Council of Official Visitors

Annual Report 2002-2003

Artwork produced through the
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The Honourable J A McGinty MLA
Minister for Health
30th Floor Allendale Square
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PERTH WA 6000

Dear Minister

In accordance with section 192(3) of the *Mental Health Act 1996* I submit for your information and presentation to Parliament the Annual Report of the Council of Official Visitors for the financial year ending 30th June 2003.

As well as recording the operations of the Council for the 2002 - 2003 year the report once again reflects on a number and range of issues that continue to affect consumers of mental health services in Western Australia.

It should be noted that the previous Head of Council retired in March and that I have been Head for the three months of the year to June 30th.

Yours sincerely

Dr Judyth Watson
HEAD
COUNCIL OF OFFICIAL VISITORS

October 2003

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INTRODUCTION

After a five-year tenure, the inaugural Head of Council, Stuart Flynn retired at the end of March. I take this opportunity to thank him for establishing a strong foundation of professional values and knowledge that underline the operations of the Council of Official Visitors (the Council). The work of Council and its Official Visitors is well integrated and is well accepted by consumers and providers alike.

The seven statutory functions accorded to the Official Visitors include:

To ensure that affected persons have been informed of their rights, and
To ensure that the rights of affected persons are observed
Mental Health Act 1996 section 188 (a) & (b).

I acknowledge the day to day work of each Official Visitor and the staff; each of them is tenacious in ensuring that the rights of people ('*affected persons*') protected by the *Mental Health Act 1996* (the Act) are observed. This work is often quite hard and may be prolonged; it can be in adverse circumstances; the same issues recur; but it can make a difference to the experience and life of people with a mental illness. The focus is on rights and this report addresses these and related issues, including progress and deficits.

My three-year term commenced only in April this year so some initial impressions are noted. Although there have been many changes for the better in mental health and illness that must be acknowledged and celebrated, several matters remain of great concern.

One is the enduring stigma surrounding mental illness. It could be argued that this is contributed to by inadequate resources allocated to this field for services and programmes, including for accommodation. Decision-makers send a very powerful message about the priority that mental illness has when budgets are allocated.

Mental health budgets have been reduced in real terms. They are not quarantined and remain vulnerable to redistribution by and within the Department of Health.

The voices of individuals who have been diagnosed with a mental illness and their worn out carers are seldom heard - or listened to. This reinforces the place they hold in the illness hierarchy. The vulnerability of people who have a mental illness - or who are at risk – is exacerbated because they do not have the priority they need and deserve.

Although the dedication of committed health care providers is acknowledged, substantial concerns remain about persistent negative attitudes towards rights by some service providers. Such views can only compound fiscal problems and the stigma attached to these illnesses.

Scarcely a day passes when Council is not approached by, or on behalf of, a voluntary patient inquiring about an aspect of consumer rights or treatment. The current provisions of the Act do not allow the Council to assist these individuals other than to refer them to other agencies. There seems to be general concurrence in the field that any person diagnosed and treated for psychiatric illness in WA should be able to access the services of an Official Visitor; the rights of all individuals with a mental illness must be observed, no matter their status. We look forward to legislative amendment.

Members of the Council share public concern about "ambulance by-pass" and waiting lists at acute general hospitals, but for many years a similar situation has existed for almost every acute psychiatric admission in the metropolitan area.

Council claims that there are insufficient acute beds for patients with acute psychiatric illness, circumstances compounded by a stark shortage of "step-down" facilities and appropriate community based services, including family support. Overcrowding in acute psychiatric wards is common.

People who live in rural Western Australia have extra burdens imposed on them and their families. Services are thinly spread and either discontinuous or at risk of being so. For instance the situation for the South West region based on Bunbury Acute Psychiatric Residential Unit (page 7) has meant that very ill people have been transferred to Perth; conditions that have been tolerated by the authorities for two years.

Inpatient services for children and adolescents are not adequate, either in terms of bed numbers or in addressing the complex nature of their acute and / or ongoing needs, including accommodation.

Psychiatric disability represents more than 25% of all disability. Accommodation for people with a long-term mental illness, many of them living in licensed psychiatric hostels, for which Council has a responsibility, is devastatingly inadequate (page 13). Some licensed private psychiatric hostel residents were the subjects of previous de-institutionalisation programmes: yet they live in institution-like conditions. No matter what the will of the hostel staff may be, any kind of serious rehabilitation or socialisation measures for this population have either been abandoned by service providers, or rationed at best.

The issues affecting acutely ill and also disabled consumers, young consumers and rural consumers and those outlined above, present ongoing challenges for the brief of Council to protect the rights of '*affected persons*'. These and related challenges could, and would, be substantially improved were realistic budgets allocated to mental health services.

The situation for people treated by Community Treatment Order (CTO) and involuntary patients whose case is to be reviewed by the Mental Health Review Board, present challenges for Council to address and improve in the coming year.

Although Council functions are primarily designated by statute, the practical experience and knowledge of its members and executive are increasingly relied on throughout the sector to contribute to policy development and systems reviews.

Finally some observations are recorded about the capacity for family, friends and colleagues to visit individuals in hospitals and hostels, and the absence of provisions to facilitate ongoing contact.

Despite protestations that mental illness is just another illness and that there is no reason for stigma in 2003, it must be easy to conclude that it is so different that even visitors are discouraged and dissuaded from maintaining their connections.

In most acute units visiting hours are published, but rather than making individual assessments about risks to safety, there is often a blanket ban on visitors going to the bedside or to the common room / lounge. Sometimes an interview room is made available but the time may be limited if needed for its intended purpose. This has the effect of visitors needing to wait until a room that can be monitored by staff becomes vacant.

Little wonder that when maintaining contact becomes difficult, visits become infrequent. These issues affect almost every consumer irrespective of age.

Licensed hostels, which are the person's home, set up similar problems with spaces for visitors. In this first three months of my appointment (and to the time of writing) I have never seen one visitor in any of the hostels I have visited.

These and related issues are addressed in more detail in this report, as are those that represent ongoing and unresolved matters of concern to Council.

PART ONE

THE LEGISLATIVE AND OPERATIONAL FRAMEWORK

LEGISLATIVE FRAMEWORK

The Council of Official Visitors (the Council) was established in accordance with the *Mental Health Act 1996* (the Act), Part Nine, sections 175 - 192.

The Minister for Health appoints people from the general community to be Official Visitors in accordance with section 177 of the Act.

OPERATIONAL FRAMEWORK

The *Mental Health Act 1996*, Part Nine, prescribes the functions and responsibilities of the Council of Official Visitors.

The major focus of the Council's role is to ensure that '*affected persons*', as defined in section 175 of the Act, are aware of their rights and that those rights are respected. This includes monitoring the quality of care provided to ensure that it is of the highest possible standard.

The Council also has a responsibility to undertake a complaint management role for '*affected persons*'. '*Affected person*', under the Act (section 175), includes:

- an involuntary patient, including a person subject to a Community Treatment Order;
- a mentally impaired defendant who is in an authorised hospital;
- a person who is socially dependent because of mental illness and who resides, and is cared for or treated, at a private psychiatric hostel; and
- any other person in an institution prescribed for the purposes of this section by the regulations.

The Council is required to ensure that an Official Visitor or panel visits each hospital authorised under section 21 of the Act at least once per month and each licensed private psychiatric hostel at the direction of the Minister for Health (currently at least once every 2 months). In practice each hostel is visited every month, alternating formal with informal visits. The Council has maintained an active visiting programme visiting eleven authorised hospitals and twenty licensed private psychiatric hostels, including four sets of group homes during 2002 – 2003.

The facilities visited by the Council are listed at Appendices 1 and 2.

An '*affected person*' or another person on their behalf (section 189) can also request a visit from an Official Visitor. A visit is then arranged as soon as is practicable (section 186 (c)). Requests can be made in writing or via telephone or personal contact. 599 consumers had contact with Official Visitors during 2002 – 2003, an increase of almost 15% over the previous year.

Reporting Lines

Official Visitors

The Council and its individual members are directly responsible to the Minister for Health. Any Official Visitor, or person on a panel, who considers that the Minister for Health or the Chief Psychiatrist should consider a matter may make a report to that person (section 192).

Executive Officer & Other Staff

The Council's Executive Officer and other office staff are public servants (as per section 182 of the Act) and employed by the Department of Health.

Council Composition 2002 – 2003

A list of the members of the Council during the 2002 – 2003 financial year and their terms of appointment is contained at Appendix 3.

Panel Appointments

Three individuals were appointed as Panel Members of the Council, as prescribed in section 187 of the Act, during 2002 – 2003. Panel members are not paid sessional fees for work undertaken as result of that appointment.

Council Meetings

The Council had full Council meetings six times throughout 2002 – 2003, with two of these having a specific professional development focus. The Executive Group, comprising representatives from each of the sub groups of the Council, met five times to act as the decision making body for the Council between meetings of the Full Council. A summary of the meetings attended by Council members during 2002 - 2003 is contained at Appendix 4.

Budget

The Council was allocated a budget of $410,000 for 2002 – 2003. Expenditure for the financial year 2002 - 2003 totalled $391, 718 at 30 June 2003, however, a number of expenses incurred during 2002 – 2003, including some Official Visitors' sessional fees, were unable to be processed before 30 June 2003 (Appendix 5).

PART TWO
MAJOR ISSUES
THE RIGHTS OF PEOPLE WITH A MENTAL ILLNESS

FRAMEWORK OF PRINCIPLES

The *"Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care"* (UN Principles) was adopted in 1991 by the General Assembly of the United Nations.

Building on this resolution twelve Guiding Principles were adopted in Australia in December 1996 to underline the *National Standards for Mental Health Services*. It was agreed that each set of guidelines for policy development and service delivery be developed against this framework of national and international principles. They address issues of human rights, including those, for example, of the inherent dignity of the individual and the rights to respect and privacy.

The UN Principles recognise that the role of community and culture is important with each consumer having the right to be treated and cared for, as far as possible, in the community in which he or she lives, a point taken up in the WA legislation.

The *Mental Health Act 1996* (the Act) accords a set of legal rights to consumers that protect them and mental health professionals. The functions of the Council of Official Visitors are rights focused.

Submissions to the legislative review of this statute (page 24) recognise that a more rigorous approach to rights is required. For instance, the rights of children and voluntary patients would be better protected were the functions of Official Visitors broadened and the definition of '*affected person*' redefined.

The objects of the Act (section 5) reflect, but do not elaborate on, international principles. It does specify, however, (section 5(a)) that there must be *"the least interference with their rights and dignity"*.

Council's functions include the observance of those rights and it has the power, among others, to inspect consumers' records in order to ensure that those rights are being observed, including that explanations have been given verbally and in writing to the individual.

A pamphlet published by the Office of the Chief Psychiatrist sets out, in an abbreviated form, some of the rights accorded to consumers treated under the Act, viz:

- "Written and verbal information about your legal status, rights and entitlements.
- Copies of most of the orders made about you.
- An interview by a psychiatrist.
- Access your medical records (this right may be restricted).
- Make a complaint to the hospital authorities, the Council of Official Visitors, the Chief Psychiatrist or the Mental Health Review Board.
- A second opinion from another psychiatrist.
- Ask questions and be fully informed about any treatment you are offered.

- Contact people by letter or phone and be visited, use of personal possessions at the hospital, and vote at elections (these rights may be restricted).
- Obtain legal advice (The Mental Health Law Centre can provide free legal advice about your rights under the Mental Health Act 1996).
- Ask the Mental Health Review Board to review your case.
- Request a visit from an Official Visitor".

A strategic planning exercise undertaken by the Council in May 2003 has established a number of targets for the next three years that continue the focus increasing the protection of consumer rights (Part Four Priorities for 2003 – 2004).

EXAMPLES OF BREACHES OF THESE PRINCIPLES

In the course of its work, the Council's Official Visitors have identified issues that demonstrate that in practice, the rights of consumers in hospitals and hostels are not always observed. Readers are invited to ask themselves whether these breaches would occur and / or be tolerated by and for individuals with physical illnesses.

The Council recognises that there is pressure on inpatient beds throughout the whole system and that more than the accepted number of people are commonly admitted to units. The Council also recognises the problems facing services and providers charged with delivering services. Any practices identified as not being conducive to patient care and likely to impact adversely on treatment and recovery must be raised, especially those which breach rights accorded either in principle or law.

Case examples that outline these concerns and on which Council has intervened, follow. They illustrate that the observation of patients' rights to information, to second opinions and to privacy, dignity and respect are not always observed.

Examples 1 to 6 outline how the structure and resourcing of facilities contribute to unsatisfactory standards of care; examples 7 to 10 outline treatment decisions that breach the requirements of the Act. These ten examples are primarily reported from authorised hospitals.

1 Overcrowding in Authorised Hospitals (Adult)

A consumer in Ward 4.1 of the Alma Street Centre was received at the hospital and accommodated in a side room, with only a mattress on the floor. This was the consumer's first admission to a secure unit. She was extremely distressed. Her distress appeared related to her accommodation.

The Official Visitor raised concerns with ward and management staff on the day regarding the inappropriateness of the use of the side room and mattress on the floor to accommodate. It was suggested that on occasions where consumers had to be received into the Unit 'over the count' that furniture i.e. a proper bed should be made available for them to ensure that the person was appropriately accommodated, even if only temporarily.

The Official Visitor was advised that the hospital's policy was not to provide such furniture, as it would be expected that the movement of patients around the wards would alter the person's situation. It was also suggested that if such furnishings were provided then there would be the continued expectation for an additional person or persons to be admitted to the ward.

As the individual had already been received / admitted into the hospital it is the Council's view that appropriate furnishings, viz a bed, should have been provided.

The lack of an available bed does not excuse any hospital from providing appropriate and convenient facilities for any patient no matter what their diagnosis. There is a community expectation that when an individual is ill enough to be admitted to a hospital s/he will be provided with a bed, not a mattress on a floor in rooms other than designated bedrooms.

The Council does not, and cannot, support the use of seclusion or side rooms as temporary bedrooms.

2 Refusal to admit Involuntary Patients – *Mental Health Act 1996*, section 47

On 31 August 2001 the Bunbury Acute Psychiatric Residential Unit ceased admitting involuntary patients, on the basis that staffing and facilities were not of an appropriate level for consumer and staff safety.

The Service has utilised section 47 of the Act to legitimise this action. Section 47 of the Act allows an authorised hospital to decline to accept a person if the facilities are inadequate to accommodate the person. Council's view is that this section was intended for use on an individual, case by case basis, not blanket refusal of all persons referred under the Act for 2 years.

This decision resulted in consumers who required involuntary inpatient care having to be transferred to Perth, away from their family and community. As noted in the Council's 2001 – 2002 Annual Report this also has a flow on effect to the Perth metropolitan area:

"Historically people from the South West had been admitted to Graylands Hospital for treatment but with opening of the Unit in Bunbury the beds allocated for South West patients at Graylands Hospital were closed as the service was to be provided locally. This means that even a small of number of consumers being transferred from the South West to Perth places an additional pressure on the beds available.".

During 2002 – 2003 a psychiatrist was recruited to provide a service to the Bunbury Unit but, as of 30 June 2003, almost two years later, the Unit was still not admitting involuntary patients.

During inspection visits to the unit the lack of occupational/rehabilitation and other non-pharmacological therapies was consistently noted as an area needing attention. Since August 2001 little appears to have been done to employ appropriate allied health / therapy staff to ensure that a multidisciplinary service is provided to consumers within the unit, irrespective of their status under the Act.

This failure to provide a service funded for the purpose of admitting involuntary patients is an indictment. There has been no local professional or managerial commitment to ensure that this crucial regional service was provided.

3 Hospital Emergency Departments – Management of people with Mental Illness

The flow-on effect of inadequate acute mental inpatient beds is the potential for increased pressure on Emergency Department (ED) personnel to manage the situation whilst mental health consumers await beds in authorised hospitals.

Concern has been expressed by providers to the Council regarding practices that were reportedly being used in EDs in relation to mental health consumers who were being referred to an authorised hospital for assessment under the Act. These concerns related to the practices instituted once a person had been assessed as requiring referral and were reported as follows:

1 If there are no beds available at an authorised hospital the ED could be required to hold the person for up to 12 hours.

2 If there was pressure on beds in the ED the following practices could be instituted to manage this shortage and pressure on the ED:

(a) restraining the person to the bed using four points of restraint; or

(b) heavy sedation which in effect almost anaesthetises the person.

It was reported that the expectation was that the person would be held in the ED as a Duty of Care.

The Council was concerned that if these practices were occurring as described they were being used to manage the administrative problems associated with bed shortages rather than to manage the clinical condition, including risk assessment, of the consumer concerned.

These concerns were raised with the Office of the Chief Psychiatrist who has indicated an interest in inquiring into these matters. It is understood that that Office is currently reviewing the issue of the use of emergency treatment for psychiatric patients in Emergency Departments.

4 Access to telephones and visitors – *Mental Health Act 1996*, sections 167 & 168

The Act provides that consumers have the right to make and receive telephone calls and receive visitors of their own choosing in reasonable privacy. These rights can be restricted or denied on an individual basis. The facilities provided for consumers, particularly in secure wards, to exercise these rights varies greatly. The privacy offered is often limited by the design of the facilities. Inconsistency in policy and practice is not uncommon between and within units. The following list is far from complete.

For example:

Swan Valley Centre – secure ward has no designated Visitors' room. Consumers are unable to receive Visitors in the common room, their bedrooms or the outdoor area. This means that visitors have to "book" access to the Interview room on the ward that is also used by clinical staff. Clinical staff have priority access to the room.

Joondalup Mental Health Unit – secure ward has no designated Visitors' room or other room available for consumers to receive visitors. They are allowed to receive visitors in their bedrooms, the common room or the outside courtyard.

Telephones are often placed in corridors and near staff offices. This results in limited privacy for consumers, and frequently in noisy locations. Some facilities do provide access to cordless phones that consumers can take to private areas however this equipment varies between facilities and access may also be dependent on staff.

Consumers may have to ask staff to make telephone calls as the public telephone provided may not be functional or there may only be access to a cordless telephone held by staff. Unless there is a restriction or denial of the consumer's right to make telephone calls (as per the Act) then the consumer should not be required to advise staff who they wish to ring, as this is really not staff business.

It should be noted also that the licensed private psychiatric hostels are not required to provide access to telephones or private visiting areas. Some hostels have coin operated telephones available for consumers on site, others may grant access to the office telephone for some calls, others require the person to access the nearest public telephone, wherever that may be.

5 Failure to ensure Privacy – Authorised Hospital

For an extended period during 2002 – 2003 the consumers within the High Dependency Unit (HDU) of the Armadale Adult Mental Health Unit had no certainty of privacy to shower or use the toilet. All locks on these doors in the HDU were faulty, meaning that consumers could not lock them when using the shower or toilet. This lack of privacy was further compounded by the fact that the bathroom doors open on to the common area of the HDU.

Consumers complained to the Council about this situation. We know of one instance when a man walked in on a woman in the bathroom. This was distressing for all concerned.

The door locks were first reported as faulty in September 2002. In May 2003 one of the locks was removed leaving a not-insignificant hole providing vision into the bathroom.

Despite repeated requests by the Council, the doors and locks were not repaired. Council was advised that the door fittings needed to be changed therefore this would all be done at the same time. This situation was accepted by the staff for 8 months.

Whilst there was verbal acknowledgment of the lack of privacy there was no recognition of the significant impact this unacceptable delay was having on every consumer. Ultimately and in sheer frustration, the Council approached the Area Clinical Director, Directorate of Mental Health Services to get the situation remedied; and it was. His involvement should not have been necessary.

6 Access to Allied Health Professionals/Multi-disciplinary team

The Council consistently encounters situations where access to allied professionals (e.g. Occupational Therapist, Social Worker) for inpatients in authorised hospitals is limited or non-existent. A number of the newer units have either had difficulty recruiting appropriate staff or allocated funding has not been utilised to employ such staff.

Official Visitors received numerous complaints from consumers regarding lack of access to such services, including the lack of appropriate activities. Whilst diversional activities may be undertaken by nursing staff, assessment of activities of daily living, and skill development generally are the function of Occupational Therapy (OT) staff. Access to OT and other therapy staff, (social worker, psychologist etc) ensure that an holistic approach to the person's treatment, recovery and long term health is undertaken.

At June 30th:

- Kalgoorlie Mental Health Inpatient Unit: no access to Occupational Therapy or Social Worker services;
- Armadale Adult Mental Health Unit: recently appointed an Occupational Therapist; and
- Bunbury Acute Residential Psychiatric Unit: temporary Nurse Therapist appointed but no Occupational Therapist and limited access to Social Work services.

Little appears to have been done in the last 2 years to recruit appropriate allied health / therapy staff for allied health services throughout the system.

7 Right to a Second Opinion – (*Mental Health Act 1996*, sections 111 & 164(2))

Acceptance of Requests

An involuntary consumer in Graylands Hospital complained that when she approached a nursing staff member to request that a second opinion be arranged, she was advised such a request had to be placed in writing. The nurse indicated that it was his understanding that it was hospital policy that such requests must be made in writing.

However, the Council confirmed that this was not Graylands Hospital's policy nor is it a requirement under the *Mental Health Act 1996*. Graylands Hospital management undertook to clarify the process with staff.

Despite law and policy, Official Visitors encounter differing practice on the process for second opinion requests within the same hospital. In some wards nursing staff accept a consumer's request for a second opinion (verbal or written) and in other wards the consumer is expected to ask the treating doctor directly.

The Council remains concerned that staff practices (and knowledge) may give wrong information to involuntary patients (request must be in writing and / or must be made directly to the treating psychiatrist). This can disadvantage them to the point that they do not exercise their right to a second opinion.

8 Right to a Second Opinion – *Mental Health Act 1996*, sections 111 & 164(2)

Delay in Receiving Opinion

An involuntary consumer in the WAY Centre, Bentley (i.e. a legal child) complained that there had been a delay in receiving a second opinion. An Official Visitor checked the medical record and noted that a written request for a second opinion had been received sixteen days previously. There was no indication on the record that the opinion had been provided. When the Official Visitor spoke with the consumer three days later she indicated that she had yet to receive the second opinion.

The consumer had not requested that the opinion be provided by a psychiatrist external to Bentley Health Service. The consumer had a Mental Health Review Board hearing scheduled for a few days later and she wished to have received the second opinion prior to this.

Nineteen (19) days is an unacceptable delay for arranging such an opinion therefore the Council raised this matter directly with the Director of Mental Health, Bentley Health Service.

9 Electroconvulsive Therapy – *Mental Health Act 1996*, sections 104 - 107

As in previous years, the Council was approached by a number of consumers (or their family members) expressing concern regarding planned treatment with electroconvulsive therapy (ECT).

The Council's role in these instances has been to ensure that:

1 the requirements of the Act have been met to authorise the use of ECT;

2 the consumer is aware of her / his rights in relation to the proposed treatment (e.g. second opinion, application to the Mental Health Review Board); and

3 the treating staff have discussed the matter adequately with the consumer and / or her / his family.

Individual consumers may feel that they can not make a decision within what appears, to them, to be a short period of time. It is not uncommon in these situations for the Official Visitors to ask the treating medical staff to discuss the matter again with the consumer (or their family) to answer any queries and / or concerns they may have. Such requests are generally met positively. It should be noted that the Act (section 105) provides that involuntary patients should be assessed as to their capacity to give informed consent for these procedures.

10 Community Treatment Orders – *Mental Health Act 1996*, sections 65 - 85

Treatment Plan and Arrangements for follow up

An Official Visitor was asked to assist a consumer at his forthcoming Mental Health Review Board (MHRB) hearing. The consumer had been discharged to rural WA subject to a Community Treatment Order (CTO) following admission as an involuntary patient in an authorised hospital in Perth.

The wording of the treatment plan on the CTO was unclear and included abbreviations unfamiliar to the consumer. Among other criteria, it required that he "*attend f/u appointments with treating psychiatrist or GP*". There did not appear to have been any communication between the staff of the authorised hospital and the community mental health service in the country. No arrangements had been made for the consumer to have an appointment with the treating psychiatrist in his home town. The consumer contacted the local clinic to make this appointment and was told he would have to see his community mental health nurse before this occurred. The Official Visitor contacted the clinic on the consumer's behalf and arranged for an appointment with the treating psychiatrist.

At his MHRB hearing it was agreed to vary his CTO such that it specified the date he was to attend his follow up appointment with the community Psychiatrist and that the frequency of subsequent visits would be determined at that appointment.

This situation raised a number of issues for the Council:

1 the lack of communication between the authorised hospital staff discharging the person and the community mental health service;

2 the difficulty the consumer experienced in arranging his required appointment with the psychiatrist; and

3 the lack of detail in the treatment plan in the CTO.

Good discharge planning involves discussion between the referring and receiving services and the consumer. This is particularly important when the consumer is to receive treatment on a CTO. By the nature of the issuing of the CTO the consumer must be deemed to be a risk to themselves or others. In addition failure to abide by the CTO conditions can result in the person's detention. Placing additional barriers in front of the consumer when s/he is endeavouring to ensure that s/he meets the requirements of her/his CTO appears counterproductive and not conducive to establishing a positive relationship with the treating team.

In the WA Supreme Court Decision of "EO" v Mental Health Review Board [2000] WASC 203 (25 May 2000) it was ruled that:

"great importance that details should be given to a patient so that he or she knows precisely what is required in terms of attending for treatment and is left in no doubt about the requirements" (at 80). Later (at 88) "*The Act is clear: the order itself must contain the relevant details …*" Further (at 92) "*… the provisions of the Act should be strictly complied with before the detention or continued detention of an involuntary patient is permitted. I have adopted that approach of strict construction in relation to s68 because, as I have said, although that section does not itself result in the detention or continued detention of an involuntary patient, it is a provision which may lead to that result."*

The wording of the above CTO failed to provide detail of the treatment to be met with the inherent potential for this person to be unable to comply.

APPROPRIATE ACCOMMODATION

About 20% of the population in WA will be diagnosed with a mental illness during their lifetime. The nature of these illnesses is that many are recurrent, but pharmacotherapies are increasingly available to control and / or manage exacerbations. Of the new illnesses diagnosed in WA each year a good proportion are bound to progress to disability and of them, many if not most will eventually require supported accommodation. There are no plans to meet this predictable need.

People with long-term psychiatric illnesses and disability too often live on the margins of, and in the shadow of, the community, mostly neither accepted nor challenged by it and not connected to it. Psychiatric disability represents more than a quarter of all disability. It is unthinkable that people diagnosed with physical illnesses characterised either by remission and exacerbation, or by a gradual deterioration and disability would be left with inadequate services, excluded from others or be made vulnerable to exploitation in some of their housing options.

Official Visitors regularly meet individuals admitted to hospital with acute illness essentially because of accommodation issues. We learn of others whose behaviour has led to a prison sentence, and yet others who sleep rough. In 2003, it is difficult to accept that individuals with long-term psychiatric illness continue to be at risk of homelessness, or forced by circumstance to live in sub-standard conditions because there are neither sufficient nor appropriate housing options.

Many individuals require concentrated support, not in hospital, but as part of a family or community, and support that provides ready access to specialised services as required. It remains an unjust burden on all those affected as consumers or carers that there is such a dearth of community based support services and / or accommodation options. The impact of psychiatric illness and disability is magnified and the quality of life diminished by living conditions. The housing needs are acute and urgent and a range of solutions, including supported accommodation, should be available.

The current state government committed to an expenditure of $4m over 4 years (project Community Options 100) to provide supported accommodation options for people with chronic illness. Council welcomes this commitment. The individuals concerned include 30 of the 42 residents, most of them involuntary patients, some for up to 30 years, of Murchison Ward at Graylands Hospital. The other 12 occupants require a secure environment, perhaps being built as cluster housing on site at Graylands Hospital.

A lengthy consultative and planning process is underway with Council participation, but Council remains concerned that preparation for transition, including socialisation activities, is yet to commence.

Residents of licensed psychiatric hostels are generally socially dependent because of mental illness and Council has a statutory obligation towards them.

To the end of June 2003 there were 584 beds in 15 licensed psychiatric hostels with a further 41 beds in 5 sets of group homes, all in the Perth metropolitan area. The hostels are predominantly privately owned and operated as business concerns; the group homes (Richmond Fellowship and Casson Homes) and two hostels are run by non-profit, non-government agencies.

Some residents have lived in hostels for between 20 and 50 years, and it is hard to escape the conclusion that this population remains institutionalised. Few have their own bedroom and options for privacy or challenges that stimulate. Any choices at all are scant. A small proportion of residents move between hostels and to and from (unlicensed) boarding houses.

No matter what the will of the hostel may be, any kind of serious rehabilitation or socialisation measures have either been abandoned by service providers, or rationed at best. There are inadequate supports from service providers, local communities and in many cases (and perhaps understandably) from families.

Many hostel residents have additional degenerative and lifestyle health problems associated with age as well as other physical health problems. A meagre care package of $5 to $12 per day is provided by the State to hostel owners, but only for those individuals who are most severely disabled. Disability and aged care services provide models that could, and should, be adopted and modified for the mental health field.

We note with concern too, that there are no age appropriate facilities for adolescents who not infrequently need an option of supported accommodation. The absence of this choice can only enhance their vulnerabilities and those of their families.

The Council welcomes the development of the Department of Health's Licensing Standards and Care Standards for licensed private psychiatric hostels. The Care Standards have been developed through the Office of the Chief Psychiatrist. The Council looks forward to the implementation of these standards starting in 2003 –2004.

In relation to hostels, the following issues are some that have given Council concern in the past year.

1 Level of Supervision - Licensed Private Psychiatric Hostels

In December 2002 a resident of a psychiatric hostel died unexpectedly on the premises. It appeared that her room had not been checked for several days, thus her body lay undiscovered for a few days. This tragic event was subject to a Coronial Inquiry.

The WA Police Service Coronial Inquiry Section approached the Council for any comments or concerns it had in relation to this situation. In part, the Council offered the following comments and suggestions:

"Whilst the Council would not wish to argue for unnecessary intrusion into residents' lives or restrictions on their right to privacy, a psychiatric hostel should have protocols in place which ensure that undue absences are noted and acted upon.

It is not unusual for hostel residents to leave the facility for extended periods; however, the hostel should have clear agreements with residents whereby such absences are notified in advance.

Unless such an absence has been advised a basic duty of care is required if the resident is not sighted within a reasonable period of time. The Council believes that meal times offer the best opportunity for timely, non-intrusive checks.

This would be followed by knocking on the door of the bedroom and, in the absence of any reply, entering.

The Council is also of the view that daily routines such as cleaning, collecting laundry etc offer the opportunity to check rooms without compromising privacy or dignity.

Given these comments the Council is of the view that, if as you indicate "it appears that her room was not checked for a few days", such an omission is unacceptable."

The Council understands that the Hostel concerned, immediately after the incident, undertook the development of policies and procedures to ensure that a resident, whose whereabouts were unknown, was not seriously ill or deceased on the premises.

All hostels need to implement such practices.

2 Licensed Private Psychiatric Hostels - Medication management and staff training

The people who have debilitating and chronic mental illnesses are usually dependent on a complex mix of prescribed medications to maintain some kind of equilibrium. Each has its own purpose but may also promote a series of side effects or unintended consequences. Some of the medications must be given in strictly controlled and supervised conditions. Some have adverse effects when taken in conjunction with others (prescribed or not) and alcohol does not mix well with most.

Only a minority of hostels employ registered nursing staff. Most medication is given to residents by unqualified staff who have undergone some training as required for approved supervisors. Medications, often for the coming 24 hours, are placed into small containers by the supervisors, to be handed to residents at the appropriate time/s.

So-called Webster Packs which are sealed when dispensed by the pharmacist contain exact doses labelled with time of day to be taken, are increasingly accepted by hostel managers. However, it is known that some supervisors used to the previous method re-dispense the medications out of the sealed pack into small containers to be handed to individuals. This is fraught with potential danger and exacerbated by the number of interruptions during this process. The individuals are charged a small amount by the pharmacist for this service: any value for money the residents receive in these instances is questionable.

Council recognises that the management and administration of medication has potential dangers. In hospitals the number of medication errors and their consequences is treated very seriously and protocols are in place for recording and reporting such errors.

There is no knowledge of the number of errors made in this sector. While it is understood that hostels are unlikely to employ registered nurses, the industry is urged to review its procedures, to order Webster Packed medication, distribute it in the intended manner and to commit to regular training updates for their supervisory staff.

3 Provisions for individual possessions and security

The facilities provided for consumers to store their clothing and belongings varies greatly between hostels. Some hostels provide individual wardrobes, others do not. In some this is due to the number of beds in bedrooms meaning that there is no space for wardrobes or even for small personal pieces of furniture.

Some hostels provide lockable bedroom doors so that people have a degree of privacy and a safe place for them and their belongings. Others will not claiming that consumers will lose the key and staff will not be able to enter which may pose a risk, especially if there is a fire.

This claim is flawed. Some hostels, with similar resident populations, already provide locks on bedroom doors for residents. If the person loses his / her key or staff need to enter for any reason, including fire, this can be done by utilising a master key system.

It is a widespread community expectation that individuals should have control over personal belongings and over who enters one's home and in particular one's bedroom.

These lack of provisions to ensure, what most would consider basic human rights of, privacy, dignity and security is unacceptable.

In conclusion, besides the need for appropriate acute care and "step down" facilities, the need for a variety of suitable supported accommodation is emphasised. This is the right of the range of very vulnerable men and women, elderly and young; for people from diverse backgrounds, including indigenous Australians.

Design and Furnishing of Units – Authorised Hospitals

Much of the accommodation in acute hospital settings is also open to criticism. Ward environments reflect decision-making processes that did not engage with providers or consumers in the planning stages. For example few have separate visiting rooms, few have adequate outside areas, especially those where secure facilities are imperative.

Quite often it is impossible to make a private telephone call because of the location of telephones. These environs impact adversely on consumers, unable either to meet visitors or to exercise in the fresh air unless staff can be spared. In others, repairs take an inordinate time to be effected, leading to impressions of drabness and inertia. The Council has continued to make representations about these concerns which impact on the rights of individuals.

It is a welcome change to have been asked this calender year to comment, along with service providers, at the planning stage of renovations planned at Mills Street Centre, Albany and Graylands Hospitals.

1 Armadale Mental Health Units

Following a visit in August 2002 to the Armadale Mental Health Units the then Head of Council raised a number of concerns with that service's management regarding the physical facilities of the Units.

Many of the observations had been raised in the Council's routine inspection report summaries from as early as July 2001, with a number of issues being raised following a visit to the unit by Council representatives in October 2000, prior to the Unit's opening.

Two matters should have been addressed immediately; viz the paucity of furnishings in the Adult High Dependency Unit (HDU) and the signage and provisions for access to the Units after hours.

The paucity of furnishing in the HDU (secure ward) and its external area were an indictment. Such physical surrounds could not be considered therapeutic and were not conducive to improvements in mental health. The environment was reminiscent of some of the worst features of the institutions the new mental health units replaced.

The provisions for access to the units after hours were grossly inadequate. If similar arrangements were in place in an aged care residential facility the facility would not be granted accreditation. This issue had been raised in the Council's routine inspection report summaries since July 2001 with no action to remedy the situation.

In January 2003 the Council was advised that:

- the background work on the furnishings had been completed and the working party would be convened and the "*improvements should be made in the very near future*"; and
- a telephone is to be installed at the entrance to improve access to the units after hours. No time frame was provided.

In February 2003, due to the delay in receiving positive action to rectify these matters the Council raised them with the Minister for Health. Shortly thereafter the signage and after hours access was improved and some soft furnishings were purchased for the HDU.

Had the Council had not raised this issue to this point it is likely that there would have been no change.

2 Design and Furnishing of Units - WAY Centre

The WAY Centre at Mills Street Centre authorised hospital, Bentley provides, in part, an inpatient service for adolescents, both voluntary and involuntary. It includes a small Focal Care Area (FCA) which can be locked for adolescents who require a secure environment.

Over this and previous years the Council identified numerous problems with the physical facilities within the Unit. In part these related to the décor and furnishings which served to give the Unit an institutional and custodial feel. Other matters related to poor maintenance or design faults and included:

- poor visual observation in areas requiring staff to intrude on consumers;
- poor lighting or lights not turned on, creating an uninviting environment;
- dull colour schemes, chipped walls and paint;
- wall decorations that were not age-appropriate;
- external courtyard areas that were unkempt and uninviting; and
- limited space in the FCA.

Council was concerned that by providing adolescents with a severe, drab and uncared for environment that was not age-appropriate, their recovery would be adversely effected. In no way could the physical environs be described as therapeutic.

These concerns were discussed by Council representatives with hospital staff who responded positively to suggestions for improving the physical environment in the WAY Centre for consumers on the ward.

Some attention has been given to painting doors in the FCA to reduce the institutional feel; using the open area for FCA consumers while consumers from the open area are attending the programme at the Transitional Unit; and improving the courtyard behind the open area.

A number of other short term and long term strategies were identified to address these shortcomings.

The Council commends the Hospital on its positive response to the concerns raised. We will continue to monitor this most crucial area.

The Council trusts that the design and furnishing of new Units and renovations to existing ones will address these types of issues. Further, it trusts that it will not require correspondence with the Minister for Health or senior management to rectify relatively minor matters that have a major impact on consumers.

ONGOING ISSUES OF MAJOR CONCERN

A number of the serious issues raised in the Council's previous Annual Reports (1998 – 1999 through 2001 – 2002) remain unresolved and have continued to give concern during 2002 - 2003. Listed below are those matters previously reported on that remained unresolved with a brief update on progress. Some require amendment to legislation for progress to be made.

For details concerning these issues please refer to the Council's previous annual reports, available through the Council's website or from the Council's office.

ISSUES THAT REQUIRE REMEDY

	YEAR FIRST RAISED	RECOMMENDATION	PROGRESS / OUTCOMES
LICENSED PRIVATE PSYCHIATRIC HOSTELS			
Absence of, or minimal, support services provided to residents of psychiatric hostels	1998 – 1999	Identify individual needs for: • allied health services • community based recreational/ socialising activities and appropriate services: and make necessary provisions. The Council recommends that residents' access to such services be considered as part of the Care Standards monitoring for hostels undertaken by the Office of the Chief Psychiatrist (OCP).	Services have continued to be reduced through inadequately funded Government programmes.
Lack of standards for licensed private psychiatric hostels	1998 – 1999	Standards related to licensing and quality of care be implemented and continually monitored and subject to publicly accessible reporting.	Standards related to licensing and quality of care have been developed through a consultative committee process undertaken by the Licensing Standards and Review Unit (LSRU), Department of Health and the OCP. Due to be implemented in 2003 – 2004.
Medication management and training	2002 - 2003	As a first step hostels be required to order medications dispensed in Webster Packs and use accordingly. Regular training updates for supervisors be provided. Where possible registered nurses should give medication to residents.	In part will be addressed via the LSRU standards governing hostels due to be implemented during 2003 – 2004.
AUTHORISED HOSPITALS			
The impact of over-crowding in authorised hospitals	1998 – 1999	Increase the number of places in step down facilities for transition from hospital to community. Re-assess the number of acute beds and need to provide more.	No progress yet. The Council trusts that the impact on consumers of this situation will be considered as part of any Clinical Reviews undertaken by the OCP.
Definition of "*affected person*"	1998 – 1999	Amend the Act to enable Council to attend to voluntary patients including children.	Legislative review is considering recommendation of extension of this function.

Shortage of specialist adolescent beds	1999 – 2000	Age appropriate facilities required for children and adolescents. A contingency plan is required for occasions when all beds are full at the WAY Centre.	Office of Mental Health (OMH) has circulated a discussion paper to seek responses to policy proposals.
Lack of system wide policies that have direct impact on consumers	1998 – 1999	Policies and guidelines that complement legislation should be developed in relation to searches of the person, video surveillance and mobile telephones, among other issues.	Policies continue to be developed by OCP and OMH, and must include process to ensure services develop policies. Issues continue to be monitored by Council as they are brought to our attention.
Design of facilities	2000 – 2001	Council, consumers and providers invited to participate in planning renovations and new units to ensure a consumer perspective considered in design.	Among other matters, standard of facilities for visitors, outdoor areas and telephone access differ between acute units. The Council has been asked to comment on proposed renovations for a small number of facilities.
Mentally impaired defendants restricted access to outside areas at Frankland Centre	1999 - 2000	This is an issue related to staffing levels that need to be resourced. Budgetary allocation required.	
Human relations and need for intimacy	1999 - 2000	These issues require urgent attention if individuals are to be appropriately rehabilitated and socialised. Staff training is required, especially in relation to the acceptance that needs for physical, emotional and spiritual intimacy are universal.	Little progress made, even on a very practical level where visits and telephone calls need to be in private and too often this privacy is not provided.
Consumer access to personal records *Mental Health Act 1996*, s 160 & 161	1998 - 1999	The Act allows for a "*suitably qualified other*" person to access a consumer's medical record on his/her behalf if it is determined that the consumer should not have this access. The Chief Psychiatrist's restriction of "*suitably qualified other*" to being only psychiatrists should	The Chief Psychiatrist has received advice that legal practitioners can not withhold information from their clients. Therefore the restriction to psychiatrist for "*suitably qualified others*" will remain. Amendment to the legislation is required.

		be reviewed as a matter of urgency to allow the involvement of other professional groups.	
Medical Treatment May Be Approved by the Chief Psychiatrist - *Mental Health Act 1996*, section 110	1998 - 1999	The Chief Psychiatrist has chosen to delegate this power to the Heads of Mental Health services and believes this allows for separation of "authoriser" and "prescriber". Guidelines be developed regarding the use of the Chief Psychiatrist's delegated authority to approve medical treatment to ensure an adequate degree of separation between the prescribing doctor and the authorising psychiatrist.	It is understood that this issue is being reviewed by the OCP. Approval of medical treatment is being considered as part of the Review of the Act.
Second opinions	1998 - 1999	Consumers are offered a range of options so that second opinions are independent of the treating team and, if requested, of the treating service.	OCP has issued an Operational Circular stating that it is desirable that second opinions are independent of the treating team and whenever possible the opinion arranged should be seen to be independent. The effect for consumers of the implementation of this requires monitoring (note two examples above).
Access to Allied Health Professionals/ Multi-disciplinary team	2002 - 2003	All patients should have access to a multi-disciplinary team of professionals to ensure that they receive an holistic approach to their treatment.	Continues to be raised with OMH and OCP.

In its 2000 – 2001 and 2001 - 2002 Annual Reports, the Council identified 10 simple and inexpensive ways by which to improve the quality of life for consumers of mental health services, including those resident in psychiatric hostels. A report on progress follows, with only 2 issues satisfactorily addressed and a further 1 added.

HOW TO IMPROVE THE QUALITY OF LIFE FOR PATIENTS IN MENTAL HEALTH SERVICES AND RESIDENTS OF PSYCHIATRIC HOSTELS

ISSUES	YEAR FIRST RAISED	RECOMMENDATION	PROGRESS / OUTCOMES
LICENSED PRIVATE PSYCHIATRIC HOSTELS			
Lack of facilities and privacy in licensed hostel bathrooms and toilets	1998 - 1999	Residents should be confident that soap and plugs are available in bathrooms and that shower and lavatory doors are opaque and lock.	Some hostels still fail to meet these basic requirements/ standards.
Bedrooms and wardrobes in psychiatric hostels don't always ensure privacy and security	1998 - 1999	All bedrooms should have doors that can lock and wardrobes that are lockable.	Some hostels still fail to meet these basic requirements/ standards.
Powdered, not fresh, milk only provided at some psychiatric hostels	1999 - 2000	Fresh milk should be available for residents of private psychiatric hostels.	Some hostels refuse to provide fresh milk.
Most residents of licensed psychiatric hostels do not have a resident agreement with the licensee	1998 - 1999	A resident agreement should, among other requirements, detail the rights and responsibilities of the resident and the owner/ licensee.	Resident agreements will be incorporated into new licensing standards that hostels must meet.
AUTHORISED HOSPITALS			
The outside area at Joondalup Mental Health Unit secure ward is inadequate	1997 -1998	The outdoor area should be extended to an appropriate size and configured to enable access to the garden.	Improvements yet to be made.

Often no access to on-site gyms, or to exercise equipment etc	1999 - 2000	Increase access to gyms and to equipment (bikes, balls etc).	Access to physical exercise opportunities varies between hospitals and wards.
Need to improve opportunities for social-isation for people with a long term illness	2000 - 2001	Involve hospital patients, especially long stay in preparing food and cooking meals, including BBQ.	Some slow improvement. Socialisation activities are basic human needs that must be provided for.
State wide policies concerning many issues are not available	1998 - 1999	In order to comply with standards for care and achieve consistency, it is essential to develop policies that apply state wide including use of video monitors, mobile telephones.	The Office of the Chief Psychiatrist has advised services of some matters that require policy development, rather than issue specific policies.
Specific Visitor areas are in-adequate or non-existent in many inpatient facilities	2002 – 2003	Any new inpatient facilities, particularly secure units, have designated Visitors' areas incorporated into their design. Existing Units are altered to address lack of designated areas.	The facilities available for individuals to receive visitors in privacy vary between inpatient facilities and wards within those facilities. See case example above.
SATISFACTORILY RESOLVED DURING 2002 – 2003			
Use of the term "Acting Psychiatrist" or "Psychiatrist" used for medical practitioners who are not Psychiatrists	1999 - 2000	Staff to be clear in discussion with consumers and others of the correct title of medical staff responsible for their care.	Mental health services appear to have addressed and rectified the problem.
Lack of adequate lighting in the car park adjacent to the Bunbury Acute Psychiatric Residential Unit	2000 - 2001	Lighting to be installed in the car park adjacent to the Bunbury Acute Psychiatric Residential Unit to improve safety.	Lighting installed.

POLICY AND LEGISLATIVE ENVIRONMENT

REVIEW OF THE *MENTAL HEALTH ACT 1996 AND THE CRIMINAL LAW (MENTALLY IMPAIRED DEFENDANTS) ACT 1996*

Council members, together with a large number of individuals and other organisations, have participated in the review of the *Mental Health Act 1996* and the *Criminal Law (Mentally Impaired Defendants) Act 1996*. We had membership of the Stakeholder Committee and six of the seven committees established to review particular sections and aspects of these statutes.

Council takes this opportunity to applaud the review process and to congratulate all participants in their commitment to modernising this important area of human rights law. We welcome the general consensus that an increased and explicit emphasis on rights should be incorporated into the new legislation. Council trusts that a new Mental Health Act will be a priority for Government and that a bipartisan approach will be taken to its passage in the Parliament.

The Council made written submissions in relation to the Review, which are available from the Office of the Review of the Acts' website accessed via www.health.wa.gov.au/mhareview.

One of the Terms of Reference for the Review was a review of the effectiveness and need for the continuation of the functions of the Council itself (the Act, section 215). The Council welcomed this opportunity to review its operations and lodge a written submission.

The Executive Summary of the Council's submission noted:

> "This submission is predicated on the imperative that the rights of consumers of mental health services must be protected and enhanced.
>
> Thus, its primary objective is to ensure the continuation of the functions performed by the Council of Official Visitors.
>
> It will also contend that the Council has been effective during the first 5 years of its operations. Such effectiveness has, however, been of necessity constrained by the limitations placed on the Council's role by the current legislation.
>
> Consequently, this submission argues that the scope of the Council's role should be expanded in relation to both hospitals and hostels. Further, it is contended that the Council's role in policy development and system review should be formally recognised. Whilst the rights of individual consumers will always be the first priority, it would be short sighted to exclude the combined wisdom of the Council from the policy making process. … There is convincing evidence that the Council has been a major contributor to policy development and this potential should be recognised and protected.
>
> The submission also contains some suggestions as to how the administration of the Council can be improved and how its services can be brought to the attention of consumers who are under-represented in the Council's current workload. Mental health systems need independent watchdogs which can bark and bite. The recommendations that follow will enhance the potential of the Council to do both in the interests of consumers."

Additionally, and as indicated throughout this report, the Council is concerned that the rights of voluntary patients can also be trespassed on without the individual having the capacity to access mainstream services either due to their health state and / or the treatment they are receiving. We receive numerous inquiries from individuals and family members concerning voluntary patients but we are unable to act on them other than to refer the individual to another agency.

The definition of '*affected person*' in the Act should be broadened.

As noted in the Council's 2001 – 2002 Annual Report (page 22):

> "It has been the Council's consistently held view that the definition of "affected person" under the Act (section 175) should be amended to include all patients in an authorised hospital, no matter their status under that Act. This would be in addition to involuntary patients in the community (i.e. subject to a community treatment order) and residents of psychiatric hostels. The Council is of the view that the arbitrary decision to limit its contact to involuntary patients in authorised hospitals appears flawed given that the services that the individuals receive are the same no matter what their legal status.
>
> … the Council has no role with the numerous unlicensed hostels and boarding houses where many of the people the Council is concerned about are living. The Council is worried by what we know about some aspects of the licensed hostel sector. The community should be even more uneasy about what we don't know about those facilities beyond the Council's limited purview.
>
> … Any amendments to the Act are unlikely to occur until 2002 – 2003 therefore serious consideration must be given to mechanisms to ensure that the rights of these individuals are respected and ensured."

MENTAL HEALTH REVIEW BOARD

It is the statutory right of involuntary patients to have their status reviewed by the Mental Health Review Board (Part 6 of the Act) and to appear with a legal representative and / or an Official Visitor. As raised in the Council's 2001 – 2002 Annual Report, the low levels of legal representation and / or non-legal advocacy accessed by consumers at their Mental Health Review Board hearings remain of concern. Questions of justice are raised about such minimal representation and advocacy.

Discussions continue with the Mental Health Law Centre regarding strategies to address this, including undertaking research to identify the reasons for this low level of utilisation of these services.

It is unclear what impact the proposed inclusion of the functions of the Mental Health Review Board into the State Administrative Tribunal (SAT) will have. In acknowledging the potential advantages of a SAT in general, Council needs to be reassured that a beneficial outcome in terms of consumer contact and representation will occur. To the time of reporting, Council believes that individual consumers should have access to appropriate specialist panels for their review. Certainly, consumers' right to access legal representation or the assistance of an Official Visitor must remain.

The issue of representation at hearings will be further progressed with the Mental Health Law Centre and the Mental Health Review Board (or its successor) during 2003 – 2004 (Part Four Priorities for 2003 – 2004).

The Council's previously reported concerns regarding consumers' timely access to the medical and other reports provided to the Mental Health Review Board continued during 2002 – 2003 (Council of Official Visitors Annual Report 2001 – 2002).

GUARDIANSHIP AND ADMINISTRATION ACT 1990

The relationship between the *Guardianship and Administration Act 1990* and the *Mental Health Act 1996* provisions relating to medical treatment (section 110) has been an area of concern for the Council for a number of years. Section 110 of the Act allows the Chief Psychiatric to approve medical

treatment of involuntary patients in authorised hospitals. This power has been delegated to the psychiatrists in charge of those hospitals.

The Council is concerned at the use of delegated authority for the prescription of non-psychiatric treatment, highlighted by so called "lifestyle issues"; in this case contraceptives to prevent pregnancy in a woman at risk of pregnancy and not for a designated medical condition. This case illustrates the lack of an adequate degree of separation between the prescribing doctor and the authorising psychiatrist, and also the hospital. Nowhere are the powers of the Chief Psychiatrist and/or his/her delegate under section 110 the subject of a review process. The Council has made a submission in relation to this issue to the Review of the *Mental Health Act 1996*.

Contraception and *Mental Health Act 1996*, section 110

It came to the attention of the Council that an involuntary detained patient had been assessed, by the treating team, as competent to make choices with regard to contraception. When asked what would happen if she refused to take the oral contraceptive hospital staff indicated that they would ensure she took the contraceptive under the hospital's duty of care to her.

Alarmingly, there did not appear to be any understanding that if an individual has the capacity to consent she also has the capacity to withhold consent (i.e. refuse the medication) and the hospital's duty of care cannot be used to override this.

In Council's view the potential for a conflict of interest in a hospital focussed decision-maker must be acknowledged. The danger is that the contraception could be for the convenience of the hospital and not necessarily in the best interests or the will of the patient. The approval under section 110 of the *Mental Health Act 1996* should be explicit and clearly in the best interests of the patient.

The *Guardianship and Administration Act* contains specific provisions that must be met by an appointed guardian in the decision making process. Importantly in section 51(2)(e) of that Act there is to be consultation, as far as possible, as to the wishes of the represented person. No such obligation exists for a decision by the Chief Psychiatrist, or delegate, to approve a medical treatment.

If a Guardian is appointed and the hospital staff wish to give or see the need for medical treatment then that matter should be referred to the Guardian who can then make a decision on the facts / information provided, to consent or not.

A Guardian's appointment is not for the purpose of being a monitor of Mental Health Services. An appointed Guardian is the keeper of the best interests of the represented person and in that role may question the Mental Health Service actions. If concerned, the Guardian could refer Mental Health Service actions or decisions to the appropriate investigative or monitoring body.

It is the Council's view that the consultation required under the *Guardianship and Administration Act 1990* and the statutory scheme of setting out specific considerations for 'best interests', results in less restriction of the freedom and rights of the protected person because it ensures that the person, so far as possible, has a degree of self determination.

These matters illustrate potentially difficult ethical as well as clinical issues that will continue to be monitored by the Council. It is critical that the right of the person - or their Guardian - to accept or refuse treatment other than psychiatric treatment is protected.

PART THREE
ACTIVITIES OF THE COUNCIL

The Council of Official Visitors' major areas of responsibility are to:

- respond to requests from consumers as soon as is practicable; and
- undertake visits of authorised hospitals and the licensed private psychiatric hostels.

Mental Health Act 1996, section 186

INSPECTION VISITS

The Act specifies that an Official Visitor or panel must visit each authorised hospital at least once in each month. In addition the Minister, in accordance with the Act, has directed that an Official Visitor or panel should visit designated psychiatric hostels at least once every two months. In practice they are visited each month.

Inspection visits focus on ensuring that '*affected persons*' are aware of their rights, these rights are observed and that the facility is kept in a "*condition that is safe and otherwise suitable*" (as per section 188 (c) of the Act).

A summary of the inspection visits to authorised hospitals and licensed private psychiatric hostels by the time and day of the week is detailed in Appendices 6 and 7 respectively. All operational authorised hospitals were visited as planned. One hundred and eighteen (118) of the planned 119 visits to the licensed private psychiatric hostels occurred, with Shannon House being visited five out of the programmed six times.

The Council continued to make informal visits to the licensed private psychiatric hostels, with the exception of the small group homes, on a bi-monthly basis. The focus of informal visits is to actively seek out the residents of the hostels. These visits occurred during the alternate months to the formal inspection visits.

The Council had set itself the target of increasing the percentage of inspection visits outside "normal" working hours (i.e. other than Monday to Friday, 9.00 am to 5.00 pm). The targets were:

- 40% of visits to licensed private psychiatric hostels; and
- 25% of visits to authorised hospitals

being at these times.

The Council's performance in conducting inspection visits outside normal working hours was similar during 2002 - 2003 to the previous year with a total of 45.4% of such visits to authorised hospitals and 55.1% of such visits to psychiatric hostels occurring outside these hours (Appendix 8).

Ensuring that a proportion of visits to secure wards in authorised hospitals occurs on weekends and public holidays will be a focus for the Council during 2003 – 2004.

The majority of inspection visits occurred without notice, as provided for by section 190 (2) of the Act.

CONSUMER CONTACTS

Authorised Hospitals and Licensed Private Psychiatric Hostels

During 2002 – 2003 a total of 1126 requests for contact with the Council were received from 599 consumers (Appendix 9). These requests resulted in 974 visits by Official Visitors to consumers and a further 1474 telephone calls either to or on behalf of the consumers as reported by the Official Visitors. The number of consumers contacted and actions taken by Official Visitors in response to a request during 2002 – 2003 are summarised at Appendix 11.

Compared to the previous year there was a 15% increase in the total number of consumers having contact with the Council for the year 2002 – 2003. Similarly there was a 39% increase in the number of requests received (Appendices 9, 12A and 13A).

There has been a 65.5% increase in the total number of consumers requesting contact with the Council since it became fully operational in 1998 – 1999 (Appendices 12A, 12B).

Similar to previous years the most significant number of consumers with whom the Council had contact were receiving treatment in Graylands Hospital: 289 individuals (Appendix 10).

The trend of limited requests being received from consumers from non-metropolitan areas continued during 2002 – 2003.

The Bunbury Acute Psychiatric Residential Unit suspended admission of involuntary patients effective 31 August 2001 however remained authorised, admitting voluntary patients and was visited monthly by Official Visitors in accordance with the Act (section 186). Two voluntary inpatients from that Unit made contact with the Council during 2002 – 2003. One individual was to be transferred to Graylands Hospital as an involuntary patient. This individual was provided with initial contact in the Bunbury Unit and subsequently seen whilst an inpatient in Graylands Hospital. Given the restriction of the Council's role to exclude voluntary patients (the Act, section 175) the other was provided with a limited response from the Council and referral to another agency for assistance.

The Council received 28 pieces of anonymous correspondence, primarily via the mailboxes at Graylands Hospital.

Community Mental Health Services

Whilst there was an increase in the number of consumers from metropolitan clinics contacting the Council (29 individuals in 2001 – 2002 to 46 in 2002 – 2003) the number of consumers from non - metropolitan clinics contacting the Council remained low (2 individuals in 2001 – 2002, 4 in 2002 – 2003). This is a very small proportion and of concern to the Council. It is unclear how knowledgeable these individuals, in particular those in non-metropolitan areas, are regarding their right to access the Council for assistance.

Contact with consumers subject to Community Treatment Orders remains an area that requires further attention by the Council to ensure that these consumers' rights are being observed and they are aware of the availability of the Council's service (Part Four Priorities for 2003 – 2004).

Overall the total number of contacts between Official Visitors and consumers following requests has consistently increased since 1998 – 1999 (Appendix 13A).

The decrease in the letters written by Council in relation to consumer complaints compared to the previous years continued. This appears likely to be related to Official Visitors addressing issues at the lowest possible level, i.e. on the ward or in the hostel.

Mental Health Review Board

During 2002 - 2003 there was a 79% increase in the number of Mental Health Review Board hearings attended by Official Visitors in a support / advocacy role compared to the previous year (43 hearings in 2001 – 2002 to 77 in 2002 – 2003). These figures only represent a very small percentage of the total hearings conducted.

The Council's concern regarding the low percentage of involuntary patients supported or represented at their Mental Health Review Board hearings by either a legal practitioner or member of the Council continues despite this increase. It remains an area of concern requiring further attention by the Council (Part Four Priorities for 2003 – 2004).

Analysis

A summary of the issues raised by consumers is contained at Appendices 14A & 14B. Issues are categorised based on the consumer's view of the matter. The major issue raised is the one categorised. For example, when assisting a consumer to apply for a Mental Health Review Board hearing, the right to request a second opinion will also be discussed. This will generally be categorised as Mental Health Review Board Application if no further assistance is required with exercising the right to a second opinion.

Approximately 30% of contacts with consumers during 2002 – 2003 related to issues associated the *Mental Health Act 1996*, including Mental Health Review Board applications (13.5%) and attendance (11%). Twenty percent (20%) of issues related to discharge or transfer arrangements, with the majority of these based on the consumer's complaint that they did not require inpatient treatment. A small proportion to these related to delays in transfer to open wards. A further 10% of complaints related to Quality of Care, in particular inadequate treatment (8%).

The Council continued to utilise the same categorisation of complaints as that adopted by the Office of Health Review. Not all requests by consumers relate directly to those complaint categories. In addition to the categories added by the Council related to the *Mental Health Act 1996* and the *Criminal Law (Mentally Impaired Defendants) Act 1996* the Council added a new category of *Guardianship and Administration Act 1990*.

OTHER ACTIVITIES

POLICY REVIEW AND DEVELOPMENT

Since its inception the Council has undertaken a role in policy development and advocacy at the local and systemic levels.

Position Statements

The Council's Position Statements related to "*Consumer's Right to Receive Visitors in Reasonable Privacy* (*Mental Health Act 1996* section 168)" and "*Translating Legal Rights into Building Design Guidelines*" are yet to be finalised.

Submissions

As reported above the Council made submissions in relation to the Review of the *Mental Health Act 1996* and *Criminal Law (Mentally Impaired Defendants) Act 1996*.

The Council provided comment and submissions in relation to:

- WA Statewide Obstetrics Services Review Discussion Paper;
- Community Accommodation Planning Project (CAPP) Discussion Document – Office of Mental Health;
- Development of a set of National Mental Health Standards for Mental Health Services for the non-government sector – Office of Mental Health;
- Review of the Office of Health Review;
- Joint Review of the Western Australian Community Legal Centres;
- Various policies being developed by individual authorised hospitals including Internet use, use of video monitoring and search of patient's belongings and / or person; and
- proposed changes to the outdoor area of the open section of the Swan Valley Centre.

Committee participation

- *Private Psychiatric Hostels Standards Reference Committee*

The Council has been an active participant in and contributor to the *Private Psychiatric Hostels Standards Reference Committee* convened as part of the Licensing Reforms process instigated by the Department of Health. The initial focus of this committee was on the development of licensing standards relating to the arrangements for the management, staffing and equipment of hostels.

The Office of the Chief Psychiatrist subsequently utilised this committee to assist in the development of that office's Care Standards for the licensed private psychiatric hostel industry.

- *Community Options 100 Project Reference Group*

The Council has a representative as a member of the Community Options 100 Project Reference Group for the community housing of people with serious and persistent mental illness, who have been long stay patients in public mental health inpatient facilities, primarily at Graylands Hospital.

- *Human Rights and Social Justice Committee*

The Council continued to have membership of the Human Rights and Social Justice Committee convened by the WA Association for Mental Health.

Additionally, Council representatives participated in the Australian Council on Health Care Standards – In depth Review of Mental Health Services Surveys for Graylands Selby-Lemnos and Special Care Health Service and South West Health Service.

QUALITY ASSURANCE

The Council of Official Visitors is committed to continuous quality improvement in its service delivery and welcomes feedback of an informal and formal nature regarding its operations. It is essential that not only the entity of the Council but also the conduct of individual Official Visitors or staff is open to assessment by customers of its service and other stake holders.

Codes of Conduct and Ethics

The Council's Code of Ethics and Code of Conduct bind all members of the Council. A copy of these Codes is available from the Council's office.

Complaints Regarding Council Operations

During 2002 – 2003 four formal complaints were received regarding the operation of the Council. The content of these complaints were:

1. Inaccurate and / or biased references to another agency in the Council's Annual Report 2001 – 2002;
2. Council did not follow due complaints management process, using language which appeared to prejudge the complaint outcome;
3. Inappropriate and / or unauthorised access to, and viewing of, medical records, inaccurate information given by Official Visitor; and
4. Breach of carer's confidentiality by providing information to a consumer.

The complaints were investigated in line with the Council's complaint management policy, a copy of which is available from the Council's office. The complaints were found to be unsubstantiated.

Professional Development Activities

The Council's commitment to providing a quality service to consumers accessing its service continued. The Council endeavours to ensure that all Official Visitors, metropolitan and regional, are provided with appropriate training and development opportunities to enable them to carry out their functions efficiently and effectively.

A two day orientation programme was provided to members of the Council during 2002 - 2003. In addition a number of Official Visitors attended lectures, workshops and conferences external to the Council.

PRESENTATIONS TO COMMUNITY GROUPS

The Council provided presentations to community during the 2002 - 2003. The major aim of these presentations was to increase people's awareness and understanding of the Council's role under the Act. Presentations were made to various groups including:

- Post Graduate Programme Presentation, Graylands Hospital & Health service;
- LAMP, Inc., Busselton;
- Advanced Skills in Mental Health Course, Fremantle Hospital & Health Service;
- "*Whatever happened to mental health and human rights?*" seminar – Mental Health Law Centre;
- Mental Health Law Centre - Volunteer Training Programme; and
- State Forensic Community Mental Health Service.

PART FOUR
PRIORITIES FOR 2003 - 2004

Although the functions of the Council are prescribed in the Act, its value base is also embedded in the protection of the rights of individual consumers. In day to day activities, and in longer term planning, these values underline the Council's priorities.

In May 2003 a Strategic Planning exercise, in which all Official Visitors participated, was undertaken and priorities developed for the next three years.

Three key activity areas were identified, viz;

1 To address the rights and quality of life of '*affected persons*'.

1.1 The rights and quality of life of involuntary patients in hospitals

1.2 The rights and quality of life of hostel residents

1.3 The rights and quality of life of people with a Community Treatment Order';

2 Professional Development for Official Visitors; and

3 Raise the profile of Council.

Arising from this exercise, the priorities for the year to 30 June 2004 include:

- Increase by 25% the number of Mental Health Review Boards hearings attended by Official Visitors at the request of consumers;
- Increase by 50% the number of consumers on Community Treatment Orders who receive assistance from the Council; and
- Increase the total number of '*affected persons*' having contact with Council by 10%.

Although these functions relate directly to the statutory function of Council, it should be made clear that budgetary considerations may influence achievement of these goals. They are modest aims, however, that will be distributed between all Official Visitors.

Council will also develop position statements covering the following areas:

- Access to second opinions that are independent;
- Authorised Hospital environments and practices that promote such rights as privacy for telephone calls and visitors, care of patient property and recreation; and
- Licensed Private Psychiatric Hostels' environments and practices that promote best practice relating to rights and improved quality of care/life for residents.

Council has almost completed the development of a series of focus areas to guide inspections of licensed private psychiatric hostels and authorised hospitals, and which guide observations over and above the standard inspection report documents.

Such focus areas are derived from the Australian *National Standards for Mental Health Services* and/or the *Mental Health Act 1996*. They include a series of questions and observations of both consumers and staff on, for example, ease of access to a second opinion in hospital or clinic, protocols for purchase and care of clothing in hostels, and access to recreational facilities for both. These are currently being tested and will be evaluated by Official Visitors prior to formal implementation.

Official Visitors will continue to participate in meetings convened to plan improvements in services and / or conditions for consumers. At the time of going to print these include:

- Community Options 100 Project Reference Group;
- Refurbishment of Mills Street Centre, Ward 6; and
- Stakeholder Committee, Review of the *Mental Health Act 1996* and the *Criminal Law (Mentally Impaired Defendants) Act 1996*.

APPENDICES

APPENDIX 1: AUTHORISED HOSPITALS

(As per *Mental Health Act 1996* section 21)

Albany Mental Health Unit
Albany Regional Hospital
Hardie Road
Albany

Fremantle Hospital and Health Service
Alma Street Centre
Alma Street
Fremantle

Armadale Health Service
Acute Adult Mental Health Inpatient Unit
Acute Inpatient Mental Health Unit for Older People
Albany Highway
Armadale

Bunbury Regional Hospital
Acute Psychiatric Residential Unit
South West Mental Health Service
Bunbury Health Campus
Bunbury

Graylands Selby-Lemnos and Special Care Hospital
Graylands Hospital
Brockway Road
Mount Claremont
Including Frankland Centre (forensic)

Graylands Selby-Lemnos and Special Care Hospital
Selby Older Adult Psychiatry Service (Selby Lodge)
Lemnos Street
Shenton Park

Kalgoorlie Regional Hospital
Mental Health Inpatient Service
Piccadilly Street
Kalgoorlie

Joondalup Health Campus
Joondalup Mental Health Unit
Shenton Ave
Joondalup

Bentley Hospital and Health Service
Mills Street Centre
Mills Street
Bentley
Including Mills St Lodge
WAY Centre

Mercy Hospital
Ursula Frayne Unit
Thirlmere Road
Mount Lawley

Swan Health Service
Swan Valley Centre & Boronia Inpatient Unit
Eveline Road
Middle Swan
Including Sheoak Rehabilitation Centre
Swan Adult Mental Health Centre

APPENDIX 2: LICENSED PRIVATE PSYCHIATRIC HOSTELS

(As per "*Functions of the Council of Official Visitors Direction 2003*", May 2003)

Casson Homes	
Aitken House	55 View Street North Perth
Casson House	2-10 Woodville Street, North Perth
Violet Major House	47 View Street, North Perth
Woodville House	425 Clayton Road, Helena Valley
Richmond Fellowship	
	56 Glyde Street, East Fremantle
	58 Glyde Street, East Fremantle
	4 - 6 Mann Way, Bassendean
	23 Walton Street, Queens Park
Devenish Lodge	54 Devenish Street, East Victoria Park
Dudley House	24 Dudley Street, Midland
Franciscan House	16 Hampton Road, Victoria Park
Glyde Street Hostel	48 Glyde Street, Mosman Park
Honey Brook Lodge	42 John Street, Midland
John Wilson Lodge	38 Hamilton Street, East Fremantle
Maude Armstrong	16 Davies Road, Claremont
Romily House	19 Shenton Road, Claremont
Rosedale Lodge	22 East Street, Guildford
St Jude's Hostel	26 & 30-34 Swan Street, Guildford
Salisbury Home	19-21 James Street, Guildford
Shannon House	23 Coolgardie Street, Subiaco
Sherwood House	5 Kalamunda Road, South Guildford
Success Hill Lodge[1]	1 River Street, Guildford

[1] Ceased operation effective 8 May 2003

APPENDIX 3: COUNCIL OF OFFICIAL VISITORS 2002 - 2003 MEMBERSHIP

Head of Council	Expiry Date of Term
Dr Judyth WATSON	01 April 2006
Mr Stuart FLYNN	31 March 2003
Official Visitors	
Mr Bruce AMROSIUS	07 April 2005 [2]
Mrs Di ANNEAR	07 April 2005 [3]
Ms Joyce ARCHIBALD	07 April 2005
Mrs Sherril BALL	07 April 2005
Mr Scott BARNDON	07 April 2005
Ms Sandra BROWN	07 April 2003
Mrs Rita BURGESS	07 April 2003
Mr Clive DEVERALL	07 April 2005 [2]
Ms Jane ENSOR	07 April 2003 [4]
Mr Adrian GAVRANICH	07 April 2004
Ms Jane GIBSON	07 April 2006 [2]
Ms Amara HOGEVEEN	07 April 2003
Mr Kevin HOGG	07 April 2006 [2]
Mr Darren JONES	07 April 2005
Dr Helen LETTE	07 April 2006 [2]
Mrs Ann McFADYEN	07 April 2004
Ms Edana McGRATH	07 April 2004
Mr Sean O'CONNELL	07 April 2005 [5]
Ms Val O'TOOLE	07 April 2005 [2]
Ms Leanne PECH	07 April 2005 [2]
Mrs Rosalind SAWYER	07 April 2006 [2]
Mrs Maxinne SCLANDERS	07 April 2006 [2]
Mrs Sheila STEPHENS	07 April 2004
Ms Margaret STOCKTON METCALF	07 April 2004
Ms Hilary TUFFIN	07 April 2005 [6]
Ms Catriona WERE - SPICE	07 April 2005
Ms Rachael WILSHER – SAA	07 April 2005 [2]

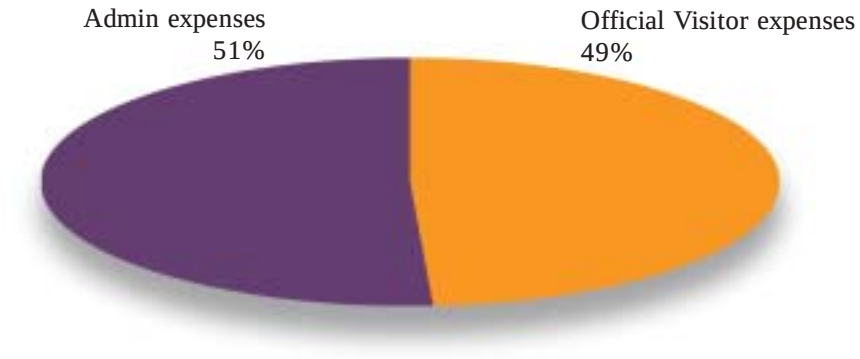
[2] Appointments effective 21 January 2003
[3] Resigned effective 30 June 2003
[4] Resigned effective 20 September 2002
[5] Leave of absence from 31 August 2002 to 26 March 2003
[6] Resigned effective 25 October 2002

APPENDIX 4: COUNCIL OF OFFICIAL VISITORS' MEETINGS ATTENDANCE 2002 - 2003

OFFICIAL VISITOR	FULL COUNCIL		EXECUTIVE GROUP	
	Present	Apologies	Present	Apologies
Mr Stuart FLYNN (Head of Council) [7]	3	2	3	-
Dr Judyth WATSON (Head of Council) [8]	1	-	2	-
Mr Bruce AMBROSIUS [9]	2	-	-	-
Mrs Di ANNEAR	4	2	2 (Proxy)	-
Ms Joyce ARCHIBALD	6	0	-	-
Mrs Sherril BALL	5	1	2	-
Mr Scott BARNDON	5	1	-	-
Ms Sandra BROWN	5	-	1	2
Mrs Rita BURGESS	3	2	-	-
Mr Clive DEVERALL [9]	1	1	-	-
Ms Jane ENSOR [10]	-	2	-	-
Mr Adrian GAVRANICH	3	3	-	-
Ms Jane GIBSON	4	1	-	-
Ms Amara HOGEVEEN	3	2	-	-
Mr Kevin HOGG	6	-	1 (Proxy)	-
Mr Darren JONES	6	-	3	-
Dr Helen LETTE	4	2	1 (Proxy)	-
Mrs Ann McFADYEN	6	-	-	-
Ms Edana McGRATH	6	-	5	-
Mr Sean O'CONNELL [11]	3	1	-	-
Ms Leanne PECH [9]	2	-	-	-
Ms Val O'TOOLE [9]	2	-	-	-
Mrs Rosalind SAWYER	6	-	4	1
Mrs Maxinne SCLANDERS	4	2	4	1
Mrs Sheila STEPHENS	5	1	-	-
Ms Margaret STOCKTON METCALF	6	-	1	-
Ms Hilary TUFFIN [12]	2	-	-	-
Ms Catriona WERE - SPICE	6	-	-	-
Ms Rachael WILSHER - SAA [9]	2	-	-	-

[7] Term expired 31 March 2003
[8] Appointment effective 01 April 2003
[9] Appointments effective 21 January 2003
[10] Resigned effective 20 September 2002
[11] Leave of absence from 31 August 2002 to 26 March 2003
[12] Resigned effective 25 October 2002

APPENDIX 5: SUMMARY OF EXPENDITURE 2002 - 2003



As required under the *Electoral Act 1907* Section 175ZE (1), during 2002 - 2003 the Council expended the following in relation to the designated organisation types:

(a) advertising agencies: nil;
(b) market research organisations: nil;
(c) polling organisations: nil;
(d) direct mail organisations: nil; and
(e) media advertising organisations: $1, 905.00.

APPENDIX 6: LICENSED PRIVATE PSYCHIATRIC HOSTEL INSPECTIONS BY HOSTEL & TIME & DAY OF INSPECTION 2002 - 2003

LICENSED PRIVATE PSYCHIATRIC HOSTEL	TOTAL NUMBER OF INSPECTIONS *	TIME OF INSPECTIONS		
		Mon – Fri 9 am – 5 pm	Mon –Fri 5 pm – 9 am	Sat / Sun / Pub Hol
Casson Homes [13]	6	2	3	1
Casson House	6	3	1	2
Devenish House	6	2	2	2
Dudley House	6	3	3	0
Franciscan House	6	2	1	3
Glyde Street Hostel	6	4	1	1
Honey Brook Lodge	6	4	2	0
John Wilson Lodge	6	2	1	3
Maude Armstrong	6	4	1	1
Richmond Fellowship - 175 Anzac Terrace [14] & 6 Mann Way, Bassendean	6	4	1	1
Richmond Fellowship – 56 & 58 Glyde Street, East Fremantle	6	1	2	3
Richmond Fellowship – 2 & 13 Teague Street, Victoria Park [15]	3	2	1	0
Richmond Fellowship – 23 Walton Street, Queens Park [16]	3	0	2	1
Romily House	6	3	1	2
Rosedale Lodge	6	2	2	2
St Jude's Hostel	6	3	1	2
Salisbury Home	6	3	1	2
Shannon House [17]	5	4	1	0
Sherwood House	6	2	2	2
Success Hill Lodge [18]	5	1	2	2
Woodville House	6	2	1	3
TOTAL	118	53	32	33

* Note: The 118 recorded inspections represent the minimum requirement of the Act as decreed by the Minister for Health (viz at least every 2 months). However informal inspections in alternate months are also undertaken to seek out residents who may be particularly vulnerable. The actual number of visits is approximately double that recorded above.

[13] 'Casson Homes' includes Aitken House and Violet Major House
[14] Licence surrendered in October/November 2002
[15] Ceased operating at this location in December 2002
[16] Commenced operating at this location in January 2003
[17] No inspection visit in April 2003, informal visits occurred in March 2003 and May 2003
[18] Ceased operating as a licensed private psychiatric hostel on 8 May 2003

APPENDIX 7: AUTHORISED HOSPITAL INSPECTIONS BY HOSPITAL & TIME & DAY OF INSPECTION 2002 - 2003

AUTHORISED HOSPITAL	TOTAL NUMBER OF INSPECTIONS	TIME OF INSPECTIONS		
		Mon – Fri 9 am – 5 pm	Mon –Fri 5 pm – 9 am	Sat / Sun / Pub Hol
Albany Regional Hospital – Mental Health Unit	12	11	0	1
Alma Street Centre	24	7	15	2
Armadale Health Service – Adult and Elderly Units	24	11	8	5
Bunbury Acute Psychiatric Residential Unit [19]	12	11	1	0
Graylands & Special Care Health Service	28	12	13	3
Joondalup Mental Health Unit	12	6	5	1
Kalgoorlie Mental Health Unit [20]	3	3	0	0
Mercy Hospital, Ursula Frayne Unit [21]	4	4	0	0
Mills St Centre	30	20	4	6
Selby Lodge	12	6	5	1
Swan Health Service Boronia Unit & Swan Valley Centre	24	10	8	6
TOTAL	185	101	59	25

[19] Suspended admission of involuntary patients effective 31 August 2001, however remained authorised under the *Mental Health Act 1996*

[20] Unit authorised in May 2002, commenced admitting patients 26 March 2003, visits commenced April 2003

[21] Unit authorised in January 2003, commenced admitting patients March 2003, visits commenced March 2003

APPENDIX 8: PERCENTAGE OF FACILITY INSPECTIONS BY TIME & DAY OF INSPECTION 1998 - 1999 TO 2002 - 2003

FINANCIAL YEAR	FACILITY TYPE	TIME OF INSPECTIONS(% OF TOTAL)			
		Mon - Fri 9 am - 5 pm	Mon –Fri 5 pm – 9 am	Sat / Sun / Pub Hol	Mon - Fri Time not recorded
1998 – 1999	Authorised Hospitals	77.8%	13.8%	0.6%	7.8%
	Licensed Private Psychiatric Hostels	75.2%	16.5%	0%	8.3%
1999 – 2000	Authorised Hospitals	69.7%	12.9%	17.4%	0%
	Licensed Private Psychiatric Hostels	77.6%	14.6%	5.2%	2.6%
2000 – 2001	Authorised Hospitals	71.1%	17.6%	11.3%	0%
	Licensed Private Psychiatric Hostels	63.3%	27.5%	9.2%	0%
2001 – 2002	Authorised Hospitals	48.6%	26.2%	23.5%	1.7%
	Licensed Private Psychiatric Hostels	46.6%	24.6%	25.4%	3.4%
2002 – 2003	Authorised Hospitals	54.6%	31.9%	13.5%	0%
	Licensed Private Psychiatric Hostels	44.9%	27.1%	28%	0%

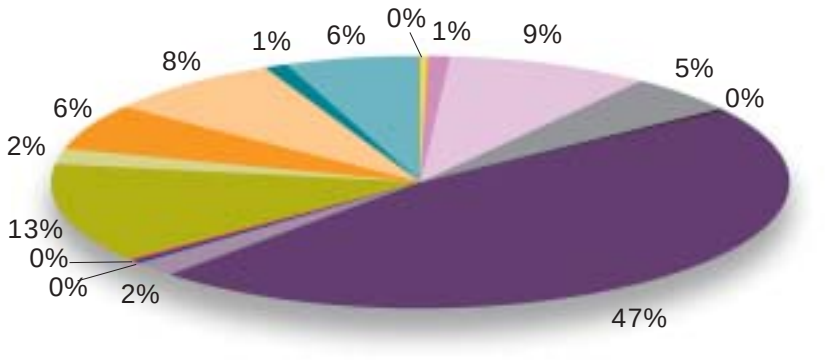
APPENDIX 9: NUMBER OF CONSUMERS AND REQUESTS BY FACILITY 2002 - 2003

FACILITY	NUMBER OF CONSUMERS CONTACTED	NUMBER OF REQUESTS RECEIVED
Albany Mental Health Unit	5	6
Alma Street Centre, Fremantle	51	67
Armadale Health Service – Adult & Elderly Units	29	40
Bunbury Acute Psychiatric Residential Unit [22]	2	2
Graylands & Special Care Health Services	289	612
Joondalup Mental Health Unit	13	36
Kalgoorlie Mental Health Unit [23]	1	1
Ursula Frayne Unit [24]	0	0
Mills Street Centre, Bentley	77	125
Selby Lodge	10	23
Swan Mental Health - Swan Valley Centre & Boronia	35	71
Metropolitan Clinics	46	85
Non – Metropolitan Clinics	4	6
Psychiatric Hostels	36	51
Other	1	1
TOTAL	599	1126

Note: A number of consumers made multiple requests for contact from the Council. These consumers are recorded once.

[22] Suspended admission of involuntary patients effective 31 August 2001, however remained authorised under the *Mental Health Act 1996*
[23] Unit authorised in May 2002, commenced admitting patients 26 March 2003
[24] Unit authorised in January 2003, commenced admitting patients March 2003

APPENDIX 10: PERCENTAGE [25] OF TOTAL CONSUMERS BY FACILITY 2002 - 2003



- Albany Unit - 1%
- Alma Street Centre - 9%
- Armadale Adult & Elderly Units - 5%
- Bunbury Unit - 0%
- Graylands Hospital - 47%
- Joondalup Unit - 2%
- Kalgoorlie Unit - 0%
- Ursula Frayne Unit - 0%
- Mill Street Centre 13%
- Selby Lodge - 2%
- Swan Valley Centre & Boronia - 6%
- Metropolitan Clinics - 8%
- Non-Metropolitan Clinics - 1%
- Psychiatric Hostels - 6%
- Other - 0%

[25] Percentages rounded to nearest whole value

APPENDIX 11: CONTACTS WITH CONSUMERS BY FACILITY 2002 - 2003

FACILITY	NUMBER OF CONSUMERS CONTACTED (# Requests)	CONTACT TYPE			
		VISIT	TELEPHONE CALL	LETTER	MHRB [26] ATTENDANCE
Albany Mental Health Unit	5 (6)	4	3	0	0
Alma Street Centre, Fremantle	51 (67)	67	67	5	2
Armadale Health Service – Adult & Elderly Units	29 (40)	31	36	2	3
Bunbury Acute Psychiatric Residential Unit [27]	2 (2)	1	3	0	0
Graylands & Special Care Health Services	289 (612)	617	751	30	30
Joondalup Mental Health Unit	13 (36)	12	54	1	4
Kalgoorlie Mental Health Unit [28]	1 (1)	1	0	0	0
Ursula Frayne Unit [29]	0 (0)	0	0	0	0
Mills Street Centre Bentley	77 (125)	95	188	8	7
Selby Lodge	10 (23)	30	19	1	3
Swan Mental Health - Swan Valley Centre & Boronia	35 (71)	43	124	4	5
Metropolitan Clinics	46 (85)	18	119	8	22
Non - Metropolitan Clinics	4 (6)	0	13	0	1
Psychiatric Hostels	36 (51)	54	92	7	0
Other	1 (1)	1	5	1	0
TOTAL	599 (1126)	974	1474	67	77

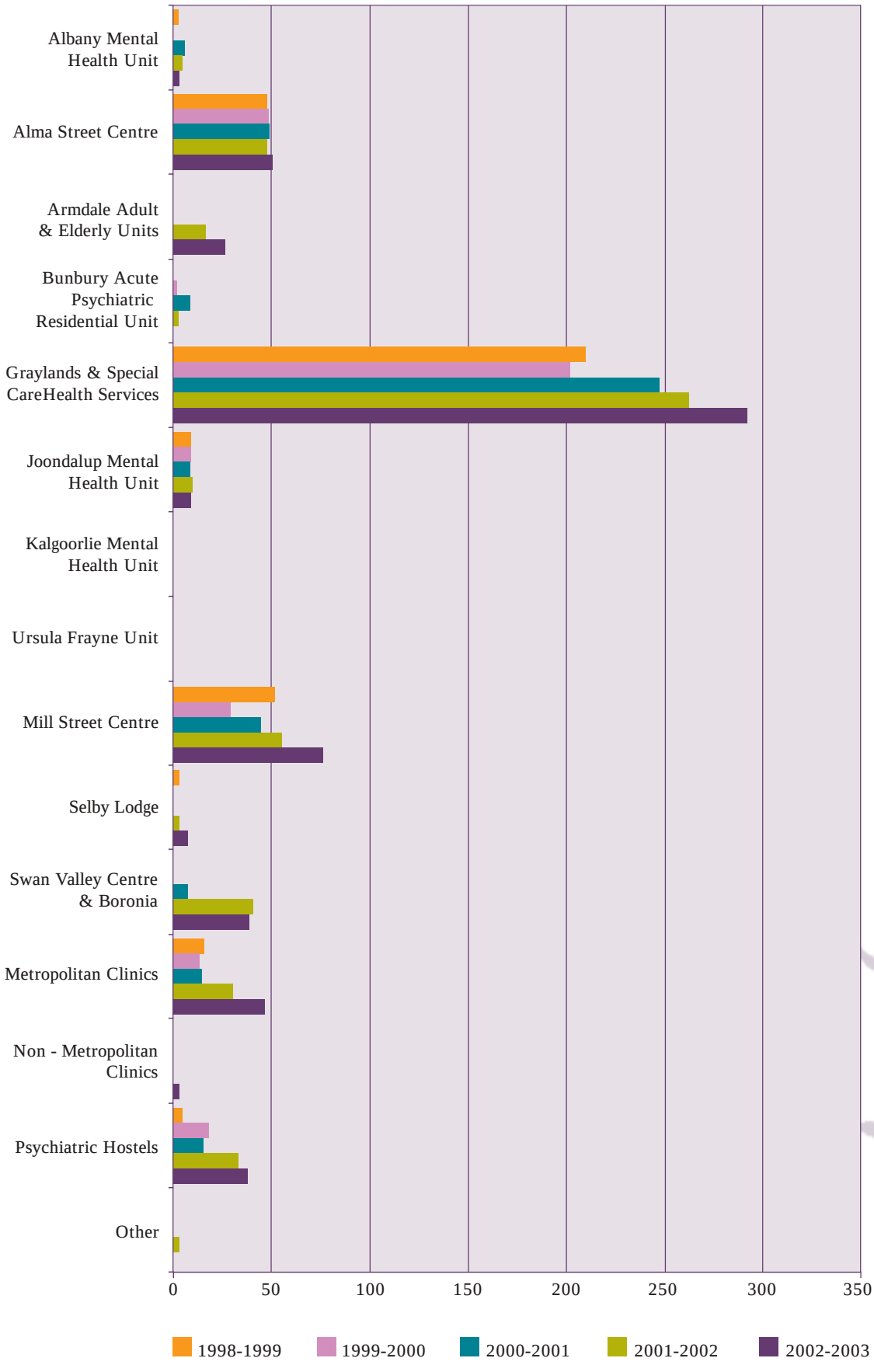
[26] MHRB - Mental Health Review Board
[27] Suspended admission of involuntary patients effective 31 August 2001, however remained authorised under the *Mental Health Act 1996*
[28] Unit authorised in May 2002, commenced admitting patients 26 March 2003
[29] Unit authorised in January 2003, commenced admitting patients March 2003

APPENDIX 12A: TOTAL CONSUMERS CONTACTED BY FACILITY 1998 - 1999 TO 2002 - 2003

FACILITY	NUMBER OF CONSUMERS				
	1998 - 1999	1999 - 2000	2000 - 2001	2001 - 2002	2002 - 2003
Albany Mental Health Unit	4	2	9	8	5
Alma Street Centre, Fremantle	45	48	48	45	51
Armadale Health Service - Adult & Elderly Units	-	-	-	17	29
Bunbury Acute Psychiatric Residential Unit [30]	2	3	12	4	2
Graylands & Special Care Health Services	212	203	245	266	289
Joondalup Mental Health Unit	13	13	14	15	13
Kalgoorlie Mental Health Unit [31]	-	-	-	-	1
Ursula Frayne Unit [32]	-	-	-	-	0
Mills Street Centre, Bentley	52	29	42	57	77
Selby Lodge	4 [33]	1	1	4	10
Swan Health Service-Swan Valley Centre & Boronia	1 [34]	0 [34]	11	38	35
Metropolitan Clinics	20	16	18	29	46
Non – Metropolitan Clinics	0	0	0	2	4
Psychiatric Hostels	7	22	20	32	36
Other	2	2	2	4	1
TOTAL	362	339	422	521	599

[30] Suspended admission of involuntary patients effective 31 August 2001, however remained authorised under the *Mental Health Act 1996*
[31] Unit authorised in May 2002, commenced admitting patients 26 March 2003
[32] Unit authorised in January 2003, commenced admitting patients March 2003
[33] Lemnos Hospital
[34] La Salle Hospital / Boronia Unit only

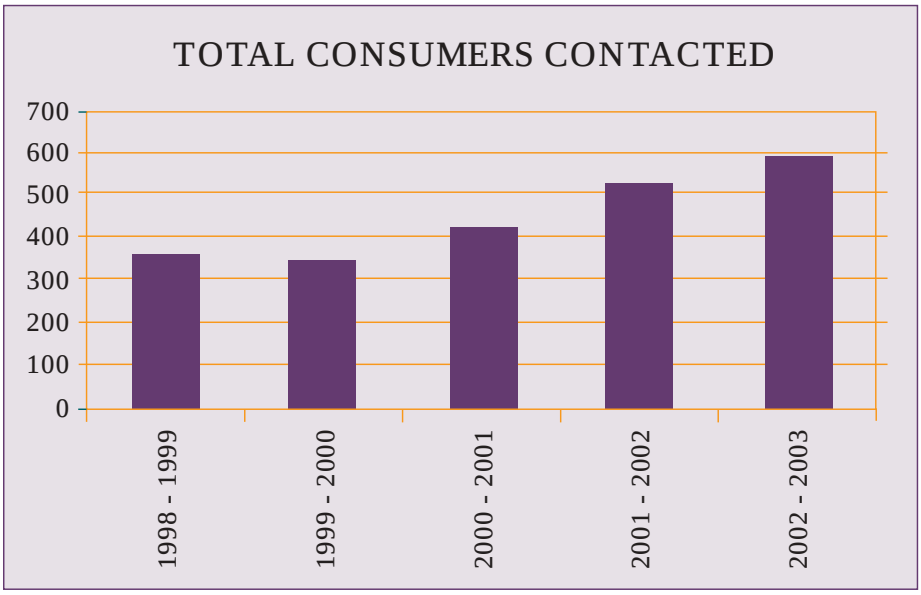
APPENDIX 12B: GRAPH - TOTAL CONSUMERS CONTACTED BY FACILITY 1998 - 1999 TO 2002 – 2003



APPENDIX 13A: TOTAL CONTACTS WITH CONSUMERS 1998 - 1999 TO 2002 - 2003

FACILITY	NUMBER OF CONSUMERS CONTACTED (# Requests)	CONTACT TYPE			
		VISIT	TELEPHONE CALL	LETTER	MHRB[35] ATTENDANCE
1998 - 1999	362 (439)	519	189	48	Not Reported
1999 - 2000	339 (511)	515	374	93	12
2000 - 2001	422 (963)	656	558	114	36
2001 - 2002	521 (807)	722	931	98	43
2002 – 2003	599 (1126)	974	1474	67	77
% increase 2001 – 2002 to 2002 - 2003	15% (39.5%)	34.9%	58.3%	- 31.6%	79%
% increase 1998 - 1999 to 2002 - 2003	65.5% (156.5%)	87.7%	679%	39.6%	541.6% [36]

APPENDIX 13B: GRAPH - TOTAL CONSUMERS CONTACTED 1998 - 1999 to 2002 - 2003



[35] MHRB - Mental Health Review Board
[36] 1999 - 2000 to 2002 - 2003 only

APPENDIX 14A: TOTAL CONSUMER CONTACTS BY ISSUE CATEGORY - ALL FACILITIES 2002 - 2003

1. ACCESS		NUMBER	PERCENTAGE (%) OF TOTAL
1.1	Delay in Admission or treatment	21	1.87
1.2	Waiting list delay	0	0
1.3	Non-attendance	6	0.53
1.4	Inadequate or no service	30	2.66
1.5	Refusal to admit or treat	4	0.36
1.6	Discharge or transfer arrangements	226	20.07
1.7	Access to transport	1	0.09
1.8	Physical access/entry	0	0
1.9	Parking	0	0
	TOTAL	288	25.58%

2. COMMUNICATION		NUMBER	PERCENTAGE (%) OF TOTAL
2.1	Inadequate information about treatment options	5	0.44
2.2	Inadequate information on services available	13	1.15
2.3	Misinformation or failure in communication	17	1.51
2.4	Failure to fulfil statutory obligations	7	0.62
2.5	Access to records	5	0.44
2.6	Inadequate or inaccurate records	2	0.18
2.7	Failure to provide interpreter	0	0
2.8	Certificate or report problem	0	0
	TOTAL	49	4.35%

3. DECISION MAKING		NUMBER	PERCENTAGE (%) OF TOTAL
3.1	Failure to consult consumer	4	0.36
3.2	Consent not informed	1	0.09
3.3	Consent not obtained	67	5.95
3.4	Private/public election	0	0
3.5	Refusal to refer or assist to obtain a second opinion	5	0.44
	TOTAL	77	6.84%

4. QUALITY OF CARE		NUMBER	PERCENTAGE (%) OF TOTAL
4.1	Inadequate diagnosis	5	0.44
4.2	Inadequate treatment	87	7.73
4.3	Rough treatment	16	1.42
4.4	Incompetent treatment	1	0.09
4.5	Negligent treatment	0	0
4.6	Wrong treatment	7	0.62
	TOTAL	116	10.30%

5. COSTS		NUMBER	PERCENTAGE (%) OF TOTAL
5.1	Inadequate information about costs	1	0.09
5.2	Unsatisfactory billing practice	0	0
5.3	Amount charged	4	0.36
5.4	Overservicing	0	0
5.5	Private health insurance	0	0
5.6	Lost property and/or reimbursement	1	0.09
	TOTAL	6	0.53%

6. PRIVACY / CONSIDERATION / DISCOURTESY		NUMBER	PERCENTAGE (%) OF TOTAL
6.1	Inconsiderate service/lack of courtesy	33	2.93
6.2	Absence of caring	16	1.42
6.3	Failure to ensure privacy	3	0.27
6.4	Breach of confidentiality	0	0
6.5	Discrimination	2	0.18
6.6	Discrimination of public consumer	0	0
6.7	Sexual impropriety	4	0.36
6.8	Sexual transgression or violation	3	0.27
6.9	Assault	18	1.59
6.10	Unprofessional conduct	0	0
	TOTAL	79	7.02%

7. GRIEVANCES		NUMBER	PERCENTAGE (%) OF TOTAL
7.1	Inadequate response to a complaint	4	0.36
7.2	Reprisal following a complaint	0	0
	TOTAL	4	0.36%

8.	OTHER	NUMBER	PERCENTAGE (%) OF TOTAL
8.1	Administrative practice	11	0.98
8.2	Catering	19	1.69
8.3	Facilities	37	3.28
8.4	Security	23	2.04
8.5	Cleaning	4	0.36
8.6	Fraud/illegal practice	0	0
	TOTAL	94	8.35%

9.	*MENTAL HEALTH ACT 1996* (OTHER)	NUMBER	PERCENTAGE (%) OF TOTAL
9.1	Mental Health Review Board Application	152	13.5
9.2	Mental Health Review Board Attendance	125	11.1
9.3	Second Opinion Request (not 3.5)	17	1.51
9.4	*Mental Health Act 1996* Information	23	2.04
9.5	*Mental Health Act 1996* Non-Compliance (not 2.4)	12	1.06
	TOTAL	329	29.21%

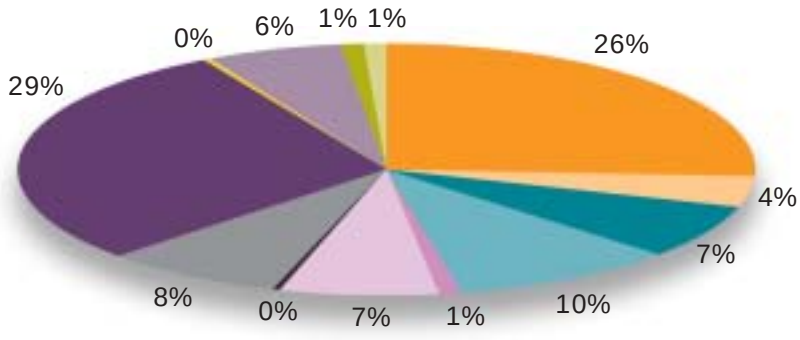
10.	*CRIMINAL LAW (MENTALLY IMPAIRED DEFENDANTS) ACT 1996*	NUMBER	PERCENTAGE (%) OF TOTAL
10.1	Mentally Impaired Defendants Review Board	0	0
	TOTAL	0	0%

11.	UNABLE TO BE DETERMINED	NUMBER	PERCENTAGE (%) OF TOTAL
11.1	Unknown / Undetermined	70	6.22
	TOTAL	70	6.22%

12.	COMPLIMENTS	NUMBER	PERCENTAGE (%) OF TOTAL
12.1	Compliments	6	0.53
	TOTAL	6	0.53%

13.	GUARDIANSHIP AND ADMINISTRATION BOARD	NUMBER	PERCENTAGE (%) OF TOTAL
13.1	Information on processes	7	0.62
13.2	G & A Board attendance	1	0.09
	TOTAL	8	0.71%

APPENDIX 14B: PERCENTAGE [37] ISSUE CATEGORY - ALL FACILITIES 2002 – 2003



- Access - 26%
- Communcation - 4%
- Decision making - 7%
- Quality of Care - 10%
- Costs - 1%
- Privacy/Consideration/Discourtesy - 7%
- Grievances - 0%
- Other - 8%
- Mental Health Act (Other) - 29%
- Criminal Law (Mentally Impaired Defendants) Act 1996 - 0%
- Unable to be Determined - 6%
- Compliments - 1%
- Guardianship and Administration Board 1%

[37] Percentages rounded to nearest whole value