability and whose admission is approved by the Minister for Disability Services.

Since it opened, the 10 bed facility has only ever had between one and three residents. Advocates have pressed for the admission to the DJC of several other consumers on Custody Orders at the Frankland Centre. Only two have been admitted, and the Minister later withdrew his consent in one case. The Chief Advocate has raised the under-utilisation of this facility with the Minister for Disability Services.

Children in detention

No children were admitted to an adult ward from Banksia Hill Detention Centre in 2019-20, as far as the Advocacy Service is aware. Children in Banksia Hill are now admitted to one of the two youth wards when they need inpatient care or are put on a hospital order by the courts for assessment.

In some more good news, work begun by the Advocacy Service the previous year advocating for a security review of the EMYU so that Banksia Hill custodial officers did not have to remain on the ward came to fruition. The security review was completed, funding obtained for the work and the work carried out. This was a win-win for everyone - young people on the ward, the EMHS and Department of Justice.

Advocacy continued during the year for broader action to plug the gaps in mental health services for youth in and out of prison. This work began in 2017-18, when the Advocacy Service facilitated a meeting of all the relevant departments at Banksia Hill.[10]

From that initial meeting a working group was established and in February 2020 a significant report was issued: *Forensic Youth Mental Health Mapping of Pathways: Access to Care Report* (the Report).

The Chief Advocate sent the Report to the Ministers for Mental Health, Justice and Community Services, and the heads of their respective departments. The report was written by people working on the ground in these departments which made the findings and recommendations even more powerful. The Report sets out what is missing, the risks and a blueprint of what is needed - but the recommendations require significant collaboration.

Some of the recommendations were not new and dated back many years to previous reports.[11] If the recommendations are implemented, there will be long-lasting benefits to these young people, the community and the state, as well as cost savings by dramatically reducing the public services needed as these children become adults.

The Advocacy Service has been told that a joint response is being provided from the departments of Justice and Communities and the Mental Health Commission (MHC) but individual responses have also been received commending the report.

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9. The DJC is run by the Department of Communities. The Advocacy Service is also required to provide advocacy services to DJC residents pursuant to the *Declared Place (Mentally Impaired Accused) Act 2015.*

10. See the Mental Health Advocacy Service 2017-18 Annual Report.

11. Youth Justice Think Tank 2012.

COVID-19 Impacts

Advocates continued to deliver services during the height of the COVID-19 pandemic restrictions in WA but did more work by phone and took part in Mental Health Tribunal hearings by videoconference. HSPs were notified that Advocate powers and functions under the Act remained but that Advocates would abide by any public health directions or ward arrangements. Where necessary, Advocates visited the wards and this was by the Advocate's choice; those Advocates who were not comfortable visiting wards did not have to do so. On two occasions, Advocates were required to 'don and doff' personal protective equipment (PPE) supplied by the hospital because the consumer they were visiting had come into close contact with a COVID-19 confirmed case.

One of the Advocates in PPE to visit a consumer in quarantine due to COVID-19.

Issues relating to COVID-19 dealt with by the Advocacy Service included:

- learning and dealing with erratic technology to participate in ward and family meetings and help consumers take part in their Mental Health Tribunal hearings (see also below under *Tribunal COVID-19 arrangements*)
- advocating for a consistent and proportional response across mental health wards in relation to restrictions imposed on consumers as part of the COVID-19 response
- the response by and in relation to hostels, which are considered high risk due to congregate living, with shared bathrooms, bedrooms and living areas, and visitor restrictions (see below under *Hostel response to COVID-19*)
- educating staff across mental health services that the Act and consumer rights continued to apply and were not over-ridden by the 'Public Health Act'
- the legality of the *Mental Health Infection Control Direction* made on 6 April 2020 and related amendments proposed to the Act
- children waiting in EDs for admission - this was exacerbated for two weeks after Easter when beds were closed on one of the two youth wards for COVID-19 adult patients (see above under *Trying to get into hospital …nowhere else to go*).

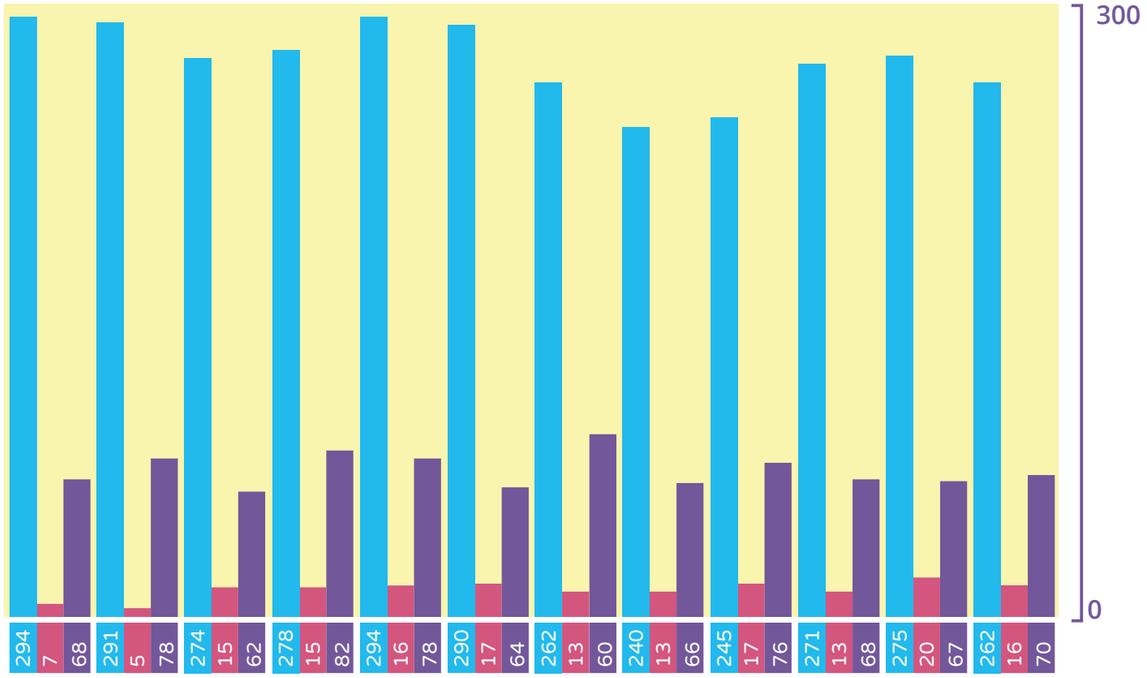
The number of involuntary inpatient treatment orders in authorised hospitals began falling in January 2020, prior to the COVID-19 pandemic restrictions. The numbers continued to fall in February but there was a slight rise in March and a further rise in April. Overall, there were fewer orders made between January and June 2020 compared to the preceding six months, but the changes were partly due to decreases in January and February and not solely a result of COVID-19 restrictions.

Involuntary Order Numbers July to December 2019 and 1 January 2020 YTD – impact of COVID-19

Form 6A
Involuntary inpatient treatment orders in authorised hospitals

Form 6B
Involuntary inpatient treatment orders in general hospitals

Form 5A
Community Treatment Orders



Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	MONTH
369	374	351	375	388	371	335	319	338	352	362	348	TOTAL

July - December 2019

2,228

January - June 2020

2,054

Getting a proportional response

From 23 March 2020 all public hospitals limited visitors to between 10am and 11am, and 7pm to 8pm, with a maximum of two visitors per patient per day and only one visitor in the patient's room at any time. This was premised on visitors going into patient bedrooms as they do on general wards but that is not allowed on mental health wards, which were restricting all visitors to the one or two meeting rooms on the wards. Some wards set up a booking system, some didn't; others in the end realised that the rule simply did not work for mental health wards. Meanwhile, some wards were stopping all visitors and refusing patients any ground access, refusing to charge consumer mobile phones (due to infection control) and in a couple of cases tried to stop Advocates from going on the ward. There were inconsistencies across wards and services and very few wards were offering alternative means of family contact.

Advocates raised these issues on behalf of consumers, and other rights under the Act such as treatment, support and discharge planning, but were sometimes told by staff that the Public Health Act over-rides the Mental Health Act which was not the case. Some staff seemed to think that the Mental Health Act no longer applied at all.

The Chief Advocate raised the issues at various levels, reminding services that the Act still applied and that the COVID-19 restrictions needed to be proportional to the risks - some clearly were not. But it is difficult dealing with multiple hospitals and HSPs. Dr Sophie Davison, the DOH's COVID-19 Health Operations Mental Health Lead, then offered to set up a meeting with representatives from all the HSPs, the Chief Advocate and the Chief Psychiatrist, to discuss the issues. Ultimately, guidelines were agreed around visitors, patient leave and ground access, which were distributed to wards by 16 April 2020.

The guidelines resulted in some wards which had been totally locked down starting to allow consumers out for escorted ground access (EGA) and visitors in. One happy consumer who got 30 minutes EGA after being locked up for weeks, sent their Advocate a simple email with the subject line: Thank you – Went outside for some time.

Advocate and consumer COVID-19 feedback

Advocates were asked to comment on the impact of COVID-19 on them and their consumers. Their comments included the following.

The negatives:

- Already limited supported accommodation options became even more limited as some places were not accepting referrals, citing COVID-19 as the reason.
- A mixed response to telehealth services by consumers. Some preferred it, but many did not. This also was impacted by the quality of the telehealth services, with some people preferring the phone to video and other technology. A consumer with hearing difficulties had to fight to be seen in person following a prolonged stay in hospital.
- Hospital equipment was inadequate for video meetings and a serious shortage of it resulting in the use of mobile phones or just not being able to join meetings at all remotely.
- Therapy and gym activities were closed and consumers seemed to be sleeping more because there was nothing to do - however, some wards were the exact opposite and put on more activities.
- Space is usually limited in nursing stations but physical distancing requirements made it difficult for Advocates to check medical files.
- Consumer distress at not being allowed visits from children.

- Take-away food (a treat for long-term consumers) was stopped.
- COVID-19 was used as an excuse for lack of planning or communication.
- Aboriginal mental health workers stopped taking consumers out because of concerns about spreading COVID-19 to their communities, but it had a negative impact on indigenous long-term consumers.
- Making and processing of NDIS applications came to a halt for a period, so consumers had even longer to wait.
- It was difficult working with and for consumers by phone.

The positives:

- Wards were cleaner.
- Some wards, normally full and with pressure to discharge, had empty beds which meant staff had more time to spend with consumers.
- Some shared rooms, which were originally designed to be single bed rooms, were converted back to single bed (but due to bed shortages have reverted to shared rooms).
- It allowed the system to stop and be more creative because it had to be, which allowed for greater flexibility and a revision of some practices.
- Some consumers embraced technology such as Skype and similar platforms to keep in touch with family and friends. The nurses and welfare officers assisted with this.
- I did not notice any anxiety in the wards from consumers, or clinicians. It was business as usual. Consumers felt safe being in hospital as their temperature and any other sign of illness were constantly monitored.
- There was a heightened sense of being in it together, with patients taking more care over washing their hands, their laundry being done more frequently etc); an indefinable sense that patients felt there was something 'bigger' out there that they needed to know about and be concerned about (and this manifested itself in patients all listening to the news and talking about it).
- Staff sought feedback from me regarding COVID-19 isolation procedures to maintain consumer dignity and rights.
- I have had several interactions with staff where they have expressed the value of advocacy and that they value Advocates and our role on the ward. I can't really explain this in terms of the tough time that we have all gone through. It does seem that in some sense the crisis has helped to crystalize the meaning and value of our role.

And a few comments by consumers:

> *I was pacing around the house like a caged tiger. It sent my mental health out of control. I felt trapped, isolated and controlled. I felt lonely. I felt like I had no contact with the outside world. I felt depressed and bored. It is continuing and on and on...It is affecting me negatively; all the news; all the people in masks. I see no end in sight. It all feels unreal.*

> *COVID impacted on my mental health due to my TAFE course being changed, with placements requiring more hours over a shorter period of time. This caused me stress and anxiety which eventually led to me withdrawing from the course and my mental health deteriorating.*

> *When we were in lockdown I believed that this was a 'new beginning' so I stopped attending the mental health clinic for my medication. I had been on it for 20 years, but no-one came looking for me. This confirmed it for me, that it was a new beginning.*

> *I need a structure every day to support my mental health but everything just got shelved and I had reduced opportunities to meet with friends. I became really unwell and was hospitalised.*

> *I stopped taking my medication around the time of COVID, but I don't think this was because of the pandemic, I just felt it was good time to stop taking it. Everything went pear-shaped then and I was admitted back to hospital. I do think that COVID made everyone stop and think about their health.*

COVID-19 directions and amendments to the Act

In late March 2020 draft Mental Health Infection Control Directions made pursuant to the *Public Health Act 2016* (the Public Health Act) were circulated and the Advocacy Service and other stakeholders were asked if amendments to the Act were needed to deal with COVID-19.

The proposed directions required infection control procedures where the patient had COVID-19 or met other criteria requiring self-isolation, or where the practitioner had been directed to self-isolate. One of the infection control options, contrary to the Act, was that the assessment and examination of patients (to decide whether the person should be involuntarily detained) could be by audio-visual means. The Chief Advocate did not oppose the directions in principle (assessments and examinations by audio-visual means are specifically allowed under the Act but in regional areas only) but queried whether such orders would be valid under the Act. Public Health Act directions did not specifically over-ride other legislation. It was important to know this as Advocates need to make sure consumers know their rights and represent them in Mental Health Tribunal hearings.

The directions were issued on 6 April 2020 and work began on trying to get an amendment to the Act to ensure that orders made this way would be valid. Advocates were told to explain to consumers their rights as they were known to us at the time, their options (which included a Mental Health Tribunal application to test the validity of the order) and consequences (the rights, options, consequences, or ROC, principle practised by Advocates) in relation to any involuntary orders purportedly made this way. No such orders were made known to the Advocacy Service. One of the concerns and drivers of the making of the direction was that there would be a shortage of psychiatrists but that did not eventuate.

Post 30 June 2020 an amendment to the Act, in line with the directions, was being introduced via the COVID-19 Response and Economic Recovery Omnibus Bill 2020. The Advocacy Service did not seek any other amendments to the Act and opposed several suggested amendments by other stakeholders. The Chief Advocate took the view that rather than limit consumer rights, if the Advocacy Service could not meet its obligations under the Act due to COVID-19 - for example, by not meeting the timing in which to contact consumers - then this would be reported in the Annual Report.

Access to community services during COVID-19

People on a CTO are generally required to attend a community mental health service (CMHS) clinic for regular assessment and, often, medication by injection (called a depot). They can also attend their Mental Health Tribunal hearings at the CMHS. Due to various issues arising, including in relation to Tribunal hearings which were being held by videoconference (see below under *Tribunal COVID-19 arrangements*), Advocates were asked to find out what was happening.

Fifteen metropolitan CMHSs were contacted by telephone to determine the extent to which face-to-face contact was continuing and the replacement of that with telehealth and digital services. All CMHSs had reduced face-to-face contact to a minimum and were, in the main, offering phone consultations as a replacement option. Some were calling consumers quite regularly to check how they were, including in relation to food and other supplies.

All but one clinic was offering videoconferencing options to consumers, but there was differing capability, interpretation of policy, and platforms being utilised. One clinic also identified inadequate hardware and a lack of access to support to implement videoconferencing options successfully. Most clinics identified that consumers had limited personal technology access or information to utilise videoconferencing, which greatly limited uptake of this option.

Depot clinics continued as usual but there was a reported increase in home visiting to administer depots for consumers in some areas. Pleasingly, the CMHSs reported that consumers were welcome to attend the clinics for Mental Health Tribunal hearings so they could take part by videoconference. Some clinics continued to provide transport to consumers, with staff utilising PPE and placing the consumer in the back seat, and others gave taxi vouchers and provided information about public transport. They also reported no change to service delivery for hostel residents, except in relation to rules imposed by the hostels themselves.

New world of telehealth

Although COVID-19 has reportedly greatly accelerated the use of technology and telehealth, mental health consumers are not all convinced by the changes.

Comments to Advocates when they asked consumers about using the new technologies included the following:

> *I only have a cheap phone and I don't have a computer. I don't have money to be buying computers. I got the help I needed when the police took me to hospital.*

> *I did not use technology but I will need mental health services on discharge and possibly alcohol and drug services again in the future. I hope that they will be able to see me face to face as this will be much better. Technology can be good, but it is unreliable 50% of the time and human connection is important to me.*

> *I have always used telephone calls and messaging to contact my case manager, which has been essential during COVID. I was not offered and never used telehealth.*

> *I didn't really get any help, but I was getting more phone calls instead of visits or going in for appointments. I ended up having an appointment at the clinic, as I was going in for my depot anyway. I didn't use telehealth, I don't know even know what that is. The only thing I got different was phone calls.*

Culture Matters

Over-representation of Aboriginal people in mental health wards

The number of Aboriginal people[12] detained under the Act rose slightly and is considerably higher than the proportion of Aboriginal people estimated to be living in WA (3.9%[13]). In 2019-20, 190 Aboriginal people were detained on 293 involuntary orders, comprising 8.5% of all involuntary inpatient treatment orders. In 2018-19 it was 7.9% (163 people) on 262 orders. Aboriginal people were also subject to 8.2% of CTOs (form 5As), a slight fall from the previous year.

Aboriginal rights not being observed

An inquiry by the Advocacy Service into compliance with the rights of Aboriginal and Torres Strait Islander people under the Act was finalised in June 2020. It concluded that the Act is not being complied with and Aboriginal consumers are not consistently being offered their rights. While some initial progress has been made towards fulfilling the promise of the Act, and there are some positive examples of collaboration, there is still a long way to go before all Aboriginal people being assessed, examined and treated have access to the rights afforded by the Act.

The inquiry report contains 15 recommendations, all of which were supported or supported in principle in a joint response to the preliminary report from the Director General of the DOH, the five HSPs and the Acting Mental Health Commissioner. The Chief Psychiatrist, President of the Mental Health Tribunal and the CEO of St John of God Midland Hospital also replied, supporting the preliminary report. The collective responses and comments have been incorporated into the final report.[14]

The Chief Advocate proposed that the Minister for Mental Health advise the Director General of WA Health, the Mental Health Commissioner and the Chief Executives of the five HSPs that he:

1. supports the establishment of an inter-agency working party to develop an agreed action plan to implement the report recommendations for consideration and endorsement by the Mental Health Executive Committee (MHEC)

2. wants a report from the MHEC on their progress in implementing the recommendations in 12 months

3. seeks advice from the Director General of the DOH and the Mental Health Commissioner as to how the funding issues can be resolved.

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12. Based on notifications to the Advocacy Service, and identification and reporting by Advocates that an individual identifies as Aboriginal or Torres Strait Islander. The number of Aboriginal and Torres Strait Islander consumers is likely to be an under-representation.

13. Australian Bureau of Statistics estimate, based on the 2016 census, adjusted for net undercount as measured by the Post Enumeration Survey: https://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001

14. The full report is on the Advocacy Service website: mhas.wa.gov.au.

Culturally appropriate care

Truly independent and detailed further opinions are difficult to get at the best of times but getting one which considered cultural needs was a tremendous outcome for one young Aboriginal person. The further opinion was exceptional, running to six pages and highlighting the need for trauma-informed and culturally appropriate care. It is now also being used by child protection services for the consumer's NDIS application.

The value of music and art

Music and art are therapeutic tools regularly used in mental health services. The covers and design in all the Advocacy Service annual reports have been based on artworks produced by people with mental health issues.

Cowboy John's story is a testament to the therapeutic value of music.

From the wards of Perth mental health units, to the pages of Rolling Stone Magazine, and from suburban psychiatric hostels, to the cover of CDs on sale around the world, he has found triumphs amid the adversity of mental illness.

Cowboy John – or just Cowboy to some – is an enthusiastic guitarist, harmonica player and vocalist.

He has released his own CD – Secrets of the Universe – and featured on the cover of the recent Custard album Respect All Life Forms, with the latter leading to him being mentioned in the Sydney Morning Herald and Rolling Stone. Custard members also credit Cowboy John with coming up with the name for the album.

In 2013, his vocals for Perth band Pond's Hobo Rocket won him international praise, with music bible NME calling him a "local legend".

Cowboy John, who is supported by MHAS, continues to enjoy his musical pursuits.

"I feel the music is healing."

- Cowboy John

The cover of the Custard album featuring ‘Cowboy John’

Cowboy John playing the harmonica.

Not Always Safe

The Act is premised on the basis that people can, and should, be locked up on mental health wards as involuntary patients because they are a risk to themselves or others. This is one of the five criteria for being made an involuntary inpatient. People on such wards are not always kept safe, however, and do not always get trauma-informed care. Mental health wards can be very scary places and mental health consumers have a high incidence of trauma – poor care and conditions can be a trigger and re-traumatise the person.

Value of Advocate inquiries

In some cases it has taken Advocate intervention and/or an inquiry by the Advocacy Service, including getting access to CCTV footage, to convince the mental health service to believe, or respond in a timely way to, the consumer’s account:

- In one case involving restraint and seclusion, it took months to convince the mental health service that the consumer was not treated properly by ward staff – sadly, the consumer also felt that perhaps they had been to blame. The CCTV footage, once viewed by senior management, led to a number of staff being reported to AHPRA for investigation, which is ongoing.

- In another case, the hospital began an investigation into an allegation against a ward staff member but it was taking months to respond and the patient was discharged and re-admitted while the staff member continued to work at the service. The Advocate assisted the consumer to contact police, and shortly after the staff member was suspended and reported to AHPRA. The Advocacy Service is advised that the staff member no longer works for them and they are shown as suspended on the AHPRA website.

- A consumer complained that they had been restrained unnecessarily to administer medication. The consumer said they were not refusing the medication but wanted information about the dosage, name and purpose of the medication. Section 180 and principle 12 of the Charter of Mental Health Principles in the Act require involuntary patients to be provided with an explanation of the treatment and given the opportunity to discuss and obtain advice. In investigating the complaint, the Advocate reviewed the consumer’s forms on their medical file noting that the procedure required by the Act had not been completely followed because there was no post restraint check by a medical practitioner. This is particularly important due to the not uncommon occurrence of injuries during restraint and the trauma caused by such restraints. The mental health service acknowledged the omission and said it would be carrying out re-education and training for all ward staff about the requirements of the Act.

- A series of suicide attempts on a ward led to an Inquiry by the Advocacy Service raising questions about risk assessments, staff training (including in relation to staff appointed to watch people at risk, called nurse specials), use of agency nurses, lack of a safety plan and handover quality. The HSP confirmed that the incidents were reported as a SAC 1 event (the highest risk category) and were undergoing a root cause analysis. Mistakes were acknowledged, and several recommendations followed.

Sexual safety

Appropriate responses to allegations of sexual assault or abuse are not always forthcoming on mental health wards. In some cases the abuse was not on the ward, in other cases it may be part of the person's illness, but it can stem from prior trauma. In all cases, the person needs to be listened to without judgment, their wishes respected and followed and trauma-informed care provided:

- In one case the consumer said the sexual assault had occurred just prior to being admitted to hospital but no action was taken by staff when told and when the consumer asked for counselling, they were told it was not possible.

- In another case involving an allegation against a ward staff member, police were contacted without the consumer's consent.

- In a third case the consumer did not speak English and, while follow-up investigations were properly conducted, the consumer had not known that they could lock their door from the inside, probably due to not being orientated to the ward in their own language. They also said they did not feel emotionally well-supported after reporting the incident. The mental health service undertook to maintain gender specific corridors where possible, to ensure that all patients understood they could lock their doors from the inside to feel safe, ensure that patient information was available in culturally and linguistically diverse formats, and to implement changes to increase nursing staff presence in corridors on overnight shifts.

In these types of cases, the Advocates worked with the consumers and hospital staff to get outcomes according to the consumers' wishes, while also educating staff on consumer rights.

All WA mental health wards are mixed, except one which is male only. Gender and sexual identity issues can arise, but the biggest issue is for women who are often out-numbered on wards by men:

- In one case a caller to the Advocacy Service weekend phone service rang because she had been punched by a male patient. She understood he was unwell, did not wish to go to the police and said ward staff had intervened and were dealing with her injuries but she did not feel safe on the ward. With the consumer's permission the weekend Advocate sought to have the consumer moved to another hospital. Ultimately this was not possible due to bed shortages but the consumer was moved to an open ward away from the other consumer.

- The 30 bed Frankland Centre, which is the only ward in WA which takes unwell people from prison, is almost always 90% male patients. It is not uncommon to have only one female patient. On one weekend a female patient was returned to prison because staff said they could not secure her safety. In July 2019, WA Coroner Sarah Linton added to the voice of previous Coroners and recommended the state government prioritise funding a subacute mental health unit at the main women's prison and a female only secure forensic mental health unit rather than sending women to the male-dominated Frankland Centre.

- Being able to lock your bedroom door is integral to feeling sexually safe on a mental health ward. Consumers need to be able to lock and unlock their bedroom door from the inside, while staff can also open the door from the outside. Advocates' pleas for bedroom locks at one hospital were always met with the response that there were no funds, until a meeting was held with the Chief Executive where he was asked how he would feel if he were admitted on such a ward, and he immediately ordered quotes. Door locks have now been installed throughout the facility.

Physical conditions impacting on safety

The Advocacy Service has long argued that the safety and suitability of mental health wards is crucially important to good care and recovery. Advocates therefore continued to follow up on issues raised from ward inspections in June 2019. Advocates were asked to inspect the wards from the perspective of the consumers and how they might feel if it was them or a family member admitted to the ward.

The inspections of 54 wards identified:

- 78 safety concerns – primarily related to missing door locks to bedrooms, toilets and bathrooms but also some ligature issues and obvious slip or trip hazards

- 46 privacy and dignity concerns, noting shared bedroom issues including some where there is only 10 centimetres between the beds

- 415 comfort and homeliness concerns, including worn and dirty furniture, insufficient chairs in common areas, unkept courtyards and poorly maintained gardens

- 190 hygiene and cleanliness concerns, including mouldy bathrooms, unprotected and ripped mattresses, empty and broken soap dispensers, broken toilet seats and flushes, stained sanitary bins and drainage issues.

Examples of cases related to the above issues in which Advocates were involved included the following:

- Family members complained that the consumer had absconded through an exit door. The possibility of escape through that door had previously been brought to the attention of ward staff and another consumer had previously managed to abscond through the door. The door has since been secured.

- Getting a consumer who was physically unable to leave their bedroom moved to a single room so they could have privacy.

When I was admitted to a locked ward, I was shocked to see the condition of my ensuite bathroom.

The plaster and paint were flaking away from the walls. I felt that the room was unsafe and unhygienic. I could not believe that these conditions were accepted in a hospital.

I showered at night so that I did not have to see the damage. Everyone I spoke to about it seemed to think it was okay. I felt this was because standards for mental health wards are so low.

I told my advocate and she helped me to take some action. I lodged a complaint and asked that repairs be made to my ensuite. I got my voice heard this way and we made a good team.

I was told that they agreed to repair not just my ensuite, but also the others which were in a similar state.

Just before I was discharged, the work began. I was pleased to bring about a positive change for all the patients who came after me. Together we made a difference.

- Maggie

Making a Difference

Advocates' functions under the Act include protecting rights and facilitating and advocating for access to services.

Avoiding being made involuntary

- The consumer was on an expired form 1A referral order when the doctor purported to extend it (including back-dating the order). Apart from legal issues around the validity of this process, and the fact that it meant the consumer could be detained for another 24 hours, the Advocate queried whether the referring doctor had properly assessed the patient as the evidence was that he hadn't. The Chief Advocate spoke to the psychiatrist about the irregularities, and the psychiatrist agreed to do another review and assessed that the consumer did not meet the involuntary criteria.

- The mental health service asked for an Advocate to contact the consumer, who was on a referral order and looking like they were going to be put on an involuntary order. This would have been the consumer's second time as an involuntary patient but they had found the first time traumatic and really wanted to avoid being made involuntary again. By speaking to the consumer, speaking to the treating team, then attending a review meeting, the Advocate was able to negotiate an agreement which both parties were happy with and by which the consumer would remain voluntary.

Dignity – sometimes it is the little things….

When a person is taken from their home, locked up, and often can't understand why, they usually want the Advocate to 'get me out of here'. This is not often possible, at least not in the short term, but there are many things Advocates do daily to help make the consumers' lives on the ward that little bit more bearable:

- Getting access to drinking water was an issue on two wards after the water fountains were removed due to risk of infection. In one case, Advocates successfully argued for the return of the water fountain and, in the other case, access to a beverage bay with hot and cold water taps was agreed to be left open. In both cases, ward staff were of the view that consumers could ask them for a drink when needed. Advocates argued this was undignified and disempowering, as well as a waste of staff time.

- Getting the ward newspapers back. After it was raised by the Advocate it was reinstated.

- The Advocate was bothered by references in medical files to consumers on the ward being 'unkept' and 'malodorous' when the person had been brought in suddenly, without time to pack a bag, and were not provided with basic toiletries. Some patients were going without clean underwear for days and/or having to go without underwear while waiting for their one pair to dry after washing. The Advocate had been present when ward staff had said they could not provide toothpaste and toothbrush to a patient who requested them and had no other means of acquiring them. The Advocate took the issue higher to learn that management were shocked and said it would be immediately rectified.

- An Advocate was approached by a distressed consumer who asked them to have a fight. The Advocate de-escalated the situation, but the consumer told them how restricted and frustrated they felt. The Advocate suggested that a punching bag could be placed in the courtyard of the locked ward to allow consumers to release some of their agitation and energy. Staff ultimately agreed and now there is a punching bag available which has been very popular with consumers.

" Call of the day "

A consumer rang the Advocacy Service office and began singing to the staff The Animals hit song from 1965 which was popular with the troops in the Vietnam war:

I've got to get out of this place….

Animal therapy

The benefits of animal therapy have been widely recognised in a variety of settings, particularly in aged care. Any such initiatives which can make wards feel calmer are welcomed by the Advocacy Service, including the introduction of a therapy cat on an older adult ward at Armadale Hospital.

Tribunal Hearings

One psychiatrist can make a person involuntary in WA and only a psychiatrist or the Mental Health Tribunal can change that.[15] If the consumer is an adult, that review can take up to 35 days from the date of the order, and if they are a child it must be held within 10 days. Other states have shorter time periods for review or other safeguards. This makes the role of the Tribunal an extremely important safeguard. Representation in that hearing is, therefore, also extremely important, as is procedural fairness.

Advocate representation in hearings

The Mental Health Tribunal listed 4,253 hearings in 2019-20 but due to cancellations only 2,627 hearings or 61.8% were completed.[16] The reason for this is that by day 21 less than half of involuntary orders made (43% in 2018-19) remain in place. In 2019-20 people on 139 involuntary orders (or 3.2%) had their orders revoked within seven days, many of them on day two or three of the order being made. This means that many consumers who are made involuntary by a psychiatrist never get their order reviewed by the Tribunal.

Advocates represented people in 39.6% or 1,041[17] of the Tribunal hearings in 2019-20. This was an increase of 203 hearings (or 24.2%) over the previous year. Some consumers are represented by Mental Health Law Centre (MHLC) lawyers, in which case Advocates do not attend the hearing unless the consumer is a child, or the hearing is being conducted by videoconference.

Mental Health Tribunal Representation

Year	No. of completed hearings	No. of hearings involving Advocates	% of hearings involving Advocates
2016 - 17	2,101	749	35.6%
2017 - 18	2,247	766	34.1%
2018 - 19	2,320	838	36.1%
2019 - 20	2,627	1,041	39.6%

[15] The State Administrative Tribunal could also change an involuntary order but only after the order has been reviewed by the Mental Health Tribunal.

[16] Data was provided by the Mental Health Tribunal on 18 July 2019 and may be subject to change.

[17] Data was provided by the Mental Health Tribunal on 18 July 2019 and may be subject to change.

Getting procedural fairness

Apart from the Mental Health Tribunal, only psychiatrists can make a person involuntary or decide to revoke the involuntary order, but it is not uncommon for psychiatrists to fail to attend a hearing. If the psychiatrist does not attend the Tribunal hearing, the consumer or their representative does not have procedural fairness as they do not have the opportunity to ask them questions. The issue can be compounded by a poorly written medical report which states opinions without facts. The Tribunal may also want to ask the psychiatrist some questions and the only options left are to make the consumer voluntary (because there is insufficient evidence before the Tribunal that the person meets the criteria under the Act to be involuntary) or to adjourn the hearing. The latter is usually the choice of the Tribunal but it can mean consumers are detained involuntarily for longer and it always means their human right to a timely review is delayed.

In a welcome move, during the year the Tribunal President advised the Advocacy Service that she had written to a hospital about a supervising psychiatrist who failed to produce a medical report and to turn up to the hearing or arrange for another psychiatrist familiar with the consumer to attend the hearing to provide evidence..... not once.... but twice. The hearing was adjourned twice as a result. The President said she was also liaising with the Chief Executives of the HSPs about how to improve the attendance of psychiatrists and the quality and timeliness of the medical reports.

Other Mental Health Tribunal decisions

Sometimes the value of the Mental Health Tribunal hearing is getting a recommendation for a change in treatment or approach:

- The Advocate argued that a consumer who had been hospitalised with an eating disorder for four months wanted psychological counselling, which had been refused by the treating team. The Tribunal said it was unusual but they were going to recommend that it be provided.
- The Tribunal agreed with the Advocate and made a recommendation for single room for a person with a disability and with confidentiality and privacy issues.
- Involuntary patients cannot have ECT unless approved by the Tribunal. In several cases the Advocate, acting according to the consumer's wishes, successfully argued for more time for the person to improve or that the person had improved since the applications was made and the Tribunal declined to approve the ECT. But, in another case the Advocate was arguing for more ECT – again according to the consumer's wishes.
- The Tribunal continues to ask about treatment, support and discharge (TSD) plans, reinforcing this very important right of the consumer and their personal support persons. (See also under *Getting person-centred care - TSD Plans* below.)

Tribunal COVID-19 arrangements

The single biggest COVID-19 rights issue for consumers identified by Advocates has been the technology issues in Mental Health Tribunal hearings. From 16 March 2020 the Tribunal began transitioning face-to-face hearings to hearings exclusively by videoconference due to the COVID-19 pandemic. The Tribunal initially advised that hearings would be by the Scopia platform, with Tribunal members dialling in individually from their homes. There were multiple issues caused by different quality cameras, microphones, internet connections, and knowledge of how to use the technology.

Subsequently, the option of Microsoft (MS) Teams was offered because it was easier for external parties like the MHLC and consumers to take part but there were further set-backs to this. The Advocacy Service trained Advocates on both Scopia and MS Teams and made sure both could be accessed from their laptops. Advocates also continued to try to sit with the consumer during the hearings, which meant the Advocates were reliant on hospital technology. Advocates told of social distancing not being possible as everyone crowded around a small laptop to both see and be seen during the hearings.

As the COVID-19 restrictions progressed, there were increasing issues with screens freezing and parties dropping out, presumably due to increased usage across the state. Even though Advocates could seek an adjournment due to the poor quality of the hearing (usually the sound but also multiple internet 'drop-outs'), arguing lack of procedural fairness, the consumer was left for another week or two waiting for the new hearing.

Towards the end of May, the Chief Advocate wrote to the Tribunal President suggesting that having Tribunal members in the one place (at the Tribunal's office) might ease some of the technology issues. This was accommodated shortly afterwards as WA moved into phase four, but as at 30 June the issues with poor quality videoconferencing and lack of ability for all parties at the hospital or CMHS site to socially distance were continuing. The Tribunal President has advised that the Tribunal members will return to face-to-face hearings when WA moves to phase five.

Getting Person-Centred Care

A major aim of the Act was to promote person-centred care. This is reflected in the Charter of Mental Health Care Principles and the requirements that:

- all care and treatment must be governed by a treatment, support and discharge plan (TSD Plan)
- the consumer must have input to the TSD Plan
- the consumer must be given a copy of the TSD Plan
- relevant personal support persons must also be involved and given a copy of the TSD Plan.

Treatment, support and discharge plans

Compliance with the Act in relation to TSD Plans remains elusive. Advocates, the Senior Advocates and Chief Advocate continue to advocate for and educate mental health services and psychiatrists on this very important consumer right.

A few small developments towards enforcement of the right during the year included:

- The Mental Health Tribunal, in continued support for the rights of consumers and families to TSD Plans, sent out a revised medical report template for psychiatrists to complete for hearings specifically calling for a copy of the current signed TSD Plan to be provided. It also drafted a Treating Team Information Sheet setting out the preparation required for hearings which included asking for the TSD Plan to be updated to ensure it complied with the Act and to provide a copy to the consumer and the Tribunal at least three days before the hearing.
- The DOH revised the State-wide Standardised Clinical Document (SSCD) version of the TSD Plan and advised that it would be put onto the mental health database (PSOLIS) before the end of 2020. There is currently no specific TSD Plan on PSOLIS and another document is adapted for the use. The lack of a properly drafted template TSD Plan on PSOLIS was identified as a major reason for the high levels of non-compliance with the Act in the Advocacy Service's March 2018 report on TSD Plans. The Chief Advocate has written to the Chief Executives of the HSPs asking for the PSOLIS roll-out of the new document to be accompanied by staff training on consumer and carer rights in relation to TSD Plans.
- Families 4 Families WA (F4FWA) co-designed two resources relating to family rights and TSD Plans following a presentation by the Chief Advocate the previous year. F4FWA is a peer-based, well-being-focussed support and education group for families and supporters of individuals who experience multiple, unmet needs which generally include ongoing mental distress, alcohol and other drug use and criminal justice involvement. The project aimed to increase confidence and empowerment of 'ordinary' family members to engage equitably in discussions with clinical treating teams about the TSD Plan requirements and their rights. The materials produced by the project were launched in August 2019 with a panel session which included the Chief Advocate.

Panel members at the launch of the Families 4 Families WA TSD Plan materials (l-r) Sarah Cowie, Director HaDSCO, Debora Colvin, Chief Advocate, Karen Whitney, Mental Health Tribunal President, Toni Petz consumer perspective, Ron Deng family/carer perspective.

Carer and Family Rights

The Advocacy Service is designed to protect consumer rights but sometimes the rights of carers and family members are also consumer rights or can be used to support consumer rights. Advocacy Service protocols and the Act require that adult consumers[18] agree to contact and sharing of information with any third party (with some exceptions). Carers and family members can be strong allies in supporting consumers with complaints and obtaining TSD Plans that comply with the Act.

Notification of carers and family – breaches of the Act

The Act brought in new rights for carers, family members, guardians and personal support persons (collectively called PSPs) to be notified of several events through the consumer's journey to being made involuntary and then voluntary again. The Chief Advocate must also be notified on many of those occasions, including being given the details of the person notified when an involuntary inpatient treatment order (form 6A and 6B) is made; if no one has been contacted, the Chief Advocate is to be given the reasons why [19]. Notifications to the Chief Advocate are largely done automatically through the mental health service database (PSOLIS).

Based on PSOLIS data available to the Advocacy Service, the Act is regularly being breached and families and carers are not being notified that their loved one has been made an involuntary inpatient as required under the Act as:

- PSPs were recorded as notified of only 35.8% involuntary inpatient treatment orders in 2019-20 (or 1,233 out of 3,443 orders)
- at least 25.4% of form 6A and 6B orders were incorrectly categorised in the patient database as 'not requiring' [20] notification for 875 orders (noted in PSOLIS as 'not relevant')
- notification of a PSP was recorded as not being in the consumer's best interest on seven occasions – the psychiatrist is authorised to make this decision under the Act, but they are required to file a record of the decision and the reasons for it and give a copy to the Chief Advocate – the Chief Advocate has not been provided with any reasons for these decisions
- attempts were made to contact 304 PSPs about the making of an order:
  - in 131 cases, it was assessed that the PSP could not be contacted
  - however, in 173 cases an attempt(s) was made but no further information has been received from the health services; most of these orders (65.3%) were made between July and December 2019
- the PSP refused the notification or the consumer refused to give them a PSP to contact in 147 instances
- the Chief Advocate was not informed of the outcome of any attempts to contact a PSP regarding 783 orders.

[18] Children are an exception as the Act requires best interest advocacy and that the Advocate have regard to the views of the child's parent or guardian.

[19] The Chief Advocate must also be notified when a clinician decides it is not in the best interest of the consumer that their PSP is notified of their detention, further detention, transport or other notifiable event; and the notification to the Chief must include the reasons for the decision.

[20] A PSP is not required to be notified of the making of a form 6A or 6B when the order is proceeded by detention orders, namely a form 3C or 3D.

Therefore, it appears that no notification was made to a PSP for 1,754 of the 3,443 involuntary inpatient treatment orders, although it could be as many as no notification for 1,927 orders; non-compliance is therefore at least 50.9% but may be as high as 56.0% of orders.

While part of the explanation is likely to be data entry error, the Advocacy Service wrote to the HSPs in January 2019 trying to get an explanation. The HSPs collectively referred the issue to the PSOLIS Governance Committee (PGC) in early 2019. In November 2019, the PGC advised that it had concluded that it was the responsibility of clinicians to notify PSPs and undertook to write to the Chief Executives of HSPs to remind them of their responsibilities.

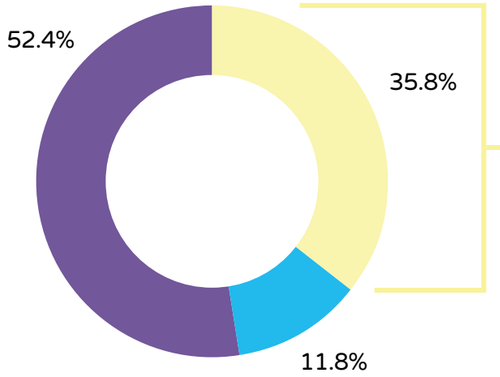
Unfortunately, the number (and proportion) of notifications being incorrectly recorded in PSOLIS as "not relevant" has increased in the second half of 2019-20. The Advocacy Service continues to follow up on the issue and notes that there are significant differences between the HSPs. SMHS, for example, appears to have notified PSPs for only 83 of the 677 involuntary inpatient orders made by its psychiatrists in 2018-19. The Advocacy Service does not know what percentage of the remaining 594 orders did not have to be contacted or were unable to be contacted. The highest percentage of recorded 'success' notifications was by EMHS but it was still less than 50%.

Notification[21] of Personal Support Persons of inpatient treatment orders[22] by Health Service Provider in 2019-20

PSP successfully notified

Notification not required under the Act

PSP notification unknown (requirement to contact or outcome)



	PSP Successfully Notified	Number of forms 6A and 6B[23]	Success Rate
SMHS	83	677	12.2%
CAHS	7	24	29.2%
NMHS	372	1,108	33.6%
WACHS	210	482	43.6%
EMHS	561	1,140	49.2%
Total	1,233	3,443	35.8%

Advocate interaction with families

The Advocacy Service functions (and funding) do not include advocacy for carers and families but, with the consumer's agreement, Advocates will often work with carers and family to advocate for the consumer. Where the consumer is a child, the Youth Advocates are required to have regard to the views of the parents or guardian, as well as the child's wishes.

[21] This information is based on data recorded in the HSPs patient database, PSOLIS. PSPs do not need to be notified of every order.

[22] Forms 6A and 6B.

[23] Excludes one facility with 12 involuntary inpatient orders – the Advocacy Service was not advised of notifications of the PSPs for the 12 orders.

Where the consumer is a child, the Youth Advocates are required to have regard to the views of the parents or guardian, as well as the child's wishes. Where the consumer is an adult, the Advocate's work depends on the consumer's wishes. Families are usually very grateful for the Advocate involvement in helping them to navigate the complex mental health system:

- at the request of a consumer who was dying, the Advocate tracked down the consumer's family. The family had not been involved with the consumer for many years but were able to be with him at the end. The parents wrote to the Chief Advocate: *'...my wife and I would like to send our appreciation to [the Advocate] for the extraordinary love, care and attentive spirit she gave to T in his last journey on earth..... it was this super extraordinary effort on the part of [the Advocate] that stirred me to write to you to place in writing our utmost, sincere and heartfelt thanks to her and the Mental Health Advocacy Service of Western Australia. My Family and I thank you.'* [The consumer's psychiatrist complained that the Advocate had gone outside their functions and should not have contacted the family. The Chief Advocate dismissed the complaint.]

- the parents of a young person who was made involuntary for the first time wrote to the Chief Advocate: *'.....We feel compelled to express our total appreciation for the outstanding service given to our daughter and ourselves over the last few weeks, by B as our Mental Health Advocate..... Without the guidance that we have all received from B, we are not sure how we could have gotten through this difficult period.....She has acted fairly and promptly to ensure that our daughter's wishes are considered and has also ensured that we are informed and heard in a new and quite foreign adult system. We feel comfortable knowing that B is there to help us navigate what may come over the next few weeks / months..... we are grateful for the assistance that she has provided whilst representing the Mental Health Advocacy Service. It has been a shining light at a particularly difficult time for our family.'*

Hostels

Licensed psychiatric hostels (hostels) are home to some of the most vulnerable and marginalised people in our society. There are 31 licensed hostels with approximately 723 beds, which were occupied in March 2020 by 692 residents. Advocates provided services to 186 hostel residents during the year. Many hostels have shared bedrooms and bathrooms and the amount of MHC funding varies widely, creating wide disparities in the level of care and quality of life – an issue the Advocacy Service has been raising for many years.

Reduced advocacy services to hostel residents

The number of hostel residents assisted by Advocates was less than previous years. It is a matter of great concern that due to lack of funding, Advocates no longer regularly visit hostels (this was because of cost-cutting measures implemented in January 2018 to try to stay within budget). Advocate visits are needed to give residents accessibility to Advocates and to assist with an oversight function, given the potential for abuse in these settings. Under the 1996 Mental Health Act, Official Visitors were required to visit all hostels every two months. This was not included in the new Act and the Advocacy Service has never been able to do such regular visits and remain in budget. In the previous two years about a third of the hostels were identified for regular visits but this had to be reduced further in 2019-20. Two hostels of concern were selected for a short two month visiting program; otherwise visits and resident contact is based on requests and issues as they are made known to the Advocacy Service.

Hostel residents assisted by the Advocacy Service from 2017-18 to 2019-20

	2017 - 18	2018 - 19	2019 - 20
Residents assisted	263	223	186
Contacts by the Advocacy Service	2,349	1,372	1,230
Issues or complaints	530	266	293

The types of issues raised in hostels with and by Advocates included:

- inability to lock bedroom doors to protect belongings and feel safe
- shared male and female bathrooms and toilets with little privacy
- cleanliness issues and worn, torn and stained furnishings
- institutional practices (e.g. evening meal starting at 4.30pm, which is against the hostel regulations[24], providing tea made in bulk with milk, and no coffee option)
- lack of suitable clothing as required by hostel regulations
- insufficient dining or living area space and chairs for all residents
- not enough staff to assist everyone who needs help showering
- only one staff member on duty overnight for over 50 residents
- inconsistent and inappropriate handling of complaints and disputes between residents
- eviction of residents when they are admitted to hospital
- lack of meaningful activities for residents to assist with their recovery
- breakdown of communication between the hostel and CMHS impacting on the residents.

After raising the issue with hostel management, the concerns were also raised with the Licensing and Accreditation Regulatory Unit (LARU), and the MHC, particularly where breaches of the LARU standards and National Standards for Mental Health Services are involved.

[24] Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997.

Hostels' COVID-19 response

The hostel sector was recognised from the beginning of the COVID-19 pandemic as a high risk area, like aged care. The sector comprises a lot of group homes with shared bedrooms and bathrooms and a low level of staffing, caring for residents with severe mental health and multiple physical health issues and/or intellectual impairment and other disabilities.

Risks included:

- a non-clinical workforce that was not trained in infection control principles and practices
- difficulty of enabling social distancing due to shared bedrooms, bathrooms and living areas and some residents unable to follow Public Health directions
- many hostels being unable to isolate residents in the event of a suspected or confirmed COVID-19 case
- lack of access to PPE and shortfalls in staff training on how to use it
- most or all staff and residents having to self-isolate if one resident was found to be COVID-19 positive due to close contact with the person
- workforce limitations in covering the burden of the extra cleaning required and cover for any illness of the existing workforce
- likelihood of poor outcomes for residents infected with COVID-19 because of multiple physical health issues.

The Psychiatric Hostels Agencies Committee (PHAC) - comprising the Advocacy Service, the Chief Psychiatrist, LARU, the MHC and a representative of the five HSPs - began meeting weekly with Dr Sophie Davison, the DOH's COVID-19 Health Operations Mental Health Lead. Hostel licensees were also invited to the meetings.

The MHC, as the purchaser of the hostel services, and LARU, as the licensing body and regulator, advised PHAC that they had directed hostel licensees that the primary source of clinical advice and information regarding the management of COVID-19 was via the WA Government's 13COVID helpline. LARU also issued a COVID-19 Fact Sheet which required hostel licensees to put systems in place to ensure they were receiving regular updates from government sources, to develop a facility management/pandemic plan and stated what the plan should include. Residential Care Facility Guidelines were to be utilised and guidelines on when and who to notify were also provided. PHAC members were told that both the MHC and LARU were informing the State Health Incident Coordination Centre (SHICC) of the hostel risks and needs. The MHC agreed to provide additional funding to some hostels for three months to assist with extra costs[25] and LARU offered access to its infection control staff.

PHAC collectively drafted a survey distributed to hostel licensees which had to be responded to by 27 March 2020. It asked questions about each hostel's COVID-19 plan and what it included, whether residents were being monitored daily for things like temperature, whether increased cleaning and disinfecting had been implemented, whether staff and residents had received instructions to minimise infection, and asking about supplies of PPE, cleaning products and to identify the three main risks they faced.

The biggest risk was the inability to isolate a person within the hostel; hostels providing 488 beds (67%) said they would not be able to isolate a resident. Even getting a resident to a testing facility or GP was considered problematic.

25. This was extended for another three months in 2020-21.

The survey also showed that the other two biggest concerns of hostel licensees were lack of PPE and staffing shortages, particularly if one resident was diagnosed with COVID-19 and staff had to self-isolate.

The MHC began working with the Department of Communities to develop an option of alternative accommodation with appropriate support for people who could not be isolated in their existing hostel. State-wide guidance on PPE in community settings was circulated to the hostels, and a management of COVID-19 flow chart was developed by the COVID-19 Health Operations Mental Health team in collaboration with the Public Health Emergency Operation Centre (PHEOC), LARU and the MHC. Dr Davison continued to raise issues and to try to clarify the role of the public health bodies should an outbreak occur in hostels.

On 23 April PHAC members were told that, should the whole hostel have to go into isolation, the PHEOC would manage the situation. The COVID-19 flow chart was sent out to hostels on 30 April, having first been run past PHEOC, and was placed on the Department of Health's website. It was also confirmed that a hostel would be provided with PPE if a COVID-19 case emerged.

Meanwhile, the MHC was working with the Mental Health/AOD Community Services Taskforce (comprising a range of members across Government and peak bodies including the Advocacy Service and LARU) that was established to ensure sector capacity, safety and continuity of supports for mental health and AOD consumers and family members/carers. This work included the development of a model of care to provide support for individuals from hostels (and other settings where self-isolation is not possible) if they were required to isolate. This model was then used for an expression of interest process for a support provider to deliver these supports if required.

PHAC members remained concerned, particularly as the COVID-19 flow chart assumed that residents might be isolated in the hostels. The PHEOC position, as made known to PHAC members, was that the COVID-19 response would be managed on a case by case basis and any inability to isolate, lack of clinical support and/or any shortages of PPE would be managed by PHEOC. The COVID-19 flow chart was also amended to make clear that if a resident was unable to self-isolate within the hostel while awaiting test results, they could access alternative accommodation through SHICC processes.

The Chief Advocate continues to raise questions and concerns about what will happen if there is an outbreak in a hostel and there are no staff available to care for the residents, and PHAC members continue to pass on information and issues to SHICC/PHEOC and the COVID-19 Health Operations Mental Health team to assist with the ongoing development of outbreak planning.

Advocacy Service COVID-19 hostel response

Advocates were not regularly visiting hostels prior to COVID-19 due to budget constraints but were still responding to individual issues as they were made known. On 31 March all hostel licensees were advised that the Advocacy Service was continuing to operate and would visit hostels where necessary but would be trying to conduct work by phone or videoconference, would call before attending the hostel and would follow any Public Health directions or hostel procedures relating to COVID-19. Hostels were asked to put up simple posters letting residents know that they could still call the Advocacy Service and to immediately let us know if a resident was required to be isolated.

During the following weeks, several concerns were raised about one hostel which was being overly restrictive by not allowing people in or out - including not letting the CMHS clinicians or other support providers onto the premises and stopping residents from leaving to attend their Mental Health Tribunal hearings. Hostel staff said the residents had agreed to such tight restrictions but there was a chain on the front door and information provided to Advocates indicated that some residents, at least, now wished to go out but feared eviction if they tried to do so. The Chief Advocate raised the concerns with PHAC members and wrote to the licensee asking for an immediate relaxation of the restrictions, noting that they were well beyond those recommended by health experts or required by Public Health directions. The letter was sent a few days before the Premier also announced further easing of restrictions and the licensee promptly lifted the hostel restrictions.

From the middle of April, an informal telephone survey of 14 hostels and 32 residents was also conducted by Advocates. The aim was to attempt to ensure that resident rights were not being abused and that all restrictions were proportional to the risks. Overall, except in the case of two hostels, the findings were positive, including:

- all hostels reported implementation of social distancing, increased hand washing and cleaning schedules along with workable contingency staffing plans if regular staff became unwell
- all hostels limited the number of people visiting inside the facility to essential services but, with two exceptions, residents could meet visitors in the gardens or off site
- regular visits from NDIS-funded support services were inconsistent, continuing for some and substantially reduced for others, which was confusing for residents
- eight hostels had established Zoom, Face Time or Skype for residents to utilise. No residents surveyed had any concerns regarding their ability to contact people
- 13 hostels did not prohibit hostel residents leaving the premises but tried to minimise the number of times they went out. They said they provided ongoing support and information and shopping was purchased for residents by hostel staff
- mostly, the residents understood and accepted the restrictions and limitations.

Hostel bed closures

In mid-May St Judes Hostel gave the required 90 day notice that it was closing 16 beds. Supported accommodation is in short supply and having to move to a new facility can be very distressing for residents. The PHAC members have an agreed hostel closure strategy which was immediately initiated. It includes finding other suitable accommodation for the residents. The work of the Advocates is to provide support to the residents and to ensure that their wishes are upheld. This work is unfunded but considered crucial to ensuring that residents' wishes are observed in the move.

> *Our son James is 34 years old. He was diagnosed with paranoid schizophrenia at the age of 18. Our lives as a family have been very traumatic on many occasions, with James ending up on mental health wards. On these occasions, - and I wasn't aware of this at that time - he had a wonderful, compassionate, caring person beside him to look out for him and fight for his rights as being an involuntary patient. Without this valuable support my son would not have had the support and knowledge of how to tackle jargon of laws within the mental health system and how it works. I first met the Advocate at a facility where James was living four years ago. It was extremely stressful at the time and really touch and go whether James could continue to live there. The Advocate managed to save his accommodation and has been his angel ever since. James does not communicate very well with people but with the Advocate he has a very healthy relationship whenever he needs help. I know that having the Advocate there, James will always feel safe and people like my son need these very experienced people in their lives. Without Mental Health Advocacy our family believe people with a mental illness will be lost in a system they cannot understand and could easily be at a serious risk for their lives. Please continue your valuable help to the most vulnerable lives in our community, without your help they will be lost.*
>
> ***- Michelle***

NDIS Advocacy

NDIS funding has the potential to assist consumers to leave the hospital or hostel environment and live in the community. Advocates are increasingly becoming involved in issues relating to the NDIS, primarily with hostel residents, but also for people in hospital, as part of their function to advocate for and facilitate access to other services:

- A consumer who has been in institutions since their early teenage years with intellectual disability, separate mental illness diagnosis and a traumatic life story was on a mental health ward because there was nowhere else for them to go – they were no longer welcome at the group home where they had been living and the only family member available had not been able to cope. The consumer had little capacity to understand anything, or to express their wishes in any meaningful way. They were under guardianship and administration orders with the Public Advocate and Public Trustee but were essentially voiceless in the system. The Advocate used uninstructed advocacy to speak to the family member to find out what the consumer might like if they could speak. Working with the hospital social worker they were able to fast-track a new funding package with NDIS to provide appropriate supported accommodation which could manage the consumer's behaviour. Separately the Advocate argued that the

consumer did not meet the criteria for an involuntary order and the consumer had not tried to leave the ward so the orders should be revoked, which was agreed.

- A hostel resident who had NDIS funding had been asking for help to achieve independent living but their NDIS-funded support worker was only taking them out for coffee with another resident. While this assisted with reconnecting with community, it was not working towards the resident's stated wish and longer term goal. The Advocate contacted the agency providing the support who said that the resident had not raised the issue with them. The Advocate explained that the resident had raised this goal multiple times with Advocates. The agency agreed to add this goal of independent living to the resident's recovery plan and start a process to work towards it.

- Advocates often have the advantage of knowing the hostel resident well, so attending NDIS planning meetings can be very useful to support the person to articulate their goals and needs. This was the situation in another case where the result was an increased NDIS package for the resident. The Advocate said they discussed the resident's needs and barriers to achieving their goals beforehand and that they were able to advocate for greater levels of services based on their knowledge of the resident.

- During COVID-19 restrictions in March and April, NDIS-funded support workers were limited in their ability to visit some hospitals. This restricted consumer access to their NDIS-funded activities delayed some NDIS assessment processes that were important to the consumer's discharge planning. Advocates raised concerns on behalf of individual consumers and where wards had prevented NDIS-funded support workers having contact with consumers, the issue was raised at higher levels.

- In another case, the Advocate raised the issue of the hostel resident needing a female NDIS-funded support worker who she could feel more comfortable with in relation to the intimate issues she was facing, which was agreed to.

- A frequent issue and cause of NDIS-funded support delays reported by Advocates is the difficulty in sourcing suitably trained support workers to provide the assistance required by the consumer as they return to live in the community after spending a significant amount of time in hospital. In some cases the NDIS assessment process had resulted in an underestimation of the costs of meeting the consumer's needs. Advocates assisted individual consumers to have their voice heard in these processes and the systemic issues raised with the NDIA.

Resourcing, Data and Disclosures

Involuntary orders continue to increase

Advocates assisted 3,427 people who met the definition under the Act of an identified person in 2019-20. This was an increase of 9.1% over the previous year.

The total number of involuntary treatment orders (form 5A, 6A and 6B orders) made in Western Australia increased by 4% in 2019-20

Number of involuntary orders and number of consumers[26]

Based on notifications received by the Advocacy Service from health services for orders[27] made between the date ranges and the number of consumers.[28]

Type of Order	2016 - 17		2017 - 18		2018 - 19		2019 - 20		Difference in orders 2019-20 compared to 2018-19
	Orders	Consumers	Orders	Consumers	Orders	Consumers	Orders	Consumers	
Form 6A Inpatient treatment order (authorised hospital)	3,148	2,417	3,203	2,432	3,117	2,431	3,275	2,534	5.1%
Form 6B Inpatient treatment order (general hospital)	97	86	134	115	149	128	168	128	12.8%
Form 5A CTO	796	656	817	661	850	679	839	702	-1.3%
Total Involuntary Orders / Consumers	4,041	2,618	4,154	2,644	4,116	2,650	4,282	2,744	4.0%

26. Verification of ICMS data is ongoing and figures may be subject to change.

27. All orders are based on the date the order is made.

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

The total number of involuntary treatment orders (form 5A, 6A and 6B orders) made in Western Australia increased by 4% in 2019-20 and has been increasing every year since the Advocacy Service began. The biggest increase was in inpatient orders (form 6A and 6B) where people are detained on wards – up 5.4% or an extra 177 orders over the previous year. The number of consumers put on involuntary orders (CTOs and form 6A and 6B) also increased by 3.5% over the previous year (noting some consumers are put on involuntary orders more than once during a year).

Increasing numbers of other 'identified persons'

The number of people in other 'identified persons' groups as defined by the Act who are entitled to advocacy services have also increased significantly since the Advocacy Service began.

Referred persons are on orders for a compulsory examination by a psychiatrist (a form 1A) and often in EDs. 'Voluntary children' and 'voluntary - ongoing issues' refer to people who meet the definitions in the Classes of Voluntary Patient Direction 2016. As a percentage of hospital admissions, most children are not made involuntary, but they are, nevertheless, detained on a locked ward. They do not have the protections of the Act such as a Mental Health Tribunal hearing but the issues can be just as or more complex than for children made involuntary. The 'voluntary – ongoing issues' class allows Advocates to continue to try to resolve an issue when an involuntary patient is made voluntary. Usually the issue is a serious one resulting in a complaint or inquiry. All other voluntary patients are referred to the Health Consumers Council or Helping Minds for advocacy.

Other classes of identified person include hostel residents and people on a Custody Order:

- Work in hostels has been reducing over the years because the Advocacy Service lacks funds to make regular visits (see above in the section on Hostels).
- The number of people on Custody Orders in an authorised hospital doubled in 2019-20 (see above for more information in the section on *Custody Order Issues)*.

Budget and resourcing

2019-20 Expenditure

In 2019-20 the Advocacy Service's total allocated budget was $3,078,000, which comprised:

- $2,719,000 under direct control of the Chief Advocate for service delivery
- $359,000 (or 11.7% of its overall budget) to cover the cost of some corporate services, predominantly for 6.0 FTE Advocacy Services Officers and said to be provided 'free of charge' by the Mental Health Commission.[29]

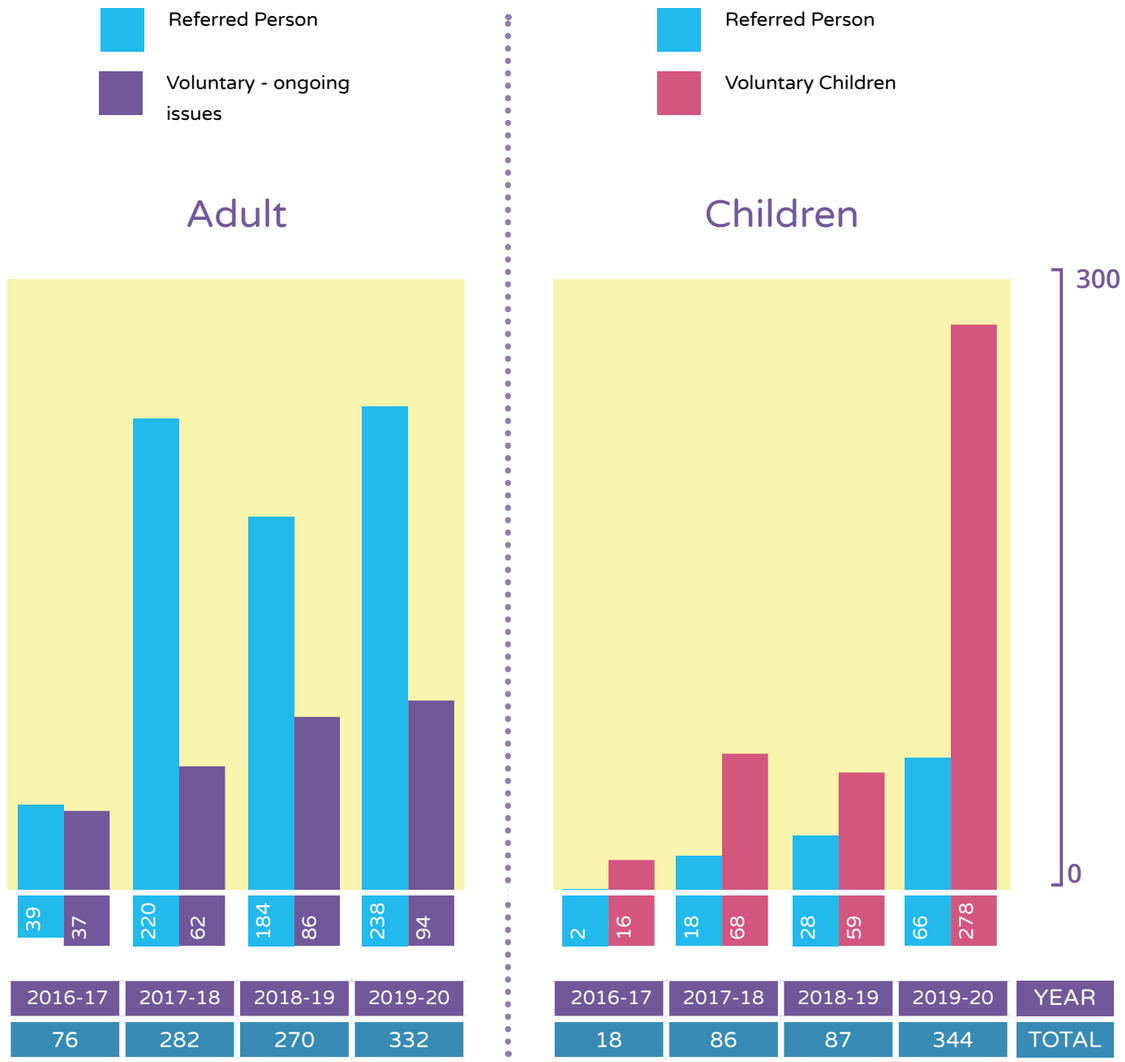
The Advocacy Service aims to work within the budget allocated, however expenditure was $3,368,555, which was $290,555, or 9.4% over budget.[30] Similarly, the Advocacy Service exceeded the budget under its direct control by $282,048 (or 11.0%) as its expenditure was $3,017,802. The increased expenditure was almost exclusively due to payments to Advocates for additional workload because of significant increases in the numbers of referred persons, involuntary inpatients (adults and children) and voluntary children, additional systemic advocacy work[31], increased numbers of Mental Health Tribunal hearings including increased representation by Advocates, and an annual pay rise for Advocates. The Chief Advocate advised the Minister in December 2019 that the Advocacy Service would not be able to come within budget. The final expenditure was slightly less than estimated in December 2019 although some extra expenses were incurred because of COVID-19.

[29] The Advocacy Service 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 received include payroll and human resources support for staff, processing some invoices and some financial services, and IT infrastructure, some of which is provided by Health Support Services.

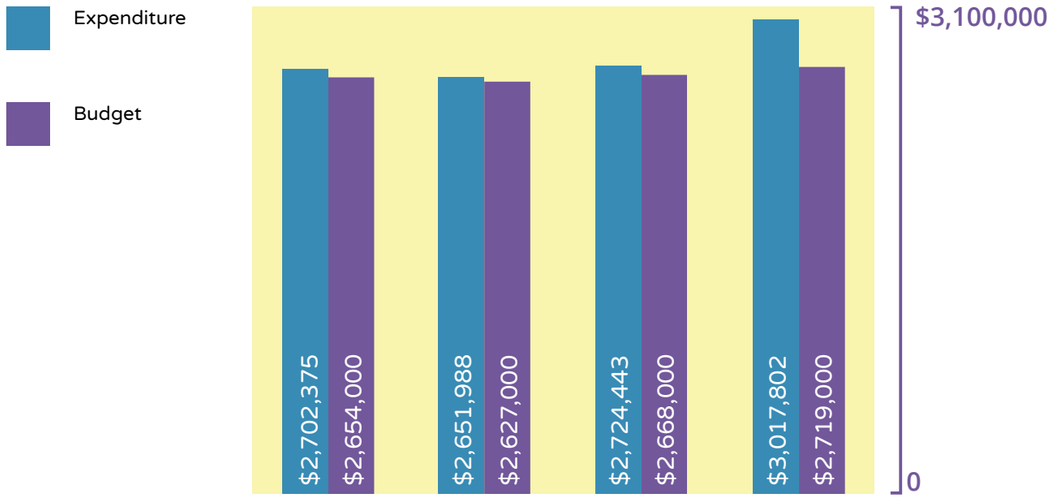
[30] The cost of services received free of charge from the Mental Health Commission in 2019-20, as advised by the Mental Health Commission, was $350,753. This was an increase of 7% or $74,370 on 2018-19 costs.

[31] Additional systemic advocacy costs were largely because of the Royal Commission into Institutional Responses to Child Sexual Abuse and the Advocacy Service's Inquiry into Services for Aboriginal and Torres Strait Islander People and Compliance with the *Mental Health Act 2014.*

Other 'Identified Persons' based on contact with Advocates



Advocacy Service's allocated budget 2016-17 to 2019-20



The Advocacy Service has increasing difficulty working within its allocated budget in each year of its operations and considers that it was underfunded from inception in November 2015. The inadequate funding means that the Advocacy Service is not able to completely fulfil its statutory responsibilities, particularly systemic inquiries and investigations.

Cost-saving measures continue to be explored but impact on the range and quality of statutory services available to consumers. In 2018 the Advocacy Service implemented widespread cost-saving measures and undertook a functional review of support services which reduced its services and expenditure to try to remain within budget. Further cost-saving measures are increasingly difficult to identify and place greater pressure on those who work for the Advocacy Service who are repeatedly compromised in the services that can be provided. The turnover and burnout rates across the organisation are increasing and the impacts of repeated recruitment on workloads and juggling people to backfill have an increasingly negative impact on wellbeing, organisational effectiveness and consumer rights.

The cost of Advocates, including the Chief Advocate, comprised 65.7% of the expenditure and reduced slightly from the previous year. The remaining costs were for corporate services from the Mental Health Commission, Advocacy Services Officers' salaries and on costs, building lease, travel, training and other goods and services.

2020-21 Budget

The 2020-21 budget for service delivery (i.e. excluding the cost of services received free of charge from the Mental Health Commission) is $2,858,000, which is 5.6% less than the Advocacy Service's expenditure last year. An annual pay rise for Advocates (unfunded) and staff will further restrict the Advocacy Service's ability to remain within budget, and impact on service.

Advocate remuneration

Advocates (including the Chief Advocate and Senior Advocates) are entitled to remuneration as determined by the Minister.

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). As they are engaged on contracts for service, they have no entitlement to paid leave and must supply their own car and mobile phone, although a laptop is provided to maintain security of information.

In October 2018, the Minister approved the first pay increases for Advocates and Senior Advocates since commencement of operations in 2015. The increase is in-line with the salary increases under the Public Sector CSA Agreement and resulted in:

- Senior Advocates' rate increasing from $60.65 to $61.30 per hour
- Advocates' rate increasing from $50.65 to $51.30 per hour.

On 21 April 2019 the annual remuneration of the Chief Advocate was increased for the first and only time since November 2015 by $1,000.

Recruitment and induction of new Advocates

In 2019-20, there were three intakes of new Advocates, which included five Youth Advocates (though one was already working as an Advocate and one resigned within the year) and one Aboriginal Advocate. The Chief Advocate also appointed three Senior Advocates (two had been working as Advocates and one of those now works only on the Disability Justice Centre under different legislation). Attraction and retention of Advocates, specialist and Senior Advocates in particular, has become increasingly difficult. This is partly due to the structural model laid down in the Act where they must be on contracts for services paid an hourly rate with variable workloads, no leave provisions and on three year contracts.

New Advocates undergo an intensive four-day in-house training program and complete a four-hour e-learning program on the act and an e-learning program on aggression prevention. New Advocates are mentored and observe and are supervised by experienced Advocates in the field for several weeks and attend at least one Mental Health Tribunal hearing before working alone with consumers.

Advocate training and development

Advocate training and development has been severely reduced over the years due to lack of funding, as have team meetings. This is a serious issue in terms of the quality of Advocate work and Advocate retention. Advocates work alone in the field in what can be extremely stressful situations, and team meetings allow the sharing of information and learnings, discussion of difficult cases, to check-in on issues, highlight systemic issues and changes, and to provide some sense of collegiality, which is an important contributor to job satisfaction.

In previous years, Advocates attended half- and full-day training and development sessions on a quarterly basis in Perth, which included bringing in regional Advocates. This had to be abandoned in 2017-18 due to severe budget constraints.

In 2019-20 the number of training sessions and team meetings was further reduced due to lack of funding. One training session of 2.25 hours was held which dealt with working in EDs and writing inquiry and complaint letters. Regional Advocates took part by videoconference. Nine team meetings were held during the year for metropolitan Advocates (fewer meetings were held for specialist Advocates; and regional Advocates met 10 times for an hour) and reduced to two hours duration on average (and in 2020-21 have been further reduced to 10 meetings of one hour).

A weekly email newsletter by the Chief Advocate, called the Chattering Chief, is used to raise issues and keep Advocates in touch with developments.

Advocacy Services Officers

The Chief Advocate must be provided with Advocacy Services Officers to assist her to perform her functions under the Act. The full-time equivalent complement of staff remained unchanged from the previous two years (6.0FTE), costs savings having been achieved the previous year by abolishing, a level 5 position and creating a new level 4 position.

Electoral Act Requirements

As required under the *Electoral Act 1907*, section 175ZE(1), the Advocacy Service recorded $4,500 in expenditure related to the designated organisation types between 1 July 2019 and 30 June 2020, which is broken down as follows:

- Advertising agencies: $4,500 (WACOSS)
- Media advertising organisations: nil
- Market research organisations: nil
- Polling organisations: nil
- Direct mail organisations: nil.

Quality assurance

The Advocacy Service is committed to continuous quality improvement in its service delivery and welcomes feedback of an informal and formal nature regarding its operations. Every budget submission, the Advocacy Service applies for $25,000 funding to have an external party conduct an evaluation (the external party having provided a quote based on a reduced version of an evaluation for a similar advocacy service funded in another state). The funding was not granted again this year.

Complaints

The Advocacy Service received 14 complaints about its service during 2019-20 (compared with 13 complaints the previous year):

- 11 complaints were made by HSP staff
- one complaint was made by a consumer
- two complaints were made by other parties.

Complaints were handled according to the Advocacy Service's complaints protocol (a copy of the protocol is available on the Advocacy Service website). One complaint was ongoing at the end of the financial year, two of the complaints were withdrawn, four were dismissed as unsubstantiated and seven were resolved (with three resulting in an apology and four found to be a misunderstanding about the Advocacy Service's role).

Advocacy Service breaches of the Act

It is a right of all consumers to be contacted by an Advocate 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 on 94.9% of all involuntary orders by an Advocate within statutory timeframes in 2019-20. This is slightly higher than the previous year and there was no apparent impact from COVID-19 on Advocates making the statutory contact. Advocates will still seek to contact a consumer even if it is after the seven day timeframe (or 24 hours for children) if they are still subject to an order.

Although all children were contacted by an Advocate following an involuntary order being made, this was not achieved within the statutory 24 hour timeframe in 14 cases out of 135 orders. This was due to the notification not being received within two hours, as agreed by health services, and in half the cases it was not received within 24 hours.

The Advocacy Service counts as breaches even those cases where the order is revoked within the seven day or 24 hour period and before the Advocate has made contact. These accounted for 64.1% of breaches in 2019-20 – people on 139 involuntary orders had their orders revoked within seven days, many of them on day one, two or three of the order being made. The number of orders revoked within seven days increased by 12 and it would be useful to analyse what is happening in these cases but the Advocacy Service does not have the funding or resources to investigate.

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 2019-20 no such 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 particular service is visited (see s355 of the Act). There were no such directions issued during 2019-20.

Youth Advocate training.

Committees, submissions and presentations

The Chief Advocate, or her proxy, was a member of 14 committees and took part in 11 consultations or provided written submissions during 2019-20, as set out in appendix 1.

Presentations are also given by the Chief Advocate and Senior Advocates to facility staff and other stakeholders on the role of the Advocacy Service and consumer rights. The presentations are an important educational tool which help protect consumers' rights and improve understanding of the role of the Advocacy Service. This work has had to be curtailed due to lack of funding and associated resources with the number of presentations falling from 35 last year to only 18 in 2019-20. A lot more work could be done in this area to promote the Charter of Mental Health Care Principles and educate mental health staff. A list of the 18 presentations given is provided in appendix 2.

Records management

In accordance with section 19 of the State Records Act 2000, the Advocacy Service has a record-keeping plan governing the management of all its records, which was approved by the State Records Commission in August 2018. The plan required the Advocacy Service finalise its Record-keeping Procedures Manual and classification system of functional keywords by mid-2018. The Procedures Manual was completed in July 2018, however the classification system remains outstanding due to resourcing issues. An evaluation of the Advocacy Service's Record-keeping Plan is scheduled for 2023, in accordance with the State Records Commission Standard 2, Principle 6.

Appendices

Appendix 1: Committees and submissions

Continuing committees

1. Private Hostel Agencies Committee
2. National Visitor and Advocacy Bodies Group
3. Accountability Agencies Review Working Group
4. OCP - Sexual Safety of Mental Health Consumer-Standards and Guidelines Reference Group
5. Joint Advocacy Agencies Group
6. Co-Leadership Safety and Quality Mental Health Steering Group
7. Forensic Youth Mental Health - Mapping of Pathways
8. Mental Health Network Executive Advisory Group
9. Review of the Mental Health Patient Journey at Perth Children's Hospital
10. Independent Oversight of Child Related Services Working Group
11. Child and Adolescent Mental Health Services Eating Disorder Review Steering Group

New committees in 2019-20

12. St Jude's Hostel Closure Steering Committee

COVID-19 committees

13. Community Services Taskforce and subgroups:
    - Alternatives to ED in the COVID-19 response to Support People in Distress subgroup
    - Vulnerable Cohorts subgroup
14. Youth Taskforce subgroup:
    - Working Group 4 – Supporting Young People's Health and Mental Health

Submissions, forums and consultations

1. WA Complaints Management Policy (2015) Consultation, Submissions – July 2019
2. Project to improve the Magistrate's Court response to accused persons with mental illness who may be deemed unfit to stand trial – meeting of the working group consultation, MHAS Manager - September 2019
3. State Disability Plan consultation workshops on health and support services attended by two Youth Advocates – August 2019
4. Review of CAHS restraint of patients' policy – September 2019
5. Consultation on submission to HSPs to admit people on Hospital Orders working with the MHLC and DOH – September 2019
6. Comments on Final Draft Discussion Paper by the Chief Psychiatrist – People with Severe Mental Illness and Challenging Behaviour – November 2019
7. Response to Productivity Commission Draft Report into Mental Health – January 2020
8. Fremantle Hospital, MHPWG Risk Workshop (20 new secure beds V5) - Advocate - March 2020
9. EMHS Mental Health Transitional Care Unit Model of Care consultation – Advocate – April 2020
10. WAAMH/MHC Mental Health COVID-19 workshops on Supported Accommodation and Decision Making Forum – Chief Advocate and Advocates - April 2020
11. MHC Alcohol and Other Drug Crisis Intervention System Service Model Project focus group consultation – Advocate – May 2020

Appendix 2: Advocacy Service presentations

1. Mental Health Matters 2 - Launch of Resources to Support Families with Respect to Treatment, Support and Discharge Plans, Panel discussion, Chief Advocate – August 2019
2. Information on MHAS and in particular focus on Treatment, Support and Discharge Plans for Bentley Hospital staff, Senior Advocate - August 2019

3. Presentation on role of MHAS for new Registrars at Rockingham Hospital, Senior Advocate - August 2019
4. Presentation on role of MHAS for new Registrars at Fremantle Hospital, Senior Advocate - August 2019
5. Presentation on role of MHAS for ward 5A staff at Perth Children's Hospital, Senior Advocate - August 2019
6. Presentation on role of MHAS for mental health nurses study day at Fiona Stanley Hospital, Senior Advocate - September 2019
7. Presentation on MHAS and focus on Treatment, Support and Discharge Plans for Fremantle Hospital staff, Senior Advocate - September 2019
8. A Journey Through Youth Mental Health Services hypothetical and MHAS stall – Panellist, Chief Advocate – October 2019
9. Patient Rights, presentation to the NMHS consumer and carer peer workforce, Chief Advocate - October 2019
10. Presentation on role of MHAS on medical wards and in EDs, at Perth Children's Hospital, Senior Advocate - October 2019
11. Presentation on MHAS and focus on residents from hostels who are brought in to hospital and evicted, for Bentley Hospital Social Worker and Welfare Officers, Senior Advocate - November 2019
12. Presentation on MHAS to the Peel and Rockingham Kwinana MH Guidance Group, Senior Advocate - November 2019
13. Presentation on MHAS and focus on MHAS presence in ED's, General Hospitals & Treatment, Support and Discharge Plans for FSH Registrars, Senior Advocate - February 2020
14. Presentation on role of Advocates, Team Meeting CNS/Nurse Managers Graylands Hospital, Senior Advocate - February 2020
15. Presentation on MHAS and focus on MHAS presence in ED's, General Hospitals & Treatment, Support and Discharge Plans for Rockingham Medical staff, Senior Advocate - February 2020
16. Presentation on role of MHAS for Eating Disorder Pod staff at Perth Children's Hospital, Senior Advocate - March 2020
17. Presentation on role of MHAS for Adolescent Medicine staff at Perth Children's Hospital, Senior Advocate - March 2020
18. Presentation on MHAS and focus on MHAS presence in ED's, General Hospitals & Treatment, Support and Discharge Plans for Fiona Stanley Registrars, Senior Advocate - June 2020

Glossary of Acronymns and Terms

Act	Mental Health Act 2014
Advocacy Service	Mental Health Advocacy Service
Advocate	Mental Health Advocate
CAHS	Child and Adolescent Health Service
Chief Advocate	Chief Mental Health Advocate
Child protection services	A division of the Department of Communities, known as Child Protection and Family Support
CLMIA Act	*Criminal Law (Mentally Impaired Accused) Act 1996*
CMHS	Community Mental Health Service which is part of an HSP
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
Disability services	A division of the Department of Communities
DOH	Department of Health
ED	Emergency department
EMHS	East Metropolitan Health Service
EMYU	East Metropolitan Youth Unit
FASD	Foetal alcohol spectrum disorder
FSH YU	Fiona Stanley Hospital 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 (by a psychiatrist), and a type of involuntary 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
MHC	Mental Health Commission
MHLC	Mental Health Law Centre
MHM2	Mental Health Matters 2, consumer and care group
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
PSOLIS	DOH database for people in mental health wards which records the status of people under the Act
RPH	Royal Perth Hospital
SAT	State Administrative Tribunal
SCGH	Sir Charles Gardiner Hospital
SJOG	St John of God
SMHS	South Metropolitan Health Service
Tribunal	Mental Health Tribunal
TSD Plan	Treatment, support and discharge plan
WACHS	WA Country Health Service

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