MHAS MENTAL HEALTH ADVOCACY SERVICE

Annual Report

30 November 2015 – 30 June 2016

A prime function of the Advocates is to check that people are not detained illegally or for any longer than they need to be and that their rights are observed at all times when detained.

Hon Andrea Mitchell MLA

MINISTER FOR MENTAL HEALTH

In accordance with sections 377 and 378 of the *Mental Health Act 2014* I submit for your information and presentation to Parliament the Annual Report of the Mental Health Advocacy Service for the financial year ending 30 June 2016.

As well as recording the operations of the Advocacy Service for the 2015-2016 year, the Annual Report reflects on a number and range of issues that continue to affect consumers of mental health services in Western Australia.

Debora Colvin
CHIEF MENTAL HEALTH ADVOCATE

30 September 2016

CONTENTS

FOREWORD BY THE CHIEF MENTAL HEALTH ADVOCATE

Welcome to the inaugural Annual Report of the Chief Mental Health Advocate. For those of you who have, over the years, read and valued annual reports of the Council of Official Visitors, the predecessor to the Mental Health Advocacy Service, you may be both pleased and disappointed at the same time.

You will be pleased because you will see that the Mental Health Advocates have taken over the mantle of the Official Visitors with the same diligence and passion and are continuing their good work but with the added advantage of being available to advocate for more people. Under the new Mental Health Act 2014, Advocates must see every adult consumer within seven days and children within 24 hours of being made involuntary and there are more classes of patient who are entitled to an Advocate.

You may be disappointed because you will be reading about the same types of issues and concerns raised in past years. Many consumers and carers have been pinning their hopes on cultural change as a result of the new Act. But culture does not change overnight and this Annual Report reflects only the first seven months of the new Act and the Advocacy Service. It should also be said that the transition to the new Act was remarkably smooth so everyone involved in that should be congratulated.

That does not mean all sections in the new Act are being complied with because this is not the case, particularly in relation to the inability to get a psychiatrist from outside the ward to do a further opinion and the lack of involvement of consumers and carers in Treatment Support and Discharge plans and the failure to give them a copy. Wards also struggled to come to terms with consumer rights such as access to electronic communication.

The Report reflects on some of those issues but I am sure change is underway and there were some immediate benefits such as increased access to advocacy.

Indeed the Advocacy Service hit the ground running on our first morning with a call about a young person on referral orders awaiting examination in an Emergency Department for three days. This was new jurisdiction as previously only people who were already involuntary could ask for help. To help ensure that Advocates contact every involuntary person within the time limit, the Advocacy Service is sent a copy of every involuntary order made in Western Australia. On day one we received 23 notifications. Overall the workload has doubled from that of the Council of Official Visitors with Advocates dealing with 1,670 people put on 2,324 involuntary orders and making contact with 1,961 people over seven months.

Feedback about the role of the Advocates in making contact with consumers in the first days of being made involuntary has been very positive. For a person locked up against their will, often brought in by police, it can be a very frightening and disempowering experience. To have someone whose entire job is to listen to you, to help you get your voice heard, and make sure that the very complex legislation responsible for detaining you is being followed, is extremely re-assuring.

The role of the Advocate in helping ensure that no-one is detained wrongly or a day longer than necessary is in the interests of both the person detained and others needing a hospital bed. As will be seen in Part 2 of the Report, delays in Emergency Departments and people living on wards due to a lack of appropriate community support and accommodation continue.

The Youth Advocate is a new specialist advocacy role required by the new Act but it is limited in its scope because they cannot assist voluntary children. Most children in the State's adolescent unit are not under involuntary orders but they cannot leave the ward. They can be restrained and secluded and refused access to their phone or visitors, but have no access to the Youth Advocate or regular review by the Mental Health Tribunal. It is particularly concerning as 16 and 17 year olds will not be admitted to the new Perth Children's Hospital and are currently facing admission to adult mental health wards, though we are hopeful that the better outcome will be the opening of new youth mental health wards. There are various stories in the Report about these issues.

Finally, although the monthly and bimonthly inspection role that Official Visitors had is no longer a legislative requirement, Advocates have the power to inquire into and investigate any matter relating to conditions in mental health services which might be adversely affecting consumers' health, safety and wellbeing. We plan to do more work in this area in the next 12 months, funding permitting, but for the first seven months, the focus was on vulnerable hostel residents.

I would like to thank all the Advocates and the Advocacy Services Officers for their tireless efforts in what has been a very challenging and exhausting seven months. Particular mention should be made of the two Senior Advocates and Advocacy Service Manager who have carried much of the load.

Debora Colvin
CHIEF MENTAL HEALTH ADVOCATE
September 2016

The Act requires that the Chief Advocate must be notified by mental health services of every person who is made involuntary in Western Australia.

PART ONE
THE MENTAL HEALTH ADVOCACY SERVICE

THE LEGISLATIVE FRAMEWORK

Part 20 of the *Mental Health Act 2014* (the Act) requires that mental health advocacy services be provided to certain classes of mental health patients with a view to ensuring that their rights are protected. The Chief Mental Health Advocate is charged under the Act with ensuring such services are provided.

Under Part 20, the Minister for Mental Health (the Minister) appoints a Chief Mental Health Advocate (the Chief Advocate) who engages, under contracts for services, the Mental Health Advocates (the Advocates) which must include a specialist Youth Advocate. Public service officers are also appointed, or made available under the *Public Sector Management Act 1994* Part 3 to assist the Chief Advocate. Together they form the Mental Health Advocacy Service (the Advocacy Service).

Who the Advocacy Service can assist

The Advocates' functions are governed by the terms of the Act, and they can only assist certain classes of people, who are defined in s348 of the Act as an "identified person". These are mainly involuntary patients including people on a Community Treatment Order. They also include:

- people referred for an assessment to consider whether they should be made involuntary who may already be a voluntary patient in hospital asking to leave or someone waiting in an Emergency Department (ED)
- people on Hospital Orders who have been charged with criminal offences and referred for psychiatric assessment
- mentally impaired accused people on a Custody Order in an authorised hospital or the community under the *Criminal Law (Mentally Impaired Accused) Act 1996* (the MIA Act)
- private psychiatric hostel residents
- other classes of "identified person" as directed by the Minister of which there were none at 30 June 2016.

The definition excludes most voluntary mental health patients. Further details are provided in appendix 10.

Identified persons are referred to by Advocates and hereafter in this Annual Report as consumers.

Functions of the Advocates

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

People who are awaiting assessment by a psychiatrist who request contact must be contacted with three days and other requests for contact by consumers must be responded to "as soon as practicable" or within seven days, and in the case of certain classes of children, within 24 hours (see s357 of the Act). The Act therefore also requires that the Chief Advocate must be notified by mental health services of every person who is made involuntary in Western Australia.

On making contact with a consumer the job of the Advocate (as set out in s352) includes:

- inquiring into or investigating the extent to which they have been informed of their rights and the extent to which those rights have been observed
- inquiring into and seeking to resolve their complaints including being their representative in relation to complaints to the Health and Disability Services Complaints Office (HaDSCO)
- assisting them to protect and enforce their rights under the Act generally
- assisting and representing them in any proceedings under the Act before the Mental Health Tribunal or the State Administrative Tribunal (SAT) and to access legal services
- in consultation with the medical practitioners and mental health practitioners responsible for their treatment and care, advocating for and facilitating their access to other services.

Advocates also have the function of inquiring into or investigating any matter relating to the conditions of mental health services that is adversely affecting, or is likely to adversely affect, the health, safety or wellbeing of consumers. This may include a systemic inquiry in relation to rights.

Advocates may attempt to resolve any issues arising in the course of an investigation or inquiry by dealing direct with staff members or refer the issue to the Chief Advocate if they cannot resolve the issue or consider it appropriate to do so (see s363). The Chief Advocate may provide reports about any issues raised to the person in charge of the mental health service, the Minister, the Chief Psychiatrist, the Commissioner for Mental Health and the Director General of the Department of Health. They must advise the Chief Advocate of the outcomes of any further inquiry or investigation.

Further information about Advocates' functions and those of the Chief Advocate are set out in appendix 10.

Advocates' powers

The Advocates have considerable powers of enquiry and right of attendance on mental health wards and in psychiatric hostels and other mental health services provided in s359 of the Act. This is aimed to ensure rights are protected. It includes rights to:

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

Further detail on Advocates' powers is provided in appendix 10.

OPERATIONAL FRAMEWORK

Minister and Chief Advocate

The Chief Advocate is responsible for Part 20 of the Act being complied with but the Minister may, in consultation with the Chief Advocate, and at the Chief Advocate's request, issue written directions about the general policy to be followed by the Chief Advocate in performing functions under the Act.

The Minister may also issue a direction requiring the Chief Advocate to report to the Minister about the provision of treatment or care by a mental health service (which includes psychiatric hostels in Part 20 of the Act) to a person or to ensure that a mental health service is visited by an Advocate.

In each case, the text of a direction must be laid before each House of Parliament on or within 14 sitting days of the House after the day on which the direction is issued and it must be included in the Annual Report by the Chief Advocate. Treasurer's Instruction 903(12) also requires the Chief Advocate to disclose information on any Ministerial Directives relevant to the setting of desired outcomes or operational objectives, the achievement of desired outcomes or operational objectives, investment activities and financial activities. No such directives were issued by the Minister between 30 November 2015 and 30 June 2016 inclusive.

The Minister must cause a copy of the Annual Report by the Chief Advocate to be laid before each House of Parliament within 21 days of receipt of the report (see s378).

The Chief Advocate is appointed for five years and may only be removed by the Minister on the grounds of mental or physical incapacity, incompetence, neglect of duty or misconduct. The Chief Advocate's remuneration is determined by the Minister on the recommendation of the Public Sector Commissioner.

Chief Advocate, Senior Advocates, Youth Advocate and Advocates

The Chief Advocate engages Advocates on a contract for services and must engage at least one Youth Advocate with qualifications, training or experience relevant to children (see s350(2)). There are no other specific qualifications required for Advocates but the Act allows for the appointment of Advocates with qualifications, training or experience relevant to a particular group in the community. The Chief Advocate can also delegate their powers or duties to another Advocate (see s374).

As at 30 June 2016 the Advocacy Service had one Youth Advocate, 26 other Advocates, including one specialist Aboriginal and Torres Strait Island Advocate, and two Senior Advocates. The Senior Advocates are specifically engaged to carry out delegated duties of the Chief Advocate (refer to s374), in particular providing advice, assistance, control and direction to the Advocates, ensuring identified persons are contacted, developing standards and protocols, ensuring Advocates are adequately trained and preparing an annual report to Parliament. In practice, Senior Advocates and Advocacy Services Officers work closely to coordinate Advocates' responses to notifications and requests for assistance.

Advocates were appointed in the Perth metropolitan area and wherever there is an authorised hospital which is currently Bunbury, Albany, Kalgoorlie and Broome. In the metropolitan area they are divided into four teams which are based around particular hospitals and hostels. Work is allocated to Advocates by the Senior Advocates. Most Advocates are not guaranteed work, with a few exceptions where minimum hours have been agreed.

Advocates may be appointed for up to three years. For operational reasons some Advocates are appointed for one year, others for two or three years. The Minister determines the Advocates' remuneration.

Advocates' must comply with confidentiality provisions in the Act which apply to them in the same way as they apply to all mental health service staff. In addition the Advocates' contracts require compliance with protocols and standards set by the Chief Advocate. The Chief Advocate may remove an Advocate from office pursuant to s372 of the Act on grounds of mental or physical incapacity, incompetence, neglect of duty or misconduct. The Act also contains conflict of interest provisions in s373 which are specific to Advocates.

A Code of Conduct must be signed by Advocates prior to appointment and it contains further conflict of interest provisions and forms a part of the Advocate's contract with the Chief Advocate. A copy of the Code of Conduct may be found on the Advocacy Service website: www.mhas.wa.gov.au.

Monthly team meetings are held by the Senior Advocates and joint team meetings were attended by all Advocates which included training (regional advocates attend by video-link) in February and May 2016.

Advocacy Services Officers

Public service officers (Advocacy Services Officers) must be appointed, or made available under the *Public Sector Management Act 1994* Part 3 to assist the Chief Advocate in performing his or her functions.

The Chief Advocate may also, by arrangement, use the facilities of a department and services of any officer or employee of the Public Service or a State agency or instrumentality. A Memorandum of Understanding is to be negotiated with the Mental Health Commission (MHC) regarding the use of corporate services such as processing payrolls and invoices, and information technology services.

There are four FTE permanent Advocacy Services Officers including a Manager. The Chief Advocate has delegated a function under s351(1)(a) to Advocacy Services Officers to ensure that consumers are contacted in accordance with the Act and Advocacy Services Officers are entitled to request copies of all orders or notifications required to be provided to the Chief Advocate.

Advocacy Services Officers are bound by confidentiality provisions in the Act and the MHC's Code of Conduct. They must also implement the protocols and comply with the standards set by the Chief Advocate including declaring any conflicts of interest.

Executive of the Advocacy Service

The Chief Advocate has established an Executive team comprising the Chief Advocate, the two Senior Advocates and the Advocacy Service Manager. The Executive acts as the advice and decision making body in relation to protocols and operational decisions as well as planning and conducting training for the Advocates.

ADVOCACY APPROACH

The Advocacy Service has adopted the "pure advocacy" approach to individual advocacy which means that Advocates do not take a "best interest" approach when advocating for individual consumers. The exception to this is children as the Act requires best interests Advocacy for young people under 18 years old.

Consumers have many other people making decisions in their "best interest". Instead Advocates act as a mouthpiece for the consumer and are partial to the consumer. The Advocate will tell the consumer their rights and options as well as consequences of taking particular actions (the "ROC Principle") and then will act according to the consumer's wishes. They do not make decisions for the consumer and are not counsellors, though they do need to be good listeners and sometimes act simply as a support person.

Where a consumer is not able to say what they want and the Advocate is concerned that rights are being infringed, they will take action as required under the Act to ensure that the consumer's rights are observed. Advocates may, in such cases, use "non-instructed advocacy" which is described in the Code of Conduct.

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

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

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

Advocates act as a mouthpiece for the consumer and are partial to the consumer.

The Advocate will tell the consumer their rights and options as well as consequences of taking particular actions (the “ROC Principle”) and then will act according to the consumer’s wishes.

PART TWO
ACTIVITIES OF ADVOCATES AND CONSUMER RIGHTS AND ISSUES

There were 1,670 people put on 2,324 involuntary orders[1] in the first seven months of the Advocacy Service's operation from 30 November to 30 June, based on notifications to the Chief Advocate. In total, Advocates made contact with 1,961 people.

A prime function of the Advocates is to check that people are not detained illegally or for any longer than they need to be and that their rights are observed at all times when detained. This is why the Act requires that all people who are made involuntary be contacted by an Advocate within seven days if they are an adult and 24 hours if they are a child (the "statutory contact").

Advocates are also required to respond to requests for contact by consumers, including requests by those people referred for assessment who are not yet involuntary and psychiatric hostel residents, and to support consumers in Mental Health Tribunal and SAT hearings. In some cases the consumer raised issues when the statutory contact was made; in other cases they called seeking contact later.

While visiting hospital wards and carrying out the statutory contacts and responding to requests for assistance, Advocates also from time to time inquired into conditions of the mental health services that they considered were, or might be, adversely affecting, the health, safety or wellbeing of consumers[2]. Regular visits to some psychiatric hostels were also conducted under the inquiry power in s352(1)(b) of the Act .

The stories highlighted in this part of the Report illustrate the activities of Advocates in carrying out their functions. More statistical information can be found in Part 3 of the Report.

The Act requires that all people who are made involuntary be contacted by an Advocate within seven days if they are an adult and 24 hours if they are a child (the "statutory contact").

1. 1,552 people put on 1,854 involuntary inpatient treatment orders and 401 people put on 470 CTOs but a number of people were put on both types of orders and/or put on orders several times.
2. As required by s352(1)(b) of the Act.

THE CONSUMER'S JOURNEY AND RIGHTS ISSUES

Consumers have the right to have the Act complied with in all aspects including the processes set out in the Act, regulations, and Chief Psychiatrist's standards and guidelines as well as:

- the "*Charter of Mental Health Care Principles*" in Schedule 2 of the Act
- the United Nations "*Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care"*
- the "*National Standards for Mental Health Services"* which are designed to guide policy development and service delivery in each of the states.

The stories below reflect the consumer's journey and illustrate issues dealt with by the Advocates in assisting consumers to protect and enforce their rights in accordance with their functions in s352 of the Act.

1. The Road to Being Made Involuntary

The first stage to being made involuntary is referral for (mandatory) examination by a psychiatrist. An innovation of the new Act is a right to access an Advocate during this stage and health services staff must give them opportunity and the means to do so. The person is often in an ED and on a form 1A and detention order (form 3A). The orders last 72 hours in the metropolitan area (this can be extended to six days in regional areas) but due to bed pressures it is not uncommon for the forms to simply be replaced with new ones.

Advocates can make sure the person understands their rights, that the strict timing required by the Act is not breached, and advocate for access to a bed or other services.

Contact by an Advocate was requested by 91 people referred for examination by a psychiatrist under the Act. Fourteen people on a Hospital Order, which is a similar referral pathway via the court and forensic mental health service, also requested contact.

Referral and Transport orders invalid

- A consumer was ordered to be picked by police and continue to be detained under a form 3C awaiting examination by a psychiatrist for several days when the Advocate picked up that the referral (form 1A) was invalid. The consumer was not seen and assessed by an authorised mental health practitioner within 48 hours before the form 1A was made. The authorised mental health practitioner hadn't seen the consumer for four days and had left blank the details on the form 1A which is what alerted the Advocate. The consumer was examined by a psychiatrist and then discharged without being made involuntary but had suffered the trauma of being picked up the police and having to wait several days to be allowed to go home.

- In another case, a psychiatrist signed the form 1A referral for examination and was intending to do the examination for the form 6A. This is not allowed under the Act which requires that two clinicians see the person before they are made involuntary. When queried by the Advocate it turned out that the psychiatrist had not seen the patient in the previous 48 hours either so the form 1A was invalid. Following the matter being raised by the Advocate the person agreed to stay as a voluntary patient and the psychiatrist was counselled about the provisions of the Act.

Breach of privacy and right to dignity

A consumer came into the hospital ED on a Friday for physical issues but was put on a form 1A. The psychiatric assessment by the registrar for the form 1A was conducted while other patients and their families were in the shared ward and the consumer was told they would be detained under the Act in their presence, all of which was extremely distressing. The consumer contacted the Advocacy Service (which conducts a weekend phone roster service). An Advocate supported them to prepare for the examination by a psychiatrist on Monday morning and was also present at the examination. The consumer put their case forward to be discharged and complained to the psychiatrist about the treatment from the two registrars who had failed to respect their privacy and dignity. The consumer was allowed to go home with voluntary community follow up. The consumer said they felt reassured by the Advocate's presence which allowed them to be more confident in the examination by the psychiatrist and put forward their complaint about the conduct of the registrars. The psychiatrist agreed to take up the issue with the registrars. Their actions breached Principle 10 of the "*Charter of Mental Health Care Principles*" in the Act which states that a mental health service must respect and maintain privacy and confidentiality and possibly s576 of the Act.

Children stuck in EDs for days

The Advocacy Service was made aware of a number of cases of children held in EDs or adult wards for over five days due to shortage of beds, particularly since the decision to close eight beds in ward 4H in Princess Margaret Hospital (PMH) on 29 March and divert patients to the Bentley Adolescent Unit (BAU). The decision included having the BAU prioritise 12-15 year olds with an expectation that young people aged 16 and 17 would be treated at Fiona Stanley Hospital. Patients under 12 years were to be managed on a case by case basis. See also below under "Systemic Issues".

Advocates can make sure the person understands their rights, that the strict timing required by the Act is not breached, and advocate for access to a bed or other services.

- In one case a child was discharged from hospital around lunchtime despite telling staff that they would kill themselves and having no access to a community based Case Manager. By nightfall the child was in an ED. Five days later the Advocacy Service was called by the carer who said the child had "virtually been a prisoner on a gurney". Various calls were made by a Senior Advocate including to the ED Consultant and the Clinical Nurse Specialist on the hospital's adult mental health ward who agreed it was unacceptable and said the issue had been escalated to State-wide bed flow coordinators. The Senior Advocate relayed the information to the carer which provided them and the young person with some reassurance. On the sixth day the child was admitted back into hospital.
- In another case where the child was in ED and then a general ward for six days waiting for an appropriate bed in a mental health ward, the subsequent stay in the mental health ward was only two days – suggesting that quicker access to specialised community mental health care could have avoided the long wait and associated suffering.
- In a third case the young person was in the ED for five days and, while not under any forms, was told by staff that if they left the ED, ward staff would call security and if they went off hospital grounds staff would call the police. The distressed young person told Advocates they had seen seven doctors during that time.

In most of these cases the child was voluntary and not on a form 1A. This means they were not an "identified person" so did not have a right to an Advocate. Calls for help came from family members or hospital staff. There was no added cost to the Advocacy Service because the work was carried out by a Senior Advocate and the powers under Part 20 of the Act were not exercised but this is an area of need and the Advocacy service will be seeking a direction from the Minister allowing Advocates to assist voluntary children. See further below under "Systemic Issues".

"Emergency psychiatric treatment" ss 202 – 204 of the Act

In some cases an Advocate's main role is non-instructed advocacy to ensure that rights are observed. Two security officers were called in to assist nursing staff carry out a forced injection of medication on a non-verbal person who had been referred for examination. This involved holding the consumer down with bodily restraint. The Advocate pointed out that this was emergency psychiatric treatment as the person was not involuntary and a form 1A did not allow forced medication under the Act. The Advocate drew staff attention to the Act and the "*Clinicians' Practice Guide*" and the need to follow that process. The Advocate stayed on to observe the restraint to ensure that it was carried out with the least trauma to the person. The Advocate also pointed out that the person could not be examined properly without an interpreter. Medical staff argued that the person could understand English but was refusing to talk. The Advocate insisted on an interpreter.

Sent home without a plan

In another case a consumer was sent home after spending some time on a form 1A in an ED but complained to the Advocate that they had little support from ED mental health staff despite some complex issues and had completely lost faith in the system. The Advocate put the person in touch with the local Partners in Recovery (PIR) having convinced the consumer that PIR "sounded like something a bit different, something that might work".

2. Being Involuntary

To be made involuntary, a psychiatrist must examine the person in accordance with the Act (which includes strict time periods) and decide that the five criteria in section 25 of the Act have been met, with slightly different criteria for a person being put on a Community Treatment Order (CTO) rather than an inpatient treatment order.

The criteria include that the person has a mental illness needing treatment, that there is significant risk to the person or others, that they lack capacity to make a treatment decision as assessed by s18 of the Act, and there is no less restrictive means of treating the person. In the case of CTOs the risk includes risk of deterioration.

Assuming the criteria are met, the psychiatrist makes the order (a form 6A, or 6B if the person needs to be detained in a general hospital due to physical health issues). The involuntary treatment order initially lasts for 21 days (14 days for a child) but can then be extended every three months (28 days for a child) by means of a Continuation Order (a form 6C). A CTO lasts for three months but can be extended every three months and, after 12 months, six monthly.

Every person who is made involuntary (which means as an inpatient or on a CTO) must be contacted by an Advocate within seven days and 24 hours if they are a child.

The Advocate usually has access to a copy of the involuntary order and can check the consumer's medical file and speak to their treating team if the consumer doesn't object to them doing so. Thereafter the Advocate's role is to make sure the person is not detained as an involuntary patient a day longer than necessary and that their rights continue to be observed. In assisting consumers who don't believe that they should be involuntary to enforce their rights, the usual processes are to ask for a further opinion or a Mental Health Tribunal hearing.

Invalid and unnecessary involuntary orders

One of the first tasks of the Advocate is to check the involuntary order to make sure it is valid. The form used to make a person involuntary has five boxes (to be ticked by the psychiatrist to indicate that they have considered the requirements of s25 of the Act and there should be notes of the examination on the medical file. The timing of the order also needs to be checked to ensure that the order could be made when it was made (so there needs to be a valid referral as well, except when a form 5A is done following a form 6A/6B) and that the duration of the order does not exceed the maximum time limit. Examples of cases dealt with include the following:

- The Advocate picked up that the "capacity" box was not ticked on the form 6A. They raised it with the psychiatrist who then decided that the person had capacity so could not be made involuntary.

- A consumer who had been voluntarily accepting treatment for six months was made involuntary. The Advocate went through the criteria for involuntary status with the consumer who expressed reasons why they felt they did not meet the criteria for being involuntary, including having been compliant with treatment previously. With the Advocate's support the consumer told the psychiatrist this stating that they were happy to stay on the ward voluntarily for further treatment. As a result the consumer was made voluntary.

- A consumer on a CTO sought assistance from an Advocate to prepare for a Mental Health Tribunal hearing. The consumer had an appointment scheduled with their psychiatrist the next day so the Advocate suggested the consumer put forward their concerns to the psychiatrist. The consumer did this and the psychiatrist took them off the CTO.

- A form 6B involuntary treatment order (for treatment in a general hospital) was invalid because it was made in the "authorised hospital" part of the hospital rather than in the "general hospital" part which meant an earlier form 6A remained in force. The issue was brought to the attention of the psychiatrist. The ability to issue a form 6B was new under the Act and there was some confusion about its operation in the first few months.

Detention after involuntary order expired

- The consumer who was an involuntary inpatient in a general hospital was detained beyond the 21 days of the order[3] and not told they were now voluntary despite s93 of the Act requiring written advice of expiry of an inpatient treatment order to be given to the consumer and the Chief Advocate. The psychiatrist later apologised to the patient who was happy to remain in hospital but who was being treated in what they described as a punitive manner, including not being allowed to wear their own clothes, have access to their laptop or have visitors. On finding out they were voluntary the patient immediately demanded their clothing and access to their laptop and visitors[4].

- In another case a patient was detained as an involuntary patient for several months before the Advocate discovered and alerted staff to the fact that a form issued under the *Mental Health Act 1996* (1996 Act) was no longer valid and transitional provisions had not been followed. The hospital was alerted and asked to check all other long term orders.

3 The first involuntary order (forms 6A and 6B) only last 21 days and a continuation order (form 6C) must be made if the person is to remain an involuntary patient. The Advocacy Service is not notified of continuation orders so was not able to advise the person over the phone of their status.

4 Under the Act voluntary patients can have post, visitor and electronic communication restrictions placed on them but in this case the relevant processes and forms, including having to notify the Chief Advocate, had not been followed either.

3. Right to Review – Tribunal Hearings

Probably the most important safe-guard and right for an involuntary patient is the right to review by the Mental Health Tribunal. The Mental Health Tribunal comprises a lawyer, psychiatrist and community member and, apart from a psychiatrist, is the only other body that can make the person voluntary.

Every involuntary patient must be reviewed within 35 days of the person being made involuntary and thereafter every three months while they remain involuntary[5]. Hearings for children must be held within 10 days and thereafter every 28 days and should have a child psychiatrist on the Tribunal.

Advocates assist consumers to make applications to the Mental Health Tribunal and support them in the ensuing hearings and periodical reviews of their involuntary status. Advocates also support people in SAT hearings, primarily where an application has been made to appoint a guardian or administrator.

Support and representation in Mental Health Tribunal hearings

In the seven months from 30 November 2015 to 30 June 2016 Advocates reported attending at least 279 Mental Health Tribunal hearings representing consumers. The numbers are believed to be higher than this but, due to initial inputting errors, the reporting of this in the Advocacy Service's Integrated Case Management System (ICMS) database is not accurate.

The number of hearings attended is considerably higher than previous years by Official Visitors (219 in 2014-2015). This is because reviews are held more frequently than under the 1996 Act and the Mental Health Tribunal provides the Advocacy Service with its schedule of hearings. This allows Advocates to make sure that consumers know when their hearing is scheduled and their rights in relation to the hearing which include representation by a lawyer or an Advocate and the presence of family members or others. There were also many more reviews in the first few months of the new Act as part of the transition legislation.

Issues in Mental Health Tribunal hearings – capacity, significant risk and medical reports

Two changes in the criteria under the Act (as compared with the 1996 Act) are that the risk must be "significant" and that the person cannot demonstrate capacity as determined under the Act.

- In one case brought on urgently and carried out over two days, as facilitated by the President of the Mental Health Tribunal, the consumer, who spoke eloquently throughout the hearing, disputed the psychiatrist's diagnosis and had a further opinion from their own private psychiatrist. During the hearing the psychiatrist said that the consumer lacked capacity because they would not accept their medical opinion. The Tribunal made clear that this was not the test of capacity. The consumer was made voluntary by the Tribunal, though for different reasons. After the hearing the consumer wrote to the Advocacy Service describing the advocate as "indefatigable" and said

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

that the most therapeutic intervention of the hospital stay was their first contact with the Advocate who performed a *"verifable miracle in convening a Tribunal hearing before the working week was out and she also managed to procure the services of a solicitor in concert with whom she formed an even more formidable (and ultimately exculpating) force".*

- In another case the Mental Health Tribunal accepted that the risk was not "significant" as the consumer had good family support and close monitoring by them, had been compliant with contact with the treating team, and had agreed to continue the treatment.
- A psychiatrist in another case said that the consumer, who was prepared to stay in hospital, needed to be kept involuntary to retain the bed and avoid discharge. The Tribunal asked the consumer if it was a good idea becoming voluntary knowing that they may be asked to leave when bed pressure rose. The consumer said becoming voluntary meant a lot to them as it meant they were more in control and that was empowering. The Tribunal made the consumer voluntary.
- In another case the Advocate successfully argued that the consumer should be allowed to go home on a CTO so they could start counselling which was not otherwise available to them in hospital.

The availability of medical reports prior to the hearing (as required by the Tribunal) remains poor and the quality of such reports inconsistent. The Act requires the Tribunal to take into account the consumer's TSD plan. In the absence of such plans (see below) the Tribunal uses the medical report as the primary source of information. Having the psychiatrist or even a registrar discuss the report with the consumer prior to the hearing almost never happens. Doctors will usually cite overwork as the issue and some complain that the process is adversarial but, apart from being a right of the consumer, the preparation process for a hearing involving the consumer can build trust and understanding if done properly.

- In one case the Advocate picked up in a Mental Health Tribunal hearing that a prejudicial statement in the psychiatrist's report was wrong. The Advocate and the consumer were given the lengthy report just before the hearing and didn't get time to finish reading it before the hearing began (which continues to be a major issue and lack of procedural fairness in hearings). The Advocate had prepared for the hearing, however, and had read the consumer's file beforehand so was aware that some of the statements in the medical report were inaccurate. This and some other concerns raised in the hearing led the Tribunal to make an order that the consumer could have another hearing in a shorter time frame than usual.

Electroconvulsive therapy (ECT) hearings

ECT can only be given to involuntary patients and voluntary children aged over 14 years if agreed to by the Mental Health Tribunal. This is new for both psychiatrists and Advocates[6]:

- In some cases patients were close to catatonic and not able to express their wishes but the Tribunal or a family member requested an Advocate attend. The Advocates adopted a non-instructed advocacy approach concentrating on ensuring the proper process was followed.

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

- In many cases the ECT hearing was heard at very short notice (which caused some issues for Advocates as well as the consumers) and in one case, following a successful application to have the hearing adjourned when the consumer was able to voice their opposition, the ECT application was abandoned.
- In another case the parents of a voluntary child requested advocacy support but as the child was voluntary the Advocacy Service was unable to assist.
- The Mental Health Tribunal rejected an application in one case on the basis that the psychiatrist's application did not include a clear treatment plan and subsequently the consumer was made voluntary.

State Administrative Tribunal (SAT) hearings

The SAT reviews decisions by the Mental Health Tribunal and also makes decisions under the *Guardianship and Administration Act 1990*. Consumers regularly have a guardian or administrator appointed while they are involuntary and hospitalised and Advocates support consumers in both types of hearing while they remain an identified person.

SAT hearings for a review of Mental Health Tribunal decisions are not common, partly due to the lapse in time it takes to get such a hearing. The Advocate will endeavour to get a Mental Health Law Centre (MHLC) lawyer to attend these hearings as they can lead to further appeal and precedent decisions.

Guardianship and administration hearings are much more common areas for Advocates to be involved. The application is usually initiated by the hospital social worker and supported by reports from the consumer's psychiatrist. It is important that the consumer's voice is heard in such applications. Issues such as who is appointed and the length and extent of the appointment can all be influenced by making sure the consumer's wishes are heard and respected in the hearing. Advocates also assist with applications by consumers for review of guardianship and administration orders. Examples of cases include the following:

- A consumer believed that there was no need for the Public Trustee to continue to manage their finances and that the order should be revoked. Both the psychiatrist and social worker wrote that the order should be continued. The Advocate, working with the consumer, was able to show significant improvements, as demonstrated in the doctors' reports and that the consumer had a budget from the Public Trustee that they could now follow with significant bills to be paid automatically on Centrepay. A SAT Member asked the consumer how they would feel if control of their finances was returned to them, but with an amount saved, placed under the Public Trustee for 12 months, in case they became unwell again. The consumer agreed and was happy to once again have access and control of their finances.
- A number of cases are giving rise to questions about how far a guardian can go in consenting to things like a restriction on the person's smoking and agreeing that they have ECT or be detained on a locked ward and restrained to give medication. The Advocacy Service is very concerned about these cases and that they will lead to an

erosion of consumer protections. The Act provides more protection and rigorous oversight than the *Guardian and Administration Act 1990*. In one case where the decision is pending, the Advocacy Service, Public Advocate and Chief Psychiatrist were asked for submissions.

Lack of legal representation

Consumers are entitled to have lawyers to represent them in Mental Health Tribunal and SAT hearings. The Advocacy Service works closely with the MHLC but unfortunately their resources do not match consumer need. The major concern is in relation to consumers with criminal charges. Advocates cannot assist with criminal issues whereas they can assist with Mental Health Tribunal and guardianship and administration hearings. At times the MHLC has advised that it cannot take on any new criminal matters and they are now adopting a wait list system for all matters excluding Mental Health Tribunal hearings. Even with Tribunal hearings, however, the MHLC requires 10 days' notice (so it can obtain the relevant documentation and meet with consumers) but often there isn't 10 days available because the consumer does not find out straightaway when the hearing is scheduled. The Advocacy Service is trying to reduce this happening by having Advocates contact consumers as soon as the Mental Health Tribunal schedule is published (which is usually two weeks in advance).

In one case guardianship and administration orders were being sought for a consumer in their early 20s. The consumer wanted a lawyer as the implications for them were very serious. The MHLC put the matter on a wait list but two weeks later were unable to assist. Legal Aid offered the consumer a one hour phone advice session.

Advocates noted 86 issues relating to "other legal matters". Some of these would have included needing advice and support in police interviews, others included matters such as advice about tenancy contracts where they are about to be evicted while in hospital. Advocates also get involved in questions from consumers about fitness to stand trial where the psychiatrist is saying they are not fit. The concern for the consumer and their lawyer is that the person may be put on a Custody Order which has no end date and which is very restricting. The Advocacy Service would prefer these cases to be handled by a lawyer.

Probably the most important safe-guard and right for an involuntary patient is the right to review by the Mental Health Tribunal.

4. Right to an Independent Further Opinion

The second most important safeguard for a person who is made involuntary is the right to a further opinion from another psychiatrist about their treatment. Even if the opinion is the same as their treating psychiatrist, which it more commonly is, it can give the consumer and their Personal Support Persons[7] some reassurance. The further opinion must be given to the consumer in writing and the consumer must be examined, so the opinion cannot just rely on the medical file, both of which are improvements on the 1996 Act. There are also Chief Psychiatrist's Guidelines about the independence of the psychiatrists from whom the opinions are obtained and an Operational Directive by the Director General of the DOH.

Breaches of rights in relation to further opinions

The major infringements of consumer rights in relation to further opinions were:

1. the lack of choice and inability to get a further opinion from a psychiatrist who is not working in the hospital and often on the same ward where the consumer is being treated
2. failure to comply with the Director General's Operational Directive on further opinions (see below)
3. consumers not being provided with a copy of the further opinion as required by s182 of the Act.

The Operational Directive states that the provision of further opinions is to be based on principles of independence, timeliness and flexibility and choice, amongst other things. Timeframes and key performance indicators for the provision of the further opinions are also given in the Directive – 80% within three working days for an opinion from a psychiatrist within the same health service site and otherwise 80% within five working days. A further opinion from a private psychiatrist is to be done at the consumer's own cost "as soon as practicable". Data collection is required including the time taken for opinions to be provided.

The Advocacy Service is regularly advised (orally and in writing) by Clinical Directors (who are responsible under the Directive for organising external further opinions) that they are unable to provide an opinion from a psychiatrist outside the hospital. As one Director wrote: "Consultants from outside our service are under no obligation to give up their own working time to do this". There is no system in place for further opinion work to be shared between hospitals even within the same area health service and the position seems likely to get worse with the change from a single DOH to Health Service Boards.

As a result, all but a handful of further opinions are given by a colleague of the treating psychiatrist who works on the same ward; in some cases the person giving the opinion has taken part in ward meetings discussing the consumer's case with the treating psychiatrist. Treating psychiatrists regularly inform consumers who ask for an opinion from someone off the ward that it will take weeks

7 As defined in s4 of the Act and see glossary at the back of this report.

and may never happen. The consumer either gives up on getting the further opinion or settles for one from a psychiatrist in the hospital. One of the important roles of the further opinion – building up the trust of the consumer – is therefore lost and the opportunity for different approaches and thinking around the treatment of complex illnesses is reduced.

It is impossible to know what timeframes are being met because the Operational Directive is not being followed consistently across hospitals and the data is not being collected. The data collection is important if submissions are to be made to improve the process.

Advocacy Service data and involvement in requesting further opinions

Advocates were involved in 174 requests for a further opinion in the seven months to 30 June. This does not mean that 174 further opinions were requested as some consumers or their families may have requested further opinions without the involvement of an Advocate. It also does not mean that 174 further opinions were provided. In some cases the further opinion was never provided because the consumer requested a psychiatrist from outside the hospital, the consumer was discharged before the further opinion was done, or the consumer changed their mind.

Advocacy Service data shows that there were 337 issues (or complaints) raised about medication of which 172 were about prescribing medication, including issues such as not discussing alternatives or not supplying information and 91 were about side-effects. These are the sorts of things that patients often want a further opinion about.

Private Psychiatrists

The Advocacy Service lobbied for a survey to be conducted of private psychiatrists to ascertain how many might be prepared to do a further opinion for an involuntary patient in hospital, whether they would travel to the hospital and what the cost would be to the consumer. Ideally the Advocacy Service would like to see a panel established which offered further opinions on a no-cost or Medicare rebate basis, in the same way that lawyers have pro-bono services. Alternatively a "Further Opinion Panel" could be established and run by an independent body such as the Office of the Chief Psychiatrist (OCP). The latter would require funding so a business case would need to be put forward which is another reason why the mental health services need to comply with the Operational Directive and collect data.

- In one case a private psychiatrist agreed to give a further opinion and the consumer was given escorted access to the private psychiatrist's rooms. The further opinion was paid for by the consumer.
- In another case a psychiatrist offered to provide the further opinion for free and to attend the hospital but the Clinical Director raised the issue that the psychiatrist would not be allowed to do this unless they were "credentialed" by the hospital. Correspondence ensued with the Chief Psychiatrist who made clear his views that there is an onus on services to provide urgent credentialing and arguably credentialing was not required for external opinion providers, as they are not providing a service for to the mental health service, but are essentially acting as "visitors" at the hospital. The consumer was made voluntary so the further opinion did not go ahead.

5. Right to Freedom of Lawful Communication

The Act states that a consumer has the right to uncensored, lawful communication in privacy. This includes electronic communication such as email which is a new right under the Act and which is not always observed. It is an important right in the twenty-first century when people pay their bills via the internet and much of their social contact is made through emails and social media. To cut off electronic communication without good cause is to cut the person off from their usual life and make the detention even more restrictive. This right can be restricted under the Act but only by order of a psychiatrist when it is in the person's best interest. The order must be reviewed every 24 hours to allow for the consumer improving and to ensure the restriction is not continued unnecessarily. The psychiatrist is required to give a copy of the order (called a form 12C) restricting communication to the consumer and to the Chief Advocate (within 24 hours) and it must be reviewed every 24 hours.

The Chief Advocate was notified of 171 orders in the seven months to 30 June but it is believed that some of these orders were duplicates and some hospitals failed to notify the Chief Advocate.

Where the patient is involuntary, an Advocate will be asked to contact the consumer to ensure that they are aware of their rights in relation to the restrictions and that they are reviewed every 24 hours. In some cases a compromise of the restriction may be negotiated with the treating team.

Issues which have arisen include the following:

- When the Act first came in, a number of wards continued to have "blanket bans" on mobile phones and were not issuing form 12Cs which is a breach of consumer rights. Slowly but surely, following meetings with management and correspondence, changes were made across wards.
- A psychiatrist wrote up a form 12C and sent a copy to the Chief Advocate in the required time but the order was to remove the consumer's access to their credit card. There are no provisions in the Act allowing this and the form 12C process under s262 of the Act is only relevant to communication. The hospital admitted the mistake and apologised to the consumer. Subsequently the same issue arose in another hospital although on that occasion the Advocate was asked in advance.
- In one case an Advocate was informed by nursing staff that a consumer was restricted from accessing social media due to "risk to reputation". The Advocate reviewed the consumer notes (after speaking to the consumer) and there appeared to be no reason or documentation about the restriction of communication. Upon checking and speaking to the nurses, ward manager and registrar it was discovered that the restriction was placed against the wrong consumer.
- In another case the young consumer was seen taking photos on the ward and the Advocate negotiated with staff that the consumer be allowed to retain their phone but with a sticker over the phone camera lens.

6. Right to Treatment Support and Discharge Plans (TSD Plans)

One of the major innovations of the Act is the requirement that all involuntary patients (including those on a CTO) must have a Treatment, Support and Discharge plan (TSD plan). Perhaps more importantly the Act stipulates that:

- the plan be prepared as soon as practicable after the patient is admitted by the hospital or the CTO is made
- the patient and their Personal Support Person must be involved in the preparation and review of the TSD plan - which fits in with the consumer's right that the treating team have regard to their wishes
- the plan be reviewed regularly and revised as necessary
- a copy be given to the consumer and their Personal Support Person
- the plan must be prepared, reviewed and revised having regard to the Chief Psychiatrist's Guidelines.

The Explanatory Memorandum to the 2014 Bill which became the Act says:

> *This approach is consistent with both the Act's focus on maximising the involvement of people experiencing mental illness, and with recognising the role of carers and families… It is intended that specific requirements will promote a collaborative, holistic and recovery oriented approach…..The intention is that what is required will depend on the medical, social and personal circumstances of the person, and the decisions and preferences they express ….It is intended that providing the patient and persons involved with some knowledge of what to expect from treatment, care and support provided by mental health services, and to ensure, as far as possible, continuity of care following discharge, will be most conducive to recovery.*

One of the major innovations of the Act is the requirement that all involuntary patients (including those on a CTO) must have a Treatment, Support and Discharge plan (TSD plan).

The Act is a long way short of being consistently complied with or the "intentions" referred to in the Explanatory Memorandum being met:

- Advocates frequently report that they cannot find a TSD plan or, if there is one, it is primarily a nursing management plan. In the first few weeks one hospital said they were using a Care Management plan but did not want to show it to the consumer because it gave the full names of the treating team. Advocates told the hospital they should use a different document.
- Part of the problem is said to be that there is no State-wide standardised clinical document (SSCD). A document called a TSD plan has been prepared and is part of a suite of SSCDs but is not installed on PSOLIS, the psychiatric database. Whether this will assist much is debatable in any event, as it is a simple document with nothing which guides nor encourages holistic thinking, a collaborative approach or accountability.
- In any event the Chief Advocate is of the view that lack of an official document titled a TSD plan is not a sufficient excuse to not comply with the Act.
- Anecdotally there is also concern that Personal Support Persons are often not involved in the development of TSD plans, even when consumers have specifically requested their involvement. One consumer complained to us that their Personal Support Person had asked for five straight days if a treatment plan had been prepared with the response on each occasion being, "I'm not sure".
- Some good work has begun in a couple of hospitals where patients are now being invited into team meetings about their care.
- In a couple of other hospitals they are starting to develop a document to be used as a TSD plan which better reflects the stated aim in the Explanatory Memorandum and is designed to encourage the consumer to express their goals and wishes and help staff think more holistically and take a more recovery oriented approach.

Some good work has begun in a couple of hospitals where patients are now being invited into team meetings about their care.

7. Right to Least Possible Restriction of Freedom - Ground Access and Locked "Open" Wards

One of the objects of the Act is to ensure people who have a mental illness are provided the best possible treatment and care, with the least possible restriction of their freedom. Everyone performing a function under the Act must have regard to these objects. While this has to be balanced with other objects ensuring the protection of both patients and the community, complaints about lack of ground access and leave is the second highest issue noted by Advocates (198 complaints).

Complaints about lack of ground access are followed closely by requests to transfer to another ward (168 complaints) which usually means wanting to get to the open ward to have ground access.

In most cases the Advocate looks to the medical file and TSD plan if they can find one and will try to negotiate with the treating team and ward staff. Often the psychiatrist has agreed to escorted ground access but ward staff say they are too busy. Some of the other issues include the following:

- When the Act first came into operation some staff seemed to think that they had to prepare a leave form (form 7A) just for day-to-day ground access which caused confusion and delayed the provision of ground access. It was quickly made clear via a "Frequently Asked Questions" document produced by the *"Mental Health Act Response Group"* established to deal with issues in the first weeks of the Act's operation that this was not the case.
- There is a growing tendency to have "open" wards with locked doors so that all patients, voluntary and involuntary, must ask to leave:
  - all mental health wards at Midland, Fiona Stanley, Sir Charles Gairdner and Joondalup hospitals are locked
  - there have been particular issues in one hospital which did not have a designated smoking area. Advocates received numerous complaints and noted that the ward was more volatile with a higher than usual number of restraints due to the stress being felt by patients who could not easily get ground access. There was also a higher than usual incidence of patients going absent without leave when given ground access. The hospital responded by agreeing to set up a designated smoking area and drafted a new policy on ground access. The Advocacy Service is opposed to parts of the ground access policy which remove the decision making from the psychiatrist. Discussions continue with the hospital about this issue and legal advice has been sought.

8. Right to Dignity, Equality, Courtesy and Compassion

It is also an object of the Act to which staff must have regard that people who have a mental illness are provided the best possible treatment and care with respect for their dignity.

Principle One of the *"Charter of Mental Health Care Principles"* in the Act further states:

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

Below are just a few examples of complaints dealt with by Advocates:

- Consumers made to wear a "smock" because they had self-harmed. This is humiliating and identifies their illness to everyone on the ward.
- Children on the BAU complained after a so-called riot on the ward that there was nothing to do and staff did not engage with them[8]. Classroom time on the ward had been reduced to three sessions per week, there was no regular group therapeutic program and few facilitated leisure activities. Although nearly all the patients on this ward are voluntary, access off the ward and even to an enclosed courtyard is limited. At a meeting attended by Advocates after the incident, the young people talked about the lack of nursing staff to listen to them when they wanted to talk. The young people said they understood that sometimes staff had no time but complained that "they don't come back for a follow up". Following the incident more schooling and a seven-day-a-week activities program was introduced to the ward.
- Consumers are, unfortunately, often taken into hospital by police, with no time to pack bags and often do not have family or friends who they want to call to arrange to bring in clothing. Most hospitals therefore keep a supply of clothing, usually second hand (except for underwear). In one hospital the Occupational Safety and Health officers told staff that second hand clothing was an "infection risk" and banned them from using it. The result was consumers were left wandering around in pyjamas. After raising the issue with senior management, the Advocacy Service was advised that the "Linen Management Infection Control Guidelines" had been amended and consumers were again able to access second hand clothing.
- A consumer complained to an Advocate that both of the toilets in the female shared bathroom were "dirty for many hours with dried faeces and menstrual blood". The consumer said they had complained to nursing staff but were told the cleaner only came once a day and it was not the nurses' job to clean the toilets. The consumer asked that the toilets be cleaned more frequently and at least twice a day. The Advocate wrote to hospital management enclosing the consumer's complaint form. The hospital replied that a meeting had been held and a "formal process implemented to ensure toilets are checked and cleaned at least twice a day and more regularly if required".

8 There was also an allegation about what a nurse had said to one patient which is being followed up as a complaint and a Root Cause Analysis (RCA) report has been prepared. The Chief Advocate was a member of the RCA panel.

9 Right to Feel Safe - Restraint, Seclusion and Rough Treatment

While the number of complaints and episodes of seclusion have reduced over the years, it remains a fact that they are a feature of locked wards. Stressed, tired and sometimes inappropriately trained staff can lead to rough treatment in the process, and everyone – staff, the consumer involved, and other consumers witnessing the restraint – can be traumatised in the process.

Almost always the consumer suffers bruising and pain afterwards. It is extremely important that Advocates follow up all such cases diligently to ensure rights were observed, that help is given after the event to cope with the trauma, and that consumers' complaints about pain are not ignored. Often the consumer is reluctant to put in a formal complaint and in most cases where such a complaint is made, the hospital replies that it was a necessary and controlled restraint and it is difficult for a consumer to present evidence against the word of several staff members.

Some examples of situations include the following:

- "Code Blacks[9]" – Advocates reported a ward as having a much higher than usual number of "code blacks" leading to restraints and often seclusion. Advocates believed the issue largely related to lack of a designated smoking area, difficulty getting ground access and not enough engagement on the ward. Figures provided by the hospital management confirmed the Advocates' views and the hospital has made changes including moving towards having a small controlled designated smoking area. Advocates are maintaining a watching brief.
- Consumers with an eating disorder, including children, can be detained in a general hospital and force fed through a nasogastric tube. If the consumer refuses and continually removes the drip, ward staff will then physically restrain the consumer holding them down while the liquid is intubated which can take up to two hours and occurs daily. The process is extremely traumatic for everyone involved. Because the person is in a general hospital the provisions in the Act around restraint do not apply. This can make it more difficult for the Advocate to make inquiries.
- In one case the consumer had been calmed down by the Advocate while waiting for the doctor earlier that day, avoiding a restraint. Later, however, staff refused to allow the Advocate to do the same again and a restraint followed with the consumer suffering bruising to the upper arms as a result.
- In another case the consumer said a nurse had laughed at them when they asked about getting ground access. The consumer admitted they had got angry and had thrown a paper cup of water at the nurse. A male nurse then restrained the consumer by holding their arm behind their back before putting the consumer in seclusion. The consumer suffered considerable pain after the restraint and required pain relief. In telling the Advocate their story the consumer started to hyperventilate from reliving the trauma.

9 A code black is when a duress alarm is pressed by staff calling for assistance in an emergency. Restraint of a consumer often follows.

- Children are also restrained and it is not uncommon to be restrained by four or more male security guards. One distressed consumer told how scared they were and complained about strong pressure by the security guard with his hand under the consumer's chin. The Youth Advocate raised the complaint as a systemic issue with the Child and Adolescent Mental Health Service (CAMHS). Therapeutic Crisis Intervention training is not given to security staff and the restraint sounded dangerous.
- Complaints of rough handling are not always about staff. In several cases it was about one consumer assaulting another consumer. In one case the consumer allegedly responsible for the assault had been on a 2:1 observation special by two security guards (meaning the consumer was constantly shadowed by two staff). The Advocate raised concerns that, despite this level of observation, another consumer had been assaulted twice on the ward. Staff said they were going to change the arrangement so that a nurse and security guard carried out the 2:1 special in the belief that a nurse might better anticipate when the patient under observation was likely to hit out.

The Act says the degree of force used to restrain the person must be the minimum that is required in the circumstances and, while the person is restrained, there must be the least possible restriction on the person's freedom of movement consistent with the person's restraint; and the person must be treated with dignity and respect.

10. Rights to (and of) Personal Support Persons

An innovation of the Act is enhanced rights for carers and others, collectively defined in ss4 and 7 of the Act as "Personal Support Persons". The rights include being told when a consumer is made involuntary and the right to information and being involved in TSD plans. The rights can be over-ridden by the consumer's psychiatrist or the consumer not giving consent in certain cases. Where the psychiatrist does make such a decision, the Chief Advocate must be notified. No notifications were given in the seven months of operation of the Act. It is not known whether this is because no such decisions were made, or the Chief Advocate was not notified.

The Act also requires that the Chief Advocate be given the name and contact details of any Personal Support Person notified (as is required by the Act) of a person being made involuntary and, if no-one is notified, the reasons. Despite 1,670 people being put on 2,324 involuntary treatment orders, the Chief Advocate received only 202 notifications of Personal Support Persons and no reasons were given for any consumer who did not have a Personal Support Person notified. In short, the Act was not complied with in regard to the Chief Advocate being notified. Whether this also means that Personal Support Persons were not being notified is not known.

Nominated Persons

Another new innovation was the ability for a consumer to have a "Nominated Person" who, in essence, is to act as an advocate for the consumer's rights. The Nominated Person may be anyone of the consumer's choosing including a friend, a carer, or close family member who already has rights to information under the Act. The difference is that the Nominated Person has responsibilities as well as extra rights that are different to that of a carer or family member. The role of the Nominated Person is to assist the consumer who nominated them by ensuring that anyone performing a function under the Act:

(a) observes the consumer's rights

(b) takes the consumer's interests and wishes into account.

The consumer is also entitled to have uncensored communications with their Nominated Person and the Nominated Person must be given information and may exercise, on behalf of the consumer, any rights conferred under the Act on the consumer. In this regard, for example, a Nominated Person can say that the consumer does not object to an Advocate looking at the consumer's file in a situation where the consumer might not otherwise be able to speak for themselves.

The Act sets out a relatively formal process around the nomination which must be on an approved form (a form 12A) and be signed by both the consumer and the nominee and both signatures are to be witnessed. The Nominated Person remains in the role unless and until the nomination is revoked by the consumer.

The role of the Nominated Person is not well understood, however, as illustrated below, and there are some practical issues:

- A consumer had signed a form 12A and was waiting for the Nominated Person to come on the ward to sign the document but staff were told to shred the form and that if a person chose to "nominate" a close relative i.e. their mother, then as long as it was documented in the notes, a form 12A did not need to be completed. This was put on the basis that the form 12A was unnecessary paperwork but ignored the wishes of the consumer, the requirements of the Act, or that the nomination, if done properly, could last well beyond the length of that admission to hospital.
- It appears that ward staff do not as a matter of routine tell consumers or their Personal Support Persons about the possibility of being a Nominated Person or the advantages it brings. Access to the approved form is not obvious, though staff could easily provide it to consumers. In one case where the Advocate had advised the consumer of the Nominated Person role and asked staff to provide the consumer with the approved form, ward staff failed to do so. The Advocate intervened and produced the blank form so that the adult consumer could nominate a close family member.
- Ward staff refused to give the consumer a form 12A saying that the psychiatrist had to first decide if the consumer had capacity before they would give the consumer the form 12A to be filled in.
- A regional mental health unit which uses the form 12A regularly has had difficulties getting the Nominated Person - who may be hundreds of kilometres away - to sign the form accepting the nomination. Though they may be prepared to be the nominated person, they often don't have a fax, email or scanner available.

Despite 1,670 people being put on 2,324 involuntary treatment orders, the Chief Advocate received only 202 notifications of Personal Support Persons and no reasons were given for any consumer who did not have a Personal Support Person notified.

11. Right to Interpreters and be Treated in a Culturally Appropriate Way

The Act requires that any communication under the Act must be in a language, form of communication and terms that the person is likely to understand, and using an interpreter if necessary. There are also various provisions regarding the assessment and care of people of Aboriginal and Torres Strait Islander descent and the *"Charter of Mental Health Care Principles"* requires that a mental health service must:

- recognise, and be sensitive and responsive to, diverse individual circumstances, including those relating to gender, sexuality, age, family, disability, lifestyle choices, and cultural and spiritual beliefs and practices
- provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities, including elders and traditional healers, and Aboriginal or Torres Strait Islander mental health workers.

The Advocacy Service's policy is that anyone who does not speak English as their first language, no matter how good their English is said to be, will be offered an interpreter and an interpreter will be used where there is any doubt about the consumer's understanding. A specialist Aboriginal Advocate has also been engaged to assist both Aboriginal consumers and Advocates. Several other Advocates are from culturally and linguistically diverse backgrounds and/or have some training in working with people from culturally and linguistically diverse backgrounds.

Advocates noted 101 consumers with whom they had contact as being of Aboriginal and Torres Strait Islander background, although this is probably under-reported due to unfamiliarity with the Advocacy Service database. This was 5% of all consumers with whom Advocates had contact. The next highest number reported was Sudanese followed by unidentified African, then Somalian. Again this is likely to be an under-reporting.

Interpreter issues

Twelve complaints relating to lack of interpreters being offered were reported by Advocates. Sometimes mental health service staff would ask to use the Advocate's interpreter while they were on the ward. In one case a consumer who spoke little or no English was made involuntary without access to an interpreter and the ward was using a staff member who was also the consumer's cousin to interpret. The consumer who came from a refugee background was subjected to further trauma by being restrained on the ward.

Aboriginal and Torres Strait Islander services

Advocates report that mental health services are not consistently offering consumers of Aboriginal and Torres Strait Islander descent their rights under the Act to conduct examinations and provide treatment in collaboration with Aboriginal and Torres Strait Islander mental health workers and/or significant members of the person's community. A complaint to HaDSCO is underway in one case. Getting access to the Statewide Specialist Aboriginal Mental Health Service (SSAMHS) and traditional healers is also difficult. Some of the issues are illustrated below:

- A consumer was made involuntary on the basis that she called herself a healer which was considered a "grandiose delusion" by the treating team. The consumer regarded these beliefs as sacred and private, and did not want to discuss them in detail. The Advocate informed the consumer of her additional rights under the Act as a woman of Aboriginal descent, introduced her to the Advocacy Service's Aboriginal Advocate, and put her in touch with SSAMHS and the MHLC so she could prepare for a Mental Health Tribunal hearing. In the Tribunal hearing the consumer was supported to put forward her views about her spirituality and to request that she be discharged on a CTO. The MHLC lawyer highlighted that the risks associated with her being in the community were not significant enough to warrant her remaining in hospital. The treating team disagreed with this but the Tribunal ruled in favour of the consumer and asked that a CTO be arranged. The consumer said that the Aboriginal Advocate made her feel empowered and gave her more confidence in her healing powers.
- A child on an adult ward was told that the Aboriginal Liaison Officer available to the hospital was not contracted to assist anyone under 18 years old. The Advocacy Service wrote to hospital management who responded saying that none of the Aboriginal Liaison Officers had specialist mental health skills and knowledge but they were available to children. The clinical team had however failed to action the referral for an Aboriginal Liaison Officer despite two requests. Education for clinicians was to be rolled out. The issue was also put on the hospital risk register and plans were in place for a specialist to be recruited later in 2016.
- According to Advocates, a number of Aboriginal consumers are being detained in hospital for much longer that they need to be because there are no mental health services in their communities. If it wasn't for this issue they would be put on a CTO and allowed to go home. Their recovery is not only delayed but the length of time in hospital leads to institutionalisation and recovery becomes that much more difficult.
- The lack of intergovernmental agreements with other states and territories under Part 24 of the Act has also caused issues for at least one Aboriginal consumer who would like to be treated in their home state. If an agreement were in place, the consumer could be taken home while still involuntary.

PSYCHIATRIC HOSTELS – RESIDENTS' RIGHTS AND ISSUES

Private psychiatric hostels[10] (hereafter called hostels) are often part of the consumer's journey. They play a pivotal role in the care and treatment of people with severe and chronic mental illness in helping them to avoid hospital admission or transition out of hospital sooner, or by providing intensive care, and rehabilitation and recovery services to those whose illness and hospitalisation has been very disabling. In some cases they provide a home and care for life.

Hostel residents are "identified persons" under the Act so can request contact by an Advocate. The Act does not require bimonthly visits as the 1996 Act did, however, which considerably enhanced the accessibility of Official Visitors and increased the "watchdog" element of the role. The Council of Official Visitors considered some hostel residents to be a particularly vulnerable group and consistently over the years raised issues as to the safety and suitability of some hostels. It can also be very difficult for hostel residents to raise complaints for fear of recrimination or being evicted into homelessness.

The Advocacy Service Executive determined, therefore, that funding should be set aside so that those hostels where there are the greatest number of vulnerable residents ("identified hostels") should be visited by an Advocate every two months and all other hostels visited at least once in the seven months to 30 June. The visits were conducted as part of the inquiry function in s352(1)(b) of the Act with the aim of ensuring the health, safety and wellbeing of the residents. A full list of the hostels and bed numbers as at 30 June is set out in appendix 2.

Eighty five hostel residents requested assistance from Advocates in the seven month period since 30 November 2015. This is a significant reduction from the number of requests made to Official Visitors (202 in 2014-2015) which is of concern because there have not been any changes or improvements of significance in the sector.

1. Funding and Discrimination

There is variety of styles of hostels and significant differences in what they offer and what they are funded to do. This is important because consumers have different needs and may be at different stages in their recovery journey.

It is of major concern, however, that the living conditions, staffing levels and programs and services for recovery of residents in some hostels is considerably less than residents of other hostels. These hostels receive a lot less funding from the MHC than other styles of hostels - yet the residents of these hostels tend

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

to have the most chronic and severe mental illness with complex needs. Often they are rejected by the other, better funded hostels.

The lesser funding is discriminatory to these residents. The prime reason given for the lower funding is that the hostel is run on a "for profit" basis but that should not be an excuse to allow lower living conditions and not supply in-reach services. Either the residents in such facilities need to be better funded or alternatives provided.

2. Oversight, Governance and Services

The oversight and governance of hostels is complex with four parties involved including the Advocacy Service:

- The Licensing and Accreditation Regulatory Unit (LARU) within the DOH licences hostels under the *Hospitals and Health Services Act 1927* and regulations, approves Supervisors working in hostels and does annual inspections to check whether its "*Licensing Standards for the Arrangements for Management, Staffing and Equipment - Private Psychiatric Hostels 2006*" (LARU Standards) have been met. Certain types of serious incident must be notified to LARU. A facility which meets the definition of a hostel must be licensed by LARU whether or not it receives funding from the MHC or elsewhere. Advocates always take into account the LARU Standards when visiting hostels and taking complaints from residents to determine their rights.
- The MHC contracts with the hostel licensees at different levels of funding depending on the type of hostel. The MHC calls for self-evaluation by hostel licensees and engages contractors to conduct evaluations of hostels every three years. This program has only been running since February 2015 so some hostels are yet to be evaluated. The extent to which the hostel meets the "*National Standards for Mental Health Services*" is part of the evaluation. The MHC also requires notification of incidents which it monitors and reviews. The MHC and LARU use the same format for this. Advocates take into account the National Standards and may contact the MHC about concerns.

It is of major concern, however, that the living conditions, staffing levels and programs and services for recovery of residents in some hostels is considerably less than residents of other hostels.

- The Chief Psychiatrist is responsible for overseeing the treatment and care of hostel residents[11]. "Notifiable Incidents" as defined in s525 of the Act must be reported to the Chief Psychiatrist who has similar but slightly more extensive powers than Advocates under the Act to visit hostels, interview and make inquiries of staff and residents and view documents.

The four agencies meet quarterly as part of a "*Psychiatric Hostel Agency Committee*" to share information.

A review of the LARU Standards began in 2015. It is hoped the outcome will see an improvement of standards in hostels. The four parties along with other stakeholders including the DOH and hostel licensees are currently reviewing draft new standards.

3. Type of Issues Raised

Financial issues and welfare services were common issues raised by residents and noted by Advocates. Mostly these related to access to funds or community programs including the National Disability Insurance Scheme (NDIS). Many hostel residents do not control their own money and have an administrator (usually the Public Trustee) and a guardian (often the Public Advocate). Many have only Centrelink pensions though others have family support or may have an inheritance. Some hostel residents find it very difficult to express their needs and wishes even for simple things like some extra money to buy clothes or to put on a party for their birthday. The Public Trustee does not routinely send out statements so residents often have no idea of their funding situation. Even when a statement is requested, it can be very difficult to understand. If a person wants to leave the hostel and move to other accommodation the guardian's approval is needed so Advocates may be working with several parties to achieve the resident's wishes.

Physical health issues was another common issue for residents noted by Advocates, usually related to access to dental, podiatry and physiotherapy services. Complaints about conflicts with other residents, and sometimes staff, were also dealt with by Advocates. Some hostels have up to 70 residents, often with shared bedrooms. This can lead to tensions between residents; in one cases a resident felt bullied by another. Residents should feel safe enough to approach hostel staff about any issues they have but this is not always the case and not all hostels are equipped or staffed to deal with such situations.

4. Evictions and Admissions

While evictions were relatively few in number, they are extremely serious for the evicted resident. Advocates have particular concerns that some hostel licensees who are paid substantial amounts of money by the MHC too easily move to evict a resident particularly if the resident becomes unwell and is hospitalised. When evicted the resident becomes another patient "stuck" on a hospital ward. In other cases the admission process is not transparent. Some examples are highlighted below.

- Hostel staff and management told a resident's Advocate that the resident was not suitable for their type of accommodation, despite the resident having lived there for many years. Hostel management was arranging a guardian to be appointed with a view to getting the guardian to move the resident out. As the Advocate noted: "For a person who

11 See s515 of the Act.

previously had a number of positive relationships with people who have now left and the treating team, there doesn't seem to have been a strong effort or strategies to resolve the issues." The Advocate involved the MHLC and there was some intervention by the MHC. To date the resident remains living at the hostel and hostel staff have changed their approach.

- In another case the resident was still "living" on a hospital ward, five months after hostel management refused to allow them back after a hospital admission. The resident is not keen to go back to the hostel given what the resident considered to be hostile attitudes of hostel staff but there is no other suitable accommodation available. The eviction also added to the resident's trauma and made recovery more difficult.
- In a third case the hostel resident had not been evicted at 30 June 2016 but there was enormous pressure from the hostel staff and management for them to move out.
- In a fourth case, negotiations to retain the resident's place in the hostel were still underway at 30 June 2016[12].
- Getting in to a hostel can be just as difficult - a young homeless person was still stuck on a ward six months after being admitted. Hospital social workers were told that a hostel which appeared to be a perfect fit for the consumer had 33 people on the wait list and that it was a first come, first serve arrangement rather than based on prioritising need. Various inquiries were made and it became clear that the community mental health service was acting as a "gate-keeper". The process around admission to this hostel has since changed and the person was accepted to the hostel soon after.

5. Physical Conditions

Residents also complained about the physical conditions of hostels but residents tend to be fearful of raising these issues with hostel management so often they are raised by Advocates using their inquiry power under s352(1)(b). Illustrations of some of the concerns are highlighted below.

- A family member of a long-time resident in a hostel was inconsolable when relating what she said were "squalid conditions" of the hostel where her family member resided to a Senior Advocate. She did not want to divulge the name of the hostel for fear that her family member would be evicted with nowhere to go if the hostel owner got to know about the complaint. She said she was angry that hostel owners were allowed to "get away with such appalling services being provided while taking residents' money" (residents can pay up to 87.5% of their disability pension and any rent allowance to their hostel). There are many families who are unable to look after their loved ones at home but there are very limited options of psychiatric hostels for people who will be long-term residents with high needs.
- Advocates saw that there was no soap, toilet paper or hand towels in any of a hostel's bathrooms. Hostel management said they hand out toilet paper when residents needed to use the facilities and that residents took the soap back to their rooms. This was addressed immediately by the Advocates and subsequent visits indicated that this issue has been resolved.

12 But resolved after that with the resident allowed to stay.

- Standard Seven of LARU's Standards requires that facility equipment and infrastructure are properly maintained to ensure comfort and safety for all residents and staff. In one hostel there were no fans or cooling systems for residents. Consequently the rooms inspected were hot and stuffy on hot days and especially when the temperature exceeded 40 degrees. In winter, when the temperature can dip as low as three degrees, there was no heating for residents in two hostels. Ten residents told the Advocate that they were cold. As the result of the Advocacy Service's intervention one hostel provided heaters as promised and a few days later the Advocacy Service received an anonymous phone call from one of the residents leaving a message on the answer phone: "Thank you so much for all the heaters all over the place". The other hostel owner refused to provide heaters saying the Advocate would be to blame if something happened because residents had heaters. Resident comfort issues will continue to be followed up.

- According to Standard Nine of LARUs Standards, residents should be provided with a nutritious diet that meets their individual needs. There are also regulations around food:
  - In one hostel with a large number of residents Advocates observed a fruit bowl with four soft apples, four discoloured pears, two oranges that had bruised skins and some small hard plums in the dining area. There are many residents who cannot eat hard fruit. The door to the dining area remained closed until food was put on plates and placed at tables at meal times. Lunch served consisted of a burger with ham and lettuce filling.
  - In another hostel, the Advocates were told by the Manager that as there was only one resident who is vegetarian they could have a sandwich of their choice if they remembered to ask for it in advance or purchase food from outside.
  - A hostel introduced a curfew of 9pm which had been left in place for some time. It was lifted after Advocates raised the issue on behalf of residents.

Private psychiatric hostels play a pivotal role in the care and treatment of people with severe and chronic mental illness in helping them to avoid hospital admission or transition out of hospital sooner, or by providing intensive care, and rehabilitation and recovery services.

SYSTEMIC ISSUES

There are a number of systemic issues of concern which have come to the attention of the Advocacy Service including the following:

1. bed pressures caused by the lack of appropriate community programs and accommodation services especially for those people with the most complex needs who no-one or few will admit. Advocates regularly assist people trying to get discharged including working with the treating teams to facilitate and advocate for access to community services[13]
2. a looming crisis of care for 16 and 17 year old children who are going to be forced onto adult wards and who will no longer have a mental health service dedicated to their needs and particular issues
3. children on locked wards who are technically voluntary but without access to other protections of the Act or the Advocacy Service's Youth Advocate and often with little or no carer support
4. voluntary patients detained on locked wards who can be restrained and secluded and have other rights restricted but have less rights than involuntary patients - including older adults at a time when there are increasing reports of older adult abuse
5. lack of a dedicated mental health service for the care and treatment of complex eating disorders.

1. Bed Pressures - Lack of Appropriate Accommodation and Care in the Community

There is a bottle-neck in authorised hospital beds because there are not enough alternatives such as step-down facilities to help consumers transition from hospital to home or hostels able to care for consumers with very complex needs. Sadly having consumers discharged into short term or backpacker type accommodation is no longer unusual but it is not conducive to recovery because there is no stability of accommodation, other residents do not understand mental health issues, and there is no-one available to support the person in case of relapse. The first seven days after discharge are said to be particularly high-risk for relapse and suicide. Hospitals say they are not accommodation providers - but discharging a person into almost certain homelessness cannot be proper care.

The Council of Official Visitors first started surveying authorised hospitals in 2013 asking how many patients were "stuck" on wards as at 30 June. The Advocacy Service conducted the same survey again this year. Information was also sought from 36 psychiatric hostels regarding the number of licensed beds and vacancies as at 30 June 2016.

13 As per the Advocate's function in s352(h) of the Act.

Table 1. Summary of number of people in hospitals due to lack of accommodation or community care options as on 30 June 2016.

	Responses as at 30 June 2015 (15 out of 18 authorised hospitals comprising 578 beds)		Responses as at 30 June 2016 (15 out of 18 authorised hospitals comprising 567 beds)	
	Number of patients	Number whose discharge is delayed due to lack of accommodation and community care	Number of patients	Number whose discharge is delayed due to lack of accommodation and community care options
In hospital for 30 days or longer	272	101	177	92 – 16.2% of beds
In hospital for 90 days or longer	127	74	95	67 – 11.8% of beds
In hospital for 6 months or longer	92	63	58	47 – 8.3% of beds
In hospital for 1 year or longer	65	51	50	43 – 7.6% of beds
In hospital for 2 years or longer	37	31	43	38 – 6.7% of beds

Hospital survey results

The 15 hospitals reported 108 people or 19.0% of patients whose discharge was delayed due to accommodation issues. Fifty people had been in hospital for over a year as at 30 June 2016 and 43 for over two years. This is an improvement over last year, though the hospitals which responded are not the same which means a comparison may be flawed[14]. See table above.

All of the 43 people in hospital for over two years were in Graylands Hospital which provides the largest number of rehabilitation beds in WA. It had an increase in the number of people who had been in hospital for over two years due to no suitable supported accommodation, from 35 in 2015 to 38 in June 2016. Another five people had been in Graylands for over two years but two were currently on leave in the community, one was awaiting a vacancy in a community facility and two were considered too unwell for discharge.

People who were stuck on mental health wards due to lack of suitable accommodation were spread across various hospitals. Seven hospitals noted a variety of complex needs as the reason for difficulties in finding some mental health patients suitable accommodation. Examples of complex needs noted by hospitals included high risk patients, multiple dependencies as well as mental health issues (eg illnesses such as Hodgkinson's disease and acquired brain injury), challenging behaviours, ongoing substance abuse, aggression and significant forensic history.

14 In 2015 Armadale Hospital and St John of God Mt Lawley Hospital did not respond and Bunbury Hospital responded but the information could not be used. In 2016, Selby Hospital and St John of God Mt Lawley Hospital did not respond and Frankland Centre responded but the information could not be used.

Comments from mental health services about why they had difficulties discharging patients included the following:

- a unit that had six patients whose discharge was being delayed due to accommodation issues said there is a lack of long term accommodation options for the "chronically unwell" and/or "high risk patients who require intensive support". They also noted that non-government organisations (NGOs) are not willing to take people with complex needs
- difficulty finding suitable accommodation for patients developing organic illnesses with decreased functioning alongside their mental health issues
- families and carers refusing to take patients home
- no crisis or short term accommodation in the local area as well as long wait times for homeless accommodation services
- step-down services not providing services for high risk people
- limited transport options and lack of step down facilities
- out of area clients with complex discharge planning needs.

Eight consumers, in two of the four regional authorised hospitals, were awaiting suitable accommodation. Five of these consumers were from one regional area where, surprisingly the local psychiatric hostel also reported two vacancies. The psychiatric hostel, which is a Community Supported Residential Unit, has specific criteria for accepting residents and it was said that the consumers in hospital did not meet the criteria. One patient who had been in the same hospital for four months was also awaiting transfer to a Perth based hospital. Staff said this would speed up their accommodation placement because most facilities required the patient to visit prior to being accepted.

Hostel survey results

The 36 hostels who responded to the survey represented 820 psychiatric hostel beds and somewhat surprisingly 78 vacancies were reported. Thirty six of the 78 vacancies came from two hostels. One 25 bed facility with 11 vacancies was undergoing renovations and another hostel with seven vacancies also said renovations contributed to their vacancies. A large hostel reporting 25 vacancies commented that the reasons were "lack of referrals from other agencies due to high turnover of social workers/case workers; aged care facilities accommodating mental health clients; and lack of interest from government and community to promote such places."

Sadly having consumers discharged into short term or backpacker type accommodation is no longer unusual but it is not conducive to recovery.

Other responses from hostels with vacancies included:

- not being able to cater to the needs of referred patients due to a variety of reasons (e.g. violent or abusive behaviour, level of acuity or high needs, requiring 24 hour support, and a requirement for female only accommodation)
- the referring body not understanding the level of care offered by particular hostels, with one hostel noting they do not have the capacity to work with residents who have drug induced psychosis or drug addiction
- a Community Supported Residential Unit hostel (where people live in villas and do their own shopping and cooking and are usually required to engage in specific recovery programs before transitioning to other accommodation) stating that some consumers are concerned the program offered may restrict their lifestyle, demonstrating a lack of understanding as to what a Community Supported Residential Unit offers by both the consumer and the referring body
- hostels saying they can't accept anyone with drug or alcohol addiction
- residents being moved on to aged care facilities which the hostel cannot accommodate.

Eight of the 36 hostels said they had a waiting list suggesting there is currently more demand for certain types of accommodation than there are places available, but surplus places in other types of hostels. The Advocacy Service did not specifically ask about waiting lists so conclusions are limited. Many of the hostels without vacancies said that they receive regular calls seeking accommodation but the person was not suitable and/or that they did not keep a waiting list. When responses from hostels were compared with hospitals, it seems fairly clear that there is a lack of facilities in the community that provide care for consumers with complex needs including drug and alcohol addiction and forensic history.

A systemic gap analysis, as well as flexibility in the system would help ensure that public funding of hostels meets community needs and assists people to move out of very expensive and restrictive hospital environments that tend to institutionalise people. The MHC is undertaking a two year project to develop an accommodation and community support strategy as part of its *"Mental Health, Alcohol and Other Drug Services Plan 2015–21025".* The Chief Advocate and a number of regional advocates have provided information to the project team.

While many long term patients are being rejected by accommodation and community support providers, there are success stories which show recovery is possible and long term hospitalisation is not the answer. A consumer who was once labelled the most "dangerous and expensive patient in WA" and was on a two nurse special for 24 hours a day for a long period of time and regularly put into seclusion, has now lived in the community for over two years.

2. Children on Adult Wards

There is a crisis of care planning for 16 and 17 year old mental health inpatients. The crisis has been coming for a while as it was decided a long time ago that the Perth Children's Hospital (PCH) and CAMHS would not cater for this group. Currently the state's only authorised mental health ward for children, the BAU, is managed by CAMHS but this will no longer be the case when PCH opens. The crisis was brought to a head in March when CAMHS closed its children's ward at PMH and said it would no longer accept 17 year old children in the BAU. It means that these young people, who are defined as children under the Act, will only be able to be treated at Fiona Stanley Hospital's Youth Ward (for ages up to 25 years) or on adult mental health wards (and this is already the case for 17 year olds.) The immediate impact in April was children stuck in EDs (see above[15]).

For many this will be the child's first exposure to a mental health ward and/or involuntary status. A child on an adult ward has a high risk of being traumatised by being on a large, noisy ward surrounded by older and very unwell patients witnessing restraints and seclusions. The early treatment of a young person needs to be age appropriate and full of hope for recovery to ensure that they do not become life-long revolving door mental health consumers as so many of the people the Advocates see on locked wards are.

The Act is very clear, for a child to be on an adult ward:

- the treatment, care and support must be appropriate to the child's age, maturity, gender, culture and spiritual belief
- the child must be separated from any part of the mental health service in which adults are provided with treatment and care if, having regard, to the child's age and maturity, it would be appropriate to do so.

Unless someone has decreed that all 16 and 17 year olds are mature enough to be on an adult ward, and clearly this is not the case, many wards will not be able to meet the requirements of the Act.

The early treatment of a young person needs to be age appropriate and full of hope for recovery to ensure that they do not become life-long revolving door mental health consumers.

15 Under "The road to being made involuntary".

The *"Clinicians' Practice Guide"* further says:

- every effort should be made to avoid admitting children to facilities that do not normally provide treatment or care to children
- all children admitted to an adult inpatient facility need to be either physically separated from adult inpatients at all times or provided with a level of observation / supervision that will address their vulnerability and ensure continuous protection from others.

Having a child on an adult ward will increase that child's risk of harm, both physical and mental.

The Chief Advocate wrote[16] to the Minister, the Commissioner for Mental Health and the Director General of the DOH raising concerns that nothing had been done despite all parties having been aware of the impending issue prior to the closure of the CAMHS ward. It is understood that a "Crisis Management Plan" is being developed creating more youth wards for young people aged 16 to 24 which is a partial solution and better than being on an adult ward with older patients, some of whom may be institutionalised and/or have chronic mental health issues.

There needs to be a specialised service or directorate, however, to take State-wide responsibility for this age group to make sure they get the best-practice care for their needs which are different to older people who have been in the system a while. Co-ordination, particularly in relation to bed flow across the different health services as well as greater integration with community services, is also crucial to avoid children languishing in EDs and still being admitted to adult wards. Training and education of staff on how best to treat youth is also badly needed and this won't happen in a consistent way without such a service or directorate. Doing this is the best chance we have of enabling the recovery and reducing the prospect of relapse of these young people who, on the face of it, look like being abandoned to the adult system.

The Advocacy Service's concerns for the wellbeing of these children is exacerbated by the inability to assist many of them because they are being treated as voluntary despite being on locked wards. See below.

3. Children Without Access to the Youth Advocate

From 30 November 2015 to 30 June 2016, the Advocacy Service received notifications of 28 involuntary inpatient treatment orders and five CTOs for children. The orders included children aged from 12 to 15 but most were 16 or 17. The vast majority of children on locked mental health wards do not have access to an Advocate because they are voluntary patients.

The inability to assist voluntary children limits the new role of the Youth Advocate created by Parliament and means that children with very complex needs are greatly disadvantaged in stark contrast to adults in the same situation but involuntary. Such children may have a treatment resistant illness, broader social issues impacting on their recovery, and accommodation issues impacting on discharge planning, (particularly in relation to children known to the Department for Child Protection and Family Support), and do not have much carer/family support. Staff have told of very difficult issues when children refuse to go home or back to foster parents or vice versa.

16 In July 2016 a committee comprising representatives from all area Health Services was working on a crisis management plan as at 12 September 2016.

Voluntary children can also be given ECT and psychosurgery under the Act provided approval is given by the Mental Health Tribunal but they have no access to an Advocate to voice their concerns or views despite such serious decisions being made on their behalf.

The Youth Advocate is trained in youth issues, familiar with agencies and services which are likely to be involved or might be able to assist, and can be of considerable assistance to the child and the treating team – noting that the Youth Advocate must apply a best interests approach and has the function of advocating for and facilitating access by young consumers to other services (in consultation with the treating team).

As noted above, the Minister may issue a direction making voluntary children a class of identified person with access to an Advocate and submissions to request this are being prepared.

Examples of requests for advocacy and/or where advocacy would have ensured rights were protected include:

- parents who were concerned about a plan to put their child on an antipsychotic drug with known major side-effects and told the child would be made involuntary if they did not agree
- children who alleged that a nurse had spoken to them inappropriately suggesting that they were not really ill and were “attention seeking”
- children on award where staff removed their phones
- children who were restrained and secluded
- hospital staff request to assist a child where the Department for Child Protection and Family Services were involved and there were disagreements about the discharge process
- children who were homeless
- children on adult wards and waiting in EDs.

As noted above, the Minister may issue a direction making voluntary children a class of identified person with access to an Advocate and submissions to request this are being prepared.

The Youth Advocate is trained in youth issues, familiar with agencies and services which are likely to be involved or might be able to assist, and can be of considerable assistance to the child and the treating team.

4. Voluntary Patients on Locked Wards not Allowed to Leave

It is common for patients who are not involuntary under the Act to be on a locked ward. All the mental health wards in the Joondalup, Midland, Fiona Stanley, Albany, Kalgoorlie and Bunbury hospitals, Selby Lodge and the BAU are locked, as are all older adult wards. On these wards every patient, including voluntary patients (who, because they have agreed voluntarily to treatment, are entitled to decide when they leave the ward), must ask to be allowed to leave the ward and cannot leave the ward unless a staff member unlocks the door for them. Children and older adults, for example, are all on locked wards but very few are involuntary.

Advocates cannot assist these voluntary patients because they are not defined in the Act as "identified persons" nor can they assist people who call the Advocacy Service saying they are trying to get themselves or a loved one admitted to hospital (who are often suicidal).

Advocates also have to stop assisting a person who was involuntary the moment the person becomes voluntary, and so is no longer an identified person, despite the issue remaining unresolved.

Advocates are regularly approached by voluntary patients complaining that they have been told they cannot leave, or if they insist on exercising their right to leave that they will be made involuntary. Most commonly they are on an older adult ward or an "open" ward with locked doors. Psychiatrists say this is "less restrictive" but the voluntary patient on a locked ward is significantly disempowered and effectively has fewer rights than an involuntary patient:

- they do not have regular review by the Mental Health Tribunal which provides oversight and a process for external accountability
- they have no access to an independent Advocate also providing external oversight and increasing accountability
- they do not have a right to a further opinion also providing external oversight and increasing accountability
- they cannot leave whenever they want
- they can be restrained, secluded and have their phone and visitor access restricted without the protections that involuntary patients have.

Advocates are regularly approached by voluntary patients complaining that they have been told they cannot leave.

In such cases the person is referred to the Health Consumers' Council but Advocacy Service Advocates have powers under the Act not available to other advocates, specialist expertise and knowledge, and are spread across all major regions of WA. Both the Holman[17] and Stokes Reviews[18] called for all voluntary patients to have access to advocacy.

The Minister may direct classes of voluntary patient to be an identified person under the Act in consultation with the Chief Advocate. Submissions and costings for certain classes of voluntary patients to be made "identified persons" under the Act are being prepared for consideration by the Minister who has been given a preliminary briefing on the issue. Extra funding, resourcing and capacity building of Advocates will be required for some of these submissions.

Examples of cases reported by Advocates include the following:

- A person on a form 1A (referred for a psychiatric examination) with no family or friends to support them and on their first encounter with mental health services was assisted by an Advocate but was then not made involuntary, despite being required to remain in hospital. They were told they would be made involuntary if they didn't agree to stay. Because the person was no longer on a form 1A and was not made involuntary, they were not an "identified person" under the Act and could no longer be assisted by an Advocate. There were a number of issues and concerns raised by the person who had to be referred to the Health Consumers' Council. The consumer was very distressed by this and felt they would have been better supported by the Advocacy Service and even offered to pay privately for the Advocate's services.

A voluntary patient telephoned the Advocacy Service several times very confused over their status because they were told they could only leave the ward if they were given "escorted ground access".

17 Proposal 9.2 Holman Review of the Mental Health Act 1996 in 2004.
18 Recommendation 2.3 in the Stokes Review 2012.

- A voluntary patient was told by their psychiatrist that they would not be allowed to leave the ward unless they had a depot injection. An Advocate spoke to the psychiatrist to confirm the position. The psychiatrist was insistent that the consumer had to have the injection. The patient was then given the contact details for Health Consumers' Council and was also put in contact with Legal Aid.
- A consumer's involuntary order was allowed to expire just before a Mental Health Tribunal hearing that the consumer had requested to review their involuntary status but the consumer was not allowed to go home for six days.
- A voluntary patient telephoned the Advocacy Service several times very confused over their status because they were told they could only leave the ward if they were given "escorted ground access". The patient initially thought that police or nurses would have to accompany them and visiting family on a family outing. The patient's rights were explained to them but cases like this are common and they cannot be assisted by an Advocate any further than a quick explanation of their rights.
- A patient on an older adult ward was voluntary but had phone restrictions and was not able to go out without someone and they wanted to know why. Voluntary patients can have their rights to communication and visitors restricted, and the psychiatrist in this case told the Advocate that this was the "least restrictive" option and better than making the patient involuntary. It meant, however, that the patient did not have a regular review by the Mental Health Tribunal and had no access to an Advocate or right to a further opinion. All older adult wards are locked and most patients are voluntary so cannot be assisted by an Advocate.

5. Eating Disorders

Eating disorders are one of the hardest types of mental illness to treat. Patients are often aged 16 to 25 and, as noted in the "*WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025*"[19], the "window of opportunity" for a successful outcome begins to fade after three to four years, underscoring the importance of intervening early.

Advocates have assisted a number of patients with eating disorders in the past seven months and very sadly, one lost her life after a long battle.

There are no dedicated public inpatient mental health services for people with an eating disorder and there is a serious lack of programs and community support in WA which urgently needs to be rectified. MHC modelling showed a need for 47 eating disorder beds by the end of 2015 and parents and consumers have complained to Advocates about the lack of support in the community after discharge.

As noted above, most eating disorder patients are treated in general hospitals and not in authorised hospitals. This is often so the consumer can be force fed through a nasogastric tube. If the consumer refuses and continually removes the drip, ward staff will then physically restrain them holding them down while the liquid is intubated. This can take up to two hours and occurs daily. The process is extremely traumatic for everyone involved.

19 At page 76.

Ketamine, a drug used for anaesthesia, is also sometimes used as part of the feeding process. In one case this year medical staff canvassed putting the consumer into an induced coma for a week while tube feeding them with a view to avoiding the distress. The plan was not approved. An Advocate supported the family through this and other issues while the consumer remained involuntary.

Some of the issues in which Advocates were involved for these consumers were as follows:

- a consumer complained that they were not allowed to close the door when going to the toilet and had their room regularly searched
- another consumer complained that they had a nurse following them at all times but no access to any psychological therapies. The psychiatrist told their Advocate that this was because there was no funding
- a consumer's Advocate negotiated a "night feed" after family and friends left as the tube feeding was so distressing to the consumer
- in another case the young consumer said they thought they would find it easier to talk to a female doctor so the Advocate negotiated for a female psychiatrist on the CTO when they were discharged.

6. Ongoing Systemic Issues from Past Years

Appendix 11 provides a year-by-year, summarised list of systemic and ongoing issues which were raised by the Council of Official Visitors under the 1996 Act in each of its Annual Reports since 1998–1999 which remain ongoing systemic issues under the new Act.

Advocates have assisted a number of patients with eating disorders in the past seven months and very sadly, one lost her life after a long battle. There are no dedicated public inpatient mental health services for people with an eating disorder and there is a serious lack of programs and community support.

The vast majority of adults on inpatient treatment orders were contacted by an Advocate within seven days after being made involuntary.

PART THREE
ADVOCACY SERVICE DATA, BUDGET, AND OTHER ACTIVITIES

INVOLUNTARY CONSUMER NUMBERS

There were 1,670 people put on 2,324 involuntary treatment orders[20] in the first seven months of the Advocacy Service's operation from 30 November 2015 to 30 June 2016[21].

This is based on notifications to the Chief Advocate so may be an under-representation of the total number of orders or people affected if the Act was not complied with and the Chief Advocate was not notified as required by s145.

Of those:

- 1,552[22] people were detained on 1,854 inpatient treatment orders in an authorised or general hospital. Of these:
  - 1,518 people were detained on 1,807 inpatient treatment orders in an authorised hospital (form 6A) including 18 children who were detained on 21 inpatient treatment orders
  - 39 people were detained on 47 inpatient treatment orders in a general hospital (form 6B), including six children who were detained on seven inpatient treatment orders
- 401 people were put on 470 CTOs (form 5A) including five children who were put on five CTOs.

Statutory Contacts by Advocates

The Advocacy Service is heavily reliant on the Chief Advocate being notified and sent copies of all involuntary orders, as required by s145 of the Act, so that Advocates can be tasked with contacting consumers as soon as practicable after they are made involuntary.

Section 145 requires that all copies be sent "as soon as practicable". Just before the Act became operational, the area health services agreed that, for adults, 48 hours was a practicable time period, and two hours for children. Orders are faxed to the Advocacy Service or emailed with password protection. Once the order is received, Advocacy Services Officers enter the order into the ICMS database following which the relevant Advocate is advised (via their ICMS dashboard and/or phone) that contact is required and the deadline for contact.

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

20 Including involuntary treatment orders and CTOs and some people were put on orders more than once. Verification of ICMS data is ongoing and may be subject to change.

21 See appendix 3.

22 Note: Up to six people were detained on both a form 6A and a 6B at different times so the numbers (1,518 and 39 people detained on a form 6A and 6B respectively) are not cumulative and don't add up to 1,552.

The vast majority of adults on inpatient treatment orders (1,674 out of 1,826 inpatient treatment orders or 91.7%) were contacted by an Advocate within seven days after being made involuntary. Of those, 76.5% were contacted within the first four days of being made an involuntary inpatient.

Appendix 6 sets out the time taken for facilities to notify the Advocacy Service. Generally the response by health services was very good. While most involuntary treatment orders were sent to the Advocacy Service within 48 hours of the order being made (1,919 out of 2,324 orders or 82.6%), 292 orders were outside the agreed time period and a further 39 orders that the Advocacy Service knows of were never received by the Advocacy Service from the health service.

According to the ICMS database[23], adults on 152 inpatient treatment orders were not contacted within seven days of the order being made[24]. Adults on 43 CTOs were also not contacted within seven days of the CTO order being made.

Four children were not contacted within the 24 hour statutory time period. In one instance the order was received by the Advocacy Service 16 minutes before the 24 hours expired and in a second instance 30 minutes beforehand. In the other two cases, one order was made on the Saturday of the first weekend after the new Act became operational and the Advocate manning the weekend phone roster made a mistake and did not notify the Youth Advocate in time; in the other case the Advocate missed the 24 hour deadline by only 10 minutes.

In order to reduce the risk of consumers not being seen on the ward within the statutory time period Advocates are required by protocol to always check on the wards for people who have just been put on an involuntary order.

The Advocacy Service also runs a weekend and public holiday phone roster and calls are made each day to the BAU, PMH and Fiona Stanley Hospital. However with16 and 17 year old children being admitted to adult wards since March the risk of missing involuntary children has increased.

The reasons why adult consumers on 152 inpatient treatment orders were not contacted within the statutory time period were as follows:

- 31 inpatient treatment orders were not notified to the Chief Advocate within seven days of the order date
- 80 inpatient treatment orders were revoked within seven days and before an Advocate contacted the person - including one consumer who was an involuntary patient for only 25 minutes
- four people on inpatient treatment orders were discharged and put on a CTO within seven days and before the Advocate made contact
- 37 were Advocacy Service errors in that Advocacy Services Officers either missed the notification (sent by email or fax) or the Advocate failed to contact within the time frame.

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

24 According to legal advice by the State Solicitors Office, where the seventh day falls on a weekend or public holiday, the Act is complied with if the contact is made on the next working day. The Advocacy Service has taken the conservative approach for the first seven months of operation to count the seventh day even if it falls on a weekend or public holiday.

If an Advocate becomes aware of an order and the statutory time period for contact has elapsed (i.e. seven days for adults or 24 hours for children) an Advocate will still follow up with the mental health service and if the person is still subject to an involuntary order, they will contact the consumer.

Consumers on a CTO are all sent a letter to make contact but, where possible, Advocates will also try to contact the consumer by phone.

Future notifications to the Chief Advocate

On 28 June 2016 the DOH started using a computer system, PSOLIS, to make involuntary treatment orders either electronically, directly into PSOLIS by a psychiatrist, or by transcribing hand written orders into PSOLIS. The Advocacy Service was given a "third party view" of PSOLIS which records orders which have to be notified to the Chief Advocate. The Chief Advocate agreed that electronic orders (those made directly by the psychiatrist into PSOLIS with an electronic signature) would be accepted as notifications pursuant to s145 as they can be relied on to be accurate and is what the consumer is given, as well as received in "real time". Other handwritten orders are being transcribed by other staff (usually ward clerks) onto PSOLIS. As a result there is a risk of inaccurate transcription (there is a quality assurance process but some orders do not appear to be checked and remain "pending") and the delays before the order is put onto PSOLIS are currently too long to be able to be accepted by the Chief Advocate as notification pursuant to s145. It should be noted that there is considerable variation on these delays across health services.

PSOLIS has the potential to remove the need for mental health services to fax or email notifications to the Advocacy Service and reduce the delays in the Chief Advocate being notified, thereby decreasing the risk of consumers not being contacted by Advocates in the required time period. It also has the benefit of providing prompts to psychiatrists regarding the approved forms which will reduce the number of errors and invalid orders. Mental health services continue to send hand written orders (or "transcribed" orders) to the Advocacy Service by email or fax but it is hoped that in the future all notifications will be electronic and can be sent to the Advocacy Services via PSOLIS. In the meantime the Advocacy Services Officers are having to use two systems and manually transfer information about orders into the Advocacy Service's database, ICMS. The ability to automatically import notifications into ICMS from PSOLIS, is badly needed to reduce data entry but funding is needed to do this.

In order to reduce the risk of consumers not being seen on the ward within the statutory time period Advocates are required by protocol to always check on the wards for people who have just been put on an involuntary order.

OTHER CONTACT REQUESTS

Apart from the statutory contacts, consumers may make a request for contact while on an involuntary treatment order and requests are also received by other types of "identified persons" including people waiting in EDs on referral orders, hostel residents, and people on Custody Orders or Hospital Orders under the MIA Act. The vast majority of requests listed below are from phone calls to the Advocacy Service, however requests can also be made via the Advocacy Service mailboxes on hospital wards, by email or in person to an Advocate at the mental health service (note some requests made directly to Advocates are included in the figures below).

In addition to the statutory contacts and assisting consumers with issues arising out of those contacts there were 4,399 requests for contact by 938 individuals. The breakdown by type of consumer is set out in the table below.

Table 2. Requests for contact.

Identified Person Type	Number of requests for contact
Inpatient Treatment Order	2,467
Psychiatric Hostel Resident	1,145
CTO	381
Non-Identified Person	253
Referred Person	139
Hospital Order	14
Total	**4,399**

ADVOCACY SERVICE WORKLOAD

The Advocacy Service's workload, based on its first seven months of operation, is at least double that of its predecessor, the Council of Official Visitors:

- Statutory contacts were made with adult and child consumers on 1,699 inpatient treatment orders (and some consumers not contacted within seven days or 24 hours were nevertheless contacted after the statutory period).
- Statutory contact was made by letter, in person or by phone with people (adults and children) on CTO's within the statutory time period for 426 CTO's (and again, some consumers not contacted within the statutory period were subsequently contacted).
- In addition to the statutory contacts, 938 consumers requested further contact[25].
- The attendance of Advocates at Mental Health Tribunal hearings was also significantly higher than Official Visitors' attendance at Mental Health Review Board hearings (see above)[26].

In order to conserve costs the number of Advocates has been kept to a minimum with Advocates being asked to carry a higher workload than Official Visitors. By way of comparison, there were 29 active Official Visitors at 30 June 2015 and the Advocacy Service had 29 Advocates at 30 June 2016 (although others will need to be appointed in 2016-2017 due to workload pressures).

The Advocacy Service was using an additional 1.2 FTE Advocacy Services Officers at 30 June 2016 compared to the same period last year for the Council of Official Visitors. An independent report in 2010 said the Council needed two extra FTE and this was before major increases in consumer numbers in later years (85% increase from 2009-2010 to 2014-2015). In 2011 the Council settled for one new staff member and subsequently implemented various cost cutting measures and using temporary staff to manage the workload in anticipation of the legislative changes and new computer system.

The functions and structure of the Advocacy Service changed under the Act and together with the new database has resulted in changes to the nature, volume and flow of work. Council was under-resourced at the commencement of the Advocacy Service. Now that the Service has taken over from the Council, a review of the administrative support arrangements is needed as a matter of priority as Advocacy Services Officers are struggling to keep up with the workload.

Overall 1,961 people had contact with an Advocate in the seven months (or an average of 280 people per month) and at least 2,637[27] contacts were made in seven months (or an average of 379 per month). By contrast, Official Visitors assisted 1,772 consumers in the 12 months from 1 July 2014 to 30 June 2015 (or on average of 147 per month). Further information including a breakdown by facility is included in the appendices.

25 This figure mostly represents phone calls to the office and probably under-represents the requests for contact because consumers will approach an Advocate when they are on a ward and ask for further assistance. At this point, this data cannot be extracted from the ICMS database.

26 See under "Right to review – Tribunal hearings".

27 This figure is based on 1,699 statutory contacts with inpatients and at least 938 consumers that requested further assistance.

BUDGET AND RESOURCING

The Advocacy Service's budget is complicated because the budget of $2,477,000 for the 2015-2016 financial year was originally allocated to the Council of Official Visitors which ceased operations on 29 November 2016. Council's expenditure up to that point in time was $909,608 but included costs associated with the transition to the new Advocacy Service.

The Advocacy Service's expenditure for the first seven months of operations was $1,647,308[28] but it included final payments to Official Visitors in December 2015 and relocation costs.

As part of the budget allocation process, Council made a submission to the MHC for additional funding to transition to the Advocacy Service and establish a new database and a further $124,000 was allocated. This funding was used for Project Officers to assist with the transition, training the new Advocates, recruitment costs, developing a new internet site, developing and printing new brochures and stationary etc. A further $303,000 was also allocated as part of that budget for remuneration for the Chief Advocate (although it did not include provision for superannuation) and remuneration for two Senior Advocates for part of the year. Costs associated with the transition and remunerating the Chief Advocate and the Senior Advocates were incurred by both the Council and the Advocacy Service.

The Advocacy Service also relocated to new furbished, larger premises in June 2016 and there were relocation costs associated with the move. The previous lease had run for nearly 16 years and the landlords refused to upgrade the premises. The new lease resulted in a slight recurrent savings in future years and provides a safer and more useful space for the Advocacy Service.

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

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

Due to budgetary concerns these rates are less than what had been paid to Official Visitors who were entitled as at 30 June 2015 to $231 for a half day (as long as they worked more than 1 hour) and $336 for a full day (as long as they worked more than 4 hours). Visitors could also claim parking and telephone costs. A submission will be made to the Minister to increase the rates from 30 November 2016 in line with the government's wages policy.

As required under the *Electoral Act 1907* s175ZE(1), the Advocacy Service expended the following in relation to the designated organisation types between 30 November 2015 and 30 June 2016:

a) advertising agencies: nil
b) media advertising organisations: $457 (Adcorp)
c) market research organisations: nil
d) polling organisations: nil
e) direct mail organisations: nil.

28 The MHC provides financial services to the Advocacy Service and this figure is derived from their reports.

OTHER ACTIVITIES

Launch of the Advocacy Service

The Advocacy Service was officially launched by the then Minister for Mental Health, Hon Helen Morton MLC, on 10 December 2016. The launch also farewelled the Council of Official Visitors and was attended by key stakeholders including consumers, the shadow Minister for Mental Health Hon Stephen Dawson, Consumers of Mental Health WA (CoMHWA), the Chief Psychiatrist, DOH, Mental Health Advisory Council, Mental Health Tribunal, HaDSCO, LARU, MHLC, WA Association for Mental Health (WAAMH), Office of the Commissioner for Children and Young People, members of various reference committees, hostel licensees, Prisoners' Review Board, former Heads of Council and Official Visitors, former Official Visitors, Advocates and Advocacy Services Officers.

Presentations, Committees and Submissions

The Chief Advocate, Senior Advocates and Advocates gave various presentations on the role of the Advocacy Service and consumer rights under the Act. These are important to ensure that consumers' rights are protected and to improve communication with mental health services staff about the role of the Advocacy Service and of Advocates. They also took part in a number of committees, forums and workshops. A full list is provided in appendix 12.

Advocate and Advocacy Services Officer Training

Considerable efforts were put into training of the new Advocates prior to 30 November 2015:

- the Council of Official Visitor's Manager and an Official Visitor attended a two day "Mental Health Act 2014 Train-the-Trainer Program" in September 2015 which was used to develop the training program for Advocates
- the Chief Advocate, Advocacy Service Manager, Senior Advocates and all other Advocates were required to complete the MHC's "Clinicians' eLearning package" prior to the Advocate's six day in-house Induction Training in November 2015
- the Chief Advocate, Senior Advocates and several Official Visitors appointed as Advocates attended the Mental Health Tribunal "Professional Development Day" regarding capacity and the 2014 Act in November 2015
- Advocate Induction Training was held over six days in November 2015. Training covered the Act in detail, the role of the Advocacy Service, the Chief Advocate's and Advocates functions/powers, pure and non-instructed advocacy, the rights of involuntary patients, the *"Charter of Mental Health Care Principles"*, assessment of capacity, Mental Health Tribunal and SAT hearings, the roles of various other agencies with whom the Advocacy Service interacts, and Advocacy Service protocols and standards. Various guest presenters also attended.

- Advocates received four hours training on the new ICMS database which is used for workflow management and recording contacts with consumers in November 2015.

Other training during the ensuing seven months included the following:

- During the Advocates' Quarterly Meeting in May 2016, Advocates received training in "Aggression Prevention Intervention - De-escalation and Breakaway Techniques" presented by Karen Mueller, A/Manager, Education and Professional Development, Armadale Health Service
- "Microsoft Excel Intermediate" course for Advocacy Services Officers
- WAAMH, Western Australian Mental Health Conference 2017 (registration provided by MHC).

Disability Justice Centre

Under the *Declared Places (Mentally Impaired Accused) Act 2015* and associated regulations, the Chief Advocate has responsibility for ensuring that residents of the Bennett Brook Disability Justice Centre, the State's only declared place, are contacted by Advocates in accordance with that legislation. A separate annual report is prepared in relation to this work which is funded by the Disability Services Commission.

RECORDS MANAGEMENT

In accordance with the *State Records Act 2000,* s19, the Advocacy Service has a "Record Keeping Plan" governing the management of all of its records. The Chief Advocate wrote to the State Archivist seeking an extension to submit the Advocacy Service's updated Record Keeping Plan. The State Archivist acknowledged that the Advocacy Service is currently working in accordance with the Council of Official Visitor's Plan and agreed to extend the period for submission of the Advocacy Service's plan to August 2017. Refer to appendix 9 for the statement of compliance with s19 of this Act and State Records Commission, Standard 2, Principle 6.

QUALITY ASSURANCE

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

Complaints

There were three complaints about the Advocacy Service received during the period 30 November 2015 to 30 June 2016. Two were from family members regarding the Advocacy Service's provision of advocacy for consumers and one was from a service provider about an Advocate:

- A complaint was received after 30 November 2015 that referred to the conduct of an Official Visitor while the 1996 Act was still in effect. A family member of a hostel resident had requested that the Official Visitor investigate why the family member was being prevented from visiting the resident. After making enquiries, the Official Visitor advised that they were satisfied that the reasons for restricting the family member from visiting were reasonable and that the resident was being well cared for. The Official Visitor did not have the resident's permission to share the information with the family member. The Head of Council was satisfied that the Official Visitor acted appropriately and in accordance with the Council's Code of Conduct.
- The daughter of a consumer on an older adult ward complained that she did not want the consumer's Advocate to provide advocacy for the consumer. The Advocate confirmed with the consumer that he did not want further assistance from the Advocacy Service and ceased advocacy.
- A service provider made a complaint about an Advocate's response when following up a complaint on behalf of a hostel resident. There were also concerns about the service provider's conduct and understanding of the Advocates' roles and the Advocate lodged a complaint with the service provider at the same time. The Advocacy Service found that the Advocate did not provide details of their supervisor when asked. The agency (for the service provider) also investigated the Advocate's complaint and a new service provider was appointed to assist the resident.

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

APPENDICES

APPENDIX 1: Authorised Hospitals

Hospital name, mental health ward and address	No. of Available Beds[29]
Albany Regional Hospital, Albany Mental Health Unit Hardie Road, Albany	**16**
Armadale Health Service, Leschen Unit Albany Highway, Armadale	**41**
Bentley Adolescent Unit Mills Street, Bentley	**12**
Bentley Hospital and Health Service, Mills Street Centre Mills Street, Bentley	**76**
Broome Health Campus, Mabu Liyan Unit Robinson Street, Broome	**13[30]**
Bunbury Regional Hospital, **Acute Psychiatric Unit (APU) and Psychiatric Intensive Care Unit (PICU)** Bussell Highway, Bunbury	**27**
Fiona Stanley Hospital, Mental Health Unit[31] Murdoch Drive, Murdoch	**24**
Frankland Centre, State Forensic Mental Health Service Brockway Road, Mount Claremont	**37**
Fremantle Hospital and Health Service, Alma Street Centre Alma Street, Fremantle	**64**
Graylands Hospital, Adult Mental Health Services Brockway Road, Mount Claremont	**121**
Joondalup Health Campus, Joondalup Mental Health Unit Shenton Avenue, Joondalup	**47**
Kalgoorlie Regional Hospital, Mental Health Inpatient Service Piccadilly Street, Kalgoorlie	**6[32]**
King Edward Memorial Hospital, Mother and Baby Unit Loretto Street, Subiaco	**8**
Midland Public Hospital, Mental Health Unit Clayton St, Midland	**56**
Mt Lawley Hospital, Ursula Frayne Unit Thirlmere Road, Mount Lawley	**12**
Rockingham Hospital, Mimidi Park Elanora Drive, Rockingham	**26[33]**
Selby Older Adult Mental Health Service Lemnos Street, Shenton Park	**32**
Sir Charles Gairdner Hospital, Mental Health Unit[34] Verdun Street, Nedlands	**30**
TOTAL NUMBER OF AVAILABLE BEDS	**648**

29 The number of beds refers to the 'Total Active Beds' available for use as at 30 June 2016.
30 Broome Health Campus, Mabu Liyan Unit is a 14 bed unit, however, one bedroom is used as a seclusion room.
31 Fiona Stanley Hospital Mental Health Unit was authorised as a 30 bed unit and opened on 3 February 2015. As at 30 June 2016, 24 beds were open: eight beds in the Mother and Baby Unit, eight beds in the Assessment Unit and eight beds in the Youth Unit.
32 Kalgoorlie Regional Hospital, Mental Health Inpatient Service is a seven bed unit, however one bedroom is used as a seclusion room.
33 Rockingham Hospital, Mimidi Park is a 30 bed unit. As at 30 June 2016 active beds included four adult closed, 16 adult open and six elderly open beds.
34 Sir Charles Gairdner Hospital, Mental Health Unit was opened on 19 August 2015.

APPENDIX 2: Private Psychiatric Hostels[35]

Licensee, hostel name, and address	No. of Licenced Beds
Albany Community Supported Residential Units Albany Halfway House Association Inc. (Licensee) Ballard Heights, Spencer Park, Albany	**11**
Burswood Care Burswood Care Pty Ltd atf Roshana Family Trust (Licensee) 16 Duncan Street, Burswood	**31**
Casson Homes Inc. (Licensee)	
Casson House 2-10 Woodville Street, North Perth	**92**
Woodville House 425 Clayton Road, Helena Valley	**25**
Devenish Lodge AJH Nominees Pty Ltd (Licensee) 54 Devenish Street, East Victoria Park	**41**
Franciscan House Meski International Pty Ltd (Licensee) 16 Hampton Street, Burswood	**75**
Joondalup Mental Health Sub-Acute Service Neami Limited (Licensee) 22 Upney Mews, Joondalup	**22**
Ngatti, Fremantle Supported Accommodation for Homeless Youth Life Without Barriers (Licensee) 5-9 Alma Street, Fremantle	**16**
Ngurra Nganhungu Barndiyigu Fusion Australia Ltd (Licensee) 30 Onslow Street, Geraldton	**14**
Pu-Fam Pty Ltd (Licensee)	
St. Jude's Hostel 30-34 Swan Street, Guildford	**52**
East St Lodge 53A and 53B East Street, Guildford	**10**
Richmond Wellbeing Incorporated (Licensee)	
Bunbury Community Supported Residential Units 12 Jury Bend, Carey Park	**15**
Busselton Community Supported Residential Units Powell Court, Busselton	**10**
Kelmscott Community Options 25 Hicks Road, Kelmscott	**8**
Mann Way 4-6 Mann Way, Bassendean	**12**
Ngulla Mia 96 Moore Street, East Perth	**34**[36]
Queens Park Service 21-23 Walton Street, Queens Park	**10**
Westminster Service 32A and 32B Ullswater Place, Westminster	**6**

35 Private psychiatric hostels include group homes, Community Supported Residential Units, and Community Options homes. Bed numbers are as at 30 June 2016.

Romily House Mediwest Pty Ltd (Licensee) 19 Shenton Road, Claremont	**70**
Roshana Pty Ltd (Licensee)	
BP Luxury Care 22 The Crescent, Maddington	**44**
Honey Brook Lodge 42 John Street, Midland	**35**
Salisbury Home Legal Accounting and Medical Syndicate Pty Ltd and Calder Properties Pty Ltd (Licensee) 19-21 James Street, Guildford	**35**
Southern Cross Care (WA) Inc. (Licensee)	
Bentley House 1182 Albany Highway, Bentley	**7**
Mount Claremont House 60 Mooro Drive, Claremont	**7**
Stirling House 4 and 6 Limosa Close, Stirling	**8**
St Bartholomew's House Inc. (Licensee)	
Arnott Villas 20 Arnott Court, Kelmscott	**22**
Bentley Villas 1 Channon Street, Bentley	**25**
Cannington Accommodation Unit 73A and B Mallard Way, Cannington	**6**
Medina Accommodation Unit 61 Ougden Way, Medina	**6**
Midland Accommodation Unit 7A and 7 B George Street, Midland	**6**
Sunflower Villas 15 Limosa Close, Stirling	**25**
Swan Villas 91 Patterson Drive, Middle Swan	**25**
St Vincent de Paul Society (WA) Inc. (Licensee)	
Vincentcare Bayswater House 65 Whatley Crescent, Bayswater	**6**
Vincentcare Duncraig House 270 Warwick Road, Duncraig	**4**
Vincentcare South Lakes House 9 Plumridge Way, South Lake	**3**
Vincentcare Swan View House 8 Wilgee Gardens, Swan View	**4**
Vincentcare Vincentian Village 2 Bayley Street, Woodbridge	**28**
Vincentcare Warwick House 39 Glenmere Road, Warwick	**4**
TOTAL NUMBER OF LICENCED BEDS	**854**

36 Richmond Fellowship, Ngulla Mia was licenced for 34 beds but as at 30 June 2016 had 32 active beds.

APPENDIX 3: Notified Orders

30 November 2015 to 30 June 2016

Order / Form Number/Type	Number of Orders[37]	Number of Consumers on Orders
6A Inpatient Treatment Order in an Authorised Hospital (adults and children)	1,807	1,518
6B Inpatient Treatment Order in a General Hospital (adults and children)	47	39
5A Community Treatment Order (adults and children)	470	401
TOTAL Adults and Children	**2,324**	**1,670[38]**
6A Inpatient Treatment Order in an Authorised Hospital (children)	21	18
6B Inpatient Treatment Order in a General Hospital (children)	7	6
Form 5A Community Treatment Order (children)	5	5
TOTAL Children	**33**	**24[36]**

37 Based on notifications made to the Chief Advocate. Some consumers have been put on orders more than once during the period and must be contacted each time they are made involuntary.

38 Total number of individuals who were placed on a form 5A, 6A or 6B (i.e. some consumers were placed on a form multiple times) from 30 November 2015 to 30 June 2016.

39 Total number of individual children who were placed on a form 5A, 6A or 6B (i.e. some children were placed on a form multiple times from 30 November 2015 to 30 June 2016).

APPENDIX 4: Notifications of Involuntary Inpatient Treatment Orders (Forms 6A and 6B) by Facility

30 November 2015 to 30 June 2016 (including children)

	Form 6A Inpatient Treatment Order in an Authorised Hospital			Form 6B Inpatient Treatment Order in a General Hospital		
Facility	**Order**	**Revocation[40]**	**Expiry**	**Order**	**Revocation**	**Total**
Albany Regional Hospital	56	28				**84**
Armadale Health Service	121	57		1	1	**180**
Bentley Adolescent Unit	12	10				**22**
Bentley Hospital and Health Service	173	132	5		1	**311**
Broome Health Campus	65	44				**109**
Bunbury Regional Hospital	98	56		1		**155**
Fiona Stanley Health Service	80	22		4		**106**
Frankland Centre	112	80				**192**
Fremantle Hospital and Health Service	142	107	2		1	**252**
Geraldton Hospital				2	1	**3**
Graylands Hospital	348	244	2			**594**
Joondalup Health Campus	126	88	3	2		**219**
Kalgoorlie Regional Hospital	30	13				**43**
King Edward Memorial Hospital	6	1		1		**8**
Midland Public Hospital	206	149		3		**358**
Mt Lawley Hospital	4	4			1	**9**
Princess Margaret Hospital for Children				5	4	**9**
Rockingham Hospital	92	51				**143**
Royal Perth Hospital		1		13	3	**17**
Selby Older Adult Mental Health Service	20	10				**30**
Sir Charles Gairdner Hospital	116	59	1	15	6	**197**
TOTAL	**1,807**	**1,156**	**13**	**47**	**18**	**3,041**

40 Numbers of revoked orders may include revocation of orders made prior to 30 November 2015.

APPENDIX 5: Notifications of Community Treatment Orders (Form 5A) by Facility[41]

30 November 2015 to 30 June 2016 (including children)

Facility	CTO	Expiry of CTO	Revocation of CTO
Albany Clinic	17		<5
Albany Regional Hospital	5		
Alma Street Clinic (Fremantle)	19		5
Armadale Clinic (Eudoria Street)	25		11
Armadale Clinic (Mead Centre)	<5		
Armadale Clinic (Older Adult)	<5		
Armadale Health Service	24		6
Avro Clinic (Subiaco MHS)	13		<5
Armadale Health Service	24		6
Avro Clinic (Subiaco MHS)	13		<5
Bentley Adolescent Unit	<5		
Bentley Clinic	27		8
Bentley Hospital and Health Service	9		
Broome Clinic	<5		
Broome Health Campus	<5		
Bunbury Clinic	9		<5
Bunbury Regional Hospital	12		<5
Busselton Clinic	6		<5
Carnarvon Clinic	<5		
Clarkson Clinic	<5		<5
Denmark Clinic	<5		
Esperance Clinic	<5		
Fiona Stanley Health Service	<5		
Frankland Centre	<5		<5
Fremantle Hospital and Health Service	13		<5
Fremantle Older Adult MHS Clinic			<5
Geraldton Clinic	6		<5

41 Due to deficiencies in the form 5A which did not identify the service responsible for the CTO (this was later rectified), the Advocacy Service was in some cases unable to determine which community mental health service was responsible for the CTO so the list includes mental health services which issued the CTO.

Graylands Hospital	35		<5
Graylands Triage (Clinic)	<5		
Inner City Clinic	33		7
Joondalup Headspace	7		<5
Joondalup Health Campus	13		<5
Joondalup Mental Health Service Clinic	23		10
Kalgoorlie Mental Health Clinic	<5		
Kalgoorlie Regional Hospital	<5		
Karratha Clinic	<5		
Katanning Clinic	<5		
Margaret River Clinic	<5	<5	<5
Melville Clinic	<5		
Midland Community Mental Health Clinic	13		<5
Mirrabooka Clinic	15		<5
Narrogin Clinic	<5		<5
Northam Clinic	<5		<5
Osborne Park Clinic	20		<5
Osborne Park Older Adult Clinic	<5		<5
Peel Mental Health Clinic	6		
Pilbara West Clinic	<5		
Princess Margaret Hospital for Children	<5		<5
Rockingham Clinic	9		<5
Rockingham Hospital	10		<5
Royal Perth Hospital	5		<5
Selby Older Adult Mental Health Service	<5		<5
Shenton CAMHS clinic	<5		<5
Sir Charles Gairdner Hospital	21		5
Midland Hospital	15	<5	8
State Forensic Mental Health Clinic	<5		
Swan Adult MH	<5		
Wheatbelt (Northam) Clinic	<5		
Total	**470**		**113**

APPENDIX 6: Notifications of Orders and Advocate Contact Times

30 November 2015 to 30 June 2016

	Time taken for a health service to notify the Advocacy Service				Time taken for an Advocate to contact the consumer Difference between the date of order and the date contacted by an Advocate						
	Difference between date of order and the date received by the Advocacy Service				Children			Adults			
Day	Form 6A	Form 6B	Form 5A	**All Orders**	Form 6A	Form 6B	Form 5A	Form 6A	Form 6B	Form 5A	**All Orders**
0	903	26	255	**1,184**	19	6	4	153	1	88	**271**
1	428	10	118	**556**				278	5	136	**419**
2	156	2	21	**179**				263	4	83	**350**
3	114	4	25	**143**				295	5	35	**335**
4	70		11	**81**				272	5	29	**306**
5	31		9	**40**				189	6	28	**223**
6	11		7	**18**				122	5	14	**141**
7	6	1	3	**10**				70	1	9	**80**
>7 days (adults) or >24 hours (children)	53	3	18	**74**	2	1	1	144	8	43	**199**
Form not received	35	1	3	**39**							
Totals	**1,807**	**47**	**470**	**2,324**	**21**	**7**	**5**	**1,786**	**40**	**465**	**2,324**

Note: Pursuant to ss145 and 357of the Act: Adults to be contacted within seven days, children within 24 hours.

APPENDIX 7: Number of Consumers Who Requested Contact, Number of Involuntary Orders and Authorised Beds by Facility

30 November 2015 to 30 June 2016

Hospital	Number of Consumers who Made Requests for Contact[42]	Number of Involuntary Orders Forms 6A and 6B	Number of Consumers on Involuntary Orders Forms 6A and 6B[43]	Number of Authorised Beds
Albany Regional Hospital	24	56	49	16
Armadale Health Service	66	122	112	41
Bentley Adolescent Unit	14	12	12	12
Bentley Hospital and Health Service	75	173	149	76
Broome Health Campus	20	65	56	13
Bunbury Regional Hospital	43	99	89	27
Fiona Stanley Health Service	41	84	79	24
Fremantle Hospital and Health Service	78	142	122	64
Geraldton Hospital	2	2	2	n/a
Graylands Hospital	161	348	300	121
Joondalup Health Campus	44	128	113	47
Kalgoorlie Regional Hospital	8	30	26	6
King Edward Memorial Hospital	7	7	6	8
Princess Margaret Hospital for Children	2	5	4	n/a
Rockingham Hospital	46	92	90	26
Royal Perth Hospital	10	13	8	n/a
St John of God, Mt Lawley	4	4	4	12
St Johns of God, Midland	68	209	192	56
Selby Older Adult Mental Health Service	13	20	20	32
Sir Charles Gairdner Hospital	56	131	121	30
State Forensic Mental Health Services, Frankland Centre	64	112	105	37
TOTAL	**846**	**1,854**	**1,659**	**648**

42 A consumer has been counted twice if they have been admitted to multiple hospitals during the reporting period.
43 A consumer has been counted twice if they were placed on an involuntary order at more than one hospital.

APPENDIX 8: Consumer Issues

30 November 2015 to 30 June 2016

1. Treatment		
1.1	Diagnosis	73
1.2	Care plans	85
1.3	Ground access and leave	198
1.4	Consultant psychiatrist or registrar	50
1.5	Nursing care	23
1.6	Physical health	108
1.7	Case management services	47
1.8	Social work services	36
1.9	Occupational therapy services	8
1.10	Psychological services	20
1.11	Transfer to another ward, hospital or clinic	168
1.12	Electroconvulsive therapy (ECT)	19
2. Medication		
2.1	Prescribing medication	172
2.2	Dispensing and administering medication	48
2.3	Side effects	91
2.4	Security and storage of medication	1
2.5	Other medication complaints	25
3. Consumer Rights		
3.1	Involuntary status	709
3.2	Further opinion	68
3.3	Access to communication	69
3.4	Forms	68
3.5	Rights not explained	49
3.6	Restraint	8
3.7	Seclusion	5
3.8	Confidentiality	4
3.9	Complaints	25
3.10	Medical records	35
4. Mental Health Tribunal Hearings		
4.1	Medical report	18
4.2	Attendance by psychiatrist or medical team	3
4.3	Other MHT	69

5. Admission, Discharge and Transport		
5.1	Admission	33
5.2	Transport	10
5.3	Discharge	150
5.4	Accommodation	135
6. Access/Appropriateness		
6.1	Smoking	46
6.2	Food and beverages	34
6.3	Clothing	36
6.4	Toiletries	9
6.5	Personal possessions	69
6.6	Welfare services	143
6.7	Guardianship orders	19
6.8	Administration orders	67
6.9	Financial issues	80
6.10	Interpreter	12
6.11	Access to courtyards, facilities and recreation	22
6.12	Access to consumer	2
6.13	Consultation	19
6.14	Regional and remote issues	9
7. Safety, Dignity and Privacy		
7.1	Safety	32
7.2	Rough treatment	17
7.3	Conflicts	41
7.4	Cultural competency	4
7.5	Inattention to Aboriginality	7
7.6	Privacy	19
7.7	Special needs not accommodated	4
7.8	Serious Issue	9
8. Environment/management of facility		
8.1	Indoor furnishings	3
8.4	Temperature	7
8.5	Design and layout	1
8.7	Cleanliness and hygiene	4
9. Legal		
9.1	Criminal Law Act and Mentally Impaired Accused Review Board	9
9.2	Other legal matters	86
Total		**3,440**

APPENDIX 9: State Records Commission Compliance Requirements

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

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

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

   An evaluation of the Record Keeping Plan was completed in 2011–2012.

2. The organisation conducts a recordkeeping training program.

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

   A draft operations Manual covers recordkeeping requirements and training is provided on an ongoing basis.

3. The efficiency and effectiveness of the recordkeeping training program is reviewed from time to time.

   The training program is reviewed annually to ensure its adequacy.

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

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

APPENDIX 10: Advocate Functions and Powers

Who the Advocates can help – s348 of the Act

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

- referred under the Act for a compulsory examination by a psychiatrist who may or may not be detained and who may be in an Emergency Department or a ward in hospital or elsewhere, including prison
- a voluntary inpatient in an authorised hospital under an order for assessment (which may lead to a referral for a compulsory examination by a psychiatrist
- an involuntary inpatient, who has been examined by a psychiatrist and an order made which means they are being detained under the Act in an authorised hospital or a general hospital
- subject to a Community Treatment Order
- under a hospital order made under s5(2) of the *Criminal Law (Mentally Impaired Accused) Act 1996* (MIA Act)
- a mentally impaired accused required under the MIA Act to be detained at an authorised hospital
- a mentally impaired accused who has been released under a release order made under the MIA Act on a condition imposed under section 35(4)(a) of that Act that the mentally impaired accused undergo treatment as defined in section 4 of this Act
- a resident of a private psychiatric hostel as defined by the *Hospitals and Health Services Act 1927*
- being provided with treatment or care by a body or organisation that is prescribed by the regulations[44] for this paragraph and has or may have a mental illness (although no regulations are current)
- a voluntary patient who is in a class that the Minister directs under s354 is a class of identified person[45].

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

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

a) ensuring that "identified persons" are visited or otherwise contacted in accordance with the Act – this includes a requirement that every person who is made involuntary must be contacted within seven days and children within 24 hours of being made involuntary; to assist with this the Chief Advocate must be notified by mental health services of all involuntary orders

b) promoting compliance with the Charter of Mental Health Care Principles by mental health services

c) preparing and publishing information about, and promoting, the role of Advocates and how to contact the Chief Advocate

d) developing standards and protocols for the performance by Advocates of their functions under the Act

44 No regulations were in place as at 30 June 2016.
45 As at 30 June 2016 the Minister had not made any directions under s354.

e) ensuring that Advocates receive adequate training in relation to the performance of their functions under the Act

f) providing advice, assistance, control and direction to Advocates engaged under section 350(1) of the Act in relation to the performance of their functions under the Act

g) ensuring compliance with any directions given by the Minister under section 354(1) or the Chief Advocate under paragraph (f)

h) any other functions conferred on the Chief Advocate by the Act or another written law

i) within 3 months after 30 June each year, prepare and give to the Minister a report on the general activities of the Advocates (which the Minister must cause to be laid before Parliament).

Functions of Advocates - s352 of the Act:

a) visiting or otherwise contacting identified persons in accordance with the Act which requires that every person who is made involuntary and Custody Order patients detained in an authorised hospital must be contacted within seven days and children within 24 hours of being made involuntary or detained; people who are awaiting assessment by a psychiatrist who request contact must be contacted with three days and other requests for contact by identified persons must be responded to "as soon as practicable" or within seven days, and in the case of certain classes of children, within 24 hours (see s357 of the Act)

b) inquiring into or investigating any matter relating to the conditions of mental health services that is adversely affecting, or is likely to adversely affect, the health, safety or wellbeing of identified persons

c) inquiring into or investigating the extent to which identified persons have been informed by mental health services of their rights under this Act and the extent to which those rights have been observed

d) inquiring into and seeking to resolve complaints made to mental health advocates about the detention of identified persons at, or the treatment or care that is being provided to identified persons by, mental health services (a complaint can be made by any person who has a sufficient interest in the identified person)

e) referring any issues arising out of the performance of a function under paragraph (b), (c) or (d) to the appropriate persons or bodies to deal with those issues, including to the Chief Advocate and includes assisting the person to make a complaint to the mental health service and HaDSCO

f) assisting identified persons to protect and enforce their rights under the Act which includes assisting the person with, and representing them in, any proceedings under the Act before the Mental Health Tribunal or SAT

g) assisting identified persons to access legal services

h) in consultation with the medical practitioners and mental health practitioners responsible for their treatment and care, advocating for and facilitating access by identified persons to other services

i) any other functions conferred on an Advocate by the Act or another written law.

Advocates' powers - ss359 and 353 of the Act

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

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

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

d) making inquiries about any of these things —

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

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

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

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

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

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

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

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

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

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

h) doing anything necessary or convenient for the performance of the functions conferred on the Advocate by the Act or another written law.

APPENDIX 11: Ongoing Systemic Issues From Previous Years

1998-99 Council of Official Visitors Annual Report

1. **Need to expand the definition of "affected persons" (now called "identified persons") so that voluntary consumers have rights to advocacy.** See above[46]. The Chief Advocate intends asking the Minister to direct that some classes of voluntary patients be identified persons so they can access Advocates but funding is needed for some classes of voluntary patients.

2. **Pressures on beds in all hospitals.** The new referral process under the Act (form 1A) only allows for three days instead of seven days but anecdotally the Advocacy Service is aware of form 1As being repeated because hospitals did not manage to transfer a person to an authorised hospital for assessment within the three days. Bottlenecks on hospital wards continue due to lack of appropriate accommodation and community care. See above.[47]

3. **Lack of system-wide policies and documents that have a direct impact on consumers**. The State-wide Standardised Clinical Documentation remains largely unused because it is not on PSOLIS (DOH's psychiatric database) and health services continue to "do their own thing" with no centralised control. Of particular impact is the lack of a TSD Plan on PSOLIS. See above[48]. The good news is the introduction of many of the approved forms onto PSOLIS (notable exception is the approved forms for seclusion and restraint) on 28 June 2016.

4. **Other Opinions (now called "Further Opinions") process not providing truly independent opinions and related issues.** While the process is improved in that the consumer is now entitled to a copy of the further opinion, all other concerns with this process remain unchanged and arguably it has got worse for consumers. See above.[49]

5. **Hostel issues including minimal health care and support services, need for review of the standards, lack of proper facilities and lack of privacy and security in bedrooms.** This remains a major area of concern for the Advocacy Service. There is a review of the LARU Standards underway which is good news but the Advocacy Service would like to see amendments to the *Hospital and Health Services Act 1927* and associated regulations as well.

46 Under "Systemic Issues – Voluntary Patients".
47 Under "Systemic Issues – Bed pressures".
48 Under "Right to Treatment Support and Discharge Plan".
49 Under "Right to Further Opinions".

1999-2000 Council of Official Visitors Annual Report

6. **More respect and facilities needed for human relations and intimacy.** This continues to be an issue particularly in older and poorly maintained premises but even newer wards where rooms are either glassed like a fish bowl or families have trouble getting out of the locked room in which they have been put. Female only wards would promote children visiting, but there were none in WA as at 30 June 2016.

7. **Boredom on the wards and lack of access to on site gyms, or to exercise equipment etc.** Boredom on weekends is a particular source of complaint. Various occupational therapy type programs are run Monday to Friday but nothing on weekends. This should be questioned in this day and age when shift and weekend work is not uncommon. Children in particular need a seven day a week program which has now been introduced at the BAU and increased activities on another ward seems to have helped reduce the number of code blacks.

2002-2003 Council of Official Visitors Annual Report

8. **Lack of access to allied health professionals/multi-disciplinary teams, in particular social workers and welfare workers.** Complaints to Advocates relating to issues dealt with by, and access to social workers and welfare workers totalled 179 making them collectively the third highest number of issues noted by Advocates. Advocates raised concerns in two hospitals about lack of social workers.

9. **Need to improve opportunities for socialisation for people with a long term illness.** The issue continues particularly in relation to lack of activities and programs for many long-term hostel residents in the older style, lower funded facilities. The WA "*Mental Health, Alcohol and Other Drug Services Plan 2015-2025*" refers to *"Keeping people connected and close to home"* (pages 35-55). The Advocacy Service hopes that increased mental health community support services planned for the end of 2017 (page 42) will reach such hostel residents.

2003-2004 Council of Official Visitors Annual Report

10. **Ward environment and lack of maintenance.** Gardens and access to them sadly remain lacking which fails to acknowledge the therapeutic role that gardens can play. Advocates continue to be told there is insufficient staffing so gardens can be locked off for considerable periods of time. Ongoing funding cut-backs tend to mean that maintenance is one of the first things to go.

11. **Issues with the Mental Health Tribunal process, in particular doctor non-attendance and failure medical reports in a timely manner or at all.** As noted above,[50] issues remain.

12. **Treatment of people with a mental illness in hospital EDs including delays and not being treated with dignity and respect.** Delays continued to be an issue and are likely to remain so as noted above[51].

50 Under "Right to Review".
51 Under "The road to being made involuntary".

2005-2006 Council of Official Visitors Annual Report

13. **Neglect of dental health, hygiene and physical care treatment**. The Act makes it mandatory for people admitted to hospital to be offered a physical condition assessment but this does not appear to be happening routinely as the issue of physical health is in the top 10 list of issues noted by Advocates. Most issues were raised by hospital consumers but hostel residents and people on a CTO also raised this as an issue.

14. **Ageing of the population of psychiatric hostels.** There has been no change in relation to this issue and NDIS does not apply to people over 65 which means this group is particularly disadvantaged. The WA "*Mental Health, Alcohol and Other Drug Services Plan 2015-2025"* (at page 61) states that, by 2017 it is planned to increase the subsidy for non-acute long-stay (nursing home) places for older adults with mental illness by 63 places so the Advocacy Service looks forward to that.

14. **Seclusion practices.** Seclusion practices have undoubtedly improved and the number of seclusions and length of time in seclusion has diminished over the past few years. Complaints to Advocates are generally around rough handling during the restraint process prior to the seclusion. Bruises and soreness seem to be, but should not be, an inevitable consequence. See above.[52]

2006-2007 Council of Official Visitors Annual Report

16. **Inconsistent and inappropriate complaints processes in hospitals.** Issues include lack of independent investigators for serious issues, consumer awareness about how to make a complaint and access to complaint forms, and clarity about which government agency handles complaints. A partnership agreement between HaDSCO, the Council of Official Visitors, the DOH and MHC in August 2015 aiming to streamline complaints processes to ensure that they are clear and easy to navigate has stalled.

2007-2008 Council of Official Visitors Annual Report

17. **Long term and inappropriate placements on wards.** There remains a shortage of varied and suitable accommodation in the community particularly for people with a serious or chronic mental illness. See above[53].

18. **Smoking ban and failure to implement exemption for involuntary patients on secure wards.** This remains an issue at three hospitals. A bigger issue is the lack of programs and support designed to help people with a mental health issue to quit smoking. A new and funded approach to this issue is needed as many consumers are on a disability pension and cannot afford to smoke either from a health or finance perspective. The Advocacy Service is aware of patients choosing homelessness over paying for accommodation just so they can keep smoking.

52 Under "Right to feel safe".
53 Under "Systemic issues – Bed Pressures".

2008-2009 Council of Official Visitors Annual Report

19. **Lack of a forensic unit for youth (aged up to 24).** Nineteen, or 17.0%, of the 112 involuntary inpatient orders made in WA's only forensic (and most secure) hospital, the Frankland Centre, were for people aged under 25. This was 7.0% of the 273 involuntary inpatient orders for youth aged 16 to 24 in the seven months up to 30 June 2016. The WA "*Mental Health, Alcohol and Other Drug Services Plan 2015-2025"* (at page 92) states that the number of forensic beds in the state (for all age groups) is less than half what it should be and (at page 94) that dedicated forensic services for young people are a high priority. The Plan however is not projecting any new facilities until 2025, though community services are to be increased by the end of 2017.

2009-2010 1998-99 Council of Official Visitors Annual Report

20. **Doctor and other staff shortages.** This continues to be a major issue of concern and not only in country regions. Lack of nursing staff was cited as a reason for closing a CAMHS ward in March and there seems to be constant staff turn-over resulting in risks to patients' continuity of care. Reliance on locum psychiatrists is now almost a normal practice in some services. The WA "*Mental Health, Alcohol and Other Drug Services Plan 2015-2025"* (at page 162) states that, by 2017 it is planned to develop and commence a comprehensive mental health, alcohol and other drugs, planning and workforce development strategy that includes key priorities to build the right number and appropriately skilled mix of staff.

21. **Mandatory sentencing law.** An amendment to the mandatory sentencing laws to exclude people who were mentally unwell at the time of their alleged offence is needed. This law remains unchanged.

2010-2011 Council of Official Visitors Annual Report

22. **Imposition of phone, post and visitor restrictions in breach of the Act**. The Act introduced new rights to freedom of lawful communication including use of electronic communication in keeping with the modern world where people often pay their bills, keep in touch with friends and family via texting, use Facebook and similar media all though their mobile phone or tablet. Not all hospitals were ready for the Act's changes and it remains a regular source of complaint by consumers. See above[54].

54 Under "Right to Freedom of Lawful Communication".

2011-2012 Council of Official Visitors Annual Report

23. **Locked open wards.** See above[55]. Rights are more easily breached when wards are locked and voluntary patients lack the protections of involuntary patients.

24. **Lack of procedural fairness for Custody Order patients, a "declared place" and community facilities and accommodation for forensic patients.** The MIA Act remains badly in need of reform. The very long awaited and promised review by the Attorney-General was eventually released[56] with a number of welcome recommendations, but amendments to this Act remain a long way off. Some key submissions were not agreed to. In particular, a significant majority of submissions to the Review, including from the Supreme, District and Children's Court, recommended that:

    i) the length of the Custody Order should not exceed the length of the prison sentence which might have been imposed had the person been convicted of the offence charged and that indefinite Custody Orders cannot be justified

    ii) the role of the Executive/Governor should be removed.

    The Chief Advocate has been invited onto a working party to prepare a report for the Attorney-General, chaired by former Judge, the Hon Peter Blaxell, addressing a couple of limited issues relating to mandatory Custody Orders and what changes might be made to allow Custody Orders to operate more fairly.

    On the positive side a "declared place" as an alternative to prison was introduced and the Advocacy Service is providing advocacy services to the residents of the declared place.

2012-2013 Council of Official Visitors Annual Report

25. **Care plans and recovery principles. Issues with inconsistent quality of care plans, and lack of involvement by consumers and families and regular review of the plans**. The Act's requirements in relation to TSD plans and the notification and involvement of Personal Support Persons should see some improvements but this remains an issue as a TSD plan template is not often used and anecdotally the involvement of Personal Support Persons in the way required by the Act is occurring only in a limited way. See above[57].

26. **Long term patients and hostel resident issues about lack of co-ordination about, and access to, their money which could improve quality of life and open up doors to recovery.** This issue remains as Advocates are regularly asked for assistance by long-term patients and hostels residents about finances. See above.[58]

55 Under "Systemic Issues - Voluntary Patients".
56 April 2016.
57 Under "Right to Treatment Support and Discharge Plan".
58 Under "Psychiatric hostels – residents' rights and issues".

27. **Police interviews with involuntary patients and concerns about natural justice**. Nothing has changed in relation to this issue which was about the process for consumers who remain involuntary on wards being interviewed by police either as a witness or with a view to them being charged. The MHLC has changed its approach to the issue and will now assist a consumer but their resources are limited.

28. **Older adult mental health care and lack of access to long-term accommodation.** As far as the Advocacy Service is aware, nothing has changed since the 2013-2014 Annual Report (at page 13) by the Council of Official Visitors. The WA "*Mental Health, Alcohol and Other Drug Services Plan 2015-2025"* (at page 61) states that, by 2017 it is planned to increase the subsidy for non-acute long-stay (nursing home) places for older adults with mental illness so that accommodation numbers can increase by 63 places.

2013-2014 Council of Official Visitors Annual Report

29. **Lack of sexual safety and gender sensitivity on wards**. The state's sole female-only ward changed to an open mixed ward in 2013-2014. Plans to convert a smaller ward into a female only ward never eventuated. Issues include consumers not feeling safe due to past history of abuse/sexual trauma and disinhibited behaviour caused by the mental illness. An Official Visitor monthly inspection survey on sexual safety and gender sensitivity in 2014-2015 showed much more could be done to make wards safe. A number of incidents reflecting lack of sexual safety on wards are reported each year and this year was no exception.

30. **Unfair psychiatric hostel evictions.** Increasingly Official Visitors have been dealing with cases of hostels trying to evict residents without good cause or procedural fairness. Lack of residents' agreements or reasonably drafted agreements dealing with eviction issues and not having an exit plan for residents as required by the National Standards for Mental Health Service are part of the issue. There should be better control and oversight over this given the government funding received by hostel licensees and the disempowerment of the resident. This issue remains.

31. **Discrimination against residents of "for-profit" hostels:** Residents in this type of hostel are often the most chronically unwell but get much lower funding from the MHC. Official Visitors noted that the hostel conditions were generally poorer with few recovery or psycho-social programs on offer. An Official Visitors inspection survey in 2014-2015 confirmed that many more residents in the for-profit hostels do not have case managers in comparison to the residents of the better funded NGO run hostels, further compromising their recovery prospects and access to quality care. A review and overhaul of the funding is urgently required to ensure equity. This remains a problem.

APPENDIX 12: Presentations on the Advocacy Service

Presentations at psychiatric hostels

- Richmond Wellbeing, Mann Way residents
- Albany Community Supported Residential Units, staff and residents
- Richmond Wellbeing, Cannington head office staff
- St Bartholomew's, East Perth head office, hostel managers and staff
- Richmond Wellbeing, Kelmscott Community Options staff and residents.

Presentations at hospitals (staff or consumers) and other agencies:

- MHLC lawyers
- Mimidi Park, Rockingham Hospital, psychiatrists
- SSAMHS staff
- Bentley Hospital clinical and administration staff
- Richmond Wellbeing Mann Way residents and staff
- Rockingham Hospital ED staff
- Fremantle Hospital nurses and staff
- Bunbury Regional Hospital, Community Mental Health and inpatient teams
- Aspiring Leaders Program 'Let's talk about advocacy' panel
- MHC's Mental Health Advisory Council presentation on implementation of the Act
- Albany Regional Hospital ED and mental health inpatient unit staff
- Fremantle Hospital, psychiatrists
- Armadale Hospital, mental health inpatient staff
- Carers WA
- City Mental Health, Consumer Advisory Group
- Geraldton Community Mental Health staff
- Advocacy Learning and Sharing – WA Network
- MHC NGO Evaluators panel
- Mental Health Advisory Council forum panellist "Are the Stokes Review and Mental Health Act Making a Difference?".

Committee memberships and workshops attended:

- Private Hostels Agencies Committee – comprising MHAS and the OCP, LARU, MHC with oversight of psychiatric hostels
- Western Australian County Health Service, Western Australian Police Joint Working Party
- LARU's Private Mental Health Regulation Reference Committee – to review draft new standards for licensed private psychiatric hostels
- Planning workshop "Improving access to Mental Health, Drug and Alcohol information, advice and services".

GLOSSARY OF ACRONYMNS AND TERMS

1996 Act	Mental Health Act 1996
Act	Mental Health Act 2014
Advocacy Service	Mental Health Advocacy Service
Advocate	Mental Health Advocate
BAU	Bentley Adolescent Unit
Chief Advocate	Chief Mental Health Advocate
CAMHS	Child and Adolescent Mental Health Service
CoMHWA	Consumers of Mental Health WA
Consumer	An "identified person" as defined by s348 of the Act who can be assisted by an Advocate but excluding hostel residents
CTO	Community Treatment Order
DOH	Department of Health
ECT	Electroconvulsive Therapy
ED	Emergency Department
HaDSCO	Health and Disability Services Complaints Office
Hostel	Private Psychiatric Hostel
ICMS	Integrated Case Management System database
LARU	Licensing and Accreditation Regulatory Unit
MHC	Mental Health Commission
MHLC	Mental Health Law Centre
NDIS	National Disability Insurance Scheme
MIA Act	Criminal Law (Mentally Impaired Accused) Act 1996
Minister	Minister for Mental Health
OCP	Office of the Chief Psychiatrist
PIR	Partners in Recovery
Personal Support Person	See definition in the Act , ss4 and 7(2)(b): i. if the person has an enduring guardian or guardian — the enduring guardian or guardian ii. if the person is a child — the child's parent or guardian iii. if the person has a nominated person — the nominated person iv. if the person has a carer — the carer v. if the person has a close family member — see definition in s281 of the Act
PMH	Princess Margaret Hospital
SAT	State Administrative Tribunal
SSAMHS	Statewide Specialist Aboriginal Mental Health Service
TSD plan	Treatment, Support and Discharge plan

MHAS MENTAL HEALTH ADVOCACY SERVICE

Unit 6, 18 Harvest Tce, West Perth WA 6005
Post (no stamp required): Reply Paid 84455 West Perth 6005

T: (08) 6234 6300 or 1800 999 057
F: (08) 9226 3977
E: contactus@mhas.wa.gov.au
W: www.mhas.wa.gov.au