MENTAL HEALTH ADVOCACY SERVICE

INQUIRY BY THE SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE INTO INDEFINITE DETENTION OF PEOPLE WITH COGNITIVE AND PSYCHIATRIC IMPAIRMENT IN AUSTRALIA

SUBMISSION BY

THE CHIEF MENTAL HEALTH ADVOCATE OF WESTERN AUSTRALIA

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Background:

Part 20 of the *Mental Health Act 2014* WA (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 (the Chief Advocate), who is appointed by the Minister for Mental Health, is charged under the Act with ensuring such services are provided by people engaged by the Chief as Mental Health Advocates. Collectively they are the Mental Health Advocacy Service (the Advocacy Service).

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[1] in an authorised hospital or the community under the *Criminal Law (Mentally Impaired Accused) Act 1996* (the MIA Act)
- private psychiatric hostel residents

A prime requirement of the Act 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. The Act 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 Advocates (as set out in s352 of the Act) 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
- 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.

[1] Custody Orders in WA are indefinite under the *Criminal Law (Mentally Impaired Accused) Act 1996*.

Prime cause of indefinite detention of people with psychiatric impairment in Western Australia

The main reason for indefinite detention of people with psychiatric impairment is a bottle-neck in authorised hospital beds. The bottleneck is caused by the lack of suitable alternatives such as step-down facilities to help consumers transition from hospital to home and supported accommodation services able to care for consumers with very complex needs. The result is people staying too long in hospitals, not knowing when they will be discharged into the community. They become institutionalised and their care and prospects of recovery are compromised. It is not the least restrictive alternative as required by the Act, and in some cases patients have been "living" at Graylands Hospital[2] for years – it is no way to live.

The predecessor to the Mental Health Advocate Service (the Advocacy Service) was the Council of Official Visitors. The Council started surveying authorised hospitals in 2013 asking how many patients were "stuck" on wards as at 30 June. The results of the survey were published in Council's Annual Report which must be laid before Parliament. The Advocacy Service continued the survey this year.

I have attached as Annexure 1, an extract from the Council's 2014-15 Annual report. In summary, across the 15 mental health units (comprising 578 authorised beds) which responded to the survey, there were 65 consumers in hospital for a year or more. This represented 11.2%[3] of the authorised beds in those units across the State. This increased to 15.9% of authorised beds being taken up by consumers for 6 months or longer; and 22.0% of authorised beds being taken up by consumers who had been on the ward for 90 days or longer at the 15 units that participated. It should be noted that not all of these patients will have been detained involuntarily under the Act, though some will have no choice if they have a guardian (often the Public Advocate as the state guardian), who has decided that they are to stay in hospital. In effect they are detained.

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.

[2] Graylands Hospital is a dedicated mental health hospital with 121 beds (as at 30 June 2016
[3] Information from two facilities with 39 authorised beds was not available.

Hospital survey results

The 15 authorised hospitals which responded to the survey in 2016 represented 567 or 87.5% of the 648 authorised mental health beds in Western Australia. Overall, compared with the 2014-2015 survey responses, there was a small reduction in the number of people in hospital for long periods and whose discharge was delayed due to accommodation issues though the hospitals which responded are not the same which means a comparison may be flawed[4].

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 (in comparison to 65 the previous year) and 43 for over two years. See table below.

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

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.

[4] 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.

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 (e.g. illnesses such as Hodgkinson's disease and acquired brain injury), challenging behaviours, ongoing substance abuse, aggression and significant forensic history.

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. However, 36 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."

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.

Further information and discussion about the hostel responses can be found in the Advocacy Service Annual Report which is attached as Annexure 2.

Other causes of indefinite detention of people with cognitive and psychiatric impairment in Western Australia

The other main cause for indefinite detention is the MIA Act which urgently needs amending. I believe many submissions have already been made on this issue and the voices for change are almost unanimous.

In addition to its role under the Act, the Advocacy Service is also appointed under the *Declared Places (Mentally Impaired Accused) Act 2015* and regulations to provide advocacy services to residents of the Bennett Brook Disability Justice Centre (the DJC) which is a "declared place" for people on Custody orders with intellectual impairment. To date there have only been 3 residents. A copy of my Annual Report for the first year of operation of the DJC and the role of the Advocacy Service is attached as Annexure 3.

Comments on the urgent need to amend the MIA Act are made on page 13 of that report.

Issues for individuals with cognitive and psychiatric impairment who are imprisoned or detained indefinitely

I refer you to the two Annual reports attached as Annexures 2 and 3. People detained indefinitely have the same issues as other people who are detained on involuntary orders but obviously the situation is more distressing and depressing when the detention is lengthy with no obvious end in sight. The lack of Treatment Support and Discharge plans, or plans that do not involve the person and/or are of very poor quality, is a major issue in authorised hospitals as is the inability to get truly independent second opinions.

Other Issues - 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" so we do not know the number of people in this situation or how long they are being held on such wards. 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 because:

- 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.

We have particular concerns about elderly patients on locked psychiatric wards.

Annexure 1: Extract from the Annual Report of the Council of Official Visitors 2014-2015[5]

Illustration 2 - Access to appropriate accommodation and care in the community

The Head of Council wrote to Clinical Directors in June 2015 and sought information on the length of stay and the number of consumers who had not been discharged due to a lack of suitable accommodation as at 30 June 2015. Comment was also sought on the type of suitable accommodation required so that long term consumers could be discharged. Council received responses from 16 authorised mental health units. Information from one facility could not be used and one site did not respond.

Across the 15 mental health units (comprising 578 authorised beds), there were 65 consumers in hospital for a year or more. This represented 11.2%[6] of the authorised beds in those units across the State. There were 35 people who had been hospital for over 2 years..

Facilities noted that not all long-stay admissions were there due to a lack of accommodation, and some consumers were not discharged because they were continuing to receive treatment. The responses received from nine of the facilities are summarised below:

Hospital 1: Ten consumers were in hospital for 90 days or longer, and 14 people lacked suitable accommodation as at 30 June 2015. The facility noted that "*over the past 2-3 years the presentation of patients has included a growing group with substance abuse issues that require a supportive counselling environment in order to achieve abstinence or a marked reduction in usage pattern that will allow them entrance into some accommodation options. Maintaining wellness for these consumers on a long term basis also affects the availability of placement in appropriate external accommodation*".

The facility also noted that once people got settled into accommodation they were often less likely to want to move on, but some residential programs were limited to 12 months which impacted on the availability for other patients. They sought "*more supported accommodation with medication prompts", "services that provide a supportive framework especially regarding medication compliance and have good community support"; "if the patients are happy where they stay and can afford it, readmission rates drop*", and small facilities staffed with mental health trained nurses are "*able to manage chronic mentally ill patients*".

Hospital 2: Five consumers were in hospital for 90 days or longer and of them, accommodation had been identified as an issue but the availability date was unknown, for 4 consumers. The facility added that affordability and location were both issues for short and long term accommodation, and the delay in allocating a care coordinator impacted on discharge (ie "*intake days are not until the following week or another psychiatrist is not willing to take on a CTO*").

The facility commented that a consumer's forensic history, aggression and substance abuse could unreasonably limit the accommodation options because applications (even though some are very lengthy) placed too much emphasis on these behaviours rather than getting the history in context as the behaviour may only have been present when the person was unwell.

[5] https://mhas.wa.gov.au/assets/documents/Annual-Report-2014-2015.pdf
[6] Information from two facilities with 39 authorised beds was not available.

A lack of interim accommodation options was also reported as a problem. Interim accommodation could enable consumers to save to provide a bond and to buy furniture. They also noted that "*many of the crisis accommodation options are unsavoury and …. some would be detrimental to the consumer*".

Lastly, it was noted that an admission could result in the family deciding they couldn't take a person back but additional support for families in the home could help. This was considered an *"untapped opportunity".*

Hospital 3: Three consumers had been admitted for 90 days or longer and there were 5 consumers who had a lack of suitable accommodation. In order to discharge long term consumers they sought 24 hour supported accommodation that accepted people with complex needs including self-harm behaviours and drug use. They also sought short-term crisis accommodation and homeless accommodation.

Hospital 4: Four consumers had been admitted for 90 days or longer and 14 consumers did not have suitable supported accommodation. The facility sought "*inpatient – secure and open extended care units*", "*supported accommodation with close monitoring of mental states and compliance*" and "*upskilling of community support services to manage complex clients in supported accommodation*" to discharge long term consumers.

Hospital 5: This facility reported 20 consumers who had been admitted for 90 days or longer, and four of those had been admitted for one year or longer, however none required accommodation as at 30 June 2015. The facility commented that short-term community supported accommodation and ongoing long-term accommodation were required to discharge long term consumers.

Hospital 6: Three consumers had been admitted for 90 days or longer and one of those did not have suitable accommodation. The facility identified access to facilities that better managed dementia behaviours as a gap. They felt that facilities could not manage common dementia behaviours and the problem had been compounded by "*changes to Residential Aged Care in July 2014 when all facilities were expected to provide for all levels of care*". They sought "*better equipped/trained dementia aged care facilities*".

Hospital 7: A regional facility noted that more local 24 hour supported accommodation and more affordable housing was required in the area to avoid consumers being resettled in the metropolitan area and away from their family supports. Over the years this issue has arisen in other regional areas where Official Visitors are located.

Hospital 8: For young people the accommodation issues were different. Delays in discharge were reported as being a result of carer fatigue for families or a break down in the accommodation placement where child protection services were involved. A limited range of supported accommodation suitable for children and young people, in particular the 16 to 17 year old age group, was cited as a factor.

Hospital 9: Graylands Hospital provides the largest number of rehabilitation beds in the State and is therefore expected to have the most long stay consumers. Council did a similar survey in 2013 and was told there were 37 consumers who had effectively been living there for two years or longer. As at June 2015 there were still 35 consumers effectively living at Graylands.

Two thirds of the consumers (or 44 people) identified as part of the rehabilitation stream, (Hospital Extended Care Service) were in hospital because of a lack of suitable supported accommodation. We were told that discharge was not possible as "*current services available in WA are not suitable and/or do not provide enough support*" and an "*increased number of 24/7 supported accommodation beds*" with both CMO and clinical support were needed in the community. Also, we were told there were rehabilitation consumers who would benefit from disability services and others who were reluctant to leave hospital and often sabotaged discharge attempts. In addition there were 15% of consumers in the acute service who were not discharged because of a lack of suitable supported accommodation.

Annexure 2: Mental Health Advocacy Service 2015-16 Annual Report

To be provided after tabling in Parliament.

Annexure 3: Disability Justice Centre 2015-16 Annual Report

(Double click on image to open the PDF)

ANNUAL REPORT

by the Chief Advocate for Residents of
Declared Places Under the Declared Places
(Mentally Impaired Accused) Act 2015