MHAS
MENTAL HEALTH
ADVOCACY SERVICE
2023-2024
Annual
Report

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

We value the contribution made by those of us with a lived experience of mental ill-health and recovery and those who are or have been carers, family members and supporters. We will progress when all voices have an equal say on what matters and what works. We welcome people from all cultures, sexualities, genders, bodies, abilities, ages, spiritualities and backgrounds to our service.

Hon Amber-Jade Sanderson MLA
MINISTER FOR HEALTH AND 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 2024.

As well as recording the operations of MHAS for the 2023-24 year, the Annual Report reflects on a range of issues that continue to affect consumers of mental health services in Western Australia.

Dr Sarah Pollock
CHIEF MENTAL HEALTH ADVOCATE

September 2024

Thank you

The artwork used on the front cover of the Annual Report has been reproduced with the permission of the artist, **Charlie Poppy**.

Contents

Chief Advocate's foreword	**vi**
Executive summary	**viii**
About us	**1**
The year in review	**3**
Distribution of Advocates and authorised hospitals	**4**
Advocacy service provision	**5**
The issues consumers faced	5
Consumer cohorts we supported	7
Numbers of authorised mental health beds attended by Advocates	15
MHAS weekend phone services	16
Advocacy for children and young people	**17**
Responding to children and young people with complex support needs	19
Reducing restrictive practices on medical wards	20
Seeking improved complaint handling	20
Advocacy for adults	**21**
Holding services to account for use of restrictive practices	22
Sexual safety	25
Access to food and drink	25
Advocacy for older adults	**26**
Service shortages and accessing older adult beds	26
The right to dignity in treatment	27
Getting physical health care in a mental health unit	27

Advocacy for forensic consumers **28**
Securing treatment pathways for prisoners 28
Equitable access for women on custody orders 29
Tackling stigma and procedural fairness 30
Working with children in detention 30

Advocacy for First Nations people **31**
Stronger relationships, stronger advocacy – Kaatadjiny Waalbraniny Danjoo 32
Continuing our advocacy on the 2019 inquiry into First Nations' people's rights 33

Advocacy for consumers at the Mental Health Tribunal **34**
Collaborating with the Tribunal to resolve consumer complaints 35

Advocacy for hostel residents **36**
The right to treatment and care for physical health issues 38
Securing a preferred place to live 38
Being safe at home 39
Preventing unplanned evictions whilst at hospital 39
Advocating for financial wellbeing 40
Resident rights and standards 40

Resourcing, service development and disclosures **41**
Budget and expenditure 41
Human resources 43
Service development 46
Disclosures 48

Committees, submissions and presentations **49**

Glossary of acronyms **51**

Chief Advocate's foreword

Welcome to the ninth annual report on the Mental Health Advocacy Service's work with consumers who are identified under the *Mental Health Act 2014*. The themes and examples in this report have been selected to demonstrate the impact that advocacy has for the consumers we work with, and the flow on effect this can have on services.

A contemporary mental health system must have ways of tapping into the lived experience of those who receive its services and those who care about them and for them. Lived expertise on what works to help people live well and stay well is as important as psychiatry, psychology or any of the other mental health-related disciplines. Advocacy is one way to access this knowledge in decision-making at every level from the individual to whole-of-system.

Individual advocacy seeks to ensure that consumers get their voices heard so their needs and preferences can be met in ways that are meaningful to them. When consumers are heard and understood, they are more likely to engage in their treatment, care and support with better outcomes as a result. Listening and responding to what people say works for them is a vital part of engaging with lived expertise in the delivery of services at the individual level. It makes services better and safer. The examples in this report of our work demonstrate how Advocates help this process of talking up, listening and responding across settings, cohorts and issues.

Dr Sarah Pollock
CHIEF MENTAL HEALTH ADVOCATE

Although we are independent, we work alongside mental health services and align our efforts where possible. At the heart of our independence is the privilege we give to consumers' voices. Consumers raise issues with Advocates when things are not working for them, and we work with the service to resolve the matter. When we raise complaints or undertake inquiries and investigations, we are responding to issues that consumers have raised and to the perspective they have provided. The selection of work presented in this report shows the impact that an individual issue or complaint can have on improving service quality and safety for everyone.

Last year I wrote about the inadequacy of our resourcing and the impact this had on the health and safety of our workers and on our ability to meet demand. Unfortunately, our resourcing remains insufficient to meet demand. In the context of the commitment to lived experience in mental health, this is a missed opportunity to strengthen one of the systems available to place consumer voices at the centre of service delivery and system governance.

A commitment to walk with people during difficult experiences drives everyone who works at the Mental Health Advocacy Service. I thank the Advocates, Senior Advocates, the Deputy Chief and the advocacy support staff for their commitment and hard work this year.

Executive summary

In 2023-24, the Mental Health Advocacy Service (MHAS) has once again experienced a noticeable increase in demand for advocacy services, resulting in a 4.7 per cent increase in the number of identified persons assisted compared to 2022-23. This marks the first time where MHAS has assisted more than 4,000 consumers in a year (4,102 Consumers).

Additionally, compared to 2022-23, the number of involuntary orders increased by 5.8 per cent, the number of Advocate hours increased by 3.2 per cent, the number of consumers placed on orders increased by 6.4 per cent, and the number of issues reported to Advocates increased by 6.8 per cent.

In 2023-24, MHAS reported an overspend of $445,723 against its approved budget of $4,858,000 (excluding funds allocated for the implementation of the *Criminal Law (Mental Impairment) Act 2023*). The overspend can largely be attributed to workforce costs associated with increased demand outlined above.

Overall, 2023-24 was a very busy year for MHAS in the lead up to the commencement of the *Criminal Law (Mental Impairment) Act 2023*. This new legislation will see MHAS expand its advocacy functions to a new cohort of consumers in other settings. Significant activity occurred in 2023-24 to prepare for

this expansion, including the development of new policies and protocols, communication resources, and training materials for Advocates. Work is also underway to secure larger office space to accommodate the expanded workforce.

Throughout 2023-24, MHAS continued working in partnership with Aboriginal Elders and community members, alongside Curtin University and the Office of the Chief Psychiatrist, to improve the cultural competency and knowledge throughout MHAS, and achieve better advocacy outcomes for First Nations' consumers. Although the formal relationship with Curtin University has now concluded, the Kaatadjiny Waalbraniny Danjoo (Learning to Heal Together) partnership with the Elders and community members continues. The support provided by the staff from Curtin University over the past two-years has left MHAS well-equipped to confidently and competently work with Aboriginal people into the future.

> **[MY ADVOCATE] HAS BEEN A BEACON OF HOPE AND STRENGTH.**
>
> **RESIDENT**

About us

The MHAS exists to amplify the voices and protect the rights of people using, and seeking to use, mental health services.

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

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

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

I CAN CONFIDENTLY SAY THE SUPPORT OF [MY ADVOCATE] AND MY FAMILY WERE REALLY THE ONLY THINGS THAT GOT ME THROUGH A LOT OF MY WORST DAYS AND THAT HELPED ME OUT OF A REALLY, REALLY, REALLY DEEP HOLE.

CONSUMER

FIGURE ONE - Key functions and powers of the Chief Advocate and Mental Health Advocates

Chief Advocate

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

Pure advocacy (adults)

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

Advocate powers and functions

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

Best interests advocacy (children)

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

The year in review

4,102
Consumers assisted

8,593
Phone requests for contact

8,445
Notifications of orders

10,610
Issues raised by consumers

343
Serious issues

202
Letters of complaint, concern or inquiry

120
closed within 30 days

82
closed in over 30 days

1,188[1]
Mental Health Tribunal hearings attended

227
Further opinions requested

1 Source: Data provided by the Mental Health Tribunal for financial years 2022-23 and 2023-24. Equivalent figures in prior annual reports were based on MHAS internal data and cannot be reliably compared.

2 An authorised hospital refers to a mental health unit or ward/s that has been authorised by the Chief Psychiatrist for the reception and admission of people receiving treatment and care for a mental illness under the Act. The graphic includes Licensed Private Psychiatric Hostels which, although not classed as a hospital, are included in the definition of mental health service for MHAS. The weekend phone service covers authorised units at PCH, EMyU, FSHYU and JHCYU and provides a call back service to in scope consumers across the state, as required.

Distribution of Advocates and authorised hospitals[2]

This graphic represents the numbers of Advocates working across services on 30 June 2024 and does not equate to FTE. This figure excludes Advocates who were unavailable for work.

Advocacy service provision

The issues consumers faced

In 2023-24, Advocates assisted more than 4,000 consumers to help ensure they were aware of their rights and could access those rights. They helped them resolve more than 10,000 issues (see table one). These figures reflect a 4.7 per cent increase in the number of consumers assisted, which is consistent with the year-on-year increase in the number of consumers assisted since MHAS' inception in November 2015[3].

There were increases in numbers across most complaint categories compared to 2023-24. Of the most frequently recorded categories, the number of complaints about discharge, ground access, prescribing medication, diagnosis, physical health, care plans and side effects were each higher than in 2022-23. Involuntary status, accommodation and transfer to another ward, hospital or clinic each showed a decrease (see chart one).

Complaints and issues data depend on Advocates' coding and are impacted by consistency in practice between Advocates and across years. While the data set is large enough to consider general trends, caution is urged when considering data about specific complaints.

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

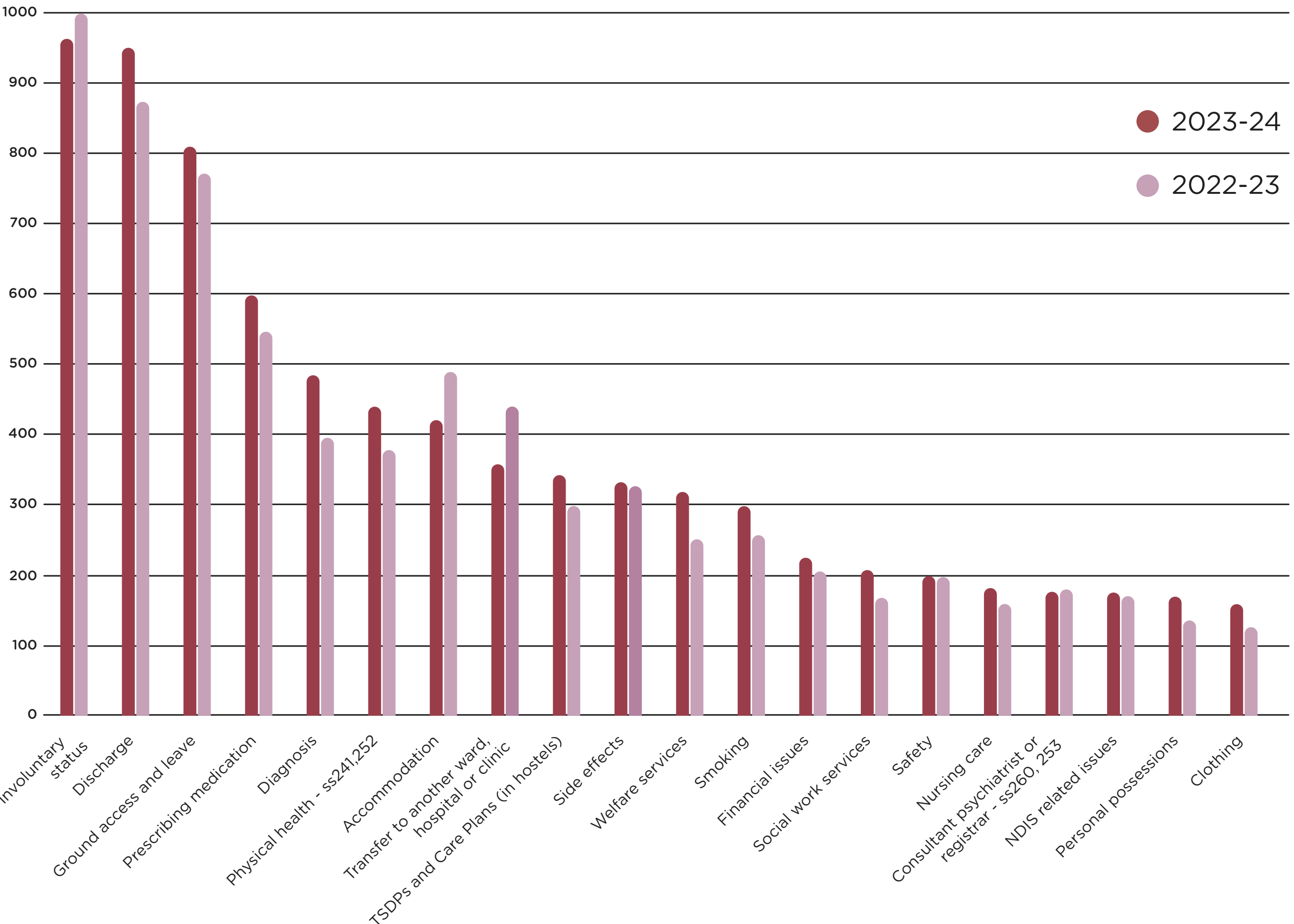
	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Number identified persons assisted by Advocates[4]	3,132	3,141	3,427	3,605	3,454	3,919	4,102
Number of issues recorded by Advocates[5]	7,373	5,081	8,970	7,581	7,226	9,937	10,610

3 The exception to this trend was 2021-22 when the number of consumers assisted dipped, likely due to the COVID-19 pandemic impacting help-seeking behaviours and service responses.

4 The number of consumers assisted is based on the number of 'identified persons' (as per s348 of the Act) contacted by an MHAS Advocate. This differs from data based on the number of involuntary treatment orders.

5 Recorded issues data comprises complaints or matters that consumers would like Advocate assistance to resolve and reflect the content of much of Advocates' work.

CHART ONE: Most common consumer complaints and issues in 2022-23 and 2023-24



The issues data includes allegations of assaults (physical, sexual, verbal, or financial), staff misconduct, neglect, or ill-treatment. These are identified as 'serious issues' in the MHAS' reporting system and require a specific response. Advocates must follow a protocol for responding to serious issues, requiring them to escalate the matter to a Senior Advocate to decide on a plan of action and who monitors the matter. Serious issues are treated as allegations, and the Advocates' role is to ensure that consumers are safe and that the service has responded appropriately to the matter.

Advocates responded to 343 serious issues in 2023-24. Many are resolved promptly at ward level, but some require further investigation and may result in a formal complaint or inquiry letter being sent. Recorded serious issues increased by 11 per cent from 2022-23.

The greatest number of serious issues were recorded against the categories of 'potential misconduct, wilful neglect or ill-treatment', followed by 'allegations of sexual harassment or assault' and 'allegations of physical abuse'.

There were 45 serious issues recorded for children aged 0-17 years, and 51 for young people aged 18-24 years, compared to 68 for children and 43 for young people in 2022-23. Although the total numbers of serious issues for children and young people have been relatively consistent over the past two years, there was a significant increase in allegations of sexual harassment or assault.

Data on serious issues is reliable but does not represent all the serious issues that consumers experience as it relies on the matter coming to the Advocate's attention.

Consumer cohorts we supported

Consumers on involuntary treatment orders

The number of new involuntary treatment orders (all types) for inpatients increased compared to the previous year, reflecting a 5.8 per cent increase in orders and a 6.4 per cent increase in the number of consumers placed under orders (see table two and chart two). This continues the overall upward trend in order numbers since MHAS' inception.

The number of inpatient treatment orders (ITOs) made in authorised hospitals (Form 6A) for treatment in a mental health unit increased by 5.1 per cent, and the number of consumers by 5.6 per cent. The numbers of ITOs have fluctuated within a narrow range over the past seven years, other than a substantial drop in 2021-22, likely due to the COVID pandemic, and the increase this year. It is unknown what is driving this increase, nor whether it reflects a trend or a single year impact.

The increase in ITOs made in general wards (Form 6B) has continued, with more than a three-fold increase in order numbers since 2016. In these situations, most consumers assisted by Advocates are being treated for an eating disorder. This reflects a national trend in the increasing prevalence of diagnosed eating disorders, and it is reasonable to assume that demand for treatment of all types, including involuntary, will follow this trend. A smaller number of orders are for those being treated for physical trauma injuries. The advocacy for consumers in general hospitals is often more intensive and requires more hours of input as there are commonly more issues involved and more complexity in them. Moreover, staff in general hospitals are less familiar with the requirements, responsibilities and oversight of involuntary detention and treatment, including the legal implications.

There has been a steady increase in the number of new Community Treatment Orders (CTO) since 2016[6]. Over the past year there were 1005 new CTOs made. It is possible that the greater availability of treatment and support services in the community, and new models such as Hospital in the Home, are encouraging clinicians to consider the use of CTOs as a less restrictive option for some consumers.

TABLE TWO - Number of involuntary orders[7] and number of consumers[8]

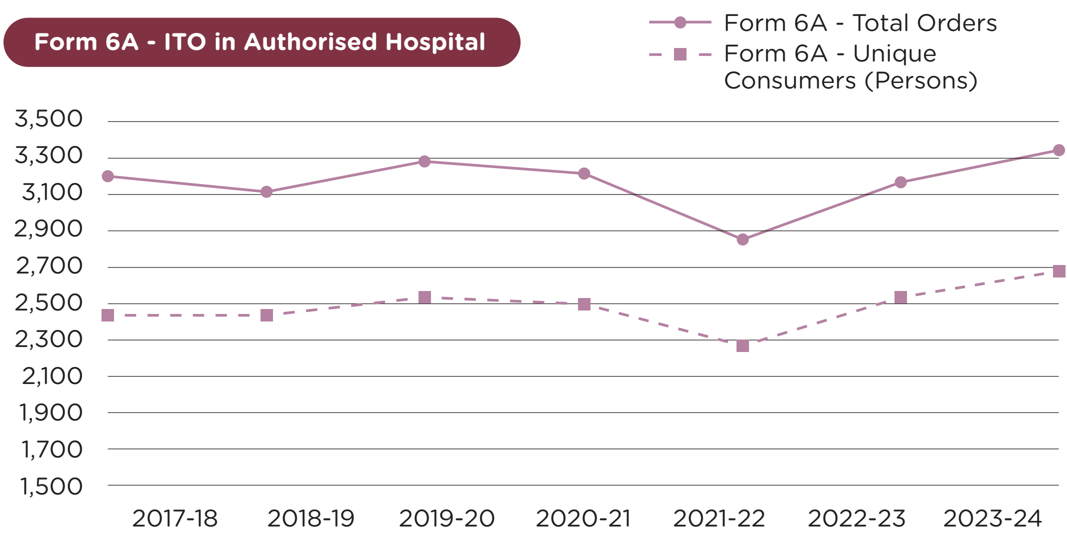
Type of Order	2017-18		2018-19		2019-20		2020-21		2021-22		2022-23		2023-24	
	Orders	Persons	Orders	Persons	Orders	Persons	Orders	Persons	Orders	Persons	Orders	Persons	Orders	Persons
Inpatient treatment orders in authorised hospitals - Form 6A	3,203	2,432	3,117	2,431	3,275	2,534	3,208	2,498	2,844	2,270	3,170	2,533	3,333	2,675
Inpatient treatment orders in general hospitals - Form 6B	134	115	149	128	168	128	181	139	255	189	282	222	331	258
Community treatment orders - Form 5A	817	661	850	679	839	702	884	718	884	726	963	781	1,005	808
Total Involuntary Orders / Consumers	**4,154**	**2,644**	**4,116**	**2,650**	**4,282**	**2,744**	**4,273**	**2,729**	**3,984**	**2,573**	**4,415**	**2,842**	**4,669**	**3,024**

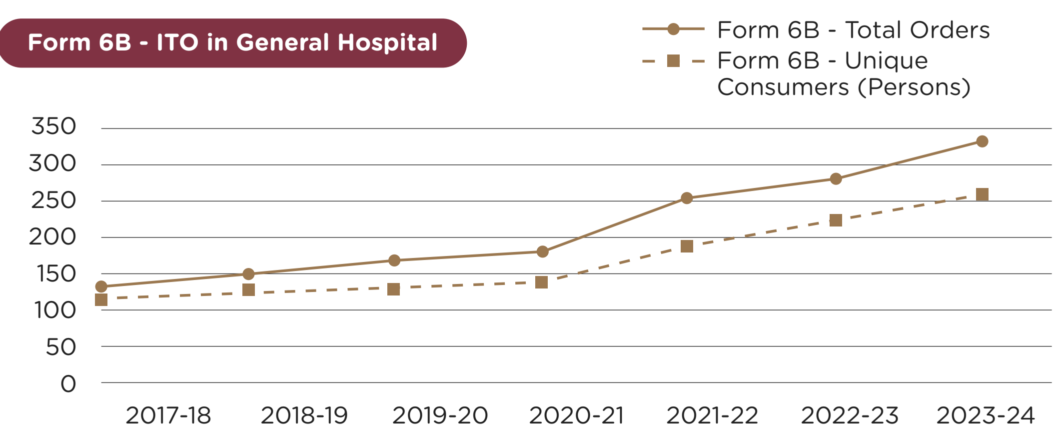
6 CTO numbers are based on new CTOs notified to MHAS and recorded in the ICMS database and do not include ongoing CTOs in place at the commencement of the financial year.

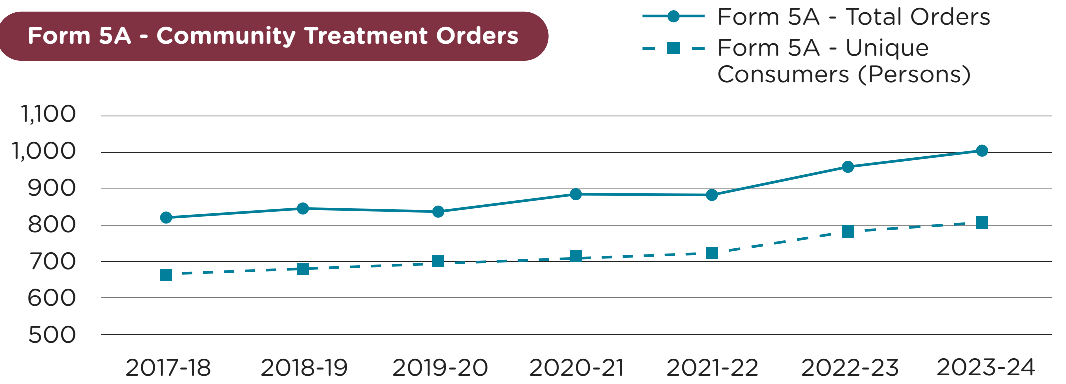
7 Order totals are based on the commencement date of involuntary orders notified to MHAS by health services. Verification of ICMS data is ongoing, and figures may be subject to change.

8 Consumers may be subject to more than one order of each type during each financial year. The persons column indicates the number of unique individuals that the total for each order type relates to.

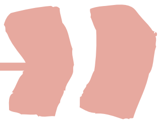
CHART TWO: Number of involuntary orders and number of consumers from 2017-18 to 2023-24







> THE KINDNESS, COMPASSION, AND PATIENCE [MY ADVOCATE] HELD FOR ME WERE SOMETIMES THE ONLY THINGS THAT WOULD MAKE ME FEEL AS THOUGH I HAD A CHANCE IN THIS WORLD.
>
> CONSUMER



Children aged 0-17 years

MHAS has a statutory obligation to contact children aged 0-17 years within 24 hours of an involuntary order being made, and ensure they are aware of their rights under the Act. Advocates must consider the child's wishes along with the views of the parents or guardians when advocating for the best interests of the child. The added perspectives increase the complexity of advocacy for children. A fair proportion of children have several government and non-government organisations involved in their treatment, care, support and accommodation.

The number of children treated under any involuntary order decreased to 183 orders in the current year. The number of orders for children has almost tripled in the past seven years and doubled in the past six.

Other than population increase it is not clear what has been driving this increase. Contributing factors may include a greater awareness of childhood mental illness and associated increase in help-seeking, insufficient early intervention and community services and impacts of wider social deprivation.

The trends by type of order varied:

- There was a small increase in orders made in authorised hospitals for children following the overall increasing trend since 2017-18.
- There was a large decrease in inpatient orders made in general hospitals for children following a smaller decrease last year. This may suggest a reversal of the trend over the past seven years.
- The number of CTOs for children increased slightly. However, overall numbers are small, so caution is recommended in interpreting this information.

TABLE THREE - Number of involuntary treatment orders for children (0-17 years)

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Inpatient treatment orders in authorised hospitals - Form 6A	48	53	75	80	63	86	90
Inpatient treatment orders in general hospitals - Form 6B	27	28	32	42	64	61	43
Community treatment orders - Form 5A	13	24	28	42	37	47	50
Total Involuntary Orders	**88**	**105**	**135**	**164**	**164**	**194**	**183**

The number of children admitted voluntarily to authorised hospitals and assisted by an Advocate dropped compared to last year and 2020-21 (i.e. following the COVID-19 pandemic). This reduction was not necessarily due to a decrease in such children treated in hospital or seeking assistance but reflects the ongoing challenges in recruiting and retaining a Youth Advocate workforce under the current contract for service arrangement required by the Act.

Data obtained from the Department of Health (DoH) reports the numbers of children admitted to authorised mental health wards voluntarily on a calendar year basis (1 January – 31 December)[9]:

- In 2022 there were 542 children voluntarily admitted to mental health wards, accounting for 845 separations.
- In 2023 there were 536 children voluntarily admitted to mental health wards, accounting for 857 separations.

Direct comparison with MHAS data is not possible, but the consistency of these figures across two years, compared to the drop in numbers of children assisted by MHAS in 2023-24, suggests workforce issues played a part in MHAS' ability to serve this cohort. MHAS received an increase in funding in the 2024-25 budget for voluntary children, and we anticipate this will assist Advocates to better respond to demand. As MHAS does not receive notification of a child's voluntary admission to an authorised hospital, being able to meet demand for advocacy is dependent on Advocate availability and presence on wards.

In many instances, parents or guardians have consented to a child's admission and treatment. Under s302 of the Act, parents or guardians may consent to admission and treatment unless it is shown that the child can apply for admission, discharge or make treatment decisions for themselves. Usually this is at the discretion of the treating psychiatrist, and the Advocate will follow their determination in whether to treat the young person as a 'mature minor'. Children are, therefore, not necessarily admitted or treated on a completely voluntary basis, and the Advocate plays a role in ensuring their wishes are considered in decisions about them.

On 1 January 2017, a Ministerial Direction came into effect expanding MHAS' scope in relation to classes of voluntary patients. The expanded scope included any child being treated in or, seeking admission to a public hospital or authorised hospital, and children who had been assisted by an Advocate in the previous six months as a voluntary or involuntary patient. Additionally, the scope included any child who is proposed to be provided with treatment in or by a public hospital or authorised hospital.

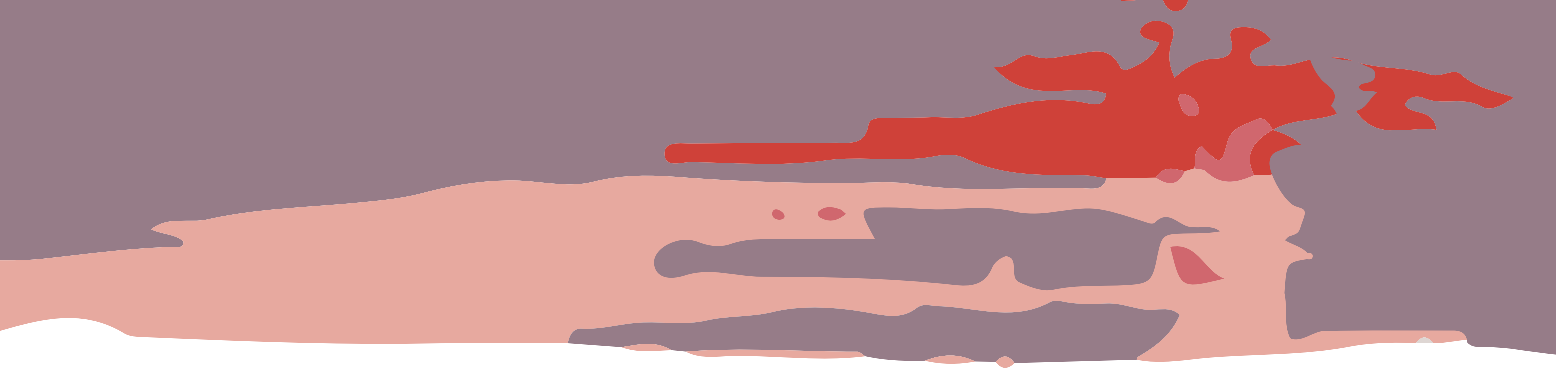
The Ministerial Direction, in combination with an increase in the number of Youth Advocates, has driven the substantial increase in voluntary children assisted over the past seven years.

TABLE FOUR - Number of voluntary children (under 18 years) assisted by an Advocate[10]

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Voluntary children (<18 years) assisted	59	59	278	460	342	462	390

9 Data received from Department of Health Information and System Performance Directorate by email on 31 July 2024.

10 Data is drawn from the MHAS ICMS database and is based on the number of child consumers (<18 years of age) contacted by an MHAS Advocate while not subject to an involuntary treatment order. Methodology for calculating 2022-23 and 2023-24 data differs slightly from previous years. Prior years' data is as published in previous annual reports.



Voluntary adult consumers

Since January 2017, MHAS has continued to assist consumers in resolving 'ongoing issues' post-discharge from an involuntary treatment order, as long as they remained connected to a public mental health service as a voluntary consumer (either in hospital or in the community)[11]. The Advocate must have been assisting the consumer with the issue, have acted towards resolution, and there must be further action that can be taken to resolve the issue or complaint.

The number of voluntary adults being assisted with ongoing issues (see table five) dropped slightly in 2023-24. Consumers are typically assisted with an ongoing issue where their order is revoked and they remain a voluntary consumer of an inpatient or community service, but MHAS has yet to receive a satisfactory response to a letter of complaint.

This year a new protocol was endorsed to govern Advocate work in relation to 'voluntary ongoing issues'. This was based on advice received from the State Solicitor's Office in 2022-23 and appears to have contained the increasing trend in voluntary adults assisted with ongoing issues.

Unfortunately, there are occasions when a person is discharged from the public mental health system outright whilst they have an outstanding complaint. In these circumstances the Advocate is no longer able to assist the consumer to resolve the complaint, because they are no longer an identified person under S348 of the Act. The Cook Government's response to the report on the statutory review of the Act, released in early 2024, supports a recommendation that the Chief Mental Health Advocate's powers and functions under the Act continue until a complaint is resolved or no further action can reasonably be taken, even when the person is no longer an identified person and subject to the person's consent[12].

TABLE FIVE - Consumers referred for examination and those assisted with ongoing issues[13]

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Referred persons assisted (adults and children)	238	212	303	333	302	323	320
Voluntary (adult) consumers assisted with ongoing issues	62	86	94	135	149	147	135

[11] Advocates can also assist hostel residents, referred persons and other classes of 'identified persons' (as per s348 of the Act) with outstanding complaints when their status changes under the Classes of Voluntary Patient Directions 2016 published in the WA Government Gazette (the Ministerial Direction).

[12] Government Response to the Report on the Statutory Review of the Mental Health Act 2014 (Western Australia), p12, accessed on 3 September 2024, Government Response to the Report on the Statutory Review of the Mental Health Act 2014 (parliament.wa.gov.au).

[13] Data is drawn from the MHAS ICMS database of notifications sent by facilities, and work recorded by Advocates and extracted as at July 2024; data is subject to change. Consumers may be assisted in multiple categories during the financial year. MHAS started providing advocacy services to children and consumers with ongoing issues via a Ministerial Direction on 1 January 2017.

Referred persons

'Referred persons' are those who have been referred by an authorised mental health practitioner or a medical practitioner for a psychiatric examination, often in an emergency department (ED). It is a compulsory referral, and the person cannot leave the hospital until they have been examined.

MHAS is not notified when someone is placed on a referral order (Form 1A) and is thus reliant on referred persons or other parties (including family and hospital staff) to request advocacy support. MHAS receives a daily centralised report (the 'Mental Health Bed Report'), which indicates the number of people (including children) waiting for a bed and identifies where they are waiting. A Youth Advocate then makes inquiries for children and young people placed on a referral order. In some situations, an inpatient bed has been identified, and the young person is waiting to be transferred. In other cases, a bed is yet to be identified. In both situations, the Youth Advocate will make contact to ensure they are aware of their rights and assist them with anything they need[14].

The number of referred persons (adults and children) assisted by an Advocate in 2023-24 was stable and is consistent with pre-COVID-19 levels (see table five).

> THANKS FOR YOUR HELP AND I'M ON [A DIFFERENT] WARD NOW AND THINGS ARE GREAT HERE.
>
> CONSUMER

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

Custody orders

The number of people subject to custody orders and detained in authorised hospitals dropped by two in 2023-24. The overall number of people subject to custody orders and the number detained for mental health treatment has increased since 2018.

In 2023-24, four new custody orders were made, and four people were discharged from their orders. This is a departure from the longer-term trend. Since 2018 the number of new custody orders issued each year has not been offset by the number of people discharged from the orders since 2018. Therefore, the number of people on custody orders has been steadily increasing (see tables six and seven).

TABLE SIX - Number of custody orders as of 30 June each year[15]

Location as at 30 June each year	2018	2019	2020	2021	2022	2023	2024
Authorised Hospital	9	11	22	29	28	32	31
Community	17	18	15	10	14	13	14
Subject to a condition they undergo treatment for a mental illness	-	15	12	7	10	10	12
Not subject to conditions about treatment for a mental illness	-	3	3	3	4	3	2
Declared Place	2	3	2	3	3	3	2
Prison	10	10	11	10	10	9	8
TOTAL	**38**	**42**	**50**	**52**	**55**	**57**	**55**

TABLE SEVEN - Number of new and discharged custody orders[16]

	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
New custody orders	8	11	6[17]	7	5	4
Discharged by Executive Government	4	3	4	2[18]	2	4

15 Source: Data supplied to MHAS by the Mentally Impaired Accused Review Board (MIARB).

16 Source: Data supplied to MHAS by the Mentally Impaired Accused Review Board (MIARB).

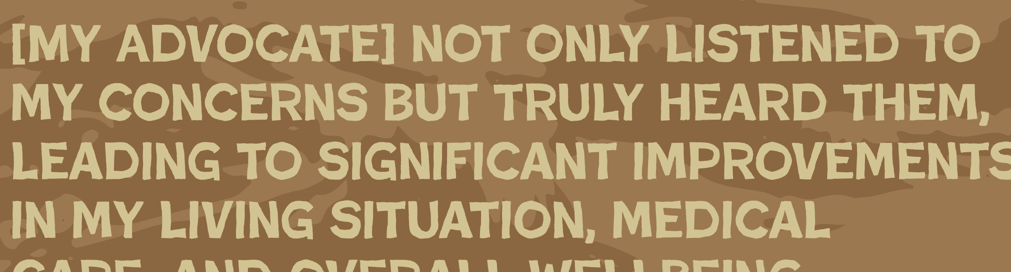
17 One mentally impaired accused person received two custody orders.

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

Licensed private psychiatric hostel residents

Advocates assisted 391 hostel residents in 2023-24 (out of a total population of around 700), compared to 349 residents in 2022-23 and 261 residents in 2021-22.

The number of hostel residents' issues or complaints Advocates assisted with increased to 1,490 in 2023-24, up from 1,076 in 2022-23 and 444 in 2021-22. MHAS contends this year-on-year increase reflects the importance of proactive advocacy to facilitate this vulnerable cohort to access their rights and get their issues raised and addressed.



> [MY ADVOCATE] NOT ONLY LISTENED TO MY CONCERNS BUT TRULY HEARD THEM, LEADING TO SIGNIFICANT IMPROVEMENTS IN MY LIVING SITUATION, MEDICAL CARE, AND OVERALL WELLBEING.
>
> RESIDENT

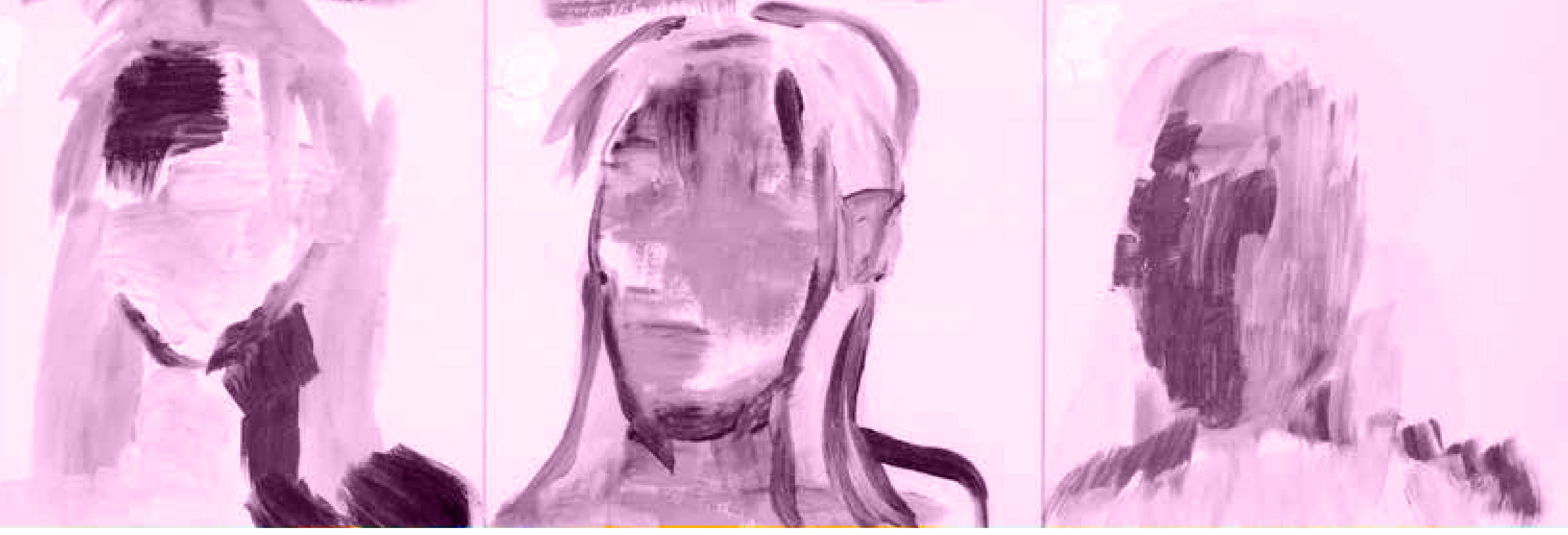
Consumers new to MHAS

The number of consumers new to MHAS dropped by 2 per cent from a peak in 2022-23 to a level more consistent with 2019-20 and 2020-21, noting the COVID-19-impacted year 2021-22 (see table eight). New consumers represented 44 per cent of all consumers represented by MHAS in 2023-24 and 47 per cent of all consumers in 2022-23. In the two years prior to the COVID-19 pandemic, the proportion of new MHAS consumers was 52 per cent.

It is too early to suggest with any confidence what is driving this apparent trend. However, most people who have used MHAS' services previously sought assistance when they were once again identified and in scope.

TABLE EIGHT - Number of consumers new to MHAS

	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	% Change from Previous Year
Consumers new to MHAS	1,566	1,798	1,876	1,526	1,844	1,808	-2.0%



Numbers of authorised mental health beds attended by Advocates

The number of beds available and inactive fluctuate over the course of a year. In 2023-24 the total average beds was 735, comprising 708 average available and 27 average unavailable (see table nine)[19]. Bed availability is impacted by, for instance, repair and refurbishment works, changes in usage, and workforce availability. It is concerning that the proportion of inactive beds appears to be increasing year-on-year.

There was a very small increase in private psychiatric hostel beds licensed by the Licensing and Accreditation Regulatory Unit (LARU) of the DoH, from 731 on 30 June 2023, to 733 on 30 June 2024. These comprise two additional beds at the Richmond Wellbeing Ngulla Mia hostel, which MHAS regularly visits. MHAS continues to operate a proactive hostel visiting program, thus ensuring that this vulnerable and marginalised cohort of people have multiple pathways to exercise their right to access advocacy.

TABLE NINE - Total authorised mental health beds, available and inactive beds

Bed numbers as at 30 June	Total beds	Available beds	Inactive beds
2020	674	671	3
2021	676	673	3
2022	680	675	5
2023	686	673	13
2024	745	713	32

[19] Data source: Mental Health Information Data Collection (MIND), System Analysis Branch, extracted 30 July 2024.

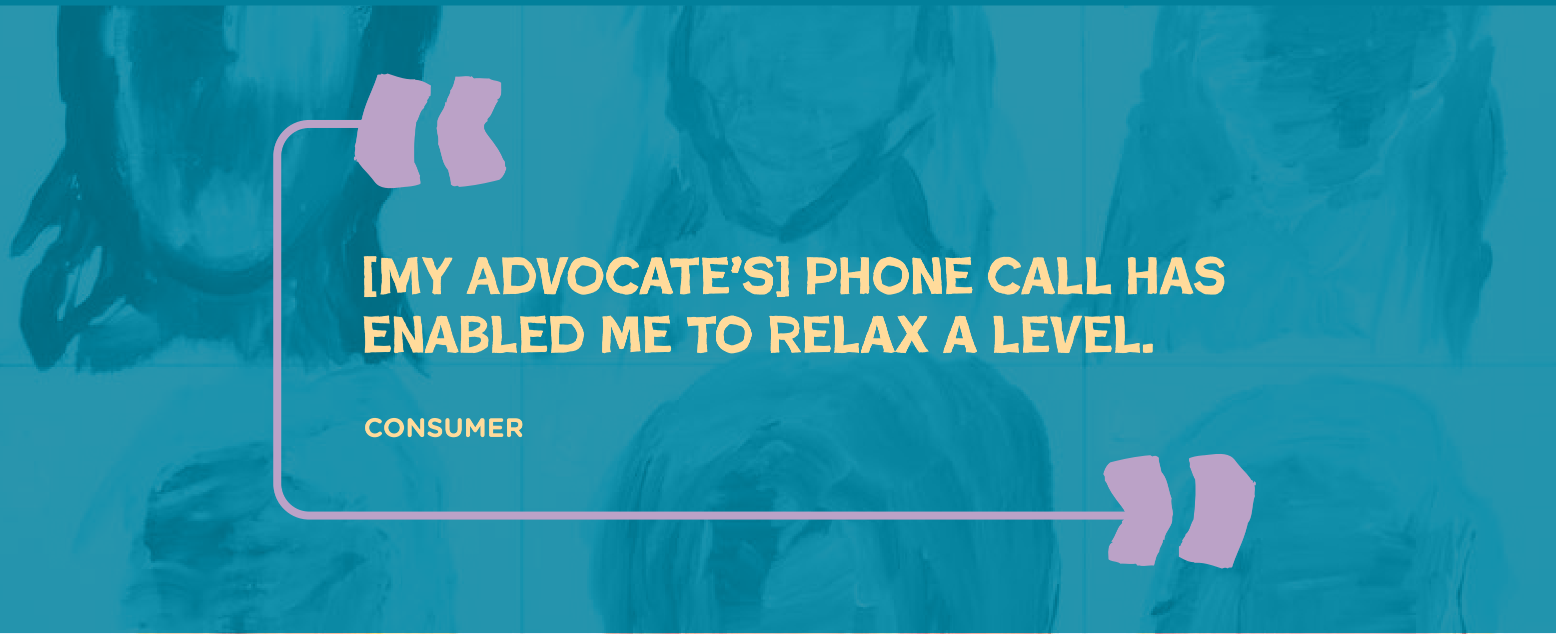
MHAS weekend phone services

MHAS operates the following weekend phone services, including over public holidays:

- Monitor messages and determine the urgency of requests. In urgent matters, the phone Advocate will contact consumers over the weekend. Otherwise, the phone Advocate will arrange for an Advocate to make contact within time periods determined by the Act or MHAS protocol.
- Contact youth mental health wards to check whether orders for children have been made, as an Advocate must make contact within 24 hours of the order being made. The Advocate also enquires about the general safety on the ward, whether any children have been referred for examination, and whether ward staff are aware of orders made in adult authorised wards, general hospitals, or regional areas.

In 2023-24, MHAS received 657 phone messages on weekends and public holidays[20]. This is a 21 per cent increase on last year when 543 calls were received.

Most of the calls were received from consumers admitted to hospital, with a small number from consumers on CTOs and in hostels. There were also a few from consumers outside MHAS' jurisdiction who were referred to other appropriate services.



20 Messages are checked up to midday on weekends and public holidays.

Advocacy for children and young people

A specialised team of Advocates

MHAS has a team of specialist Youth Advocates who have qualifications, training, and experience relevant to children and youth[21]. The number of Youth Advocates fluctuates over the year, but MHAS requires the equivalent of 7.5FTE to meet demand.

Based in the metropolitan area, Youth Advocates maintain a regular presence at the state's only authorised unit for children (0-15 years) at Perth Children's Hospital (PCH), and the three authorised units for children and youth (16 – 24 years) at Bentley Hospital (East Metropolitan Youth Unit), Fiona Stanley Hospital (FSH), and Joondalup Health Campus. They also regularly visit children and young people in ED, community mental health services, medical wards, and adult authorised hospitals[22]. Advocacy and support are provided by phone and video conferencing for children in regional areas.

Youth Advocates provide advocacy and support to:

- Children (voluntary, referred and involuntary) who are being treated, or to whom treatment is being proposed to be given, by a public inpatient mental health service;
- Children in community public mental health services, who are either on a CTO or have previously been assisted by a MHAS Advocate when either a voluntary or involuntary patient.
- Youth on ITOs or CTOs[23].
- Children and youth living in supported accommodation services licenced as psychiatric hostels by LARU, specifically Ngatti House and Momentum Queens Park.

21 A child is defined in the Act as a person under the age of 18. For the purposes of this report, 'youth' are young people aged between 18-24 years.

22 In exceptional circumstances children can be admitted to an adult ward under the oversight of the Chief Psychiatrist, as per s303 of the Act.

23 Youth Advocates assist approximately 50 per cent of 18-24 year olds on Form 6As and 67 per cent of 18-24 year olds on Form 6Bs. The remaining 18-24 year olds are assisted by General Advocates.

How Youth Advocates work

Unlike MHAS' advocacy for youth and adults, when assisting a child Advocates are required to adopt a best-interests approach. This means they must have regard to the views of the child, their parent and/or guardian, and the views of the treating team and any other relevant stakeholder. This can be challenging at times as it is not uncommon for the various parties to have differing views and priorities for treatment, care and support. Youth Advocates are skilled at holding the child's views central to decision-making processes while promoting stakeholder collaboration and supporting and maintaining the child's rights.

When a child is a mature minor[24], Youth Advocates are required to consult with their Senior Advocate and the Chief Advocate to determine if a pure advocacy approach is appropriate.

While the issues raised by children, youth, and their families vary in nature and complexity, often depending on the environment in which they are receiving treatment and support, Youth Advocates play an important role in humanising bureaucratic processes and helping children and young people navigate a complex healthcare system and access their rights.

24 A child may be treated as a *'mature minor'*, whereby they can make decisions. A mature minor is assessed by a clinician as being able to fully understand the nature, consequences, risks and implications of the proposed action or non-action.

Below are some examples of how Youth Advocates have worked to secure better outcomes for children and young people.

Responding to children and young people with complex support needs

MHAS is concerned about service and system responses to children and youth with complex support needs. This cohort typically has support needs that span multiple sectors, including health, mental health, disability, housing, education, alcohol and other drugs, justice and child protection. They often present with distress-related behaviours that place themselves and others at risk of harm. Consequently, they are frequently subject to restrictive practices including sedation, bodily and chemical restraint, and seclusion. Often their families and carers need more support than they have and are disillusioned from their experiences of seeking help.

While the number of children and young people with complex support needs is comparatively small, they take up a disproportionate number of resources and advocacy supports, often over extended periods of time. Our work with this cohort magnifies systemic issues including inadequate interagency coordination and collaboration and possible service gaps. Advocacy for this cohort generally focuses on issues arising from:

- poor communication
- breakdowns in relationships between children, young people, families, and/or service providers
- safety
- dignity
- access to treatment and support including National Disability Insurance Scheme (NDIS) funding that would sustain the child/young person and their family in the community
- inconsistency in treatment decisions between clinicians, services and admissions
- inadequate or inappropriate discharge planning
- barriers to accessing appropriate and meaningful accommodation
- child protection matters
- police and youth justice involvement.

During 2023-24, following complaints from several children and their families or guardians, and the observations of Youth Advocates, MHAS completed an inquiry into the PCH response to children with complex support needs and challenging behaviours. In doing so, MHAS acknowledged the provision of appropriate care and support to this group of children requires a whole of system response and is not solely the responsibility of Child and Adolescent Health Service (CAHS), PCH or the DoH. Although the inquiry focused on the response of PCH, many of the issues identified in the inquiry have, at times, been observed in other services providing treatment and support to children and youth.

We have received a comprehensive response to this inquiry, which demonstrates CAHS' commitment to addressing the issues raised through a range of initiatives designed to improve how treating and nursing teams work with families. We continue to work closely with them on the implementation of their intended actions, and on the system issues that impact this cohort of children and young people.

Reducing restrictive practices on medical wards

Youth Advocates spend a significant amount of time assisting children and young people admitted to medical wards for the treatment of eating disorders. In 2023-24, the majority were admitted to PCH (<16 years) and FSH (16-24 years).

The issues that are typically raised by children and young people admitted for the treatment of an eating disorder relate to:

- assertive clinical interventions such as nasogastric feeding, daily weighing, bladder scans and electrocardiograms
- one-to-one nursing, often at arm's length
- meal support
- the use of security guards and their conduct
- bodily and mechanical restraint
- attitudes and conduct of nursing, allied health, and medical staff.

Throughout the year, Youth Advocates worked constructively with ward staff to address issues as they arose. Their actions were supplemented by other advocacy measures including:

- routine meetings with senior nursing staff at FSH and PCH to address persistent and unresolved issues and to provide consumer feedback.
- education sessions for nursing staff and allied health about the role of Advocates and rights of consumers.
- advocates requesting and attending mediation sessions with young people and their families and facility staff.
- reviewing CCTV and security bodycam footage in the case of contentious incidents.
- advocacy for investment into staff education that includes input from people with lived experience of involuntary treatment for an eating disorder.

The impact of these strategies has been evidenced by a reduction in incidents resulting in complaints from children and young people being treated for eating disorders. Feedback from young people indicates improved experiences with ward and security staff following MHAS' input. Senior nursing staff have also provided feedback that the Youth Advocates' input and contributions have led to nursing practices becoming more consumer-focused.

Seeking improved complaint handling

Advocates always seek to resolve issues with the facility staff and management when they occur. However, some may result in a formal complaint by letter or email, or an inquiry being conducted. In 2023-24 Youth Advocates wrote nine complaint letters, two letters of concern, initiated eight inquiries and escalated one matter to the Health and Disability Complaints Office (HaDSCO).

Of the complaints made during this period, four of the responses received were inadequate, inaccurate or the tone of the response was not consumer-centric. In these cases, Advocates variously:

- attended mediation sessions with the child or young person, their family, and the lead clinician/s,
- attended stakeholder meetings on behalf of the family to address the concerns,
- escalated the concerns to executive staff of the relevant service via routine meetings.

These efforts resulted in:

- formal apologies from the service to the young person and their family
- changes to discharge and administrative processes at the service
- amendments to clinical documentation provided to the young person and their family
- improved complaint responses that are person-centred and feature recovery-focused language.

Advocacy for adults

The adult advocacy teams

Adults who are being treated involuntarily or are at risk of involuntary treatment can access advocacy from MHAS. This includes people aged 65 years and older, for whom there are specialist older adult mental health services (see next section). Adults and older adults make up the largest cohort of consumers that can access statutory advocacy.

There are four teams of Advocates aligned to the Health Service Providers (HSPs) in the North, South and East metropolitan areas and the WA Country Health Service (WACHS). There are Advocates in Albany, Bunbury, Kalgoorlie and Broome, who largely work with people admitted to the authorised hospitals in each of those locations. However, they also assist people on CTOs across the Kimberley, Pilbara, Goldfields, Wheatbelt, South West and Great Southern regions.

There are between 25 and 30 Advocates serving adults and older adults in authorised hospitals, EDs and other short-stay settings across the state, supervised by two Senior Advocates. Advocates bring with them varied qualifications and life experience, for example nursing, law, social work, psychology, forensics, teaching and policy writing. All have a knowledge of, and/or experience dealing with, mental health issues and contemporary concepts, and a strong commitment to human rights.

How adult Advocates work

In 2023-24 Advocates assisted 2933 adults and older adults receiving involuntary treatment[25]. This included 231 adults being treated in non-authorised (including general medical wards, EDs and intensive care units), and 780 adults treated in the community on CTOs. Advocates assisted 265 adults referred by an authorised mental health worker or medical practitioner for psychiatric examination.

Advocates deliver a model of pure advocacy when working with people 18 years and over. Within this model, Advocates act according to the consumer's instructions, amplify and/or represent the consumer's voice, and support consumers to exercise their rights, including at Mental Health Tribunal (MHT) Hearings.

Advocates work with facility staff to resolve issues at the facility level. When an Advocate is not able to resolve an issue at ward level, they escalate the matter to the Senior Advocate who is obliged to escalate the matter to the Chief Advocate if they are unable to reach a resolution with senior staff in the service. If a consumer wishes, the Advocate supports them to submit a complaint. If the issues raised indicate the likelihood of an adverse impact on the health, safety and wellbeing of identified persons, MHAS will undertake an investigation.

The following draws on key themes in our work in adult facilities this year and provides examples of the work undertaken by Advocates with adult consumers aged 18-64 years. Our work with older adult consumers is outlined in the following section of this report.

Holding services to account for use of restrictive practices

As in previous years, the use of restrictive practices on authorised wards and non-authorised areas such as EDs and medical wards was a concern raised by consumers. Responding to these concerns is an important part of MHAS' rights protection function and a means of holding services to account.

Advocates aim to assist consumers to raise and resolve their individual concerns while also promoting change at service and system levels that can either reduce the need for restrictive practices, lessen the traumatic impact on consumers or ensure compliance with the Act.

MHAS has successfully educated and shifted responses to consumer issues regarding safety and dignity during seclusion and restraint events, including:

- A consumer was assisted to lodge a complaint regarding a restraint. Bodycam footage was consulted, and staff were subsequently counselled about the use of inappropriate restraint techniques.
- An Advocate noticed visual observations during seclusions were solely being completed via live streaming equipment rather than in person. Practice changed following the Advocate raising this matter with staff.
- At one service, physical examinations after restraint and seclusion events appeared to only involve a doctor approaching the consumer and asking if they had any concerns. The Advocate queried if this was considered adequate to meet the requirements of the Act. Following this, examination for all consumers became more thorough and proactive.

25 The figures in this section relate to all people aged 18 years and over including those in the state's three youth units. It excludes 16-17 year olds in those units. It also excludes hostel residents who are counted elsewhere.

Advocate attendance at Service Executive Reviews

The Chief Psychiatrist's Standard, *Seclusion and Bodily Restraint Reduction*[26] requires services to hold a regular 'Service Executive Review' of all seclusion and restraint events, and to involve a person with lived experience in the review wherever possible. Advocates attend these reviews at some services, offering a different and independent perspective. Advocates can also strengthen the voices of lived experience representatives and, by doing so, promote their full participation.

As a result of Advocates attending Service Executive Reviews, the following outcomes have been noted:

- A more systematic deliberation of compliance, allowing broader perspectives to be considered. After attending a service where a pre-completed compliance checklist was provided, The Advocate asked that all legal paperwork be provided so it could be inspected together.
- At the request of the Advocate, a document designed to gather consumer feedback following a restraint or seclusion event was provided with the legal paperwork tabled at the meeting, ensuring the information contained within the document was fully considered during the review.
- In another service, a document was offered to consumers to gather their feedback but was often not completed. It was agreed that the Advocate would remind the consumer of their opportunity to complete the form and make their views known. Completion rates as well as the breadth of reflections offered appeared to increase as a result.

Use of security guards

Over the year MHAS has raised concerns in several facilities about the use of security guards during the provision of treatment and support to mental health consumers. Advocates communicate issues as consumers raise them and work with services to make improvements, escalating matters if resolution cannot be reached:

- A female consumer lodged a complaint regarding a restraint they felt was inappropriate and had occurred without due regard for their gender and culture. Following the complaint and subsequent escalation from MHAS, the service agreed to implement mandatory trauma informed care and cultural safety training for security guards, an outcome specifically requested by the consumer. MHAS provided feedback on the training module proposed which was welcomed by the service and incorporated.
- Following complaints regarding restraint practice on a medical ward the Advocate, nursing leadership and head of security worked together to address the issues raised. As a result, a consumer's previously experienced trauma can now be communicated to security guards prior to a restraint, and individualised de-escalation techniques utilised. Advocates report observing more person-centred and trauma-informed approaches from security guards at the facility.

[26] Chief Psychiatrist, (2015), Chief Psychiatrist's Standards for Clinical Care, Standard: Seclusion and Bodily Restraint Reduction.

Inquiry into restrictions on communication – visits by children

Consumers who are in hospital against their will have the right to freedom of lawful communication (s261 of the Act). They may see and speak to people in the hospital, have uncensored communications including visits, phone calls, email and other electronic communications, and it is expected that they will have reasonable privacy for their communications. The right to communication extends beyond family and friends to Advocates, legal practitioners and other people. In some circumstances a psychiatrist can place a restriction on communications on the grounds of safety, but this must be done in the best interests of the consumer (s262 of the Act).

in 2023-24 MHAS conducted a state-wide inquiry into communication restrictions focusing on consumer access to visits with children at authorised mental health facilities. The inquiry arose from concerns about blanket bans or limitations on visits by children at some facilities, which were inconsistent with the requirements of the Act, Office of the Chief Psychiatrist (OCP) Standards and the Charter of Mental Health Care Principles.

Initial findings were that three out of 19 facilities (16 per cent) appeared to have a blanket ban on children under 16 years visiting. Two further facilities had partial bans or limitations that imposed significant restrictions on consumer access to visits from children. In seven out of 19 facilities (37 per cent), there was no written policy or procedure for children under 16 years visiting.

The Chief Advocate reported these findings to the Chief Executive of each HSP, summarising the findings for facilities in their jurisdiction. In each case where arrangements limited, or may have limited, consumers' rights to visits by children, MHAS recommended the HSP take action to align policy and practice to the requirements of the legislation, Standards and/or Charter of Mental Health Principles.

From the HSP responses provided to date, MHAS understands that at one HSP a Mental Health Policy Working Group have developed a Mental Health Visitor Management Policy in response to the inquiry. Stakeholders included MHAS, Consumer and Carer Representatives, Lived Experience workforce and Aboriginal Mental Health Workforce. At another HSP, a Mental Health Visitors procedure has been reviewed and circulated.

Sexual safety

The Act expects consumers will be protected from harm, including abuse by other people receiving treatment or staff. In 2020 the OCP published Sexual Safety Guidelines for Health Services which define sexual safety as follows:

Sexual safety refers to being and feeling psychologically and physically safe, including being free of, and feeling safe from, behaviour of a sexual nature that is unwanted, or makes another person feel uncomfortable, afraid or unsafe. This includes sexual assault and harassment. It also extends to being spoken to using sexualised language or observing other people behaving in a sexually disinhibited manner, including nakedness and exposure or masturbation, being made to watch or shown pornographic images and lacking privacy and dignity when naked[27].

The following examples demonstrate how individual advocacy can contribute to safer environments:

- Following consumer complaints about the sexually disinhibited behaviour of another consumer on the ward and insufficient action from ward staff to address the situation, Advocates referred the matter to their Senior Advocate who formally escalated the issues to senior staff. This resulted in staff education on sexual safety and mandatory notifications of sexual safety incidents. Since this action, there has been a noticeable reduction in sexual safety incidents on the ward, and when sexual safety incidents do occur, there has been an improved response from ward staff including prompt completion of mandatory notifications.
- A consumer was distressed because staff didn't address her using her preferred personal pronouns, even though she had reminded them several times. The Advocate raised this issue with the nurse unit manager, highlighting the lack of regard being shown to the Charter of Mental Health Care principle six[28]. The nurse unit manager conducted a staff education session, and the consumer relayed to the Advocate that the issue had been resolved satisfactorily.

In addition to our individual advocacy to improve sexual safety, MHAS continued to advocate to the OCP for a sexual safety standard. The Chief Psychiatrist published a standard in July 2024. MHAS provided input into the draft.

Access to food and drink

Access to food and drink emerged as a recurrent issue at several facilities in 2023-24. They ranged from water taps only being turned on for limited periods, water only being available on request, no cups being provided, and no signage to indicate whether the water was potable, through to inadequate responses to cultural and religious dietary requirements and refusal to accommodate personal preferences regarding food.

Advocacy efforts to address these types of issues have resulted in:

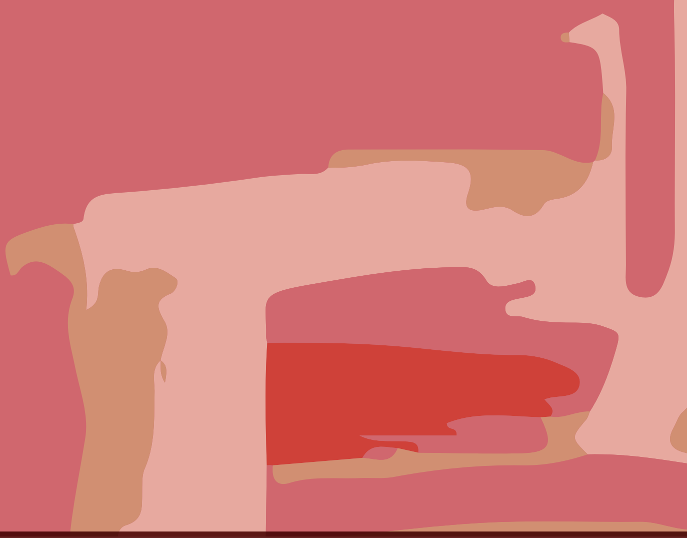
- cups being made available
- installation of signage, indicating water is drinkable
- a variety of solutions being put in place across various facilities to ensure consumers could access food outside of regular mealtimes if they missed a meal due to being asleep, feeling unwell, or being on ground access or leave
- the provision of meals that met the needs or preferences of people from diverse cultural backgrounds.

In one service, persistent advocacy over a three-year period, which involved the completion of two systemic inquiries, finally resulted in a fridge being installed on a ward so consumers could store food brought into hospital by family and friends.

[27] Chief Psychiatrist, Guidelines for the Sexual Safety of Consumers of Mental Health Services in WA, 2020, p. 16

[28] A mental health service must recognise, and be sensitive and responsive to, diverse individual circumstances, including those relating to gender, sexuality, age, family, disability, lifestyle choices and cultural and spiritual beliefs and practices.

Advocacy for older adults



The issues older adults face

When older adults need an involuntary mental health hospital admission, they may be admitted to one of two standalone facilities, the Ursula Frayne Unit at St John of God Hospital, Mount Lawley or Selby Lodge in Shenton Park. In addition, there are older adult wards in the mental health units at Midland, Armadale, Rockingham, Fremantle and Bentley hospitals and Joondalup Health Campus. Although MHAS does not run a specialised team, there are several Advocates who work predominantly with older adults and have developed interests, skills and expertise in providing assistance to this cohort.

In 2023-24, older adults asked Advocates to assist with issues related to being treated involuntarily, unwanted applications to the State Administrative Tribunal, and accommodation. Advocates are not always able to secure the outcome consumers want in these circumstances. However, the impact of having an Advocate walk alongside a consumer to ensure they are heard and informed is not to be underestimated, nor the impact this has on their sense of dignity, wellbeing and recovery. In these circumstances advocacy can reduce the traumatic impact of involuntary treatment by increasing engagement and autonomy.

As well as assisting people with these frequently raised issues, common themes emerge from reviewing Advocates' work over the past year where advocacy has been a driver in initiating and/or sustaining practice and service level change. The following examples demonstrate the impact that advocacy can have not just for the individual consumer but in terms of the way things are done by services.

Service shortages and accessing older adult beds

Community and inpatient services for older adults have not grown commensurate with the growth in the population aged 65 years and over. Older adults do not always get the help they need early when treatment in the community might be possible and this can result in an inpatient admission. However, due to the lack of older adult beds people aged over 65 years be left waiting for lengthy periods in Mental Health Observation Areas (MHOAs) and EDs, or on medical wards.

Multiple times during the year Advocates raised individual consumer concerns whilst the older adult was waiting for a mental health bed and advocated for prompt transfer. We have advocated at a system level for an increase in funding for older services because of the distressing impact that lengthy waits and delayed access to treatment have on older adults and their families.

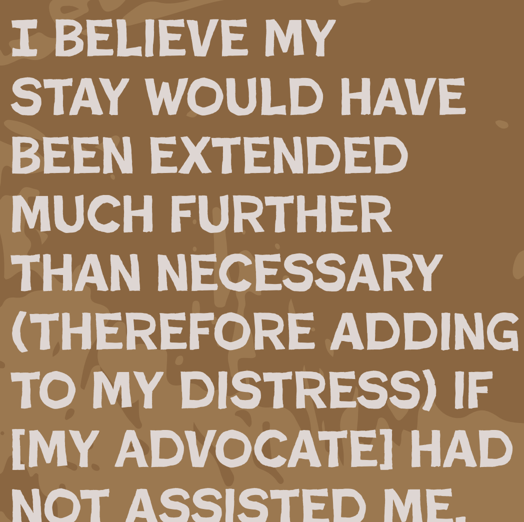
An example of MHAS' work in this area was assisting an older adult who had become very distressed whilst waiting on a medical ward for a mental health bed. The Senior Advocate liaised with the head of service about the individual's circumstances, including the older adult's concerns that the loud noises and need for security outside their door on the medical ward was adding to their experience of paranoia and distress. Through the Advocate's intervention, the older adult's perspective was included for consideration in the daily bed meeting at that service, and a mental health bed was offered shortly afterwards.

The right to dignity in treatment

Last year we reported on the lack of dignity and respect in the way that older adults can be treated, and unfortunately this is a theme that has continued into this year. However, there have been numerous times where Advocate involvement was effective in increasing the dignity experienced by older adults whilst they were in hospital. Advocates have worked constructively with facilities to change hygiene practices that did not meet needs and to resolve complaints about treatment that was experienced as undignified:

- Older adults at one ward had been refused incontinence pads and instead were only offered pull-up continence underwear. This did not suit everyone's needs and preferences and several consumers complained to their Advocate. The Advocate was able to arrange for pads to be made available so that consumers had a choice. In addition, staff were provided with education about restricting sanitary items.
- An offensive smell on an older adult ward was causing discomfort for consumers and staff alike. The Advocate and Senior Advocate worked with senior staff in the facility to understand and address the issue. As a result of MHAS' involvement, more incontinence pads were provided with greater frequency of changes, an improved cleaning regime was implemented, and room freshener was provided.

These are relatively simple issues to address and effective advocacy has contributed to a reduction in distress, better personal hygiene and related health benefits, and a pleasanter ward environment.



Getting physical health care in a mental health unit

Access to appropriate physical health care on mental health wards is a significant issue for older adults, as many have co-occurring needs and conditions. In the past year there were multiple times where good advocacy was an important driver of service and practice improvement.

In one facility a consumer who had been transferred from a medical ward had frequent falls and was supposed to be placed on a one-on-one nursing special. Advocacy at the ward level was eventually successful in getting the nursing special but only after further falls. MHAS initiated an inquiry into the delay in initiating safe nursing arrangements. The inquiry was one driver in a strong response from the service that included implementation of a daily falls huddle, risk reviews, environmental scan, surveillance, and precautions. The average monthly falls rate has halved following the introduction of these interventions.

Advocacy for forensic consumers

The Frankland Centre, a 30-bed facility on the Graylands Hospital site is the state's only dedicated forensic hospital for adults. On any given day it serves a total prison population of approximately 6,350 adult prisoners[29]. Prisoners may be admitted to hospital for examination on a Form 1A or a hospital order[30], and once assessed may remain in hospital under an involuntary order.

In addition to providing specialist inpatient treatment to acutely unwell prisoners, the Frankland Centre provides inpatient treatment for people on custody orders under the *Criminal Law (Mentally Impaired Accused) Act 1996*[31]. The high security beds at the Frankland Centre are complemented by 16 beds in the Dryandra Ward at Graylands Hospital for those who have leave provisions on their custody orders to form a pathway to transition to community[32].

MHAS has a dedicated team who support prisoners admitted to hospital and those on custody orders at the Frankland Centre and Graylands Hospital. In addition to experience working with people with a forensic history, the team has specialised knowledge of the legislation that interfaces with the Act.

Over the past year themes in our work included access to treatment pathway options and appropriate step-down services for forensic consumers, tackling unfair processes, and securing dignity in treatment. In each of these areas of work Advocates achieved good individual and service outcomes, illustrated following.

Securing treatment pathways for prisoners

Currently there are 31 people whose place of custody is an authorised hospital, currently either Graylands Hospital or the Frankland Centre (see table six, p.13 of this report). MHAS' own data indicates that 17 people on custody orders were detained to the Frankland Centre[33], leaving 13 beds available for the entire Western Australian prison population.

Accessing a bed for prisoners is very difficult and prisoners can wait for weeks and months before a bed becomes available so they can be admitted. One aspect of the access problem relates to the practice of placing very unwell prisoners (who were also refusing treatment) on a Form 1A and bringing them to the Frankland Centre for examination, and the subsequent use of a Form 6A revoked after a very short period once the prisoner has been treated involuntarily. MHAS' concerns relate to the use of involuntary treatment orders without full access to rights.

MHAS reviewed ICMS data on short admissions where prisoners were given a depot injection and discharged back to prison in less than a few hours. We raised concerns at routine meetings with Frankland Centre, the State Forensic Mental Health Service (SFMHS) and the North Metropolitan Health Service (NMHS) mental health executive. In addition, MHAS completed an inquiry into the treatment of one prisoner were there were apparent multiple breaches of rights and standards.

As a result of this advocacy the Frankland Centre changed their model to reserve a bed at the Frankland Centre to provide for longer examination admissions for prisoners who would formerly have been brought in and treated under a 'brief 6A'. The change has enabled better understanding and treatment of consumers' mental health prior to return to prison. Since the change to the model was made, MHAS has seen a vast reduction in the use of 'brief 6As'.

29 Department of Justice Annual Report 2022-23 p.26

30 A form of court order made when a magistrate or judge considers that the person may have a mental illness that is likely to impair their ability to take part in judicial proceedings.

31 The 1996 act was replaced in full on 1 September 2024 by the Criminal Law (Mental Impairment) Act 2023.

32 Data from MHAS' ICMS system, current at 30 June 2024.

33 Data from MHAS' ICMS system, current at 30 June 2024.

Equitable access for women on custody orders

Currently there are a further 14 people on custody orders detained to Graylands Hospital. All are men. These beds function as a 'step-down' pathway for people to whom the MIARB has granted leave of absence orders, or where the MIARB has ordered Graylands Hospital as the place of custody following application from the treating team on the basis that the person is fit to start transition to community.

As reported last year, this situation is inequitable and has been for some time. In 2018, Hutchison Ward at Graylands Hospital, which had single bedrooms and was therefore potentially suitable for mixed gender occupancy, was closed. Its occupants were moved to Murchison East Ward which had a mixture of dormitory and single bedrooms. The people on custody orders from Hutchison Ward were moved into the dormitories on the basis that shared accommodation was better suited to their higher level of functioning than they were for the existing consumers on the ward, who then took up the single rooms. Although there were no women on Hutchison Ward at the time it was closed, the decision to only use the dormitories for people on custody orders on Murchison East effectively curtailed the pathway for women on custody orders.

Following prolonged advocacy from MHAS for many years, during 2023-24 an allocation of beds for women has been made within the Dryandra Ward at Graylands Hospital, however this pathway remains closed because of delays in required works to security and privacy systems in the ward. MHAS has continued to advocate to SFMHS and NMHS executive on this matter, and understands works are in the pipeline[34].

MHAS continues to raise concerns about the lack of low security, forensic step-down beds for women including options that rely on operational solutions rather than the provision of dedicated beds. The situation has been inequitable for many years, and the impact on women on custody orders will increase with the anticipated rise in use of custody orders under the new legislation for people with mental impairment who are accused of offences.

34 As of the first week in August 2024, works have been completed but no women have been transferred because of ongoing safety concerns for placing sole women on the ward.

Tackling stigma and procedural fairness

Consumers report that the treatment and care they receive whilst at the Frankland Centre is largely and respectful and fair. However, there were occasions when this was not the case, and the Advocate was able to follow up. Advocates also raised concerns where treatment by external agencies appeared unfair or more restrictive than necessary. The individual advocacy outcomes have led to service improvements through education and policy development.

Some examples of this work include:

- A staff member accused a consumer of stealing before the facts had been fully explored. They were assisted by the Advocate to make a formal complaint. The service accepted the complaint and agreed to the consumer's request for staff education as well as an acknowledgment of the distress and stigma they had experienced.
- Staff allowed a consumer to attend an interview with the Victim Mediation Unit without warning and without first consulting with the treating psychiatrist. The consumer had no access to legal advice or support during the interview. They reported to the Advocate that this had a traumatic impact on them, and they raised concerns about signing documents without legal advice. Although there was only one instance of this in 2023-24, the complaint mirrors similar complaints from previous years, so MHAS undertook an inquiry. The service accepted the complaint. The Frankland Centre is now developing and implementing an external visitor policy incorporating MHAS recommendations which will safeguard the rights of forensic consumers.

Working with children in detention

In addition to the adult prison population there are, on any given day, an average of 94 children in youth detention[35].

MHAS is pleased to report that following the joint Ministerial round table led by the Minister for Mental Health, Minister Sanderson and attended by Minister for Corrective Services, Minister Papalia at the end of June 2023 where agreement was reached on the development of a pathway for admission for children from Banksia Hill Detention Centre and Unit 18 at Casuarina Prison, we have received few requests to provide advocacy to detained children. The establishment of a clear pathway for detainees aged 10-15 years and those aged 16-17 years appears to have reduced the need for Advocate intervention to secure access to an inpatient bed when required.

[MY ADVOCATE] MADE ME FEEL HEARD AND VALIDATED, AND THAT MY RIGHTS AND NEEDS WERE IMPORTANT.

CONSUMER

35 Department of Justice Annual Report 2022-23 p.26.

Advocacy for First Nations people

The Act provides additional rights for First Nations consumers that attempt to address aspects of the unique systems of belief that have sustained them for millennia. Sections 50, 81 and 189 seek to involve significant members of a consumer's community including Elders, cultural healers and Aboriginal and Torres Strait Islander mental health workers. However, these rights are only invoked to the extent that it is 'practicable and appropriate' to do so, where the final decision rests with the treating psychiatrist.

These are important rights but too often are impacted by lack of resourcing, capability and knowledge and inadequate policy and protocol. General system-wide compliance with the requirements of the Act remains poor and there continues to be insufficient investment in changes that would ensure a culturally secure and legally compliant response to First Nations people when they are treated or are at risk of being treated under the Act.

Concerningly, First Nations people are treated involuntarily at a higher rate than non-First Nations people. Data obtained from DoH identified 454 First Nations consumers who were treated under an involuntary order, equivalent to 9.7 per cent of all involuntary consumers[36]. In these circumstances it becomes more important that they can access the full range of rights under the Act.

"IT'S TRULY BEEN AMAZING WORKING WITH [MY ADVOCATE] AND HAVING HER SUPPORT ME THROUGH MANY CHANGES AND CHALLENGES."

RESIDENT

36 Based on ABS 2021 Census Data, 'Census of Population and Housing – Counts of Aboriginal and Torres Strait Islander Australians'.

Stronger relationships, stronger advocacy – Kaatadjiny Waalbraniny Danjoo

MHAS has invested in developing our own competence and confidence in working with First Nations consumers. In a partnership with the OCP and led by the Looking Forward team at Curtin University, we have been working with Elders and younger community members through the Kaatadjiny Walbraaniny Danjoo ('learning to heal together') project (KWD). Through the project we have developed strong relationships with community and strengthened our cultural understanding and confidence in working relationally with First Nations people.

The project concluded in June 2024 with an agreement with the Elders and younger community members to engage directly with MHAS to continue to embed cultural competency and community governance within the service, and to use this to improve outcomes for First Nations consumers.

Our growing confidence and competence are demonstrated through our individual advocacy with First Nations consumers, illustrated through the following examples:

- Successfully advocated for a 17 year old First Nations consumer from regional WA to access cultural healing on their own country prior to an involuntary admission in a mental health unit in Perth. This was achieved by the MHAS' Aboriginal Mental Health Advocate and the Senior Youth Advocate who worked with the family to understand what their preferences were, and advocacy to the service to help them understand the importance of the cultural protocols and then respond to the family's wishes.
- The family of a First Nations child admitted to a mental health unit in Perth had been considering relinquishing care to Child Protection Services because they did not feel ready to take their child back home. The Advocate provided support to the child and family, resulting in comprehensive discharge planning, community supports and enough time for the family to feel confident that they could safely care for their child at home.
- The Advocate was aware that an adult consumer had a loving relationship with their father but had not been supported to maintain this during an extended admission. Following advocacy over a long period of time, the father was included in discussions and meetings, had visits and accompanied the consumer on escorted ground access leave at first with staff escorts, but later just with the consumer. Staff observed the love and care that father and son had for each other and heard them say 'I love you' to each other.
- A Noongar consumer on a long admission had not engaged much with their peers. The Advocate spoke to them about learning their language and brought in a children's Noongar vocabulary book. This created interest amongst other people on the ward and they sat together and learned Noongar words from the Noongar consumer.

In each of these cases the advocacy was effective because the Advocate spent time building a relationship with the consumer, their family and others whom the consumer and family wanted to be involved and because of the respect paid by the Advocates to culture. Enhanced confidence in understanding the importance of the relationships for the consumer and the cultural values and protocols also contributed in each case.

Continuing our advocacy on the 2019 inquiry into First Nations' people's rights

For five years MHAS has been reporting on the progress against recommendations made in the inquiry into the rights of First Nations people under the Act undertaken in 2019-20. Despite broad agreement from the MHC and DoH with the 15 recommendations, progress has been slow. The current Chief Advocate and her predecessor each followed up regularly to try to hasten progress against the recommendations.

DoH were charged with progressing the action plan for the recommendations. A progress report was provided in February 2023 (reported last year) and a second in June 2023. Following that, reports were suspended because little progress was visible between quarters.

In February 2024 MHAS undertook an audit of observed actions in mental health services and found clear disparities between what HSPs had reported to DoH and what Advocates were reporting on the ground. MHAS is not suggesting that HSPs were providing incorrect data. It is more likely that the systems for reporting within HSPs were not sufficiently attuned enough to identify service level activities.

Key themes identified in the audit where there were apparent failures in systems and resources to uphold First Nations' people's rights were:

- Access to Aboriginal Mental Health Workers.
- Involvement of family, community members and access to cultural healing.
- Access to appropriate cultural supports, where treatment was given off country for the consumer or access to gender specific workers not being available.
- Lack of overall understanding of cultural needs and how to respond to these, including existing available services, by healthcare professionals.

MHAS provided the findings from the audit to the Mental Health Branch of DoH, and then met to discuss these in June this year. MHAS will continue to liaise with the Joint Leadership Group of the MHC and DoH to ensure that the accepted recommendations are implemented.

Despite the disappointing overall picture, there were some good supports reported by Advocates in cultural competency and associated positive outcomes. Mental health services at Fremantle, Armadale and Broome Hospitals all currently have some good practices. Rockingham Hospital has several strategies to recruit and retain First Nations staff, including training, Aboriginal Champions and improved cultural supports.

In each of these cases strong leadership has played a part in improvement, and as such is vulnerable to personnel moving on and initiatives languishing. The same is true for MHAS' KWD project, and in the coming years we will focus on how to embed gains into our systems, policies and procedures so they become part of how we do things.

Advocacy for consumers at the Mental Health Tribunal

Access to independent review by the MHT is an important right of consumers subject to an involuntary order under the Act. MHAS assisted consumers to express their views and exercise their rights at hearings and worked with the MHT to improve consumer experience and outcomes. Advocates assisted consumers to exercise rights to have involuntary orders and restrictions reviewed by the MHT.

WITH [MY ADVOCATE] IN THE MEETINGS PROMISES HAVEN'T BEEN GIVEN AND THEN TAKEN AWAY- THERE HAS BEEN A MARKED DIFFERENCE IN MY TREATMENT.

CONSUMER

TABLE TEN - Representation at Mental Health Tribunal hearings[37]

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Number of hearings listed	3,446	3,618	4,253	4,007	3,908	4,118	4,550
Number of hearings conducted	2,247	2,320	2,627	2,659	2,742	2,557	2,841
MHAS hearing attendance[38]	-	-	-	-	-	-	1,188
Percentage of hearings attended by MHAS	34.0%	36.0%	40.0%	40.0%	43.5%	41.0%	41.8%
Percentage of hearings attended by the MHLC	9.0%	9.0%	8.0%	11.0%	10.0%	9.0%	8.9%

How Advocates support consumers at hearings

In some instances, consumers on involuntary inpatient orders were discharged to treatment in the community, either on a voluntary basis or with a CTO as a less restrictive option, following Advocate assistance at MHT hearings. As well as assisting the consumer to express their wishes, the Advocate can point out protective factors such as community services and family support.

On one occasion, an application was made to the MHT to review imposed communication restrictions. After receiving the application, the service immediately reduced the restrictions, allowing some daily phone and computer access. The consumer was pleased to have the restrictions reduced and expressed that this made the hospital admission more tolerable.

Collaborating with the Tribunal to resolve consumer complaints

MHAS and the MHT have worked to build a positive relationship, with both parties seeking solutions to issues that arise. This year the MHT President and Registrar attended new Advocate induction training, just as in the past the Chief Advocate and a Senior Advocate have participated in the training of new MHT Members. The involvement of senior officers from the MHT was greatly appreciated.

There were delays in access to hearings for some consumers during the reporting period. MHAS assisted consumers who wanted to lodge a complaint that their hearings were listed outside the statutory timeframe. In response to some consumers, the MHT reviewed listing procedures and implemented a stricter prioritisation process to prevent or minimise delays.

37 Data is based on information published in the Mental Health Tribunal's annual reports from 2017 onwards.

38 Data provided by Mental Health Tribunal.

Advocacy for hostel residents

Licensed psychiatric hostels

People living in a private psychiatric hostel as defined in the *Private Hospitals and Health Services Act 1927* and licensed by LARU have the right to access an Advocate. Hostel residents generally experience co-occurring physical and mental health issues, disability, social isolation and regular hospital admissions. They are a marginalised and disadvantaged cohort of people whose voices are often overlooked.

Around half of the total cohort of approximately 700 hostel residents live in older buildings with shared bathroom facilities and sometimes shared bedrooms. Safety issues are rife, the care provided is minimal and Advocates report frequent breaches of people's dignity, humanity and rights. Although the infrastructure and supports provided are regulated by LARU it is arguable that these would not meet community expectations for the care of people experiencing multiple disadvantages. Transition to contemporary approaches for people with psychosocial disability has been slow, and a strategy for reform remains elusive. As well as the impact on current residents, this is a lost opportunity to create a pathway to outcomes for a better life for future cohorts of people with psychosocial disability who need accommodation and support.

As the state embarks on this transition, advocacy is an essential safeguard to ensure people can access their rights, are treated with dignity and humanity and their health, safety and wellbeing needs are attended to – including in newer, purpose-built environments.

Advocacy services for hostel residents

In addition to being a marginalised cohort, many hostel residents do not have their own phones or have limited access to uncensored communications. To help ensure people can access advocacy, MHAS has proactively visited hostels since January 2022 as part of the Enhanced Hostels Visiting Program funded by the MHC. A dedicated team of up to three hostel Advocates provides a service to the people who live in psychiatric hostels, although for much of the year the team ran at only two Advocates.

In 2023-24:

- Advocates assisted 391 hostel residents, of whom 121 were new to MHAS, up from 349 residents in 2022-23.
- There were 362 requests for contact to the MHAS liaison service from 114 people.
- Advocates made 4760 contacts with hostel residents, and recorded 1490 issues, up from 1076 issues in 2022-23.
- The five most reported issues were physical health (146), accommodation (122), NDIS (101), financial issues (82) and safety (69).
- There were 66 serious issues, most resulting in written complaints and inquiries including two that culminated in external investigations.
- The average length of time taken to resolve serious issues was 39 days.
- Advocates addressed 125 facility issues. The most common issues were raised at multiple facilities and were indoor furnishings (20), safety (13), food and beverages (10), and temperature (10).
- Most facility issues were addressed on site by staff, although some were escalated to management and required multiple meetings to resolve. In a small number of instances matters were escalated to the regulatory bodies (LARU and OCP) or the MHC.
- MHAS interventions resulted in furniture replacement, long standing bathroom mould issues being addressed, and improved staff-to-resident communications.

Hostel advocacy focuses on ensuring that people get timely and comprehensive access to the services they need and are treated with dignity and humanity.

Following are some examples of how Advocates have worked to secure better outcomes for hostel residents across the most commonly occurring issues.

The right to treatment and care for physical health issues

Many of the residents in the older, institutional-style hostels are ageing. Poor physical health is a risk factor resulting in falls and hospital and intensive care admissions. Poor physical health impacts residents' quality of life and if unattended to may contribute to early death.

Many issues that residents raise, and Advocates resolve on site, contribute to poor physical health including food quality, cleanliness and hygiene (environment and personal), crowding and low staff/consumer ratios, mental health medications and financial issues.

Over the past year advocacy has focused on:

- Regular visits by advocates so that issues are noted and addressed.
- Establishing and maintaining relationships with hostel staff, mental health clinics, visiting doctors and NDIS providers. Through these relationships Advocates follow up on issues and ensure matters are addressed in a timely manner with a whole of systems approach.
- Advocating for access to medical services.
- Following up when a resident is admitted to hospital (most hostel managers do not advise MHAS when residents are admitted to hospital, so MHAS has implemented measures with hospitals to ensure that hostel residents admitted voluntarily are visited by an Advocate).
- Advocating to hospitals to ensure issues, including physical health, are adequately addressed before discharge.
- Encouraging staff to arrange follow up appointments for residents and assist with transport.
- Advocating for changes to contributing factors noted above.

Securing a preferred place to live

Some residents want to explore alternative accommodation options but are often afraid to risk current accommodation so do not voice their preferences to service providers. A combination of conditions and staffing often contribute to the desire to move; for instance, overcrowding, shared facilities, conflicts between residents, unsafe buildings (stairs without handrails, mould, showers without anti-slip mats), threats of eviction and gatekeeping accommodation from suitable candidates.

Over the past year advocacy has focused on:

- Liaison with NDIS support workers to explore accommodation options with residents independently of hostel staff.
- Monitoring vacancies at all hostels and facilitating access to alternative accommodation when a resident wants to move.
- Liaison with hostel staff and management to arrange aged care assessments when moves to nursing homes were requested.
- Writing support letters to alternative providers including Department of Housing.
- Raising apparent unsafe building issues with LARU, resulting in some unannounced visits and subsequent improvements.
- Preventing people from being evicted without due process being followed, and ensuring that when people are evicted they have somewhere else to live.

Being safe at home

Safety issues range from environmental conditions (shared bathrooms, doors without locks, lack of lockable storage for possessions) to the interpersonal (sexual safety, drug dealing on site and sharing needles, conflict between residents, treatment and communication from staff that leave residents feeling unsafe and/or contribute to a decline in their mental health).

Over the past year advocacy has focused on:

- Collaboration with treating teams to support residents to access rehabilitation services for alcohol and drug dependency.
- Meeting with service managers to address drug use and ways of maintaining safety for residents.
- Sexual safety, including raising complaints at several hostels and advocating for training to improve staff and residents' understanding of what constitutes sexual safety. As a result, one of the larger congregate care hostels undertook a sexual safety workshop on consent run by an external provider for seventy residents and staff.
- A major inquiry into sexual safety at a hostel which led to changes in reporting and notification processes, and substantial investment by the licensee in training for staff on sexual safety. MHAS considers that the hostel now has strong provisions to safeguard the sexual safety of residents.
- Advocating for posters in communal areas of hostels reminding residents about sexual and physical safety rights and responsibilities.
- Addressing the need for lockable doors and cupboards, including undertaking an inquiry in a hostel where repeated requests to address these matters failed to achieve change.
- Raising low staff to resident ratios in several hostels with LARU, now addressed. Four hostels where residents had reported not feeling safe, especially at night, now have higher staff ratios as per the required standards.

Preventing unplanned evictions whilst at hospital

In October 2022 the Chief Advocate inquired into the unplanned eviction of a hostel resident whilst they were attending ED following a suicide attempt. The inquiry asked questions of the hostel licensee and the HSP providing both community mental health services and the emergency response. Unable to satisfactorily resolve the inquiry, in October 2023 the Chief Advocate prepared a report on the matter to the Director General, Department of Health and the Mental Health Commissioner. In their response, received in May 2024, the Director General and Commissioner advised that the MHC would, in the coming six months, vary its service agreements with HSPs and private psychiatric hostel licensees to include a requirement that the parties develop agreements to govern communication, collaboration and escalation, and a process put in place to address potential failed accommodation placements.

The Chief Advocate welcomes this requirement, and considers the matters raised in the original inquiry settled.

MHAS also made changes to its own practices when a hostel resident attends or is admitted to hospital. Because hostel residents are classed as voluntary patients unless otherwise admitted, MHAS is not notified when someone attends or is admitted to hospital. We asked every mental health service to identify admitted hostel residents and reminded hostels to let the Advocate know if a resident was going to hospital. Hostel advocates have been vigilant in following up hostel residents who are admitted voluntarily or who are attending ED.

Since this new system has been in place we are not aware of a single eviction during the course of an admission to or presentation at hospital.

Advocating for financial wellbeing

Hostels can charge up to 87.5 per cent of a resident's base pension, leaving very little disposable income. Residents may also have their finances managed by a guardian or the Public Trustee. Income poverty combined with a loss of control over finances can have a marked negative impact on people's mental health and wellbeing.

During the past year Advocates have secured 'wins' for residents including:

- Helping residents get access to their money from the Public Trust, including access to superannuation.
- Pharmacies providing cheaper brands of medication.
- Community mental health clinics providing vouchers for certain medications.
- Hostel licensees providing residents clothing and toiletries in line with the LARU standards.
- Helping residents get regular access to their financial statements from hostels (following residents' complaints that they did not know how their money was received and disbursed).
- Sourcing itemised statements from Trust Managers for some residents.

Resident rights and standards

In May 2024 and in response to evidence of breaches of standards and resident rights from Advocates attending one hostel, the Chief Advocate wrote to the Chief Psychiatrist, LARU and MHC to raise her concerns about the immediate risks to the health, safety and wellbeing of residents, and associated risks to government as regulator of the hostel program and funder of supports to residents. The Chief Advocate called the hostel accountability agencies to an urgent meeting, and it was agreed that LARU would undertake a no-notice inspection promptly.

The inspection report did not find any breaches, nevertheless Advocates continue to report apparent breaches, supported by photographic evidence of poor cleanliness and inadequate food. It is the Chief Advocate's view that the differing methods of inquiry and inspection available to each agency had a bearing on the outcome of the inspection. She remains concerned about the health, safety and wellbeing of residents at the hostel and does not consider the matter resolved. MHAS will continue to monitor, investigate and inquire.

Resourcing, service development and disclosures

Budget and expenditure

In 2023-24 the total allocated budget for MHAS was $5,740,000 which comprised:

- $4,380,228 under direct control of the Chief Advocate for statutory advocacy services.
- $477,772 (8.3 per cent of the total budget covering the cost of corporate services provided by the MHC.)
- $882,000 for planning and policy development activities to prepare for implementation of the *Criminal Law (Mental Impairment) Act 2023* (CLMI).

Excluding the funding and expenditure relating to the CLMI Bill implementation, the allocated budget for MHAS statutory advocacy services and corporate support services from the MHC in 2023-24 was $4,858,000. MHAS worked to the best of its ability to operate within this budget, however, due to several factors, expenditure in 2023-24 was $5,303,723, which was $445,723 (9 per cent) over budget[1].

In 2023-24, MHAS incurred costs of $354,985 relating to the implementation of the CLMI, resulting in an underspend of $527,015 against the project. This underspend is largely attributed to the commencement of the CLMI being delayed by two months to 1 September 2024.

The total expenditure for MHAS in 2023-24 (including CLMI), was $5,658,708, which was $81,292 under budget.

> I FEEL LIKE [MY ADVOCATE] JUST DOES THINGS BECAUSE HE IS A GOOD HUMAN AND HAS A GOOD HEART AND WOULDN'T EXPECT IT SO DESERVES ALL THE GOODNESS IN THE WORLD FROM THE UNIVERSE.
>
> CONSUMER

TABLE ELEVEN - MHAS allocated budget and expenditure 2019-20 to 2023-24[39]

	2019-20	2020-21	2021-22	2022-23	2023-24
Expenditure	$3,017,802	$3,095,685	$4,129,100	$4,810,557	$5,303,723
Budget	$2,719,000	$2,858,000	$4,060,000	$4,294,000	$4,858,000

TABLE TWELVE - Cost of resources received free of charge in 2023-24

Agency	Resources received free of charge	Amount
Mental Health Commission	Corporate support services	$477,772
State Solicitor's Office	Legal services	$6,697
Department of Finance	Leasing services	$13,328
TOTAL		**$497,797**

The cost of advocacy services, including payments to the Chief Advocate, Senior Advocates, Team Leaders and Advocates comprised 68 per cent of MHAS expenditure in 2023-24. Employment costs for advocacy support service staff (including agency staff and payroll services for Advocates) comprised a further 17 per cent of the total expenditure. Other goods and services accounted for 6 per cent of MHAS expenditure. This included costs such as building lease, telephone, printing, and fleet vehicle expenses. The remainder of MHAS costs (9 per cent) were contributed to corporate support services provided by the MHC.

39 This excludes funding provided for CLMI implementation.

Human resources

Advocacy Service

In 2023-24 the total number of Advocate hours undertaken was 39,175 representing a 3.2 per cent increase compared to the 37,959 Advocate hours undertaken in 2022-23.

As at 30 June 2024, the Advocacy service comprised:

- The Chief Mental Health Advocate
- Deputy Chief Mental Health Advocate
- Seven Senior Advocates (three Senior Advocates temporarily engaged for discrete periods/projects to implement CLMI reforms).
- Three part-time Team Leaders (not continuing in 2024-25).
- Forty-two Advocates comprising:
    - Twenty-two general Advocates operating in the Perth metropolitan area
    - Six Advocates operating in regional Western Australia (Broome, Kalgoorlie, Bunbury and Albany)
    - One Advocate providing a weekend phone service;
    - Five youth Advocates
    - Four hostel Advocates, and
    - Four Advocates on contract but unavailable.

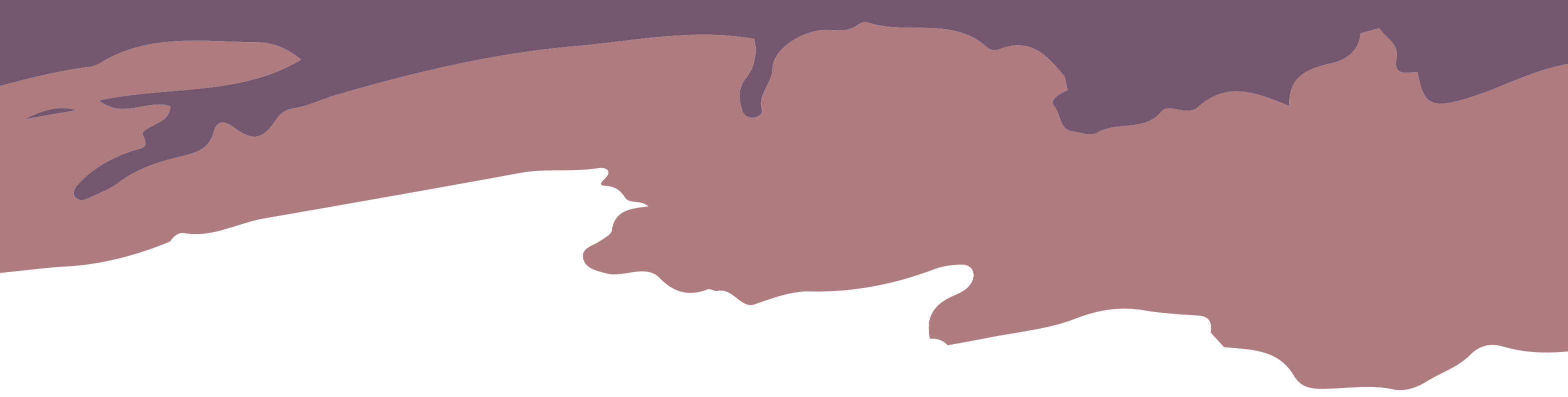
Three part-time (15 hours per week) Team Leader positions operated as a trial for 18 months from January 2023 until 30 June 2024. The positions provided support to the Senior Advocates with some of the day-to-day coordination of Advocates, allowing the Senior Advocates more time to focus on statutory functions, such as inquiries, investigations, and serious issues. The trial of the Team Leader positions concluded on 30 June 2024, the continuation of these positions is being considered within the review of the Advocacy Service.

Remuneration

Advocates (including the Chief Advocate, Deputy Chief Advocate, Senior Advocates and Team Leaders) are entitled to remuneration as determined by the Minister for Mental Health. The Chief Advocate's remuneration is determined by the Minster, on the recommendation of the Public Sector Commissioner.

Advocates are paid an hourly rate plus superannuation and any milage claimed and have no entitlement to paid leave. Advocates supply their own vehicle and mobile phone, while laptops are provided to maintain security of information.

In 2023-24 MHAS continued to work on its Advocate Payment and Availability Protocol to reduce unnecessary burden and improve equity amongst Advocates.



Recruitment and induction of new Advocates

As per the Act, Advocates are engaged on a contract for services for a period not exceeding three years, which can be renewed by mutual agreement. Whilst engaged on a contract, Advocates can declare themselves unavailable for work for a fixed period or resign from the position. Upon resignation, Advocates' contracts are terminated. The Chief Advocate can also terminate an Advocate's contract in the case of mental or physical incapacity, incompetence, neglect of duty or misconduct.

During 2023-24, ten Advocates resigned, or their engagement ceased, and seventeen new Advocates were engaged. Throughout the year, there were four Advocates that were not available for extended periods.

Before commencing, new Advocates complete an intensive in-house induction, participate in observation days at mental health facilities and complete the MHC's clinicians' e-learning module. Additionally, new Advocates are mentored by experienced Advocates for several weeks where they participate in a variety of key advocacy tasks including attending Tribunal hearings. Once new Advocates have completed their training and assessed as competent, they work alone with consumers under the general guidance of their Senior Advocate.

In 2023-24, MHAS amended its induction program to incorporate storying sessions with local Aboriginal Elders on the first day of the Advocate induction process. The ongoing relationship with the Aboriginal community has improved MHAS' cultural competency as well as the knowledge and confidence of Advocates when working with First Nation's peoples. This has resulted in better advocacy outcomes for First Nation's consumers.

Advocate training, development and support

Advocates are on a regular basis, often multiple times a day, exposed to traumatic situations and/or information. This may include exposure to frequent and/or serious incidents of self-harm, disclosures of abuse, consumers with very high levels of distress associated with, for instance, eating disorders, past trauma, assaults and sexual assaults within mental health facilities, death of consumers through suicide or misadventure and coronial inquests.

The Chief Advocate is committed to improving Advocate safety and retention by focusing on improving Advocate support. In 2023-24, MHAS engaged an external consultant (Converge International) to undertake a trial of supervised peer reflective practice sessions for Advocates. The introduction of supervised peer reflective practice sessions provides an opportunity for Advocates to come together with their peers to discuss common issues relating to their work in a safe and supported way.

Advocates also participated in a regular meeting called the 'Kookaburra Call', where the Chief Advocate provided important information to Advocates and staff and sought input on practice and organisational matters. Additionally, Advocates attended regular team meetings.

Review of MHAS structure

During 2023-24, MHAS commissioned a HR consultant (NEXUS Network) to undertake a functional review of its structure. The review was undertaken in two parts, with the first focusing on the Advocacy Support Service, and the second focusing directly on the Advocacy Service.

The review of the Advocacy Support Service found that MHAS is significantly under resourced, and without significant additional resourcing, MHAS would struggle to meet its statutory responsibilities, especially with the expansion into CLMI.

The review made several recommendations to address the resourcing issues, including a proposed structure. Whilst most of these recommendations are scheduled to be implemented from 2024-25, the following changes were implemented during 2023-24:

- Establishment of the Deputy Chief Mental Health Advocate position; and
- Establishment of a fixed-term General Counsel position to assist with the implementation of CLMI.

Advocacy Support Service

Public Service officers are appointed to assist the Chief Advocate to perform functions under the Act. The Advocacy Support Service comprises a small team that undertakes a variety of policy, executive support, data management, system support, administration support and consumer liaison functions.

The number of full time equivalent (FTE) advocacy support services staff has increased to 8.1 FTE, not including the CLMI positions. The increased FTE relates to an additional consumer liaison position, which is a service delivery brought on to manage the increased workload through CLMI. MHAS continues to experience resourcing pressures and relied heavily on temporary agency staff and fixed term contracts to fill positions in 2023-24.

The current level of support staff does not align to the needs of the organisation, impacting on multiple functions not being performed to the required standard or within the expected timeframes. Additional resources are required to ensure better efficiency, alleviating the Chief Advocate and other senior staff from being involved in unnecessary matters.

In 2023-24, MHC engaged a financial consultant (2020 Global) to assist MHAS to better understand its actual cost drivers and improve financial planning, resource management and decision-making. The review found, that whilst demand for mental health advocacy has grown at a considerable rate, funding for MHAS services has not increased to the same level. It also found that MHAS is operating in scope and has followed its functions as defined by the various MHAS legislation.

Service development

Quarterly Reporting

In 2023-24, MHAS expanded its quarterly reporting process to incorporate a summary report provided to each of the HSP Chief Executives as well as the Minister for Mental Health and the Mental Health Commissioner. Feedback received to date has indicated that this information provides senior staff with an oversight of services' responses to consumer issues, complaints and enquiries. MHAS continues to refine and improve this practice.

Review of Business Systems

To date, MHAS has been unable to take advantage of contemporary technology to support its mobile and dispersed Advocate workforce. In 2023-24, MHAS engaged an IT consultant (8 Squad) to undertake an end-to-end review of its digital capabilities. The review focused on digital solutions to better equip Advocates with contemporary communication infrastructure, improve website functionality and accessibility, and better integration of the client management system. Recommendations from the review will be used to develop an investment business case.

Client Management System upgrade and migration

In 2023-24, MHAS migrated its client management system from an unsupported 2013 Microsoft Dynamic Customer Relationship Management software to a contemporary Microsoft Dynamic 365 Cloud based platform. The update has improved data security and system functionality in preparation for a system expansion to accommodate CLMI, as well as vastly improving reporting capabilities which will assist MHAS to develop new insights into its business operations.

'CLMI' - a new advocacy service for mentally impaired accused people

MHAS has been working on the development of a new service in response to the reforms to the legislation for people accused of a crime where the question of fitness to plead has been raised. Under CLMI this cohort of people will, for the first time, have the right to access advocacy from the point at which fitness is raised to the time when supervised person's orders are discharged, a major development in human rights for Western Australians.

With the commencement of CLMI confirmed for 1 September 2024, MHAS put in place a project team to undertake development work and ensure operational readiness. Over the 2023-24 year its work included the development of:

- resources for CLMI identified persons and their families and supporters
- training materials for Advocates who will be working with the new cohort
- communications supports to assist Advocates working with people with diverse communication needs
- new and revised protocols and guidelines to govern Advocate practice.

The team of CLMI Advocates will be working in new environments including prison and adult community corrections, youth detention and court systems, interfacing with new services, as well as working with a different cohort of consumers (people with intellectual disability regardless of whether mental illness is present). The intention of the new advocacy service is to ensure that the voices of people in the CLMI system are heard, that they receive procedural fairness, and are reintegrated into the community as soon as feasible in a safe manner, in line with the principles and intent of the CLMI Act.

Pre-implementation work has highlighted several concerns in relation to the right for CLMI identified people to access advocacy services. These include the uncertainty about the number of people who will be entitled to advocacy and the ability to meet demand, the practicalities of ensuring timely provision of statutory notifications from the courts and prisons to MHAS, and the adequacy of resourcing for all CLMI agencies to meet the requirements of the new legislation. In response, the Chief Advocate and other members of the CLMI team have raised these concerns with relevant parties. Some contingencies have been built into implementation to ensure the best chance of meeting demand in a timely manner.

MHAS is pleased to launch its new service in September 2024 and to be collaborating with new government and non-government partners with the shared aim of improving the experiences of those with mental impairment in the criminal justice system.

Disclosures

Records management reporting

In accordance with section 19 of the *State Records Act 2000*, MHAS maintains a record keeping plan which governs the management of its records. The plan required MHAS to finalise its record-keeping procedures manual and classification system, which was completed in 2018.

Record Keeping Plans are required to be reviewed within five years of being approved. MHAS reviewed its Record Keeping Plan in August 2023. As MHAS is anticipating changes to the service in the next couple of years it has been recommended that MHAS review its Record Keeping Plan within two years.

Freedom of Information Disclosures

In 2023-24, MHAS received three Freedom of Information Requests pertaining to personal records.

Electoral Act requirements

As required under the *Electoral Act 1907*, section 175ZE (1), MHAS recorded $4042.50 in expenditure related to the designated organisation types between 1 July 2023 and 30 June 2024, which is broken down as follows:

- Advertising agencies: Bigwig Advertising Pty Ltd $4042.50 (Graphic design of Annual Report)
- Media advertising organisations: Nil
- Market research organisations: Nil
- Polling organisations: Nil
- Direct mail organisations: Nil

Complaints

In 2022-23, MHAS received five complaints about our service, each of which was handled according to the MHAS complaints protocol. All complaints have been resolved, and none remain in process. The complaints process is published on the MHAS website. All five complaints relate to Advocacy services and no complaints relate to Advocacy support services.

MHAS breaches of the Act

The Act requires Advocates to contact consumers within seven days of an involuntary treatment order being made for an adult, and within 24 hours of an order being made for a child. Consumers were contacted by an Advocate within the statutory timeframes for 95.0 per cent of involuntary treatment orders. This is a very slight improvement compared to 2022-23 when 94.6 per cent of consumers were contacted within the statutory period.

The most common reason for a breach was due to the order being revoked or a subsequent order made within that timeframe (71.4 per cent of all breaches). In addition, 16.7 per cent of breaches (up from 13.5 per cent in 2022-23) were due to orders being revoked within two days. Revocations within a few days of an order being made are a concern; they raise questions whether a Form 3C should have been used to enable further examination by a psychiatrist with the possible outcome of avoiding the need for an involuntary order.

Contact was achieved within statutory timeframes for 94.5 per cent of children (173 out of 183 orders). This is an improvement on the previous year when 91.8 per cent of children were contacted in time (178 out of 194 orders). Six out of the ten total breaches occurred as a result of orders either being revoked within 24hrs, or where the HSP did not notify MHAS within two hours (as agreed), or within 24 hours of the order being made.

Ministerial directions

The Minister for Mental Health may issue written directions to the Chief Advocate about 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 2023-24 no directions were issued, nor did the Chief Advocate request directions.

Similarly, the Minister for Mental Health may request the Chief Advocate report on the provision of care by a mental health service or ensure that a service is visited (see s355 of the Act). There were no directions issued during 2023-24.

Committees, submissions and presentations

Committees, reference and working groups management reporting

The Chief Advocate, or nominated proxy, was a member on the following committees in 2023-24:

- Psychiatric Hostels Agencies Committee
- Criminal Law Mental Impairment Implementation Steering Committee
- Criminal Law Mental Impairment Transitional Provisions Steering Committee
- Mental Health Act Compliance Steering Group
- Community Treatment and Emergency Response Project Reference Group
- Developing a Statement of Intent on Use of Restrictive Practices in WA Health Services Reference Group
- The Mental Health Act 2014 Compliance Steering Group
- Restrictive Practices Mandatory Policy Advisory Group
- Criminal Law Mental Impairment Mental Health Agencies Implementation Group
- Working Group for the new National Safety and quality Mental Health Standards for Community Managed Organisations
- Secure Rehabilitation and Recovery Model of Care Working Group
- Perth Children's Hospital Ward 5A Refurbishment Project Working Group
- Use of Restrictive Practices in Non-Authorised Healthcare Settings Policy Advisory Group
- Training Content – Use of Detention and Restraint in Non-Authorised Healthcare Settings Working Group

Presentations and education sessions to external parties

The Chief Advocate and Senior Advocates regularly give presentation to facility staff and other stakeholders on the role of MHAS and consumer rights. The presentations are an important means of helping to protect consumers' rights and improving understanding of the role of MHAS. In 2023-24, MHAS provided the following education session to external parties:

- The MHS conference presentation on rights and accountability
- Role of MHAS and systemic advocacy services, presentation to new Mental Health Tribunal Members
- Role of MHAS and the work of Advocates, Aboriginal Legal Service
- Role and functions of MHAS, presentation to the Child and Adolescent Health Service Board
- A Practical Guide to the New System for Criminal Law Mentally Impaired Accused for Legal Aid's CPD Summer Series for Barristers
- Navigating Complexity Symposium: Advancing realistic solutions, introductory address
- Working with services to promote safety and quality improvement, WACHS
- MHAS and consumer rights under the MHA – psychiatry registrar trainee program
- Education sessions on the role and functions of MHAS at Bentley Hospital, Albany Hospital, Cockburn Clinic, PCH, Graylands Hospital, Sir Charles Gairdner Hospital

Submissions

- Preliminary feedback - Statutory Review of the *Health and Disability Services (Complaints) Act 1995*, and Part 6 of the *Disability Services Act 1993*.

I WAS IMPRESSED BY YOUR ADVOCACY FOR THE CLIENTS AND FAMILY. I HAD SOMEONE TO DISCUSS MATTERS WHEN I WAS UNABLE TO MANAGE THE INTRICACIES WITH FAMILIES.

CLINICIAN

Glossary of acronyms

Act	Mental Health Act 2014
CAHS	Child and Adolescent Health Service
CCTV	Closed circuit television
CLMI	Criminal Law (Mental Impairment) Act 2023
CTO	Community treatment order, also called a Form 5A
DoH	Department of Health
ED	Emergency department
EMyU	East Metropolitan Youth Unit
Form 1A	Referral for examination by a psychiatrist
Form 3C	Continuation of detention to enable further examination by psychiatrist
Form 5A	Community treatment order
Form 6A	Inpatient treatment order in an authorised hospital
Form 6B	Inpatient treatment order in a general hospital
FSH	Fiona Stanley Hospital
FSHYU	Fiona Stanley Hospital Youth Unit
HECS	Hospital Extended Care Service
HSP	Health Service Provider
ICMS	Integrated Client Management System
ITO	Inpatient Treatment Order
JHCYU	Joondalup Health Campus Youth Unit
KWD	Kaatadjiny Walbraaniny Danjoo project
LARU	Licensing and Accreditation Regulatory Unit, Department of Health
MHAS	Mental Health Advocacy Service
MHC	Mental Health Commission
MHLC	Mental Health Law Centre
MHOA	Mental Health Observation Area
MHT	Mental Health Tribunal
MIARB	Mentally Impaired Accused Review Board
NDIS	National Disability Insurance Scheme
NMHS	North Metropolitan Health Service
OCP	Office of the Chief Psychiatrist
PCH	Perth Children's Hospital
RPH	Royal Perth Hospital
SAT	State Administrative Tribunal
SCGH	Sir Charles Gairdner Hospital
SFMHS	State Forensic Mental Health Service

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