COUNCIL OF OFFICIAL VISITORS

ANNUAL REPORT 2012-13

Hon Helen Morton MLC
MINISTER FOR MENTAL HEALTH

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 30 June 2013.

As well as recording the operations of the Council for the 2012–2013 year the Annual Report reflects on a number and range of issues that continue to affect consumers of mental health services in Western Australia.

Debora Colvin
HEAD, COUNCIL OF OFFICIAL VISITORS

October 2013

Cover Image

The artwork on the front cover and throughout the Annual Report is by Daniel Reid. It is titled "Giving Birth" and reproduced in the 2012–2013 Annual Report with the artist's kind permission.

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INTRODUCTION – 15 YEARS IN REVIEW

It has been 15 years since the Council of Official Visitors (Council) began operations in July 1998 and this may be Council's penultimate year of operation - the Mental Health Bill, if enacted, will transform Council into a Mental Health Advocacy Service. It is therefore timely to look back and reflect.

In its first year of operation the 19 Official Visitors and Council's Executive Officer had contact with 355 consumers and took part in 585 inspections. Fifteen years later Council's 32 active Official Visitors assisted and had contact with 1,539 consumers and took part in 791 hostel and hospital inspections.

The statistics suggest a greater emphasis on individual advocacy, particularly in the past five years, and the Mental Health Bill will further cement that shift. The support provided by Official Visitors over the years, to what must be thousands of people, is immeasurable. Being locked up on a ward can be a very lonely, frightening and disempowering experience, despite the best intentions of well-meaning staff. Knowing there is someone there just for you, to look out after your rights and with time to spend with you, can significantly reduce the trauma and even be therapeutic. Measuring that as an outcome is difficult, but the significant growth in consumer numbers and the very high level of repeat consumers (941 in 2012–2013) indicates that Official Visitors have been getting it right from a consumer perspective.

Systemic advocacy has also been a feature of Council's work since its first Annual Report. Being an independent body with a mandate to regularly inspect facilities, demand answers from staff to questions, and to do individual advocacy, places Council in the unique position of seeing the issues at ground level and being able to authoritatively stand up and speak out for change.

Measuring the outcomes of such systemic advocacy is notoriously difficult – major change is always slow and rarely brought about by just one individual or body. Changes brought about, or contributed to, by Council at a systemic level include the following:

- Introduction of psychiatric hostel standards and a requirement for resident agreements – Council took over from its predecessor (the Boards of Visitors) to agitate for these when it was established in 1998-1999. It took part in the development of the standards which were eventually issued in 2004 and today all hostels have some kind of residents' agreement. The standards and hostel regulations are, however, now badly in need of review, and oversight and compliance are ongoing issues.
- Agreement by the Minister for Health in 2007 that it was unjust to charge involuntary patients hospital board and lodging charges – this has opened up additional recovery opportunities for some long term consumers using the money saved.
- Stopping the practice in 2006-2007 of some wards using communal underwear.
- Extra funding of $1.37m provided in June 2010 by the Minister for Mental Health to two hospitals in dire need of maintenance work identified by Official Visitors in their annual environmental audits. The audits, which Council has been conducting annually for the past four years, are also sometimes used by hospitals to support business cases for extra funding. Official Visitors also regularly directly approach hospital engineering departments and get maintenance work carried out sooner rather than later.
- The substantial renovations to the Bentley Adolescent Unit (BAU), completed this year, followed on from Council's advocacy that the unit was not suitable and was more like a prison than a place of care for young people.
- Council has also contributed significantly over the years to the calls for more, and a greater variety of, supported accommodation and there is significantly more accommodation today than 15 years ago - although we still need more.
- While there are still some hostels which fall well below acceptable standards, the conditions in most have improved, largely because of constant "nagging" by Official Visitors – more needs to be done but conditions are better and rights are protected as a result of the bimonthly visits by Official Visitors to these facilities.

- Following a concerted strategy, Council has doubled the level of consumers supported in Mental Health Review Board (MHRB) hearings over the past ten years, with the percentage of people supported by either an Official Visitor or lawyer rising from 16.9% in 2003-2004 to 35.1% in 2012–2013. The support by Official Visitors rose from 8.5% to 22.3% in the same period.
- Also as a result of a campaign over many years by Council to improve procedural fairness for involuntary patients in MHRB hearings, there have been improvements to mental health policies and practices and MHRB requirements requiring, amongst other things, that patients be given a copy of the medical report in a timely manner in advance of the hearing. Council continues to work on this issue.
- Due to Council's advocacy, an exemption to the smoking ban for involuntary patients on locked wards was granted this year – the smoking ban for such unwell patients, locked up against their will, was cruel and led to increased aggression, anxiety and seclusion on wards.
- As a result of Council negotiations with individual hospitals and Council's internal processes, second opinions are generally occurring in a timelier manner and a roster of psychiatrists was instituted at Graylands. Where there are delays, Council follows up to determine why. Council continues to strongly advocate for change and improved procedures in relation to this very important human rights protection.
- Based on comments made in earlier annual reports, the level of awareness and attitude of staff to patient rights, in particular the need to repeat the rights several times over during the early part of admission, and to explain the rights to a friend or relative seems to have improved as a result of Council's monthly visits where staff are questioned and educated about these issues on an ongoing basis.
- Many of the provisions in the Mental Health Bill 2012 followed on from issues and deficiencies in the *Mental Health Act 1996* raised by Official Visitors in meetings, letters and annual reports over the years. These include:
  - changes in the procedures relating to second opinions (although more work needs to be done to make sure they are independent)
  - improvements in, and expansion of, the jurisdiction of the Mental Health Review Board (to be renamed a tribunal) including review of phone and visitor restrictions and compliance notices
  - improved provisions about informing patients of their rights, including telling them when they are voluntary
  - clarity of rights and information given to patients on leave from hospital
  - provisions about children on adult wards
  - the broadening of Council's jurisdiction to include people waiting for psychiatric assessment and other classes of voluntary patients agreed to by the Minister (though Council would prefer that all voluntary patients are able to access the new advocacy service)
  - provisions about complaints and information sharing
  - respecting patient rights and dignity and supporting empowerment and diversity as reflected in the Charter of Mental Health Care Principles.

I would like to take this opportunity on behalf of Official Visitors to thank all those people working in mental health who recognise and respect the rights of consumers and who assist Official Visitors in their advocacy and inspection work, as well as all the Official Visitors themselves and support staff who have worked over the past 15 years for Council, for their compassion and commitment.

The enormous courage and resilience of consumers and their carers and loved ones also never ceases to amaze me. They are the real heroes.

Debora Colvin

Head, Council of Official Visitors
October 2013

PART ONE
THE LEGISLATIVE AND OPERATIONAL FRAMEWORK

FUNCTIONS AND POWERS OF COUNCIL AND OFFICIAL VISITORS

The functions and powers of the Council of Official Visitors (the Council) and its members, called Official Visitors, are set out in ss175 – 192 of the *Mental Health Act 1996* (the Act).

It is the responsibility of the Council (s186 of the Act) to ensure that an Official Visitor or panel visits:

- each hospital authorised under s21 of the Act at least once per month. In practice, visits take place more often. Official Visitors visit consumers on request, conduct formal and informal inspections and check Council mailboxes on the wards for correspondence from consumers. This is part of making themselves accessible and ensuring that the wards and hostels are "safe and otherwise suitable" as required by s188 of the Act
- each private psychiatric hostel at the direction of the Minister for Mental Health. Currently this is at least once every two months but sometimes more often based on the number of consumer requests for visits from particular facilities or where an ongoing issue has been identified which requires follow-up
- all consumers who request a visit as soon as practicable after the visit is requested. Council aims to respond within 24 hours to a new consumer and otherwise within 24 to 48 hours.

It is the responsibility of the Official Visitors (s188 of the Act) to:

- ensure that "*affected persons*" (see definition below) are aware of their rights and that those rights are observed
- ensure that places where consumers are detained, cared for or treated under the Act are kept in a condition that is "safe and otherwise suitable"
- be accessible to hear and to enquire into and seek to resolve complaints concerning consumers made by the consumer, their guardians or their relatives
- refer matters on to other relevant bodies where appropriate
- assist with the making and presentation of applications and appeals under the Act, primarily Mental Health Review Board (MHRB) and Guardianship and Administration hearings and appeals.

The term "*affected person*" is defined by s175 of the Act to mean:

- an involuntary patient, including a person subject to a Community Treatment Order (CTO)
  - a mentally impaired accused person 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
- any other person in an institution prescribed for the purposes of the section by the regulations (no institutions have been prescribed to date).

Affected persons are referred to by Council and hereafter in this Annual Report as consumers when they have requested assistance from an Official Visitor or residents if they reside in a psychiatric hostel.

RIGHTS PROTECTION

The rights which the Official Visitors seek to protect are derived from:

- the United Nations *"Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care"* adopted in 1991 (the UN Principles) and in particular Principle 2 which reads:

  "all persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person"

- the Act, which accords a set of legal rights to consumers in Western Australia
- the *"Licensing for the Arrangements for Management, Staffing and Equipment: Private Psychiatric Hostels"* prepared by the Licensing and Accreditation Review Unit (LARU) of the Department of Health (DOH) as regulated by the *Hospitals and Health Services Act 1927*; and various standards including *"Service Standards for Non-Government Providers of Community Mental Health Services"*
- the *"National Standards for Mental Health Services"* designed to guide policy development and service delivery in each of the States.

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. The objects of the Act (s5) reflect, but do not elaborate on, international principles. Section 5 specifies, however, that there must be:

"the least restriction of their freedom and least interference with their rights and dignity".

The statutory rights provided to consumers by the Act include the right to:

- a prescribed procedure to order involuntary status in hospital or the community (Part 3, Division 1)
- information about rights and a written explanation being given to them and another person of their choosing every time an order is made (ss156 and 157)
- a copy of the order when made, varied, cancelled (s159)
- access to personal records (with potential restrictions) (s160)
- access to personal possessions (s165)
- access to letters (s166)
- access to a telephone (s167)
- access to visitors (s168) (with procedures to be followed if any of ss66 - 168 are denied)
- request and receive an opinion from another psychiatrist (ss76 and 111)
- assessment and review by a psychiatrist (ss37, 43, 49, 50 and 164)
- access to an Official Visitor (s189)
- review by the MHRB – periodic and requested (ss138, 139 and 142)
- specified requirements being followed in relation to the authorisation and recording of seclusion and mechanical bodily restraint (Part 5, Divisions 8 and 9).

Statutory rights are also implied through requirements in the Act for consumers to:

- have information about them maintained in a confidential manner (s206)
- be detained, treated, cared for in a safe and otherwise suitable environment (s188(c))
- have access to proper standards of care and treatment (s13).

POWERS OF OFFICIAL VISITORS

In order to ensure that consumers' rights are observed and that they have been informed of their rights, Official Visitors have the power pursuant to s190 of the Act to:

- visit facilities without notice at any time and for as long as the Official Visitor or panel sees fit and to inspect any part of the place
- see any consumer and make inquiries relating to their admission, detention, care, treatment or control
- inspect consumers' medical records (with their consent) or any other documents required to be kept in order to check whether rights have been observed.

INDIVIDUAL ADVOCACY APPROACH OF OFFICIAL VISITORS

Council has adopted the "pure advocacy" approach in its Code of Conduct which means that Official Visitors do not take a "best interest" approach when advocating for individual consumers. Consumers have many other people making decisions in their "best interest". Instead Official Visitors act as a mouthpiece for the consumer. This means they are partial to the request of the consumer and act according to their wishes. They do not make decisions for the consumer and are not counsellors, though they do need to be good listeners and sometimes act simply as a support person. The Official Visitor will tell the consumer their rights and options as well as consequences of taking particular actions but will act according to the consumer's wishes.

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

OPERATIONAL FRAMEWORK – REPORTING LINES

Official Visitors

The Council and its individual members are directly responsible to the Minister for Mental Health who appoints people from the general community in accordance with s177 of the Act. Any Official Visitor, or person on a panel, who considers that the Minister or the Chief Psychiatrist should consider a matter, may make a report to that person (s192 of the Act). The Head of Council is required to make a report to the Minister as soon as practicable after the end of each financial year on the activities of the Official Visitors and the Minister is to table this report in Parliament (ss192(3) and 192(4) of the Act).

In practice, Official Visitors deal with issues at ward and hospital level to the extent that they can. If the issue cannot be resolved at that level or if, for example, it involves a serious or systemic issue, it is taken to the Head of Council. Head of Council will then draft a letter, call for a meeting, telephone or email appropriate parties. Examples of these include the Clinical Director of the hospital or service concerned, the Chief Psychiatrist, the Mental Health Commissioner and, when warranted, the Minister for Mental Health.

Similarly with hostels, Official Visitors first try to deal with issues by speaking to the hostel supervisor or licensee. Sometimes, however, Head of Council will also meet with the licensee or raise issues with other bodies such as the Office of the Chief Psychiatrist (OCP) or LARU.

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

Administrative support - Executive Officer and other staff

Council is provided with an Executive Officer and three other fulltime equivalent staff members, all of whom are public servants employed under Part 3 of the *Public Sector Management Act 1994*. Their role is to provide administrative support as required by s182 of the Act. Staff were employed by the DOH until September 2012 when staff were moved to the Mental Health Commission (MHC) under s65(2) of the *Public Sector Management Act 1994*.

The Manager (as the Executive Officer) is legislatively responsible for the Council records (ss 183 and 184) and taking requests from affected persons for visits by Official Visitors (s189). The Manager also has the delegated responsibility for ensuring that the Official Visitors visit authorised hospitals, comply with Ministerial directions and visit affected persons as soon as practicable after a visit is requested in accordance with s186 of the Act.

COUNCIL COMPOSITION 2012–2013

A list of individuals who were members of the Council during 2012–2013 and their terms of appointment are contained in Appendix 3. Eleven Official Visitors were reappointed following the expiry of their terms during 2012–2013 and four new Official Visitors were appointed. There were two resignations and three Official Visitors did not seek reappointment at the expiry of their terms. As at 30 June 2013 therefore Council had 31 active Official Visitors (plus Head of Council) with two on an extended leave of absence.

PANEL APPOINTMENTS

Section 187 of the Act allows the Council to appoint two or more persons, at least one of whom is an Official Visitor, to be a panel for the purposes of that part of the Act. The Act is silent on who may be empanelled or the purpose of panels but individuals appointed to be members of a panel have generally fallen into four categories:

1. Expert - appointed when issues arise and direct access to professional or expert advice during a visit or contact is required.
2. Interested community members - appointed when members of the community seek a greater understanding of the role of the Council.
3. Interim appointments - preliminary to being made an Official Visitor.
4. Council office staff - for the purposes of better understanding the work of Official Visitors.

There was one panel appointment in 2012–2013 of Mr Danny Ford, Senior Project Manager Aboriginal Services, MHC for the purposes of developing Aboriginal cultural awareness training, although Mr Ford did not visit any facilities.

COUNCIL MEETINGS

Full Council Meetings (FCMs)

Council held FCMs in November 2012 and May 2013. These were combined with training days and metropolitan and regional group meetings. Further information is contained in Part 4 of this Annual Report.

Executive Group

The Executive Group is delegated the responsibility of making decisions in between FCMs and conducts most of the strategic and developmental work of Council, though major decisions are referred back to Full Council for ratification. The Executive Group comprises representatives from each of the sub-groups of the Council (regional and metropolitan), Head of Council, Deputy Head of Council, and the Manager (non- voting).

During 2012–2013 the Executive Group held meetings in August, October, January and March. A summary of the Full Council and Executive Group meetings attended by Council members during 2012–2013 is contained in Appendix 4.

Country and metropolitan meetings of Council

Official Visitors are allocated to eight teams:

- four teams in regional areas based on the location of authorised hospitals: South West (Bunbury/ Busselton), Lower Great Southern (Albany), Goldfields (Kalgoorlie) and Kimberley (Broome)
- four teams in Perth and the outer suburbs (from Joondalup to Armadale to Rockingham) based roughly on north, south, west and central geographical regions of the metropolitan area.

The four metropolitan and four regional teams met on nine occasions which included two meetings which coincided with FCMs. The OVs meet both separately in their teams and in combined sessions. The joint meetings are used to discuss issues identified by Official Visitors across the metropolitan or regional areas and for occasional training. Seven of the nine meetings with Official Visitors in regional areas were conducted by video link.

Focus Area Person

The Focus Area Person (FAP) nominates areas of concern to be considered by Official Visitors when conducting the formal monthly inspections of authorised hospitals and psychiatric hostels (see Part Two, Issue 7 of this Annual Report for further information). The FAP drafts the inspection question sheets which Official Visitors take with them on these visits. A summary of the inspection reports is prepared most months which provides an understanding of the issues across all hospitals and hostels in that month.

PART TWO
VISITS, INSPECTIONS, ISSUES AND ACTIONS IN 2012–2013

In this part of the Annual Report we set out a selection of the issues dealt with by Official Visitors during the year to illustrate the work of Council. The consumers assisted by Official Visitors – involuntary patients and psychiatric hostel residents – have a range of rights under the Act, under various regulations and other legislation, licensing standards, the "*National Standards for Mental Health Services*", hospital and DOH policies, hostel contractual arrangements, the *"National Mental Health Statement of Rights and Responsibilities"*, and human rights generally.

The issues and cases illustrated relate to breaches of those rights and reflect the disempowerment of consumers and the importance of patient-centred care which includes respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of family and carers and access to care[1].

While there are some **"good news"** stories and improvements noted, the range of issues does not differ markedly from previous years. This demonstrates the importance of an independent inspection and advocacy body because there will always be breaches of rights in circumstances where people are made vulnerable by the inevitable disempowerment that comes with detention.

ISSUE 1: THE RIGHT TO RECEIVE THE BEST CARE AND TREATMENT WITH THE LEAST RESTRICTION OF FREEDOM AND THE LEAST INTERFERENCE WITH RIGHTS AND DIGNITY – S5 OF THE ACT

Official Visitors recorded 102 complaints or issues raised by consumers relating to "dignity, privacy and staff attitude" during the year[2]. Other related categories of consumer complaints or issues recorded by Official Visitors included ground access and leave (242), access to allied services such as occupational therapy, social workers and case managers (260) and issues with care plans and discharge plans (220).

After issues relating to checking, explaining and assisting with rights under the Act and complaints about medication, these issues form the bulk of Official Visitor advocacy complaint work. The illustrations below give some examples of the cases.

Illustration 1 – Complaint of staff misconduct

An Official Visitor responding to a request for a visit, found a consumer lying on a hospital bed in a nightgown that was pushed up around her shoulders, wearing an adult incontinence "nappy" that was partially pulled down and was full of faeces. The consumer was shaking, crying and very visibly distressed. The bed linen beneath her was wet through. Her first words to the Official Visitor were: "*Thank God, you're here, please save me*".

1 Australian Commission on Safety and Quality in Health Care (2011), "*Patient-Centred Care: Improving quality and safety through partnerships with patients and consumers*", ACSQHS, Sydney at p1.
2 See Appendix 11.

The Official Visitor quickly reassured the consumer and then went to find the senior nurse for the ward. Together they cleaned the consumer up. The consumer said she couldn't move or walk so could not get out of bed to help herself. The consumer normally wears calipers on her legs. She also said that her nurse had been shouting at her for some time that she had to clean herself up and that staff were not going to help her, not even help her out of bed.

When the Official Visitor had telephoned the ward earlier in the day to speak to the consumer, she was told by a nurse that the consumer wouldn't come to the phone and they refused to take the cordless phone to the consumer. When the Official Visitor turned up to visit the consumer she asked a nurse where the consumer was. The nurse replied: *"She's in her room and will be going to a medical ward but she won't be going anywhere till she gets out of her bed and cleans herself up".* The nurse then took the Official Visitor to the consumer's room, first checking through the peephole into the room. The nurse opened the door and let the Official Visitor in. The Official Visitor said that the stench in the room was overwhelming immediately after the door into the room had been opened, but the nurse shut the door behind the Official Visitor and left.

Action and Outcome

A detailed letter of complaint was sent to senior management in the mental health unit requesting an immediate and thorough investigation with both the consumer and Council to be informed of the details of the investigation and the outcome. We also requested an apology to the consumer. We suggested that more than one staff member was probably involved in this serious mistreatment of a patient as it seemed likely that other staff were aware of the consumer's condition and, if they weren't, they should have been. We proposed that, while the staff involved had to be given the right to explain their actions, if there was no reasonable explanation, the matter should be referred to the Australian Health Practitioner Regulation Agency (AHPRA) and the Nurses Registration Board which now falls within AHPRA, and that Corporate Governance within the DOH should also be informed.

The letter of complaint was sent by post and email on 25 January 2013.

Apart from the very long time taken to investigate the complaint[3], Council was told on 28 June 2013 that, at the conclusion of the process, we and the consumer would only be advised whether the matter had been substantiated or not, and not the penalty or consequences for the staff or other outcomes. That was said to be a confidential matter between the employer and the employee. It should be noted that Council has been told that three nurses and one other medical staff member are being investigated, but neither we nor the consumer know the names of any of the staff members[4].

Illustration 2 – Seclusion issues

Being put into seclusion, or seeing someone else on the ward put into seclusion, is one of the most distressing experiences a consumer (and staff) can experience on a ward. Physical restraint is usually involved as well. As the North Metropolitan Health Service Mental Health (NMHS MH) policy on seclusion says:

> *"The use of seclusion and restraint creates significant risks for people with mental illness. These risks include serious injury or death, re-traumatisation for people who have a history of trauma, loss of dignity and other psychological harm."*

3 As at 28 October 2013 the consumer and Council were still waiting for the outcome of the investigation which is being treated by the DOH as misconduct.

4 Post 30 June 2013 Council wrote to the Director General of the DOH and the Minister for Mental Health raising concerns about the delay, the lack of transparency and accountability in this process and the lack of respect, justice and procedural fairness for the consumer who made the complaint. Correspondence is ongoing at the time of publication of this Annual Report.

Official Visitors therefore check seclusion registers on their monthly inspection visits. Statistics released during the year showed that WA had the lowest rates of seclusion (4.7 per 1,000 bed days) overall after the ACT which is obviously **"good news"**. This follows the work of the Beacon project that was started a few years ago.

Alarmingly though, nationally the rates of seclusion of children in 2011–2012 were significantly higher than for any other category (20.9 per 1,000 bed days compared with 11.9 for adults, 10.2 for forensic patients and 1.6 for older adults) and has got worse over the past two years[5].

Council followed up with the BAU about their seclusion rates. Council was told that there had been a "noticeable" reduction in the number and length of seclusions at the BAU. The physical redevelopment of the BAU (which followed on from Council advocacy about poor conditions at the BAU) was said to be one reason for the drop in seclusion along with staff training on aggression management and ongoing review of all seclusion episodes. However the rates are still too high. Similarly elsewhere the rate of reduction in the number of seclusions is said to have plateaued, so more work needs to be done.

Council also remains concerned about some seclusion practices and the conditions of seclusion rooms as shown by the following case examples:

Case 1: Clothes removed and rip proof gown used

A female consumer had her clothes removed and was placed in a rip-proof gown while in the seclusion room. The reason given was because the consumer had self-harmed while in seclusion. The consumer complained that she offered to remove her own clothes and she said that this was denied. Another complaint was that a male nurse was in the room at the time. A third complaint involved rough handling by nursing staff.

Some hospital policies say that seclusion should not be used for the sole purpose of preventing imminent self-harming behaviours as it is not effective. Similarly seclusion is not to be used for the purposes of discipline, coercion or staff convenience such as managing inadequate staffing levels. Some of the surrounding facts in this case seemed to fit these purposes. The consumer was not self-harming before the seclusion and other more dignified strategies to manage self-harming behaviours could have been utilised had there been more staff available.

The Official Visitor attended a meeting with the consumer and the senior nurse on the ward a few days later in March to raise the consumer's complaints about this and the process which led to the event as well as a number of other complaints. The senior nurse said she would look into the issues and promised to report back to the consumer. The consumer was discharged shortly after. As at 30 June 2013 the Official Visitor was continuing to follow up on the issue as the senior nurse had not reported back to the consumer or Council which was also unsatisfactory.

Case 2: Conditions in seclusion rooms

Seclusion rooms usually consist of a bare room with no, or very high, small windows with a mattress on the floor and nothing else. Consumers are generally given a pillow and blanket when put into the room. Official Visitors raised an issue with a mental health service following a monthly inspection because there were no pillows to give patients in seclusion and a lack of seclusion blankets. New pillows and blankets were eventually ordered.

5 Allan, John and Hanson, Gary, *Monitoring Use of Seclusion*, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129543928. See also : http://www.aihw.gov.au/media-release-detail/?id=60129543981

Case 3: Light on in seclusion 24 hours a day

The consumer had been held in seclusion for four days with the lights on 24 hours a day. Staff told the Official Visitor that they were unable to dim the light in the seclusion room. It had not been envisaged that someone would be kept in seclusion for so long. On the fifth day the hospital dealt with the issue by closing four beds and detaining the unwell consumer in a portion of the ward with a 5:1 nursing arrangement.

Illustration 3 – Inconsistent ward processes

The three cases below arose in relation to the same ward. They illustrate how ward culture impacts on patients' experience particularly when practices are not patient-centred.

Case 1: Consumers on locked ward having to remember to ask for their own medication

A consumer who had been admitted to a locked ward shortly before, told their Official Visitor they were worried that they had missed their 2pm medication. Nursing staff told the Official Visitor that the consumer had to ask for the medication themself. There was nothing on the consumer's medical file or care plan about this and the consumer said no-one had told them. The Official Visitor was also surprised by this, having not heard of it happening on any other secure acute ward, but asked the nurse to explain this to the consumer. The consumer pointed out that they did not wear a watch and there was no clock on the ward to check the time.

The Official Visitor then spoke to the nurse in charge, the Clinical Nurse Specialist (CNS), who said that the ward staff liked to encourage patients to be "proactive" in their treatment but the medication nurse should follow up with patients who didn't ask for medication themselves. There was no written policy. The Official Visitor said that the patient had not been told about asking for medication themself but the CNS replied that the patient "knew".

A day or so later, the consumer had a nap after lunch and slept through until about 2.30pm and then asked their nurse for medication. The consumer said that the nurse had "told them off" for not getting their medication earlier saying it was the consumer's "responsibility". The consumer was upset by this treatment and also concerned about the impact of the medication being given later. The consumer said they were also worried as to whether they needed to get their 6pm medication themself because the previous night the nurse had brought this medication into them and they were confused about what they were supposed to being doing. A different nurse told the Official Visitor that the consumer had to ask for their 6pm medication as well and again the Official Visitor asked the nurse to explain this to the patient.

Case 2: Consumer on a locked ward asking for prescribed medication and being refused

A different consumer on the same ward as Case 1 had a medical condition for which they normally took medication to relieve the pain. The medication had not been given to the consumer although it was noted in the consumer's medical notes as being known to hospital staff. The consumer raised the issue with the Official Visitor who spoke to ward staff who then provided the medication.

Two days later the same thing happened again. The Official Visitor approached the consumer's nurse allocated for that shift to ask if the consumer had received the medication. The nurse replied: "How would I know?". The conversation took place in the nurses' station. Another nurse then said that if the consumer wanted medication for anything other than their mental illness, they would have to ask for it every day. The Official Visitor was told that this was hospital procedure.

The Official Visitor pointed out that the patient had asked for the medication multiple times two days earlier but only got it after the Official Visitor intervened. The Official Visitor said the nurse's response was to "*roll their eyes at me*". They did agree however to provide the medication to the consumer.

Case 3: Different rules for different patients – inconsistent practices

A third consumer on the same ward complained to Council that on a number of occasions during their admission they found that different nurses imposed different "rules" on patients. When the consumer questioned why decisions were made, they said they were *"fobbed off"* and told that the particular decision was always the rule although this was not what the consumer had experienced or observed. Examples given included:

- being allowed to attend a daily prayer service at 8.45am three times a week then suddenly being told that no-one could leave the ward before 9am
- taking a pillow into the TV room but, after doing this for some days, being informed that it was "against the rules"
- being subjected to a test with a metal detector on return to the ward after ground access which had not been done on other occasions.

The consumer also complained of having to knock on the window of the nurses' station and having to wait for an unreasonable length of time to be attended to – this is a common complaint by consumers and Official Visitors also often see "lines" of people waiting at nurses' station doors.

Action and outcome in the three cases

In relation to the first two cases, the two very experienced Official Visitors involved were concerned about the procedure which they had not heard of before, and which did not appear to be the subject of any hospital endorsed policy nor was it reflected in the consumers' care plans. The cases raised safety issues as well as causing distress for the patients involved.

Inquiries were made of staff on two other wards who said that nurses dispensed all medication and they had never heard of patients on a secure ward needing to ask for their medication. Head of Council spoke to the Nurse Director and Clinical Director of the hospital who confirmed that this was not hospital practice and that they would speak to the CNS and ward staff.

In the third case a meeting was held with the patient by a hospital staff member assigned to investigate the complaint. They took the consumer through the various issues providing explanations and apologies and said they would be raising various issues with staff. Council also received a letter from the Nurse Director confirming the discussion with the consumer.

The issues on this ward were also raised with the Area Mental Health Executive. Head of Council was told that the CNS would be given support to ensure consistency of care to patients. Where there were treatment specific management strategies, these would be clearly evidenced in patients' care plans.

Illustration 4 – If it isn't in the medical file .... it doesn't happen

Following a meeting between a consumer, the Official Visitor, the registrar and the psychiatrist it was agreed that the patient would have injections instead of oral medication and that as a result they could have access to the open ward the next day and be moved to the open ward the day after. However the next day the patient was told by nursing staff that there was "no way" they were going to be allowed on the open ward.

Action and outcome

The Official Visitor spoke to the nursing staff who maintained their refusal saying that there was nothing on the consumer's medical file. The Official Visitor told nursing staff that she had been at the meeting when the patient was told this was happening. She insisted nursing staff check with the doctor who confirmed the position and the consumer was allowed on to the open ward for the afternoon, prior to being moved to the open ward the next day. However the following day nursing staff told the patient that they would not be moved to the open ward because the patient had been "non-compliant" in resisting oral medication. The patient had tried telling nursing staff that they didn't have to take the oral medication because they had agreed to an injection. Again the Official Visitor intervened. The registrar admitted he had forgotten to make a note on the medication chart to cease the oral medication. The consumer was moved to the open ward that afternoon. It is also important to note that had the patient not refused the medication, presumably they would have got a double dosage.

Illustration 5 – And if it is in the file, it doesn't mean it will happen either

A consumer on a large secure ward had been told by their psychiatrist that they would get "one-on-one nursing care" as part of their treatment. The consumer complained to an Official Visitor that this was not happening. It was accepted by the consumer that this would not mean one-on-one nursing 24 hours a day but the consumer said they were not getting any time.

Notes confirming the doctor's comments were made on the consumer's medical file, but the ward nurses said they knew nothing about it. It was not noted in the consumer's care plan so the suggestion was that the other file notes were irrelevant.

Action and outcome

The Official Visitor spoke to the CNS who said that the best they could offer was ten minutes every hour on day shifts depending on what else was happening on the ward. The Official Visitor also tried to speak to the consumer's psychiatrist but they were not working at the hospital that day so they spoke to the registrar who said they would write it up in the care plan and speak to nursing staff. The Official Visitor also spoke to the psychiatrist the next day who said that they envisioned a block of time of, say, 45 minutes during a shift, when the consumer would get one-on-one nursing attention. This was actioned but questions arose about whose responsibility it was to write it up in the consumer's care plan or advise the consumer. This is an area of confusion on some wards and Council has raised it as a systemic issue.

Illustration 6 – Medication errors and inconsistencies

Apart from the potential medication errors in Cases 1 and 2 of Illustration 3 and Illustration 4 above, and the well publicised case of a patient who was given clozapine meant for another patient, Council became aware of a second case where a patient was given medication meant for another patient. The names of the patients were similar and both were long-term patients on the same ward. In that case the error was realised almost immediately and Council was told that there were no adverse effects (in fact one of the patients told their Official Visitor that they felt better on the other patient's medication!).

Official Visitors had raised concerns about the issue of medication administration with Graylands Hospital in September and October 2011 following their monthly inspections which had focused on this issue. Head of Council had also raised the issue in various meetings with different hospital management. The concerns included comments by staff about lack of refresher training. Few mental health wards at that time used wrists bands for identification, as are used in general wards, and none were using photographs. Most policies relied only on two staff identifying the patient by sight.

Action and outcome

As soon as Council heard about the first incident we contacted the Chief Psychiatrist who responded confirming the incident. We were assured that there would be a full investigation. Head of Council also spoke to various relevant DOH personnel asking why mental health wards did not follow the same protocols as general hospitals with wrist bands and/or photographs. The usual response was that consumers didn't like them, but no-one could advise when consumers were last asked their opinion.

Subsequently Head of Council also wrote to the Director General of the DOH who advised that three reviews had been completed (an internal review, a root cause analysis and a review by the OCP) and all recommendations had been actioned. A key finding of all reviews concerned the inpatient culture of many of the Graylands Hospital wards which had informed the decision to implement additional staffing resources to address issues of professional standards of care and management processes.

After the second case Council wrote to the hospital and suggested a number of possible causes for the mistake which included Official Visitors' understanding of where the medication was dispensed and the potential for nursing staff to be distracted when administering medication, particularly when the process relied only on identification of patients by sight.

Following the second mistake the hospital advised Council that, amongst other things, it:

- had placed alert stickers marked "CAUTION – PATIENT WITH SIMILAR NAME" on the consumers' Medication Charts
- would be providing more education to nursing staff
- would be formulating an audit tool to measure staff compliance with the policy and will be conducting random audits
- would ask each ward CNS to develop a written medication process clearly indicating the area in the ward from where medications will be administered.

Council is aware that some hospitals are now using or planning to introduce the use of wrist bands and/or photographic identification.

Illustration 7 – Care plans and recovery principles

Care plans are meant to be a lynch pin in the organisation of modern mental health care but much depends on the quality of the care plan, how often it is updated, and how well consumers and carers are involved in the drafting and settling of the plan. Official Visitors dealt with 22 consumer complaints about care plans and 198 consumer complaints about discharge plans in 2012–2013.

Care plans should focus on the person and their recovery, involve the consumer in a meaningful way, result in a consistent approach by staff, and improve communication between ward and medical staff and the consumer, thereby ultimately producing a better health outcome for the consumer. The importance of care plans (also known variously by other names and usually including discharge/exit and behavioural management and other plans) and the importance of the involvement in them by consumers (and carers), are reflected in standards 6 and 10 of the "*National Standards for Mental Health Services"* and the associated Implementation Guidelines[6].

Hospital care plans were a focus area of Official Visitors' monthly inspections in October 2011, November 2012 and again in June 2013. A number of questions were asked of both staff and consumers.

6 See criteria 6.9, 6.12, 7.12, 10.4, 10.5.11, 10.6.3, 10.6.4 of the National Standards.

The questions were designed to start conversations that elicited information and raised awareness of recovery principles and consumers' rights to be involved in their care plans. In talking to consumers and asking them what they know about care plans, what recovery means to them, what they would like to see more of on the ward and so on, consumers are educated about their rights and Official Visitors are educated about what consumers want. A selection of the questions to consumers and their answers is set out below.

How have you been involved in your treatment plan? (Goals, medication, therapies, possible discharge date?)

- *"Not involved in any way. I ask questions about my treatment but all I am told is that I am doing well"*
- *"They talk to me a lot about discharge dates but nothing happens"*
- *"Nothing, only meds; no-one has talked to me about long term issues yet"*
- *"They talk to me about things but I'm not sure what it means"*
- *"No choice. All I want to do is take a taxi and go to a hotel for one night but I can't even do that. That's not too much to ask, is it?"*
- *"Haven't been involved. They tell me what is going to happen".*

What does recovery look like to you?

- *"5ft tall blue eyed blonde. (joking) No idea what that means"*
- *"Physically, emotionally and mentally good. Happy with self. Eating healthy and well"*
- *"Pulling positives from negatives and maintain a positive outlook"*
- *"Getting out of the hands of these people"*
- *"Being totally well. Back to full health and eventually medication free"*
- *"I am never going to fully recover; I have had this problem since I was 19 and am 38 now. Being stable on my medication is the best I can hope for"*
- *"Going to the community"*
- *"That time when I was well and was a voluntary patient; I had freedom"*
- *"Going home to mum".*

How could the hospital do a better job to assist and support you in your recovery?

- *"Get rid of the staff that don't care and get some in that want to help us"*
- *"They have been very good. Do not believe they can do anything better"*
- *"Listen to the patient and not believe every word of the family"*
- *"Happy with the hospital and staff"*
- *"Letting you do what you normally would do is important. Also I thought there would be more one-to-one counselling with a psychologist helping you work through things rather than short chats to a nurse"*
- *"Staff are helpful and will always give you assistance"*
- *"Despite the fact that I am mostly floating around here I do feel safe and secure"*
- *"To let me be more involved"*
- *"The ward is good, particularly interacting with other patients"*
- *"More 1:1 interaction, cuddle"*

- *"More weekend activities. At weekends we are left alone with our thoughts but other than that the staff are wonderful people"*
- *"Have one person who you can contact and rely on - know that they will be there (to discuss treatment, issues, doubts etc). This would make me feel safe and supported. Council of Official Visitors makes me feel safe - knowing you are there"*
- *"Computer access - for internet, editing photos etc."*
- *"More activities for blokes not old people's activities"*
- *"Better preparation for going home"*
- *"Music in the bedroom. I have TV but there is nothing else to do..... Thanks for asking me questions"*
- *"Find accommodation for people who need it, treat people so that they can recognise the 'trigger points' of their illnesses when they are getting unwell as people are not being taught to understand themselves."*

Senior ward nursing staff usually answer Official Visitors' monthly inspection questions. They have a strong influence on ward culture and respect for consumer rights and dignity. Nurses will often say that they are advocates for the patients too, so having the Official Visitors talk to them about these issues is aimed at educating and influencing ward culture.

In October 2011 staff responses to the question about consumer involvement in care plans tended to be very negative with staff confirming the consumer feedback that consumers were not being involved but also commenting that it was too difficult, consumers were not well enough, lack of resources etc.

In June 2012 the responses reflected better engagement, with staff recognising and supporting the need for more involvement by consumers in their plans and the need for the quality to improve. Barriers to improving the process were consistently listed as:

- the need to improve the computer system including more training for staff and more computers on the wards to make the documentation more efficient. As one staff member said: "Staff who are not confident will avoid the task"
- auditing of care plans and constant reinforcement with staff of the need to update care plans
- continuity of staff.

Illustration 8 – Productive mental health wards – "releasing time to care" – "good news" on the way?

In response to some of the cases and concerns raised by Head of Council, South and North Metropolitan Area Mental Health services have advised that they are proposing to implement the Productive Mental Health Ward methodology also known as *"releasing time to care"*.

We are told that the training program is aimed at freeing up nursing time on the wards but also promoting a culture of care, respect, professionalism, excellence, person-centred care and trauma informed care. The training methodology has already been piloted in some general health inpatient units and considered a success.

In addition a SRN Level 7 Coordinator of Nursing Standards positions has been established at Graylands Hospital to assist the Nurse Director address issues related to improving standards of care.

ISSUE 2: LEGAL ISSUES

Anyone who works in mental health with involuntary patients and people on a CTO must work within a legal framework. The detention of a person in a mental health ward is only allowed pursuant to the Act which was drafted to build in a series of protections – namely the process by which a person can be involuntarily detained, review by the MHRB, and the rights to other opinions and access to Official Visitors. Restrictions on visitors and to the telephone and post are also governed by the Act.

It is also common for guardianship and administration orders to be made in relation to people with chronic and severe mental illness which take away consumers' rights to control their own finances and legal decisions, including where they live. The applications for such orders are often made by social workers and supported by the consumers' psychiatrists or case managers. The decisions are made by the State Administrative Tribunal (SAT).

The illustrations below relate to the legal framework, the consumer protections under the Act, and Official Visitors' involvement in them on behalf of consumers.

Illustration 1 – Breach of the Act

The first layer of protection to ensure someone is not improperly detained against their will is the process under the Act by which a person is referred to a psychiatrist for assessment. Only a psychiatrist, as defined by the Act, can order that a person be detained involuntarily or put on a CTO. A person can be detained for up to eight weeks awaiting a mandatory MHRB hearing as a result of the assessment by that one psychiatrist.

Following on from concerns raised about "limited registration" doctors from overseas not being authorised under the Act to make people involuntary (as noted in last year's Annual Report[7] and which subsequently led to amendments to the Act[8]), Council raised further concerns in November 2012 about a doctor who was not registered as a psychiatrist but who was continuing to make people involuntary and exercise other powers under the Act.

Council was told that the doctor had been approved by the WA Medical Board to act as a psychiatrist for the purposes of the Act in 2004 but, following amendments to the Act in 2010, it seemed fairly clear that the doctor no longer met the definition of psychiatrist under the Act. Council was not aware of any complaints that the doctor had not provided proper care or treatment but the doctor was not officially recognised by the Royal Australian and New Zealand College of Psychiatrists and did not meet the requirements for specialist registration under the *Health Practitioner Regulation National Law (WA) Act 2010*. The doctor was therefore not a psychiatrist as defined by the Act and so should not have been making people involuntary or carrying out other functions of a psychiatrist under the Act.

In raising the concerns Council commented that consumers and their families are entitled to trust that, when a person is locked up in a psychiatric ward, the law is always followed; if the law is not always scrupulously complied with, distrust in the mental health system follows, as does the increased risk of serious human rights infringements.

Action and outcome

On 22 January 2013 Council was advised that legal advice had confirmed that the doctor was not a psychiatrist as defined by the Act. Head of Council asked about the invalidity of current orders – we were told more legal advice was needed.

7 See page 4, Issue 1 Illustration 4 of the 2011–2012 Annual Report.
8 *Mental Health Amendment (Psychiatrist) Act* 2012.

Concerns were also raised that the care of the affected patients had been transferred to the Clinical Director who was on leave and that patients were not being told that the order under which they were being detained may not be legally valid, nor were they referred to Council, the Mental Health Law Centre (MHLC) or the MHRB for independent advocacy and review.

Council therefore wrote to the Minister for Mental Health and others complaining about the representation of the issue as a mere "legal technicality" and the lack of respect for patients' rights. Council was advised by reply from the Minister that the patients had all been reviewed by other psychiatrists by 25 January 2013.

Contact was also made with the President of the MHRB because of the potential for cases to come before the Board and Head of Council approved joint attendance with MHLC lawyers to any hearings in which the doctor had made the involuntary orders.

Subsequently the MHLC took a case decided by the MHRB for review to the SAT which resolved some of the legal questions. SAT decided that subsequent involuntary orders made by psychiatrists which purported to continue the patient's involuntary status were also invalid. The DOH had conceded that the involuntary order made in relation to the particular patient was invalid but the implications of the decision were that every order continuing a person's involuntary status made by the doctor since October 2011 must be invalid. This meant that a lot more people would be affected.

Council then wrote to the Director General of the DOH, the Chief Psychiatrist and the Minister for Mental Health asking for the following:

- immediate advice as to what the hospital was doing about the patients affected by this decision, the number of patients affected, and how they were going about this process
- confirmation that any patients currently detained (and their guardians or carers) were being told that their involuntary orders are (or were) invalid and that they are (or were) in fact voluntary and an explanation as to how they are going about this
- that patients be given details of the MHLC for further legal advice
- proof that the doctor was properly authorised by the WA Medical Board prior to the 2010 amendments
- consideration be given to sending letters to every patient who had ever had an involuntary order made by the doctor while the doctor was not authorised as a psychiatrist under the Act informing them of the position, preferably with an apology, and suggesting that they take legal advice
- that Council and affected patients be given an explanation as to how and why this occurred and some reassurance for the future
- immediate confirmation that the doctor would not carry out any functions of a psychiatrist under the Act unless and until the doctor met the qualifications set out by the Act (this followed the doctor providing a second opinion to a patient – the hospital advised later that this was a misunderstanding and immediately provided the patient with another opinion by a psychiatrist).

The DOH replied in mid June 2013 as follows:

- A senior medical records clerk was diverted on a full time basis to identifying all Graylands Hospital patients and ex-patients for whom the doctor had administered the Act during the period 19 October 2010 to 15 January 2013.

- A letter was being drafted informing patients and ex-patients of the SAT decision and its impact on them and informing them of their right to legal advice. This letter would include a brief explanation of the change to the doctor's legal capacity to administer the Act in 1996 and note that the doctor's competence as a Senior Medical Officer was not in question. Once drafted, this letter would be reviewed by Legal and Legislative Services before being posted to all patients and ex-patients identified and located.
- At the time of the SAT decision there was only one involuntary inpatient left at Graylands Hospital. They were advised of the SAT decision and told that they were consequently a voluntary patient. The patient's medical records were amended to reflect this change in their legal status, were informed of their right to legal advice and were provided with the contact details for the MHLC. Two patients were on CTOs at the time of the SAT decision and both were similarly advised.
- The doctor had provided copies of a letter from the WA Medical Board advising of their capacity to administer the Act prior to the 2010 amendments.

Illustration 2 – Mental Health Review Board hearings

MHRB hearings are the single most important safety mechanism built into the Act to protect consumers from being detained in error or longer than they need to be. The MHRB can order that a person be made voluntary or allowed to go home on a CTO and can also make orders transferring the patient to another hospital. Consumers were made voluntary by the MHRB at 47 hearings (4.8%). This was the same number as in 2011–2012. Nineteen of those people were inpatients and 28 were on a CTO.

While MHRB hearings are not as formal as Court hearings, it is a legal process and can be a stressful experience for consumers. The attendance rate at hearings of patients on a CTO is very low (42.7%). Even when a consumer is detained on a ward, the attendance rate is only 84.6%, which has remained stable for some years. Council has concerns about hearings involving children and would like to see more attendance at hearings by guardians.

Low levels of representation and support in MHRB hearings

Since 2003 Council has had a strategic goal to increase the number of people supported in MHRB hearings by either an Official Visitor or a MHLC lawyer. The figures have almost doubled over the past ten years with a modest 3% increase this year.

Table 1: MHRB Representation – MHRB Data[9]

	Completed hearings	Number and % of hearings involving COV	Number and % of hearings involving the MHLC	% represented by MHLC and COV
2003–2004	1,250	8.5%	8.4%	16.9%
2004–2005	1,203	6.7%	7.8%	14.5%
2005–2006	1,089	7.3%	8.25%	15.6%
2006–2007	1,171	164 / 14.0%	75 / 6.4%	20.4%
2007–2008	1,101	147 / 13.4%	122 / 11.1%	24.5%
2008–2009	1,144	156 / 13.6%	80 / 7.0%	20.6%
2009–2010	1,123	191 / 17.0%	118 / 10.5%	27.5%
2010–2011	1,242	231 / 18.6%	67 / 5.4%	24.0%
2011–2012	1,135	262 / 23.1%	103 / 9.1%	32.2%
2012–2013	983	219 / 22.3 %	127 / 12.9%	35.2%

9 These figures have been updated from Council's 2011–2012 Annual Report.

Of the 983 MHRB hearings held in 2012–2013, MHRB figures show that consumers were supported by an Official Visitor in 219 hearings (22.3%) and represented by a MHLC lawyer in 127 hearings (12.9%) making a total of 35.2% representation compared with 33.2% last year[10]. The MHLC launched a number of initiatives during the year to increase representation and the extra 3% comes from hearings attended by the MHLC. Council's rate of support was unchanged which meant that Official Visitors took part in fewer hearings. There was a significant fall in the number of hearings (13.4%) but Council does not know the reason for this or its impact on the representation figures.

There is no provision for Council or the MHLC to be provided by the MHRB with a list of patients who have a MHRB hearing scheduled. Providing such a list would lead to increased representation because it would allow Official Visitors to visit consumers to check that they know about the hearing and that they understand what it involves, including their rights to contact the MHLC for legal representation and/or to have an advocate and family and other friends attend the hearing.

Council has started to make arrangements with a number of hospitals to get access to the MHRB list of hearings in advance[11] so that Official Visitors can approach consumers. It would be more efficient and cost effective, however, if the lists were sent to Council. It is not clear whether this issue will be overcome by the *Mental Health Bill*.

Council is also aware that the MHC has commissioned a consultant to review existing arrangements for representation of involuntary patients before the MHRB. One aim of the review is said to be to recommend measures that maximise the quality, accessibility, availability and efficacy of representation before the MHRB.

In this regard it has long been Council's policy that, if a patient is to be represented by a lawyer in a hearing, an Official Visitor will not attend except where the consumer is in a regional area and the hearing is being conducted by video link so that the Official Visitor can be present with the consumer. The reason is one of expenditure of public money.

Ideally, however, many consumers would have both their Official Visitor and a lawyer in the hearing. Official Visitors often know the consumer well and are trusted by them because they have spent time dealing with other issues and concerns on the ward. Because of their knowledge of the consumer, Official Visitors also often know background facts or can dispute assertions made in the hearing which may be relevant to the legal issues. As there is so little preparation time for the hearings, such background knowledge can be invaluable in informing the MHRB and making the consumer feel that they had a voice and were listened to.

Official Visitors also have a significant advantage in being able to look at the consumer's file, whereas lawyers have to apply and wait for the file to be made available to them. It is not uncommon for lawyers to have not seen the consumer's file before attending the hearing nor to have met the consumer before the day of the hearing.

As a result, Council introduced a new policy two years ago allowing joint attendance to be approved in special cases where the Official Visitor is aware that a lawyer is attending and the consumer has asked the Official Visitor to attend as well. While there is a discretion involved, approval is likely to be given when the Official Visitor knows the consumer well and is familiar with their history and there are either complicated legal issues which turn on the consumer's history or disputed facts on the medical file, alternatively where the lawyer has not had an opportunity to see the consumer's file or meet the consumer in advance of the hearing, or where a child is involved.

10 These figures differ slightly from Council's figures in Appendix 11 which record that official Visitors attended 226 MHRB hearings. There may be slight inaccuracies in either body's figures as both rely heavily on manual data entry; there are also some recording issues when both an Official Visitor and a MHLC lawyer attend hearings.

11 Official Visitors can view ward diaries and MHRB listings while on the wards under their powers under the Act.

There are some limitations on the way lawyers can interact with Official Visitors, mainly due to consent and confidentiality issues, but Official Visitors will, with the consumer's consent, contact and offer to work with the lawyers to brief them on issues of concern to the patient before the hearing.

Lack of procedural fairness - ongoing issues but some "good news"

Despite improvements in the past year, a number of procedural fairness issues remain in that most consumers do not get to see what the MHRB sees when it is deliberating over its decision, and often only get to see the doctor's report just before the hearing. Council has long argued that the report should be made available to the patient at least three days before the hearing and that the psychiatrist should discuss the report with the patient prior to the hearing. Instead it remains the case that Official Visitors often have to chase up the report and are left to show it to the consumer for the first time just before the hearing. The constant refrain from psychiatrists is that they agree this is what should happen..... but they are too busy.

The very **"good news"** is that the President of the MHRB has taken the initiative this year and amended the template letter sent to psychiatrists which now requires them to prepare the medical report three days prior to the hearing and further states that a copy of the report should be provided to, and discussed, with the patient three days prior to the review and a copy provided to the Council or MHLC if the psychiatrist knows that the consumer is represented by them.

It is hoped that this will lead to major cultural change over the next year. Council is continuing to monitor the situation and will be reporting back to the MHRB, and hospitals about the level of compliance.

Cancellation of hearings

According to the MHRB data, there were 783 cancellations and 983 reviews which were completed. Of the cancelled hearings, 502 hearings did not proceed because the consumer was no longer involuntary but 86 hearings were cancelled at the psychiatrist's request in comparison with 39 hearings cancelled at the consumer's request and ten requests for a review withdrawn. This remains an issue of concern for Council.

Good and bad news stories arising out of hearings:

Case 1: "Unfit" consumer

A consumer was declared "unfit" to attend a MHRB hearing by ward staff very shortly before the hearing. There was nothing on the consumer's medical file to indicate any change in their health or behaviour nor any record on the file about the decision, who made it or why it was made.

Head of Council wrote to the Clinical Director of the hospital who replied that a number of factors contributed to consumer's non-attendance, all of which related to staff unavailability – which was in fact the real reason – not that the consumer was "unfit to attend". The Clinical Director was unable to explain why this reason had been given to the MHRB and the Official Visitor. The Director said the case highlighted the "*extensive workload, clinical and administrative, that staff were dealing with on a day to day basis*". The consumer had a hearing two weeks later.

Case 2: If Mohammed won't go to the mountain .....

The MHRB was advised that nursing staff had refused to accompany a consumer to the MHRB hearing room. The MHRB offered to go to the ward and hold the hearing there in the visitors' room.

Case 3: A satisfied MHRB customer

Although the consumer was not made voluntary, he told the Official Visitor that he was really pleased because he had actually been listened to. The Official Visitor also complimented the Board on how respectful it had been to the consumer and how the members had really involved the patient in the process.

Illustration 3 – Guardianship and Administration orders

Official Visitors were involved in 27 SAT hearings in 2012–2013 and dealt with 96 requests relating to *Guardianship and Administration Act 1990* issues – most of the latter will have involved liaison with officers of the Public Trustee and the Office of the Public Advocate. Involuntary patients, people on a CTO and hostel residents may seek out Official Visitor support for SAT and guardianship and administration issues. Below are a few examples of issues involving Official Visitors.

Attendance in person at SAT hearings – principles of natural justice

Council was made aware that Graylands Hospital patients were not being taken to the SAT hearing rooms nor attending guardianship and administration hearings by video link. This followed damage to the video equipment which was not owned by Graylands. In at least one case the Official Visitor's mobile phone had to be used on loudspeaker so the consumer could take part as an appropriate phone could not be found at the hospital. Inquiries made by Council indicated that there was an inconsistent response by other hospitals to attendance at SAT as well, with at least one other hospital also using telephone conference facilities.

Council was concerned that such arrangements did not accord procedural fairness nor offer respect and dignity to people whose rights to control their own finances and make their own legal decisions were potentially going to be, or had been, removed from them. Council therefore wrote to various people in the DOH and the President of the SAT seeking agreement that the following principles should apply:

- Whenever possible the consumer should attend their SAT hearing in person – either at the SAT offices or with the SAT Member conducting the hearing on site at the hospital.
- If personal attendance is not possible, a video link to the hearing should be provided at a venue at the hospital.
- Exceptions to attendance by the consumer in person or by video link should be based only on:
  - the consumer's decision freely made not to attend
  - the consumer's physical ill-health
  - an assessment by a psychiatrist which concludes that the hearing would be detrimental to the patient's mental health or create a significant risk (which cannot effectively be mitigated) to the safety of anyone taking part in the hearing, (including hospital staff), which assessment would be recorded on the patient's file
  - Subject to the consumer's wishes, should personal attendance or video link facility not be available, then an adjournment would be sought until those arrangements could be put in place.

Responses were received from the President of the SAT and NMHS MH confirming the position. Graylands Hospital also subsequently set up its own video link room. In the interim SAT members agreed to hold some hearings on site at hospitals. Council continues to monitor the situation.

Importance of interpreters and having support in a SAT hearing

Administration orders were being sought in relation to a relatively young person. The MHLC advised that it could not attend the hearing due to resource issues so an Official Visitor attended. The consumer answered questions in English but when the Official Visitor asked that the questions be put again through the interpreter, the answers came out differently. The Official Visitor also argued that the orders be made for a shorter time than usual because of the youth of the consumer. The Official Visitor was successful in these submissions.

Public Trustee Issues

Official Visitors often liaise with officers of the Public Trustee about consumers' finances[12] and Council has worked closely with the Public Trustee over the years in an endeavour to ensure that hostel licensees are properly managing the funds of residents. Two systemic issues arose out of the work of Official Visitors in 2012–2013.

Case 1: Using patients' savings to enhance quality of life

As a result of an Official Visitor giving evidence at the Coronial Inquiry into ten deaths at Graylands Hospital between 2005 and 2012, Council became aware that at least one long term hospital consumer (and possibly others) had a substantial amount of money in their bank account with the Public Trustee which could have been used to enhance that consumer's quality of life and care. Because the consumer had been a patient at Graylands Hospital for years, they had not been paying for food and board and money had accumulated. The Public Trustee does not send statements to patients except on request. The patient was being given the standard $17 per day to spend by Graylands, but Graylands' welfare officers had no idea how much money the consumer had saved up.

One of the last comments the consumer made to the Official Visitor before they died was that they just wanted to be taken out and have a coffee at a café every now and then. With the amount of money the consumer had saved up, this and possibly more, could have been organised by paying for a private carer to take them out. A number of other long term Graylands' patients are doing this.

Council has raised the issue with the Public Trustee and Graylands Hospital and suggested that they confer to ensure that no other consumers are in a similar situation. Official Visitors are also making a point of telling consumers they can ask for statements from the Public Trustee and Council will continue to raise the issue. Official Visitors also took part in a meeting with staff from the Office of the Auditor General who were undertaking a performance audit focusing on the administration of trust accounts by the Public Trustee.

Case 2: Control of long term patients' monies

In the process of considering the first issue, and because Official Visitors regularly receive complaints from consumers that the amount of money they are allowed to withdraw from the hospital cashier is less than what their manager at the Public Trust would allow, Head of Council wrote to NMHS MH querying the legal basis on which they control patient monies.

The response was that there is no legal basis for restricting a patient's access to their funds unless the patient has an Administration Order and someone else is deciding how much money they should get. There seemed to be two ways in which funds were being restricted and no formal consistent process in relation to either.

Council was advised that the Social Work Department at Graylands Hospital was going to look into developing a process for negotiation and development of the budget plan and its documentation. It should be noted that some other hospitals have an ATM which consumers can access and most other hospitals do not have the large number of consumers who have been patients for years.

12 Official Visitors recorded 96 matters involving liaison or issues with administration and guardianship matters in 2012–2013. See Appendix 11.

Illustration 4 – Interaction with the police

Last year Council referred to three issues relating to interaction between the police and consumers. Updates in relation to two of those complaints are set out below.

Case 1: Police handling of a complaint by a consumer[13]

The consumer had been left handcuffed in the back of a police van on a hot day. The complaint was dismissed by the Police but Council wrote to the Corruption and Crime Commission (CCC) raising concerns about the way the Police had handled the consumer's complaint.

Action and outcome

The CCC replied in May 2013 advising that they had written to the Superintendent in charge of the Police Complaints Administration Centre (PCAC) and the Commissioner of Police. The CCC said that they had advised that the CCC was of the view that:

- the investigation undertaken, the conclusions drawn and the advice provided to the PCAC, were not in accordance with statements provided at the time by mental health staff. The statements of the mental health staff did not support those of the Police officers who transported the patient
- they did not conclude that there had been misconduct by the police, however the complaint highlighted the discomfort which can be caused to people being transported in police vans on hot days
- there are concerns about the care of mental health patients in such circumstances and the CCC wanted to draw this to the attention of the Police Commissioner for his further consideration as to the manner in which people in the care of police are transported.

In addition, Head of Council met with the police involved in the investigation at their invitation to discuss the issues.

Case 2: Police interviews with involuntary patients[14]

Council continues to have concerns about consumers being interviewed by the police while still an involuntary patient and the processes surrounding this. Apart from issues about the assessment of the patient's capacity to take part in a police interview, some of the interviews involve complaints of assault by staff against patients, yet other members of staff attend the police interviews. While this has generally been with a view to ensuring the patient's rights in the interview are protected, the patient may not see it in the same way nor realise that they are entitled to have an independent person attend the interview with them. Despite their best intentions, some staff do not seem to appreciate the conflict of interest nor the impact their presence might have on the patient's evidence.

In one case the doctor did not want to tell the patient that the police were coming to interview them the next day about an alleged assault by the patient on another doctor at the hospital because they were worried the patient would become too upset. The difficulty with this is that the patient would not have time to seek legal advice or find an independent person to go into the interview with them.

Other states and jurisdictions have an interview friend process but this is not established in WA. There is also varying responses by hospital staff to the issues. Council is continuing to work with the police and members of the DOH with a view to establishing a consistent and fair process for all mental health consumers.

13 See p16, Issue 1, Illustration 10, Case 1 in Council's 2011–2012 Annual Report.
14 See p17, Issue 1, Illustration 10, Case 3 in Council's 2011–2012 Annual Report.

ISSUE 3: ACCESS TO CARE

Council has raised the issue of access to care and the over-lapping causes and impacts of bed shortages, acuity on the wards, and lack of suitable accommodation in the community in almost every Annual Report since it began 15 years ago. In the inaugural Annual Report the then Head of Council wrote:

> *"During 1998/99 the most public controversy in mental health in Western Australia was that related to the availability of beds at metropolitan hospitals. In essence there was a fundamental difference of opinion about how many acute inpatient beds were needed and where. The Council did not believe that it was appropriate to adopt a position about the general issue but resolved to highlight the impact of changes that were occurring at the hospitals for which it had a brief"*[15].

Questions posed by Council in that Annual Report included three key questions about treatment in the community and whether it was being funded and supported appropriately.

The **"good news"** is that there is more mental health supported accommodation in the community available today than there was 15 years ago. There is also a greater variety of accommodation with the introduction of the Community Supported Residential Units (CSRUs) and Community Options houses a few years ago, the MHC's Individualised Community Living Strategy (ICLS) homes which are under way and, this year, the opening of the Joondalup Mental Health Sub-Acute Service.

However more community care including accommodation is still needed. The shortage of accommodation and after-hospital support impacts on the hospital bed pressures and resulting increased acuity on the ward. Western Australia's huge population growth has no doubt added to the need but bed shortages exacerbate the problem because people are more unwell by the time they get to hospital and take longer to get better which in turn uses up more hospital bed-days.

Even when there is supported accommodation to help consumers in their recovery after leaving hospital, the next problem is finding affordable long term housing to move on to. Non-government Organisations (NGOs) operating transitional accommodation and those operating CSRUs have identified a housing shortage as the single biggest problem they face. The result is that some residents are staying longer in these facilities than the designated time[16]. This in turn affects the number of places in supported accommodation available for patients in hospital and the waiting time for people in Emergency Departments (ED) or those just waiting to get a bed.

Bed numbers – openings and closures

Psychiatric hostels: In the past four years the number of beds in hostels visited by Official Visitors rose from 773 in 2009–2010 to 838 in 2012–2013[17] excluding the ICLS homes and the new Joondalup Mental Health Sub-Acute Service. The latter service, with 22 short-stay step-down beds (up to 28 days), opened up to its first consumer on 13 May 2013[18]. Council understands that as at 30 June 2013, 106 ICLS houses were "secured or in progress" and that 85 people had moved into their new home. A 27 bed hostel was closed in November 2012[19].

15 See paragraph 6.2 in Council's 1998-1999 Annual Report.
16 Sankey Associates Pty Ltd, "*Supported Accommodation Program Evaluation – Final Report*", p32 , Mental Health Commission, Government of Western Australia, November 2012.
17 See Appendix 2.
18 As the Ministerial directive to inspect the facility was not received until 6 September 2013, the Joondalup Sub-Acute Service is not included in Council's figures.
19 This was originally a 32 bed hostel, however the bed numbers were reduced over an 8 month period.

Authorised hospital beds: In the same period the number of authorised hospital beds increased from 580 beds in 2009–2010 to 629[20] beds in 2012–2013. However, length of stay by patients impacts on bed availability and the number and type of hospital beds which are available does not remain static throughout the year:

- Joondalup Hospital temporarily increased its bed numbers on the open ward by five to 30 June 2013 and was seeking funding to extend the beds beyond that date. This was done by having people share bedrooms on the open ward. At the same time Joondalup has had to temporarily close four acute beds.
- Graylands Hospital was meant to reduce its acute bed numbers by six when the new Broome mental health unit opened up but Council was told that, due to ongoing bed pressures and demand for acute services, only four beds were closed.
- In June 2013 Graylands Hospital had to reduce the number of acute open beds. This followed an accreditation assessment of one ward in which it was determined that the ward was not suitable for acute open bed use, mainly due to the old design of the ward. A second mirror-image ward was not subject to the accreditation but the hospital has decided it must have the same risks. The effect of these decisions is that the two 24 bed wards can now only be used for "sub-acute" patients. The hospital has made arrangements with the D20 ward at Sir Charles Gairdiner Hospital to, in effect "swap" patients but this can only be done with voluntary patients because the D20 ward is not authorised. The impact of the changes are two-fold:
  - Firstly, it means that involuntary patients at Graylands Hospital are likely to be detained on locked wards for longer as there is nowhere else for them to go. This contradicts s5 of the Act requiring the least restrictive environment and it may mean delay in recovery.
  - Secondly, it impacts on patients in EDs as Graylands cannot move people off the secure acute wards as quickly as it used to be able to. This will in turn put pressure across the mental health system as acute beds are always in short supply and high demand.

Number of involuntary/voluntary patients

The number of people who were made involuntary this year was either slightly less or about the same as last year and that number has been slowly decreasing for the past four years depending on which statistics are used[21]. This should suggest, at least in regard to authorised hospital beds, that the bed pressure is reduced, however:

- the number of authorised beds are limited in number and access to them is impacted by the length of stay of patients – if patients are more unwell by the time they get a bed, they may take longer to get well and be discharged, therefore tying up beds.
- the number of DOH mental health patients discharged increased by 5.2% in 2012–2013 and since 2009–2010 the number of mental health inpatients in DOH hospitals (ie voluntary and involuntary) rose from 9,457 to 12,040 or by 27.3% so there may be more voluntary patients taking up authorised beds.

20 See Appendix 1 to this Annual Report. The 2009–2010 Annual Report (at Appendix 1) noted 615 beds but this included 35 unauthorised beds in the John Milne Centre and Families at Work unit so the total of authorised beds was 580. Council does not collect data on the number of unauthorised beds so psychiatric wards at Royal Perth and other hospitals not visited by Official Visitors are not included in these figures.

21 See Table 2 in Part 4 of the Annual Report. There are 3 sets of statistics available to Council but there is no single statistic providing the number of people who were involuntary during 2012–2013.

Patients held up in hospital due to lack of suitable accommodation

Official Visitors dealt with 197 complaints or issues raised by consumers this year relating to lack of access to accommodation which included delays in discharge and hostel residents wanting to move to other accommodation[22]. The issue of lack of accommodation also often arises in MHRB hearings. Based on information provided to Council by a number of the larger metropolitan authorised hospitals, as at 30 June 2012 there were a significant number of patients who had been an inpatient for some time or whose discharge was being held up by a lack of suitable accommodation:

- **Hospital 1:** One patient had been in hospital for over 18 months, another for over six months and 12 patients' discharge was said to be held up by a lack of suitable accommodation.
- **Hospital 2:** One patient had been in hospital for between three to six months, another for two to three months. Nine patients' discharge was said to be held up by a lack of suitable accommodation.
- **Hospital 3:** Ten patients' discharge was said to be held up by a lack of suitable accommodation with seven of these patients having spent more than a month in hospital.
- **Hospital 4**: One patient had been in hospital for over six months, another for over three months, three for over two months and three for over one month.
- **Hospital 5:** One patient had been in hospital for over two years, another for over a year, and three patients had been in hospital for over six months. Twelve patients' discharge was said to be held up by a lack of suitable accommodation.
- **Hospital 6:** Graylands - as the State's single biggest provider of rehabilitation beds, called the Clinical Rehabilitation Service (CRS), it is to be expected that it will have many more long stay patients. As at 30 June there were 43 patients who had been in the hospital for less than 30 days but 37 patients who had been in the hospital for over two years. Of those, 21 patients had been at Graylands for over five years and one patient was admitted 21 years ago.

  Graylands Hospital advised that, of the patients in their acute beds, about five people were still in acute beds (based on a June 2013 executive review of patients with length of stay of over 28 days) and were not able to be discharged due to lack of suitable accommodation.

  For the patients in the CRS program, arguably having 37 people living in a hospital setting for over two years reflects a lack of suitable alternative accommodation for many of these patients. Rehabilitation and recovery programs do not have to be carried out on a hospital ward and some would argue that the institutionalisation which comes with living on a ward is in fact detrimental to recovery.

Impact of hospital and community bed shortages

The impact on consumers of bed shortages is multifold as the following illustrate:

- Official Visitors regularly hear about queues of people waiting in EDs for a mental health bed. A Code Yellow was called in the middle of the year because there were 17 patients in need of a secure bed in the North Metropolitan Mental Health system. The Code Yellow stayed in place for a day until the number of people waiting for a bed reduced to ten for North Metropolitan Mental Health wards.
- At least three major metropolitan hospitals have locked the doors of their open wards this year, and two are doing it regularly because of involuntary patient overflow from secure wards.
- One hospital told Council that it has patients on the open wards who ordinarily would be on locked wards and they are regularly "over the count". Their staff costs have increased dramatically as they cope by using one-on-one nursing specials.

22 See Appendix 11.

- Official Visitors hear complaints by consumers about being moved back and forwards between wards as staff shuffle beds in order to make way for new patients. This can include being woken up at night and asked to move as reported when Official Visitors conducted unannounced night visits in January 2013. Consumers are also often sent home "on leave" which makes way for new patients.
- Once again this year four beds were closed in one ward to manage one consumer. Last year Council raised this issue[23] and called for a specialist swing bed ward which would allow these very unwell consumers (who often have an Acquired Brain Injury or other disability such as severe autism) to be cared for safely without having to close beds. The multiplying effect on multiple consumers of closing even one bed, let alone four, is considerable. There is at least one consumer like this every year. The advantage of a purpose built swing bed is that the bed can revert back to the ward and so will be used all the time but can be cut off from the ward when needed.
- Council also receives complaints from time to time from family and friends who cannot get their loved ones into hospital. It is difficult to help these people because Council can only assist involuntary patients and hostel residents but we try to give them options and refer them on to people who may be able to help. In one case Head of Council contacted the Clinical Director and Executive Director of the hospital. Such cases are very difficult because the unwell person is usually suicidal or causing considerable distress to family members.
- In one case the voluntary patient was told that would have to be nursed on a mattress on the floor of a seclusion room – this patient had already been transferred from another hospital and was noted as suicidal. The patient left the hospital rather than stay.
- While it is uncommon for Official Visitors to get complaints about being discharged too soon, Council has dealt with one such complaint this year and in another case the consumer complained that they had been "rushed off the ward" before being able to say thanks to staff or goodbye to other patients. This was confirmed by hospital management as being caused by bed pressures.
- Council is also often told of ward staffing pressure because staff take sick leave when the ward has too many unwell patients. The result is the use of agency nurses and hence lack of continuity for consumers. School holidays are always a difficult time and when Official Visitors receive a lot of complaints about not having seen their psychiatrist. Doctors and nurses struggle to cope and basic rights are often overlooked under the pressure.

Young people – access to care issues

Council's involvement with children and young people (aged up to 18) is limited to those young people who are involuntarily detained at the BAU or on an adult ward. Official Visitors assisted 33 of the 37 young people detained involuntarily at the BAU this year.

The very **"good news"** was the official re-opening of the BAU following extensive renovations. The bed numbers, however, remained the same. Council was made aware of several cases where a young person was kept in ED for days and/or transferred to an adult ward pending the availability of a bed in the BAU. Staff prefer not to put young people on adult wards because they are very vulnerable and such wards can be more traumatising for the young person. In one case the young person, who had already spent three days in ED, was put on an open ward with three-on-one nursing special in order to avoid putting them on the locked ward but there were still concerns and issues. In another case the young person was on the ED for five days with two-on-one supervision on the ED.

23 See page 19, Issue 2, Illustration 1.

At least one young person was sent to the Frankland Centre (which is WA's most secure authorised hospital and which takes people from adult prisons) because there is no youth forensic facility and the BAU either had no beds or was not considered suitable.

Council is also aware that there have been up to four young people on the BAU because there was no other suitable facility/home for them to go to.

Elderly/Older adult – access to care issues

Official Visitors have dealt with a number of complaints this year about elderly consumers stuck on wards with nowhere to go. Sometimes they are on the general mental health ward and in other cases on the Older Adult mental health ward. The latter only takes patients over 65 who have dementia complicated by severe behavioural disturbance or a newly arising psychiatric condition, or if they have some physical frailty apart from their mental illness.

In some cases it has been the consumer or their family making the complaint; in other cases doctors and other staff have raised the issue with Official Visitors asking if they can help. Most elderly patients are voluntary because they are compliant and will stay on the ward or because they are on an Older Adult mental health ward which is permanently locked. This means Official Visitors cannot assist them or their families despite their vulnerability.

In one case the spouse of an elderly consumer wrote to Council about the unacceptable condition of the hospital room her husband was in and said he had been waiting for a place in a high dependency care facility for over 12 months. Although Council was unable to help her husband move out of the hospital, we did manage to improve his living conditions (see story below under Issue 6 Environmental Conditions). Sadly the gentleman died a couple of months later still waiting for a bed in the community.

In following up the issue, Head of Council has been told that those people with severe Behavioural and Psychological Symptoms of Dementia (BPSD) cannot be accommodated in mainstream aged care facilities. However there are only 16 beds in Western Australia available for people with BPSD and the current wait list is about two years. It also means that family members often live a very long way from the only two eight-bed facilities, both of which are south of Perth.

Forensic Services – access to care issues

Specialist forensic beds are another area of bed shortage. The shortage is exacerbated by consumers who are unwell but who do not need to be in such a highly secure hospital. Official Visitors advocated for three such patients who were "stuck" in the Frankland Centre because no other hospital would take them.

Often such patients have no fixed address which creates a barrier to their admission elsewhere and they are competing for a bed with people waiting in EDs. From a consumer rights perspective it means these consumers are being detained in an unnecessarily restrictive environment which is not in accord with s5 of the Act.

The other consequence is the impact on the already long waiting list of people in prison needing inpatient care. While committing a serious crime results in the punishment of being imprisoned, it cannot mean that the person is also not entitled to good health care. In just the three cases referred to above, there were 37 bed days lost to people in prison who needed the beds much more.

There are issues in the community for released prisoners as well as the following example illustrates:

- The consumer's bail condition and CTO required the consumer to report at a particular community mental health service (CMHS), but the CMHS said the consumer was "out of area" and had to go to a different CMHS. The second CMHS was not appropriate due to a history of issues. The consumer told the Official Visitor that they were running out of medication. The CMHS told the consumer to go to a GP. The consumer didn't have a GP. The consequences for the consumer of breaching the bail order and CTO and running out of medication were clearly serious. After many phone calls by the Official Visitor, a script was eventually delivered to the consumer by the second CMHS. Meanwhile the Official Visitor was told that discussions at a "high level" were continuing as the two CMHS argued over who would take the consumer. The Official Visitor was then told that the Forensic Community Mental Health (FCMH) had been asked to take the consumer but they had refused saying the consumer did not meet their criteria. A month later the consumer was again running out of medication and still no CMHS had agreed to take him. A couple of weeks after that, and following further phone calls by the Official Visitor, the consumer was allocated to a CMHS. Without the intervention of the Official Visitor to advocate for this consumer it seems reasonable to assume they would have ended up back in prison and/or the Frankland Centre.

As noted above, and in last year's Annual Report[24], there are also no specialist forensic beds for young people and at least one consumer ended up in the adult forensic ward this year - the BAU either had no beds or was not considered suitable. In that case the Magistrate had no option because of the self-harm risk posed by the young person. Special arrangements are made for these young people while in adult mental health wards with one-on-one specials or higher nursing levels, but clearly such arrangements are not ideal.

Custody Order patients and need for review of legislation

It also remains the position that the process established under the *Criminal Law (Mentally Impaired Accused) Act 1996 (CLMIA Act)* is responsible for delaying the release into the community of some Custody Order patients whose psychiatrist and the Mentally Impaired Accused Review Board (MIARB) have recommended for conditional release. Such patients are taking up scarce mental health beds and are being detained in custody for longer than they would have been if they had been convicted of the offence which led to the Custody Order.

The Government affirmed its promise of January 2013 to conduct a "further" review of this legislation and produce a discussion paper to be released for public consultation in its pre-election policy statement[25]. Council eagerly awaits the outcome of that review given the very many deficiencies in this legislation[26].

Some "good news" for some Custody Order patients

A Bill to establish "Declared Places" under the CLMIA Act is proposed by the Disability Services Commission (DSC) to accommodate people with intellectual or cognitive disability who are on a Custody Order. Council is pleased to be involved in that legislation in an inspection and advocacy capacity. The Declared Places will not be taking people who are on a Custody Orders because of their mental illness, however, so many of these people will remain in prison or the Frankland Centre.

24 See p40, Issue 6 , Illustration 3.
25 "The Liberal's Mental Health Policy: Providing responsive, respectful and supportive services for people experiencing mental health, alcohol and other drug problems" 2013. http://www.wa.liberal.org.au/sites/www.wa.liberal.org.au/files/plans/Mental%20Health%20(MH).pdf
26 See Council's comments on this issue in last year's Annual report, p39, Issue 6, Illustration 1.

ISSUE 4: COMPLAINT PROCESSES

Official Visitors have the function under the Act of enquiring into and seeking to resolve complaints concerning consumers made by them or their guardians or relatives[27]. Much of the time the Official Visitor will deal with, and resolve, the complaint immediately with ward or hostel staff. On other occasions the consumer may want to make a more formal complaint. The process for making complaints varies between hospitals and area health services and hostel licensees. Council has a number of concerns as outlined below.

Time delays responding to complaints

Delays responding to complaints creates enormous barriers for consumers to remain engaged in, and trusting of, the process. In some cases there is no acknowledgement of receipt of the complaint and responses were only received after repeated follow-ups by Council. NMHS MH has instituted a centralised process whereby an acknowledgement letter is sent to the consumer (and Council) advising the date by which they can expect a response which is both courteous and helpful. Often a second letter is received advising of a delay, but at least the consumer is being kept informed.

Issues with complaint forms

On some wards the consumer has to ask staff for the hospital complaint form and return it to them which is likely to be a deterrent. The quality of the complaint forms also varies with some providing only a few lines to record the complaint. Where an Official Visitor is involved, a letter is usually sent written either by the consumer or the Official Visitor.

Conduct of the investigation not transparent

Some responses give little or no detail about the investigation such as who conducted it, who was spoken to etc. It is not uncommon for the consumer to not be spoken to at all about their complaint. The decision as to who investigates a complaint is also a vexed one with the CNS or Clinical Director usually conducting investigations into complaints about staff unless it is deemed to be misconduct. If Council is involved we will usually call for an external person to do the investigation.

Poor quality responses

It is not uncommon for the response to say that that there was nothing in the consumer's file to verify the complaint so the complaint is therefore dismissed, yet the files are not always accurate[28]. The responses will often depend on the level of detail given in the original complaint. Where an Official Visitor is involved, this may not be such an issue but for consumers who do not have access to their file and whose literacy skills may not be particularly high, or who are affected by medication, drafting the complaint can be difficult. If the consumer is not followed up for more information it can mean that the complaint is not dealt with properly. Delays in responses are likely to affect the quality of the response as well.

Below are some case examples reflecting the concerns raised above:

Case 1: Over nine months to finalise misconduct complaint

The consumer who made the complaint referred to in Issue 1, Illustration 1 in this Annual Report was still waiting for a response nine months after the complaint was raised. It is acknowledged that the seriousness of the complaint meant that it would take longer than many other complaints to resolve, but the time delay is unacceptable. The consumer was particularly concerned that they may become unwell again and have to go back on to the same ward with the same staff working there and the complaint unresolved.

27 See s188(e) of the Act.
28 See Issue 1 Illustration 4.

Case 2: Fifteen weeks to respond

A consumer complained by letter sent to the hospital on 22 November 2012 about their treatment in ED. After various follow-ups by Council, a response was eventually sent to the consumer dated 12 March - over fifteen weeks later. Although the consumer's letter of complaint had asked for Council to be kept informed, we were not copied into the letter and only found out about the response on 22 March after making further follow-up inquiries.

With support from an Official Visitor, the consumer had put in a complaint to the Health and Disability Services Complaints Office (HADSCO). HADSCO required the consumer to put in a complaint to, and receive a response from, the health service before progressing the complaint. By the time the hospital's response was received, however, the Official Visitor had lost contact with the consumer. It is not known if the consumer received the hospital's response. The Official Visitor was told that HADSCO had also followed up with the hospital for the response and were also not copied into the hospital's reply. HADSCO advised that they accepted the hospital's reply.

Case 3: Eleven weeks

A consumer complained about a limited registration psychiatrist failing to see them often enough It appeared from the consumer's file that they had been detained for six weeks without seeing the psychiatrist. Staff had confirmed the patient's concerns to the Official Visitor. The psychiatrist then failed to attend a MHRB hearing and a registrar who had only just joined the hospital attended and provided the medical report. MHRB members noted that the last assessment they could find on the consumer's file by the psychiatrist was seven weeks earlier. There was conflicting staff evidence. The MHRB made the consumer voluntary.

The Official Visitor then wrote to the Clinical Director on the consumer's behalf raising these and several other complaints. Despite numerous follow-up letters and calls there was no acknowledgement letter from the hospital. A reply was only received eleven weeks later after Head of Council intervened and spoke to the Clinical Director. The consumer was also not copied in to the reply.

The reply from the Clinical Director was that he was satisfied that the psychiatrist had been managing the consumer appropriately and had been seeing the consumer approximately weekly, using the registrar in the interim periods and daily feedback from the ward round. It was acknowledged that there were *"short comings in documentation"* and that the psychiatrist and his team were *"now clearer in specifying who is present at meetings. It is their usual practice to document the daily brief ward rounds and this had slipped during this period."*

Case 4: Complaint not followed up as promised by staff

In March 2013 the consumer and the Official Visitor met with the senior nurse about a number of complaints after the consumer's room was searched and the consumer had been put into seclusion. The senior nurse promised to follow up with ward staff about the issues and to respond to the consumer and their carer. The consumer did not want to put in a written complaint. The senior nurse failed to follow up with the consumer or their carer and had not done so at 30 June and did not do so until the Official Visitor spoke to the senior nurse.

Case 5: The long road to HADSCO

The consumer who was on a CTO and their carer complained about a failure by the consumer's psychiatrist and the community mental health team to listen to their concerns about the adverse effects that new medication was having on the consumer. In particular they failed to accede to requests for an earlier review of the medication even after a MHRB hearing in which the concerns were raised. The consequences of the failure to review the medication were very serious from the consumer's perspective.

Council wrote to both the mental health service and the then Chief Psychiatrist on 24 July 2012. The Operations Manager of the mental health service responded by 12 September 2012 dismissing the complaint and saying that the consumer had sufficient ongoing support. The consumer, their carer and the Official Visitor were not happy with the response. Following a further exchange of correspondence a meeting was then held with the Operations Manager and the Clinical Director in March 2013.

At the meeting the Official Visitor raised a number of questions on behalf of the consumer. They were told that one of the reasons why the patient's request for an earlier consultation had not been brought forward was because the psychiatrist was *"covering for two other consultants due to leave and sickness"*. The consumer and their carer were still not satisfied with the response by the health service and so a complaint was made to HADSCO.

The Chief Psychiatrist had sent an initial acknowledgment letter saying that they would respond to the consumer direct but did not respond until April 2013 following several follow-up letters by Council. It seems there was a lapse in process following the change-over to a new Chief Psychiatrist early in 2013. In June 2013 the Chief Psychiatrist advised that he also wanted more information from the health service. The complaint is ongoing.

ISSUE 5: PSYCHIATRIC HOSTELS

There are 838 people living in psychiatric hostels in WA visited by Official Visitors. The hostels are visited every two months by Official Visitors and, as at 30 June 2013, comprised 39 licensed facilities[29], some of which are run by NGOs and some by "for profit" entities. The facilities range widely in style, size, standard of accommodation and care, and level of funding. In this Annual Report they will all be referred to as hostels.

This figure does not include the ICLS houses by the MHC. Council's jurisdiction does not cover these homes, even though consumers living under these arrangements may need advocacy, particularly in relation to any complaints they have with the NGO providing them with support.

There was a 29.5% increase in the number of hostel residents seeking visits from Official Visitors this year, rising from 139 to 180. Coming on top of the big percentage increase last year, the number of hostel consumers seeking Official Visitors' assistance has almost doubled in the past two years. This will reflect increased community beds in part, but also supports the concerns Council has about this sector and the need for advocacy and rights protection.

Below are some illustrations of matters and concerns involving hostels in which Official Visitors have been involved in this year.

Illustration 1 – Oversight, regulation and licensing

Council has for many years been calling for a review of the oversight of the sector and the *Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997* (the Hostel Regulations) and the *"Licensing Standards for the Arrangements for Management, Staffing and Equipment: Private Psychiatric Hostels" (*Hotel Licensing Standards).

It is difficult for Council in advocating for residents' rights as there are overlapping and outdated regulatory and contractual provisions and no single body which has complete oversight and can deal with the most serious issues.

29 See Appendix 2 – excludes the Joondalup Mental Health Sub-Acute Service and ICLS houses.

Support for Council's position has recently come from the Sankey report to the MHC which reported[30] that having the three bodies with oversight of hostels – LARU, Council and the MHC – caused compliance difficulties for licensees. The Sankey report also noted that if the Mental Health Bill 2012 is passed into legislation, the Council structure will change and it will lose its inspection role: *"A number of Services expressed regret about this as they believe the Council provides an important service to residents."*

The cases below illustrate Council's concerns:

Case 1: Staff member a sole signatory on resident's bank account

A hostel supervisor had made themselves a sole signatory on a resident's bank account and remained so even after the supervisor had left the hostel. The resident complained that some money had been taken out of the account without their authority. The account had a considerable sum of money in it due to proceeds from a will. The elderly resident had no family in Australia. The supervisor's name has now been removed and the supervisor gave explanations for the sums taken from the account but it is an example of the vulnerability of some hostel residents and what few protections there are in place. Council is continuing to confer with LARU and the MHC over the issue.

Case 2: Breaches of Hostel Regulation 12

Bimonthly inspections of hostels by Official Visitors showed that 16 hostels are not complying with either Hostel Regulation 12(a) or 12(b) or both and do not have an exemption from the Hostel Regulations. Hostel Regulation 12 requires psychiatric hostel licensees to ensure that there is provided for each resident, at no extra cost:

a) all clothing necessary for that resident, including under and outer garments, headwear, footwear and night attire and

b) basic toiletry items, including soap, talcum powder and toothpaste.

Hostel Licensing Standard 4.10 also requires that clothing and toiletries provided are to take into account the residents' choice and needs. Some licensees have exemptions from the Hostel Regulations and others have a dispensation from the Hostel Licensing Standard but the dispensation by itself does not overcome the legal requirement to meet the Hostel Regulation. In addition there are questions about the amount and quality of clothing provided – some hostels provide second hand clothing, for example.

Council has written to LARU and the MHC about the issue.

Illustration 2 – Lack of recovery support

The discrimination of "private hostel" residents who have little or no access to appropriate rehabilitation and psychosocial services which limits their potential for recovery and an improved quality of life is an ongoing issue raised in previous annual reports.

Council is hoping that the new Commonwealth Partners in Recovery program and perhaps the National Disability Insurance Scheme/Disability Care Australia will be the solution to this ongoing issue but in the meantime continues to lobby for inreach services to be funded by the MHC. These residents receive far less funding than residents of the CSRUs and Community Options and ICLS housing and some of the hostels in which they live are below an acceptable standard of accommodation.

30 Ibid Sankey Report at p43-44.

One such hostel was closed during the year by LARU. The licensee was required to provide adequate reports by a health architect and fire health engineer reviewing the building against the Psychiatric Building Design Guidelines and relevant Australian Standards. Beds were progressively closed between March 2012 and November 2012 as the licensee failed to meet the license conditions and deadlines set by LARU. Council was somewhat surprised by the closure because there are several other hostels which Official Visitors doubt would meet such standards. We understand the difference with this hostel was that the licensee had failed to make good on the promises made when first granted the license. Council's role in the closure was to ensure that residents were being properly consulted and kept informed and supporting them through the process. The transition went relatively smoothly, though there remained a question about the custody of residents' records.

Illustration 3 – Staff training/supervision concerns

Council has raised concerns about lack of suitable training and assessment for hostel staff for many years. The following are examples of the impact of this on consumers. Council's approach is to raise the issues and try to educate staff and management in the process.

Case 1: Staff member interfered in resident's phone conversation

A resident called Council to ask to speak to an Official Visitor. While the resident was giving their details to Council's support staff member, the phone was suddenly taken from them and, without asking who was on the end of the phone, a hostel staff member told the Council support staff member that the person they was talking to had a mental illness and not to take note of anything she said. Apart from the fact that this was rude and distressing for the hostel resident, the hostel staff member had no idea who they were talking to and so breached confidentiality. Council complained to the hostel but got no response. Eventually after prompting, a reply came back denying the version of the Council staff member.

Case 2: Hostel staff member's handling of serious allegation

In the same hostel a resident disclosed to a staff member that their psychologist had made improper advances of a sexual nature. Without the resident's consent, the hostel staff member organised a meeting at the hostel to be attended by the resident, the psychologist and others. The manager was insisting the resident attend the meeting until an Official Visitor became involved. Council met with the hostel manager and staff member to explain that this was not an acceptable way to approach a disclosure of sexual assault.

Illustration 4 - Institutionalisation

The following cases illustrate how some hostels are run more like institutions than homes and the need for regular visits by independent advocates.

Case 1: Dinner at 4.10pm

The Official Visitor arrived at the hostel at 4.10pm to find most of the residents finishing their evening meal. Residents said that this was not uncommon. Breakfast was being served at 6.30am and lunch was usually over by 11.30am. The Hostel Regulations clearly state that meals are to be served at reasonable hours with breakfast not being served before 7am, the midday meal not before noon and the evening meal not before 5pm. The Official Visitor reported that most of the residents were getting into their pajamas and were ready for bed by 5pm.

Case 2: No soap or towels in bathrooms

At the same hostel residents had to keep soap in their rooms and carry it to the toilet with a towel every time they used the toilet. The Official Visitors said this was not good enough and got the matters rectified. Experience by Official Visitors is that the issues may arise again in the future but they will remain vigilant in looking out for such issues and requiring them to be rectified by the hostel licensee.

Illustration 5 – Environmental conditions in hostels

Council's annual environmental audit did not raise as many issues of concern this year. However, Official Visitors have targeted a number of hostels throughout the year in an endeavor to improve the ongoing living conditions for residents. Largely this is done through constant "nagging", pointing out issues of concern to the hostel management. In one case the Official Visitors insisted that professional carpet cleaners be brought in and then got an undertaking that carpets would be progressively replaced. The licensee also agreed to buy the residents microwaves as a Christmas present for their units. Meals were provided but a number of the residents had complaints about the meals. It was felt that providing microwaves would encourage some residents to be more independent as well as giving them flexibility and choice in relation to meals.

Illustration 6 – "Good news" stories from the hostel sector

Case 1: Getting a life back

Council also asked hostel residents a number of questions during a regular bimonthly inspection in May/June 2013 including whether they felt that their health and well-being had improved as a result of living at the facility. Not surprisingly the results varied from facility to facility and person to person but there were many positive comments including feeling more confident and independent – "*I have got my life back*" - as well as references to making new friends and feeling supported. Where the comments were negative the Official Visitors discussed the concerns with the residents and offered advocacy assistance. In the case of one facility the issues raised by the residents were taken up with the licensee and Council advised the MHC.

Case 2: How a hostel was a home

As a testament to the caring environment at one private hostel, a consumer who was dying of cancer asked to spend the last hours of his life at the hostel – rather than a relative's home or hospice - as he regarded the hostel as his home.

Case 3: Licensee waiving right to 28 days rent

Following Official Visitor advocacy, the licensee of another private hostel agreed to waive the 28 day rent notice provisions so that the resident could quickly accept an offer to live in more independent accommodation.

Illustration 7 – Discharge from hospital to hostels

In July 2012 Official Visitors focused their bimonthly inspection on the issue of discharge into hostels. A number of the hostel staff advised that case managers sometimes omitted some information which could cause difficulties at the hostel for the resident and other residents later on. As one hostel advised, *"the paper information can be different to reality and care plans need reviewing"*. Residents spoken to were asked what choice they had in the selection of their accommodation but all said they had no choice other than staying in hospital or perhaps on the street.

The Sankey report also noted that *"inappropriate or incomplete referrals are said by NGOs to be widespread"*[31]. As a result of this and other inspections in which hostel and hospital staff were spoken to by Official Visitors, Council suggested to the MHC that a standardised referral form for hostels would assist the sector. Social workers and case managers, who do most of the paperwork when trying to find accommodation for consumers, spoke of having to fill out numerous different forms. The MHC has advised that it is considering the suggestion.

Illustration 8 – Children visiting hostels

As a result of concerns raised by a consumer at one hostel who was not allowed to have her children visit, Council wrote to hostel licensees asking about their policy regarding having children visit. Thirty-four of the 39 licensed hostels reported that they would allow children to visit. Two hostels said they would not allow children and another said *"it just doesn't happen here; there is no need for it to happen"*.

Few hostels had a specific policy on the issue but following Council's correspondence, one NGO advised that it would be developing a policy and a "Children on Site Policy" has now been received. Council will be contacting the MHC to raise awareness of the issue in terms of consumer rights and ensuring that facilities being built in future cater for the needs of families.

ISSUE 6: ENVIRONMENTAL CONDITIONS ON AUTHORISED HOSPITAL WARDS

Environmental conditions are particularly important in authorised mental health wards. Being forced to stay in a cold, uninviting environment with uncomfortable beds, curtains hanging off their tracks, where you can't smoke or access the garden at will and where the garden is more like a sandpatch, is clearly not conducive to good mental health. The ambience of a ward, along with the culture of respect and dignity, can make all the difference to a person's recovery.

Official Visitors are required by the Act to "ensure" that the conditions where people are detained or cared for in authorised hospitals and psychiatric hostels are "safe and otherwise suitable". This is done in their monthly and bimonthly inspections and an annual "environmental audit", a copy of which is given to the facilities. This year the audit was conducted in March with a view to hospitals being able to include larger items in their budget submissions. Official Visitors will also be conducting a follow-up monthly inspection in August 2013 to ensure matters identified have been attended to.

In previous years the audits were conducted in May/June and we published a summary of the audits in the annual reports. This is not being done this year, in part because of the earlier timing of the audits (so the information will be more out of date), and partly due to lack of Council resources to put the summary together.

Official Visitors have no powers to require facilities to improve the conditions but must rely on advocacy and their powers of persuasion. Over the years Council has built up relationships within facilities and learned the most effective ways of getting change. Some illustrations of the importance of the environmental conditions and issues dealt with this year are set out in the following pages.

31 Ibid Sankey Report at p31 .

Illustration 1 – Coronial Inquiry

Council was asked by the Counsel assisting the Coroner to provide submissions to the Inquest into the deaths of ten patients at Graylands Hospital between 2005 and 2012. In particular Council was asked to provide comments on:

- the living conditions
- suitability of facilities
- maintenance of facilities
- quality of food
- social amenities provided
- sporting and religious facilities
- relaxation facilities
- access to occupational therapy, physiotherapy, dental and psychological services
- staff numbers and ratios
- personal safety of patients and other patients where necessary
- post-discharge assistance including:
  - housing
  - medication
  - income
  - follow-up
- any other systemic issues Council considered the Coroner may be interested in in relation to Graylands Hospital

Council provided a 49 page report in December 2012 based on Council's records prepared by the team of Official Visitors who were responsible for visiting Graylands Hospital, with some input by Head of Council and Council's Manager.

The report went through each ward at the hospital describing current conditions as well as noting past issues as the ten deaths ranged over a number of years. The impact of boredom and poor environmental conditions were highlighted in the report as were issues about lack of access to bedrooms and courtyards.

An Official Visitor and Head of Council were also subpoenaed to give evidence. The Official Visitor had been assisting a consumer who was one of the ten deaths and Head of Council answered questions about the written report.

Illustration 2 – Unacceptable conditions on elderly ward

Council is unable to assist voluntary patients but in one case the spouse of the consumer contacted Council saying that her husband had been in hospital for over a year waiting for a bed in an elderly care facility. In addition the condition of his room at the facility was unacceptable. The consumer had no cupboards, no curtains, the carpet was dirty and smelt of urine, and the skirting board had been removed but not replaced and large sections of the paint had peeled from the walls. A number of these issues had previously been drawn to the hospital's attention. There were also issues with the lounge area and other rooms on the ward.

Although the patient was voluntary, Council took action under its function of ensuring conditions are safe and suitable. The Official Visitor bypassed hospital staff and spoke direct to the Engineering Department responsible for maintenance. They inspected the consumer's room that same day and advised that they would immediately arrange repairs. They said they had not previously been told about the condition of the room. As a result, the consumer's room was greatly upgraded within a short period of time. The wife had also complained that furniture in the general area was sub-optimal and this was also reported to hospital management. As a result, new furniture was ordered as a matter of priority.

Illustration 3 – Courtyard access and condition

Even prisoners who have committed the most serious crimes get access to an open air courtyard from time to time. An enticing garden on a pleasant sunny day can go a long way to improving anyone's mood. Official Visitors are therefore diligent about advocating for access to courtyards and that the courtyard should be maintained properly. Sadly this is often not the case.

Various descriptions of courtyards by Official Visitors over the past year have included the following –

- *"Lawn is dead, pathways are overgrown and courtyard needs attention"*
- *"The area is dirty and looks particularly uninviting"*
- *"Courtyards need attention – they lack plants and look tired and overgrown"*
- *"There are still weeds growing through the path which represent a trip hazard. Gardens on all three wards need attention. They are barren and unkempt. Lots of dead vegetation"*
- *"The sand area in the courtyard requires immediate attention. This is a safety hazard and should be marked as such until it is rectified".*

On one elderly ward the garden benches were missing several slats which was an injury risk for patients whose eyesight may be failing and who may be affected by medication. Official Visitors raised the issue with ward staff during the inspection, tried to contact senior staff and included it in their May inspection letter to the facility but a month later nothing had been done. Official Visitors took matters into their own hands and spoke to the hospital's Engineering Department who took immediate action to make them safe and ordered more permanent repairs.

Despite the very poor upkeep of most mental health ward gardens, consumers still crave access to the sun and fresh air. Following the "escape" of a patient at one mental health facility, access to all three ward courtyards were severely restricted to patients. Official Visitors received a complaint signed by all the patients on one ward and several patients on the other two wards. Submissions were made to the hospital management who replied that they believed a "compelling argument" had been put by the patients in relation to one of the wards and the restrictions were immediately lifted for that courtyard.

Illustration 4 – Toilet roll holders and beds

Some environmental issues may seem relatively inconsequential but when you are being forced to stay on a ward for weeks, months, or even years at a time, having toilet roll holders and soap dispensers in bathrooms and comfortable beds is important.

In the case of one hospital, the lack of toilet roll holders (with the roll being put on the floor or on top of a sanitary bin) and soap dispensers in shared bathrooms has been an ongoing issue and Official Visitors continue to raise the issue with management.

There is a wide variety of beds used across the mental health sector and Council has been told that there is no applicable standard for mental health beds. While some hospitals seem happy to use ordinary beds, others have gone to great lengths to make sure that there is nothing in the bed that could be used for self-harm.

As a result of issues raised by Council in previous years new beds have been purchased by two hospitals but there have been issues such as fitted sheets not fitting the beds and the beds being too high (making consumers feel unsafe because they might fall out of bed and difficult to get in and out of) or too uncomfortable.

Council wrote to the Chief Psychiatrist because that office authorises mental health hospitals to ensure they are safe. The OCP said that they do not have specific guidelines for beds in an authorised mental health hospital but would consider including broad guidelines regarding unfixed furnishings with the review and amendment to "*The Chief Psychiatrist's Standards for the Authorisation of Hospitals Under the Mental Health Act 1996*" (2007).

Council has now been advised that one hospital is going to trial a new "anti-ligature" bed which is made in the US and distributed from Queensland. We await the outcome of the trial.

ISSUE 7: OTHER ISSUES

Illustration 1- Smoking exemption – good news

After more than 4 years of advocacy by Council, in September 2012 the Minister for Mental Health announced a partial exemption to the Smoke Free WA Health System Policy. The exemption applies to involuntary mental health in-patients aged 18 years and over who are in secure wards, permitting them to smoke in a designated outdoor smoking area within the hospital grounds.

There were initially delays in implementing the exemption at a number of mental health sites because the designated smoking areas needed to comply with Occupational Safety and Health Regulations including a minimum of five metres distance from doorways and provision of shade.

As at 30 June 2013, however, all but two hospitals had established designated smoking areas and were permitting involuntary patients to smoke. Facilities that were not complying with the partial exemption as at 30 June 2013 were still in the process of making the structural changes which are necessary to establish the designated smoking area. One of those hospitals has provided a temporary solution to give involuntary patients some relief.

Official Visitors and Head of Council have been told anecdotally by management and ward staff that aggression, sedation and the number of seclusions on wards have reduced as a result of the exemption to the Smoke Free WA Policy. One consumer told their Official Visitor that the new policy on smoking meant that they could now concentrate on getting better instead of concentrating on when they might next get ground access and contemplating going AWOL just so they could have a cigarette.

Council would still like more effort to be made to educate patients to want to quit smoking and to provide support to quit, especially when they leave the hospital.

Illustration 2 - Monthly and bimonthly inspection visits

Official Visitors are required to inspect authorised hospital wards monthly and hostels bimonthly. Inspections usually include questions for relevant staff and any consumers who are happy to talk to Official Visitors based on particular "focus areas" – not a survey as such, but part of the process of ensuring rights are observed and that the facilities are "safe and otherwise suitable". The regular visits also make Official Visitors accessible to consumers as required by the Act.

The focus areas for 2012–2013 were:

MONTH	HOSPITAL	HOSTEL
July 2012	Discharge Planning	Moving Into a Hostel
August 2012	Access to Phones	Finances
September 2012	Weekend Visits and Activities	Weekend Visits and Activities
October 2012	Seclusion	Fire and Safety
November 2012	Individual Care Plans	Fire and Safety
December 2012	SWOT Analysis	SWOT Analysis
January 2013	Night Visits	Environmental Audit
February 2013	Access to Records and Rights	Environmental Audit
March 2013	Environmental Audit	Night Visits
April 2013	Discharge Planning	Night Visits
May 2013	Finances and Accommodation	Admission, Finances and Support on Leaving
June 2013	Treatment and Individual Care Plans	Admission, Finances and Support on Leaving

Each month there are also standard questions or reminders to Official Visitors to check:

- the seclusion register
- for new consumers to ensure that they have been told their rights
- for consumers on phone, post or visitor restrictions in order to ensure that the Act is being complied with
- for consumers who don't speak English as their first language
- for consumers with MHRB hearings coming up to ascertain if they would like support or advocacy at the hearing
- for children and young people on adult wards
- for consumers from regional areas
- that the ward or hostel has sufficient pamphlets/posters about consumers' right to access Official Visitors.

Illustration 3 - Some more "good news" stories

1. A hospital responded to Council's concerns raised in a monthly inspection about the lack of ward activities and nursing time advising that they had changed the configuration of ward staffing.
2. Another hospital acknowledged Official Visitors' concerns raised after a monthly inspection visit that night-shift fire and emergency drills had not been conducted for several years and immediately organised for this to be done.

3. A psychiatrist arranged an "other opinion" from a Muslim psychiatrist at another hospital as the consumer was concerned that their religious beliefs and culture had not been considered in their initial assessment.

4. Council was impressed with the speed in which the Engineering Department at Graylands responded after a fire in one of the secure wards. There was a large team of contractors in place by Wednesday afternoon (the day of the fire) and 24 hours later a great deal of progress had been made - all the air-conditioning was being removed (mechanical devices and ducting), patients' clothing was washed and given back to them, painters were on the job and new beds were being brought in.

5. The weekend phone roster, and good advocacy by an Official Visitor on behalf of the consumer and their parent, resulted in the consumer going home on weekend leave within hours of the Official Visitor intervening. The Official Visitor insisted on the consumer being reviewed that day (Saturday). Whilst the psychiatrist who attended did not make the consumer voluntary, he gave them leave until the Monday morning, when the treating psychiatrist reviewed the consumer and made them voluntary.

6. A few of the compliments sent in to Council about the work done by Official Visitors:

   - Letter sent to Council: ***"I would just like to extend a warm THANKYOU for helping my brother and being there for him in his time of need. It is great to have such a backing and support especially when we don't have anyone else to rely on ..."***

   - Email sent to Council: ***"I wish to express my gratitude for your immediate action regarding of my complaint 'Urgent improvements needed for Older Adult and Mental Health Care in WA'. My husband's room got a new non slip vinyl floor covering, a wardrobe and a cabinet. Next week a painter will fix the walls. That's a good start thanks to your quick response."***

   - A consumer who telephoned Council's office to thank their Official Visitor said: ***"Without Council help, I would have been in difficulty ... you are genuine people who stick to what they say. I keep your pamphlet in my handbag just in case I ever need help again..."***

   - Email sent to Council: ***"Thank you so much for your kindness and compassion while I was in Hospital. I couldn't have done it without you. You all are remembered with fond thoughts and appreciation in my heart and all the wonderful work you do is much needed".***

PART THREE
Ongoing issues raised in previous annual reports that still require remedy

Below is a year by year summarised list of systemic and ongoing issues which have been raised in previous annual reports.

1998–1999 ANNUAL REPORT

1. **Need to expand the definition of "affected person" in s175 of the Act so that Official Visitors can also advocate for voluntary consumers, referred persons and Hospital Order patients.** It remains the case that Official Visitors cannot assist voluntary patients. The Mental Health Bill 2012 provides that the new Mental Health Advocates replacing Official Visitors will assist certain categories of voluntary patients, but only where the relevant Minister has made a direction to that effect.
2. **Overcrowding in authorised hospitals with pressures on beds in all hospitals.** See Issue 3 in this Annual Report.
3. **Lack of system wide policies that have a direct impact on consumers**. See Issue 4 in this Annual Report regarding complaint processes. Terminology also varies. Examples include different policies relating to care/management and other "plans". Council is still waiting for the implementation of standardised clinical documentation trialled in 2010–2011 and endorsed by mental health executive directors in November 2012.
4. **Other Opinions process not providing truly independent opinions and related issues.** While not highlighted in this Annual Report nothing has changed. There are some improvements proposed in the Mental Health Bill 2012, notably that the consumer will be given a copy of the opinion in writing, but the ongoing issue of consumers having to ask their psychiatrist to organise an Other Opinion for them, and the inability to get a truly independent psychiatrist to give the other opinion, remain major issues impacting on the value of this important consumer protection. Council understands that there are some plans to try to address these issues as part of the implementation process for the Bill but is yet to be consulted about the plans.
5. **Hostel issues including minimal health care and support services, need for review of the standards, lack of proper facilities and lack of privacy and security in bedrooms.** This remains a major area of concern for Council. See Issue 5 in this Annual Report.

1999–2000 ANNUAL REPORT

6. **More respect and facilities needed for human relations and intimacy.** This continues to be an issue. See Issue 5, Illustrations 2, 3 and 8 in relation to hostels. Official Visitors dealt with 102 complaints and requests for assistance relating to dignity and privacy issues. See Appendix 11 in this Annual Report.

7. **Boredom on the wards and lack of access to on site gyms, or to exercise equipment etc.** This is an ongoing issue on many wards as was reflected in the Official Visitors' September 2012 inspection reports. It was also a feature of Council's submissions to the Coroner (see Issue 6, Illustration 1 in this Annual Report). In addition Appendix 11 notes 48 consumer complaints relating to this issue, an increase from 30 complaints last year.

2002–2003 ANNUAL REPORT

8. **Lack of access to allied health professionals/multi-disciplinary teams, in particular social workers and welfare workers.** The number of complaints related to issues involving access to social workers and welfare workers increased significantly this year from 101 to 151. See Appendix 11 in this Annual Report. Official Visitors often find themselves helping consumers because there is no social worker or welfare worker available. There were 19 complaints about lack of access to psychologists and other services such as drug and alcohol support.
9. **Need to improve opportunities for socialisation for people with a long term illness.** The issue continues in relation to lack of activities for many hostel residents. Issue 5, Illustration 8 in relation to children visiting hostels is one example. Complaints are also still being received by Official Visitors about occupational therapy activities in hospitals not being relevant and being aimed at women and not men. Appendix 11 in this Annual Report records 48 issues raised dealing with occupational therapy activities.

2003–2004 ANNUAL REPORT

10. **Ward environment and lack of maintenance.** This has been raised in every annual report since then. See Issue 6 in this Annual Report.
11. **Need for new initiatives in services for Aboriginal and Torres Strait Islander peoples.** The opening of the new mental health unit in Broome in May 2012 has made a difference as has the expansion of the Statewide Specialist Aboriginal Mental Health Service. Official Visitors endeavour to ensure that every Aboriginal consumer is put in touch with this service.
12. **Issues with the MHRB process, in particular doctor non-attendance and failure to provide medical reports in a timely manner or at all.** There have been improvements in relation to this issue because of support for Council's position by the MHRB but it remains an ongoing issue. See Issue 2, Illustration 2 in this Annual Report.
13. **CTO breaches and potential breaches of the Act.** There were fewer complaints about invalid CTOs this year but Council is aware of ongoing issues, particularly in rural and regional areas with people not being reviewed monthly as required by s75 of the Act. See also Issue 4, Case 5 of this Annual Report. The number of CTO consumers who complained this year increased by three people (from 74 to 77).
14. **Treatment of people with a mental illness in hospital EDs including delays and not being treated with dignity and respect.** Delays continue to be an issue. See Issue 3 and Issue 4, Case 2 in this Annual Report.

2004–2005 ANNUAL REPORT

15. **Low levels of representation in MHRB hearings.** The **"good news"** is that this is improving but see Issue 2, Illustration 2 in this Annual Report.

2005–2006 ANNUAL REPORT

16. **Failure to comply with s157 of the Act requiring that a relative, guardian, friend or other person also be given an explanation of the consumer's rights.** The **"good news"** is that as a result of Official Visitors continuing to raise this issue in inspection visits there have been improvements this year but, based on Official Visitors' reports from their February hospital inspections, there are still hospitals not taking this consumer right seriously. Council will conduct an audit again next year. Official Visitors also noted as a result of their monthly inspections, one hospital's ongoing failure to provide consumers with a copy of their form 6 as required by the Act which was brought to the attention of management.
17. **Neglect of dental health, hygiene and physical care treatment**. Although no illustrations are provided in this year's Annual Report, Official Visitors dealt with 123 complaints about physical health issues, a significant increase over the 86 complaints last year. See Appendix 11 in this Annual Report**.**
18. **Ageing of the population of licensed private psychiatric hostels.** This continues to be a concern but not just in the hostel sector. See Issue 3 regarding the lack of accommodation in the community for elderly people with a mental illness.
19. **Seclusion practices.** There has been considerable improvement in seclusion practices, however, Official Visitors dealt with 16 complaints from consumers arising out of seclusion. See also Issue 1, Illustration 2 and Appendix 11 in this Annual Report**.**

2006–2007 ANNUAL REPORT

20. **Inconsistent and inappropriate complaints processes in hospitals.** See Issue 4 in this Annual Report.

2007–2008 ANNUAL REPORT

21. **Long term and inappropriate placements on wards.** See Issue 3 in this Annual Report**.**
22. **Smoking ban.** As mentioned previously, Council has lobbied very hard to allow patients in secure wards to have somewhere where they can smoke. The **"good news"** is that this has now been achieved with a partial exemption to the Smoke Free Policy being provided in secure psychiatric wards.

2008–2009 ANNUAL REPORT

23. **"Bail bond kids" – young people on supervised bail orders and lack of a forensic unit for youth.** Council has not been made aware of any issues relating to bail bond kids this year but is aware of at least one young person aged under 18 years who was cared for in the adult Frankland ward. See Issue 3 in this Annual Report**.** The issue of lack of a forensic unit for youth therefore remains an issue.

2009–2010 ANNUAL REPORT

24. **Doctor and other staff shortages.** While there are no specific illustrations in this year's Annual Report, Council is aware of issues during the year, especially during school holidays. In one case the ward staff instigated an audit of the number of times per week a patient was seen by the consultant. Hospital management also advise that there is often an increase in staff sick leave when ward acuity is high. Official Visitors dealt with 78 complaints related to lack of access to their psychiatrist or medical team compared with 52 complaints last year. See Appendix 11 in this Annual Report**.**

25. **Mandatory sentencing law and need for amendment to exclude people who were mentally unwell at the time.** This law remains unchanged.

2010–2011 ANNUAL REPORT

26. **Imposition of phone, post and visitor restrictions in breach of the Act.** While no specific cases have been illustrated in this Annual Report, the number of complaints by consumers about this issue increased from 22 last year to 48 this year. See Appendix 11 in this Annual Report**.**

2011–2012 ANNUAL REPORT

27. **Locked open wards.** This was raised for the first time in last year's Annual Report. There has been an increase in the practice of closing the doors of the open wards this year due to patient acuity and bed shortages. There are serious concerns that the practice will become widespread such that most mental health wards will be locked. See Issue 3 under the heading *Impact of Hospital and Community Bed Shortages* in this Annual Report.

28. **Lack of procedural fairness for Custody Order patients, a "declared place" and community facilities and accommodation for forensic patients.** The CLMIA Act remains badly in need of reform. See Issue 3 under the headings of *Forensic Services – Access to Care* and *Custody Order Patients and the Need for Review of Legislation* in this Annual Report.

29. **How one patient with complex needs can affect the whole mental health system.** See Issue 3 under the heading Impact of *Hospital and Community Bed Shortages* in this Annual Report.

PART FOUR

Activity measures, budget, strategic plan and other activities

CONSUMER NUMBERS

Annual data collected by Council set out in Appendix 10 show increases in all measures in 2012–2013 (with the previous year's figures in brackets):

- number of consumers assisted by Council: **1,539 (1,438): 7.0% increase**
- number of issues dealt with by Council (formally called requests): **6,099** (**4,686): 30.2% increase**
- number of new consumers (i.e. consumers making their first contact with Council): **598 (580): 3.1% increase**.

Data obtained by Council from the DOH and the MHRB (see Table 2 below) however shows decreases in a number of key measures:

- number of involuntary inpatient orders to detain a person under the Act (as reported by the MHRB): **2,627 (2,626): 0% change**
- number of people put on a form 6 involuntary inpatient order (as reported by the MHRB): **2,088 (2,093): 0.2% decrease**
- CTOs issued (as reported by the MHRB): **826 (844): 2.1% decrease**
- first time on a form 6 i.e. first time made an involuntary inpatient in Western Australia (as reported by the MHRB): **890 (1,069): 16.7% decrease**
- involuntary inpatients (as reported by the DOH): **2,488 (2,426): 2.6% increase**
- mental health inpatients (voluntary and involuntary as reported by the DOH): **17,005 (15,888): 7.0% increase**
- people who contacted public mental health services (as reported by the DOH): **49,001 (50,850): 3.6% decrease**.

TABLE 2: MENTAL HEALTH CONSUMER DATA FROM COUNCIL, DOH AND MHRB

Year	No of people who asked for visits by Council	Involuntary inpatients[32] (DOH data)	Number of people put on a form 6 involuntary inpatient order[33] (MHRB data)	Involuntary inpatient orders (form 6) issued[34] (MHRB data)	No of people put on a form 6 involuntary inpatient order for the first time in WA (MHRB data)	No of CTOs issued[35] (MHRB data)	Mental health inpatients[36] (DOH data)	Mental health patients discharged from general DOH wards[37]	People who contacted public mental health services[38] (DOH data)
2003-2004	744	2,722	2,055	2,664	NA	903	11,441	7,133	35,289
2004-2005	800	2,747	2,117	2,638	NA	970	11,603	7,461	37,979
2005-2006	891	2,442	2,026	2,535	NA	951	11,655	7,728	39,806
2006-2007	979	2,518	1,975	2,513	NA	827	12,100	8,176	40,693
2007-2008	1,052	2,505	2,013	2,486	NA	771	12,189	8,273	40,744
2008-2009	850	2,464	1,898	2,397	NA	843	12,833	8,851	42,940
2009–2010	957	2,551	2,128	2,688	922	907	13,635	9,457	45,002
2010–2011	1,201	2,525	2,142	2,690	930	923	14,723	10,293	48,115
2011–2012	1,438	2,426	2,093	2,626	1,069	844	15,888	11,440	50,850
2012–2013	1,539	2,488	2,088	2,627	890	826	17,005	12,040	49,001

32 Source: Hospital Morbidity Data System, DOH. Data represents the number of people who were involuntary at some point during their admission to public mental health facilities and were discharged during the financial year. These data do not reflect multiple admissions as people who have been discharged more than once during the financial year are counted once. This figure cannot be compared directly with the MHRB data due to different data parameters. Data reported by Council in previous years has been updated by DOH.

33 Source MHRB. Data represents the number of people made involuntary during the financial year (form 6). If multiple involuntary inpatient orders were made during the year, the individual is counted once. This does not include people who are an involuntary inpatient following their CTO being revoked, an involuntary inpatient where the order (form 6) was made prior to 1 July 2011, long term patients on a form 9 or mentally impaired accused persons.

34 Source: MHRB. Data represents the number of involuntary inpatient orders made during the financial year and does not include people who are an involuntary inpatient following their CTO being revoked, an involuntary inpatient where the order (form 6) was made prior to 1 July 2011, long term patients on a form 9 or mentally impaired accused persons. A person may be counted more than once if multiple involuntary orders are made in the same financial year. Data reported by Council in previous years has been updated by MHRB.

35 Source: MHRB. This represents the number of new CTOs and the number of CTOs made on discharge of a detained person.

36 Source: Hospital Morbidity Data System, DOH. Includes all mental health inpatients discharged from any public hospital (authorised and non authorised mental inpatient units and other hospital wards). This data does not reflect multiple discharges as individuals are counted once during the financial year. Data reported by Council in previous years has been updated by DOH.

37 Source: Hospital Morbidity Data System, DOH. Represents people whose primary diagnosis was mental health, and who received treatment during their admission on a mental health ward, but were discharged from a general ward (non psychiatric ward) during 2012–2013. People may have been voluntarily or involuntarily treated as a mental health patient.

38 Source: Mental Health Information System, DOH. Includes all mental health inpatients discharged from any hospital (authorised and non authorised mental inpatient units and other hospital wards) or outpatient facility during the financial year and those who have been assessed by an outpatient facility but not admitted as an outpatient. Caution should be used with these data as it represents the big picture and does not show the distribution by activity, diagnosis and demographics. A mental health inpatient is defined as being someone who has a primary mental health diagnosis or a primary external cause of intentional self-harm or spent any time in a mental health inpatient unit during their episode where days of psychiatric care are recorded or has a legal status recorded. Data reported by Council in previous years has been updated by DOH.

ANALYSIS OF CONSUMER DATA

Numbers of involuntary patients

It is currently impossible to determine how many people were involuntary in WA in one year or at a moment in time. The MHRB data in Table 2 only counts people put on a form 6, which is the first involuntary order, and does not count those patients from previous years whose involuntary status has been extended by a form 9. The DOH data in Table 2 represents the number of mental health patients discharged during the financial year who were involuntary at some point during their admission[39]. This would include people on a form 9 but only if they have been discharged. Given the 37 patients at Graylands Hospital who have been there for over two years, for example, it is reasonable to assume that the DOH figures do not capture these involuntary patients.

Based on the MHRB data, the number of people made involuntary in WA decreased slightly in 2012–2013. The MHRB data in Table 2 shows an increase by one in the number of involuntary orders issued in 2012–2013 when compared to the previous year, but the number of people put on a form 6 (as distinct from the number of orders made) decreased by five. The number of CTOs issued also decreased by 18. The DOH figures, however show a very slight increase, up by 62 from 2,426 to 2,488 (or 2.6%).

Significantly, based on the MHRB figures, there was a substantial decrease in the number of people made involuntary for the first time in Western Australia - down by 179 from 1,069 to 890 (42.6% of all people put on a form 6 whereas last year they comprised 51.1%). Hopefully this is very **"good news"** as it may mean that people experiencing their first episodes of mental illness are getting help in the community earlier – but more analysis is needed. This statistic has only been gathered by the MHRB for the past four years (at Council's request) so there is minimal history with which to compare. It raises issues relevant to the measurement of outcomes by the DOH and MHC.

The MHRB figures recording the number of people put on a form 6, as distinct from the number of orders issued, highlight the number of people who are made involuntary several times in one year (ie the rate of return to hospital). As there were 2,627 form 6 orders recorded by the MHRB for 2,088 people, this means that up to 539 people were put on a form 6 more than once during the year. Possibly some people were put on a form 6 and therefore made involuntary two or three times during the year. In the previous year the figure was 533 and in 2010–2011 there were 548 orders made for people who had already been involuntary during the year. Again these figures have implications for the future management and planning of mental health services and should be looked at with readmission rate data.

The DOH data reported in Table 2 shows a 7% increase in mental health inpatients overall (ie both voluntary and involuntary) but a 3.6% decrease in people who contacted public mental health services overall.

Increases in Council's consumer numbers

As can be seen from Appendix 10, Council's consumer numbers increased by 7.0% last year. This reflects a slowing down of the rate of increase in consumer numbers over previous years but consumer numbers have increased by more than 60% in the past four years and more than doubled since 2003–2004. The number of people in authorised hospitals who are eligible for Council's support has also either decreased or remained static for the past four years depending on whose figures are used, which is likely to impact on the consumer numbers as well the number of people made involuntary for the first time.

39 As at the time of publication the DOH were confirming that their data represents patients who were involuntary inpatients at some point during their admission (as opposed to involuntary on discharge) and were "uncovering a number of issues with how legal status is being recorded by the hospitals...".

Consumer numbers are based on those people who have telephoned Council requesting a visit or approached an Official Visitor on a ward or at a hostel for help. Official Visitors talk to many other patients while on the wards and residents while inspecting the hostels, but these are the consumers who request specific help or support.

On the basis that there were between 2,088 and 2,488 people made involuntary in 2012–2013[40], and excluding the number of consumers on a CTO who were assisted by Official Visitors (77) and hostel residents (180), the percentage of involuntary inpatients seeking assistance for specific issues from Official Visitors was between 50.7% and 60.4%. This is a slight increase on last year (49.8% to 57.7%)

The number of consumers in hostels seeking assistance this year increased significantly again (up from 139 to 180) and has almost doubled over the past two years. The increase will reflect in part increased numbers of consumers living in supported accommodation but also efforts by Official Visitors to increase their accessibility to, and trust by, hostel residents. Working closely with hostel staff through the bimonthly inspection visits has probably also had an impact.

The number of clinic patients assisted by Council increased only slightly, up from 74 to 77. Council finds it very difficult to make itself more accessible to assist CTO consumers. A new website, posters and brochures would assist, but these have been put on hold due to financial constraints and pending the changes proposed by the Mental Health Bill.

The number of consumers who contacted Council for the first time ("new consumers") increased by 3.1% to 598, or 39% of Council's consumers overall. This means that 61% of consumers have used Council more than once and are "repeat consumers", presumably reflecting high satisfaction levels.

Source of consumer requests for Council assistance

As can be seen in Appendices 8 and 9, the bulk of consumer requests for assistance come from hospital patients (1,261) followed by hostel residents (180) and then people on a CTO (77).

Graylands Hospital was the single biggest source of hospital consumers (454). This is not surprising given that it has the largest number of beds and involuntary patients as well as a significant number of long-stay consumers. The Swan Valley Centre, Mills Street Centre in Bentley and Alma Street Centre in Fremantle are the next three biggest sources of consumer requests for Official Visitor assistance. This is also to be expected as, after Graylands, the Mills Street Centre and Alma Street Centre had, respectively, the second and third biggest number of beds and involuntary patients. Swan Valley Centre had the fourth biggest number of involuntary patients[41].

ANALYSIS OF ISSUES AND REQUESTS

The data provided in Appendix 11 is derived from individual consumer reports prepared by Official Visitors. It categorises the nature of consumer complaints or issues raised, comparing the issues noted this year with last year, as well as recording Official Visitor activity (such as attending MHRB and SAT hearings).

40 See Table 3. There is no single figure available as to how many people were made involuntary in WA in 2012–2013. The MHRB figures only count those put on a form 6 and not those who involuntary status is extended by a form 9 (ie long term inpatients). DOH figures include people who are awaiting assessment by a psychiatrist (a form 1 or form 4). People on a CTO form another category.
41 See Appendix 9.

The complaint code software used by Council was not designed specifically for mental health patient complaints nor use by Council. It was adapted manually two years ago with new issue category descriptions in an attempt to better reflect the nature of the complaints usually received by Official Visitors. There were however major limitations on how the new issue categories could be drafted and it remains a very crude tool for analysis.

The significantly increased number of issues recorded by Official Visitors this year compared to last year may also simply reflect increased familiarity with the codes by Official Visitors. It is rare for a consumer to have one single and simple complaint or issue to raise with an Official Visitor and it may be that not all issues were recorded in the previous year.

Council is hoping to get a new software system in the coming financial year which will be easier to use, significantly reduce duplication and the amount of data entry required, and provide more useful information.

The 12 most commonly raised issues recorded by Official Visitors were in the following categories (in descending order):

1. Disagreement with involuntary status or diagnosis – raised on 559 occasions – which usually results in the Official Visitor explaining the consumer's rights to them, including their options of seeking an other opinion and requests a MHRB hearing
2. Request for a MHRB hearing – raised on 483 occasions
3. Medication and treatment – raised on 421 occasions
4. Issues with the forms or explanation of rights – raised on 374 occasions
5. Transfer to another ward, hospital or hostel – raised on 248 occasions
6. Ground access or leave – raised on 242 occasions
7. Requests for or delays in providing an other opinion – raised on 205 occasions
8. Discharge plans – raised on 198 occasions
9. Accommodation – raised on 197 occasions
10. Financial Matters – raised on 184 occasions
11. Personal possessions – raised on 159 occasions
12. Social workers, welfare officers or case managers – raised on 151 occasions.

Pleasingly the number of complaints about seclusion remain very low (16) but the number of issues relating to matters of dignity, privacy and staff attitude remains high (102) and issues relating to rough treatment (37) and feeling unsafe (41) are of concern. Serious issues (20) are recorded in accordance with Council's policy as particular procedures must be followed if a consumer or anyone else makes an allegation of, for example, sexual assault.

It should also be noted that many complaints are made by consumers to Official Visitors when they are carrying out inspections of the wards and hostels. These may be referred to in the inspection reports but are not made the subject of an individual consumer contact report and so do not get counted in these figures. For example, complaints about smoking and boredom are made more often than these figures suggest.

BUDGET AND RESOURCING ISSUES

Council was allocated a budget of $1,557,818 for the 2012–2013 year which was a 3.5% increase on the previous year's budget, however this was less than Council's expenditure the previous year (ie expenditure in 2011–2012 was $1,656,440).

Council's expenditure in 2012–2013 was $1,615,057[42], which, although it exceeded the allocated budget (by 4.3% if the full expenditure is used), represented a 1.9% decrease in expenditure on the previous year (again based on the full expenditure). This was despite the increased costs caused by:

- the 7% increase in consumer numbers
- the authorisation of the new Broome mental health unit in November 2012 requiring an extra monthly visit and two new Official Visitors
- the opening of a four bed secure older adult ward at Rockingham Hospital in February.

The financial impact of the overall increase in the number of facilities and increase in number of consumers assisted with complaints was mitigated by a restructure of Council's operations in the metropolitan area. Official Visitors were divided into two groups which visited facilities north and south of the river. From August 2012 Official Visitors in the metropolitan area were grouped into four teams which resulted in a significant reduction in travel costs. Payment for mileage reduced by 16.3% and also saved some individual Official Visitors considerable time travelling (they are not paid for their time to travel to and from facilities, but are paid for their travelling time between facilities). The impact of the restructure is not easy to measure in terms of sitting fees paid to Official Visitors, however, some savings have been achieved as fewer Official Visitors are visiting each facility providing improved economies of scale. Council is evaluating the impact of the restructure in terms of consumer accessibility to Official Visitors (as required by s188(d) of the Act) at its November 2013 Full Council meeting.

Payments to Official Visitors accounted for 67.3% of expenditure with administration expenses accounting for the remaining 32.7% of expenditure. Expenditure on administration costs has significantly reduced over the past two years reducing from 36.4% of total expenditure in 2011–2012 and from 39% of total expenditure in 2010–2011. Various other belt tightening measures have been made and Council continues to review practices in order to achieve improved efficiencies and ensure funds are focused on direct service delivery to consumers.

Remuneration of Official Visitors

Official Visitors are entitled to remuneration as determined by the Minister for Mental Health (s180 of the Act). Remuneration rates were last increased from 13 February 2011. The previous increase was in October 2006.

Official Visitors are paid on a sessional (half day/full day) basis. The method of payment does not reflect the way Official Visitors work nor the hours worked and Executive Group members cannot be paid for additional work they undertake to fulfill the role or a higher rate, despite taking on increased responsibility. There is an increasing amount of report writing, email correspondence, phone calls following up on consumer complaints and requests, reading, research and record keeping, all of which is done from their own home, using their own computers and telephones. They are not paid for travel time (except when travelling between facilities), and many do not claim the costs of phone calls, parking fees or for things like printing off documents from their home computers.

42 This slightly underestimates Council's expenditure by approximately $10,000 as some costs incurred by Council were paid by the MHC (ie printing of the Annual Report and some Official Visitors' sitting fees).

Administrative support

As already noted, Council's workload has expanded significantly over the past four years in particular as measured by both consumer numbers and facilities to be inspected. Council's administration has been struggling to cope for some time. During 2011–2012 Council was provided with a temporary increase of 0.2FTE for data entry, however, this was not initially continued when Council moved to the MHC and reports were not being entered into Council's database which impacted on the effective deployment of Official Visitors.

Council has also been seeking a new database for many years as the 1999 purpose built database no longer meets its operational needs. A new database could significantly reduce the data entry currently required which is taking up a lot of Council's administrative resources. The MHC has gone to tender for the development of a new database for both Council and the MHRB.

Electoral Act requirements

As required under the *Electoral Act 1907* s175ZE(1), during 2012–2013 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

e) media advertising organisations: $4,498.

STRATEGIC PLAN 2011–2013

Council's strategic plan aims to focus Council's attention on issues of concern to Official Visitors within the parameters of their legislative functions. This was the second year of a two year plan. A copy of the plan is provided in Appendix 12. The goals reflect the six issues of greatest concern to Official Visitors:

1. to improve the MHRB process for consumers
2. to improve the standards, safety and suitability of licensed psychiatric hostels
3. to improve the quality of life and care on authorised hospital wards and in hostels in accordance with consumers having the best care and treatment with the least interference with their rights and dignity
4. to monitor, improve and raise the emphasis on consumers' right to receive the best case and treatment with the least restriction of their freedom
5. to improve Council's processes and procedures
6. to advocate for, and on behalf of, consumers in order to preserve, protect and improve their human rights in any relevant proposed legislative or other change.

The Strategic Plan is complemented by a one year operational plan. The goals have not changed significantly over the past few years and a new interim two year plan, pending the introduction of a new Mental Health Act, has been agreed to by Council for 2013-2014 in very similar terms.

OTHER ACTIVITIES

Liaison with services and other agencies

Regular scheduled meetings are held by the Head of Council with the Minister for Mental Health, the Chief Psychiatrist, the Mental Health Commissioner and various MHC staff, the President of the MHRB, the Executive Directors of the North and South Metropolitan Mental Health Services and the Child and Adolescent Mental Health Service, the clinical and nursing directors of metropolitan authorised hospitals and the manager and staff of LARU.

Other meetings attended by Head of Council during the year were with agencies and people including the MHRB, the MHLC, Consumers of Mental Health WA, the Office of the Public Trustee, HADSCO, the Office of the Public Advocate, the MIARB, the WA Association of Mental Health, Albany Mental Health Service, the South Metropolitan Area Health Service's office of Safety Quality and Risk, various hostel licensees, the Chair of the Mental Health Advisory Council, the Public Sector Commissioner, members of the WA Police Department and the newly appointed NSW Mental Health Commissioner.

At these meetings, Head of Council gathers and shares information and raises issues of concern and/or advocates for specific change both on behalf of individual consumers and at a systemic level.

Consultation processes/requests

Head of Council provided submissions on:

- the "Green" Mental Health Bill 2012
- the Declared Places legislation

and took part in two consultations for which the papers have now been published as follows:

- Barnett J, Dussuyer I, Harrison L, Kessel R and Naylor B*: The Role of Civil Society in Monitoring and Overseeing Closed Environments",* Working Paper No 2, August 2013 Monash University Law Faculty
- Laing J and Murray R, *"A Comparative Review of International Mental Health Monitoring Mechanisms – Final Report to the CQC: Part 1 Evaluation*", 21 December 2012, Human Rights Implementation Centre/Law School.

There were also ongoing meetings with MHC consultants Helen Lynes and Gregor Henderson and in May 2013 Head of Council was invited as a member of the Mental Health Advocacy Service Interim Technical Working Group which will work on the transition of Council to the new advocacy service which is proposed under the Mental Health Bill.

In addition:

- three Official Visitors met with staff of the Office of the Auditor General which was undertaking a performance audit focusing on the administration of trust accounts by the Public trustee
- two Official Visitors took part in workshops on branding mental health information held by the MHC
- one Official Visitor took part in a session on "signs of safety" run by the Department for Child Protection which followed on from work done by the Official Visitor with a young pregnant consumer
- Head of Council met with consultants engaged to draft the forms for the new Mental Health Act
- Head of Council took part as a panel member in two training forums organised by the MHRB.

Presentations on Council's role and consumer rights

Head of Council and various Official Visitors gave presentations on the role of Council and consumer rights under the Act during the year including the following:

- Head of Council took part in two radio interviews, one on a program called "*EthnicAbility*", a half-hour radio program on "*disability, ethnicity and everything in between*" presented by the Ethnic Disability Advocacy Centre (EDAC) on radio 6EBA FM and one on local Broome Aboriginal radio (Goolarri Radio) with Council's two Broome Official Visitors.
- Head of Council also gave a number of presentations during the year including one hosted by EDAC, to MHC staff on their Information Day, to a group of Child and Adolescent Mental Health Services psychiatrists new to WA, to mental health medical staff at Joondalup Hospital, at a "round table" on the Green Bill at Parliament hosted by Hon Alison Xamon MLC and to the Mental Health Advisory Council.

Official Visitors also gave a number of presentations to, or took part in events held by, the following groups:

- Aboriginal Visitors Scheme
- Graylands Hospital "Academic Hour"
- Swan Valley Centre Mental Health Week morning tea
- a joint meeting of the Broome Mental Health Inter Agency Group, Kimberley Interpreting Service and Kullari Carers' Support Group.

An Official Visitor also took part in a stakeholders' morning tea in relation to culturally and linguistically diverse issues organised by a member of the Mental Health Advisory Council.

Council also offered presentations to hostel licensees on the role of Official Visitors for residents and/or staff, and a number of presentations were given.

Official Visitor training

Training is provided to Official Visitors twice a year on the day before the two FCMs so that regional Official Visitors can also attend. In addition Council has begun inviting occasional speakers to team meetings with regional Official Visitors taking part by video link.

The November 2012 FCM training included:

- a presentation by the Department of Child Protection, Learning and Development Centre on understanding the process and advocating for parents and children
- a presentation by the MHC on the "*National Standards for Mental Health Services*"
- In house training on administrative procedures and report writing
- an advocacy discussion panel led by representatives from EDAC, People with Disabilities, Health Consumers Council and Advocare
- a presentation and discussion on Care and Discharge Plans for acute and rehabilitation patients by Drs Shymko and Tait.

The May 2013 FCM training included:

- in house training on non-instructed advocacy presented by the Head of Council
- a presentation by members and staff from the Consumers of Mental Health WA (Inc)
- a presentation by the Western Australian Association for Mental Health (WAAMH) about the role and activities of WAAMH
- a workshop on "Managing Difficult Conversations" by Oars Across the Waters.

Other training provided during the year included:

- July 2012 - a presentation by staff from the Office of the Public Trustee
- August 2012 – HADSCO provided information about the service including how they would deal with the types of complaints typically made to Official Visitors
- September 2012 – the Chief Psychiatrist, Rowan Davidson provided a presentation on seclusion
- February 2013 – a social worker and welfare officer from Rockingham Hospital provided information on their roles
- March 2013 – a presentation on "*Persuasive Presentation at MHRB Hearings*" by a Community Member of the MHRB
- training on the "*Implementation Guidelines for Non-Government Community Services*" which are underpinned by the "*National Standards for Mental Health Services*" (ie standards for hostels). The training was provided by WAAMH who have run this course for service providers, courtesy of extra funding from the MHC
- attendance by some Official Visitors and Council office staff at various seminars and workshops including the following:
  - a DSC workshop to support advocates to engage with people with disability who have communication difficulties
  - a workshop on "Managing conflict in the workplace" by Richmond Fellowship
  - Community Rehabilitation and Recovery Forum on "Facilitating Recovery Through ICLS" by the Psychosocial Rehabilitation and Recovery Association of WA
  - Seminars on "Child-friendly complaints systems" run by the Commissioner for Children and Young People.

A three day training program was conducted for newly appointed Official Visitors in November 2012. The training includes all aspects of the Act, Council's position statements and policies, and procedures. Guest speakers including a psychiatrist and people with a lived experience assist with the training. The new Official Visitors are also allocated mentors and spend time visiting facilities with their mentors before visiting alone.

RECORDS MANAGEMENT

In accordance with the *State Records Act 2000*, s19, the Council has a record keeping plan governing the management of all its records. Refer to Appendix 5 for the statement of compliance with s19 of the Act and State Records Commission, Standard 2, Principle 6.

QUALITY ASSURANCE

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

Code of Conduct and Conflict of Interest Policy

The Council has a Code of Conduct and Conflict of Interest Policy that bind all its members. Copies of the Code and Policy are available from the Council's office or on the website (under "Other Publications"). Official Visitors are also required to declare any disqualifying interests (see s178 and Schedule 3 of the Act) for 2012–2013. No disqualifying interests were identified.

Complaints regarding Official Visitors and Council operations

There were eight complaints received during the year and one complaint carried over from the previous year. Although Council has a Complaints Policy and an official complaints form which can be used (a copy of which can be found on the website under "Other Publications") most of the complaints were not made formally. Three complaints were by consumers:

- One consumer complained that their Official Visitor had not visited or contacted them in a timely manner. It was found that the Official Visitor had not responded within the terms of Council's policy and the issue was raised with him and an apology given to the consumer.
- The second complaint was that their Official Visitor was only telephoning them and not visiting them. Council records showed otherwise but the issue was resolved by a change of Official Visitor.
- The third consumer complaint was that the Official Visitor had failed to ensure that her application to the MHRB had been sent in a timely manner. The Official Visitor had asked ward staff to send the application and had tried to call the MHRB to follow the application up but it had not been received by the MHRB. On investigation it was realised that the Official Visitor had been using an old MHRB brochure and had given the wrong fax number to the ward staff and had been calling the wrong phone number. Head of Council spoke to the consumer and special arrangements were made with the MHRB to get an urgent hearing. The Official Visitor continued to work effectively with the consumer.

The other five complaints were all by mental health services or hostel licensees. Four of these complaints have either been withdrawn or resolved through meetings and correspondence with Head of Council. In the case of one complaint by a hostel licensee, more information was sought but there has been no response to that request.

APPENDIX 1: Authorised Hospitals

Hospital name, mental health ward and address	No of beds authorised[43]
Albany Regional Hospital, Albany Mental Health Unit Hardie Road, Albany	**9**[44]
Child and Adolescent Health Service, Bentley Adolescent Unit Mills Street, Bentley	**12**
Bunbury Regional Hospital **Acute Psychiatric Unit (APU) and Psychiatric Intensive Care Unit (PICU)** Bussell Highway, Bunbury	**27**
Bentley Hospital and Health Service, Mills Street Centre Mills Street, Bentley	**76**
Broome Health Campus, Mabu Liyan Unit Robinson Street, Broome	**13**[45]
Fremantle Hospital and Health Service, Alma Street Centre Alma St, Fremantle	**64**
Frankland Centre, State Forensic Mental Health Services Brockway Road, Mount Claremont	**38**[46]
Graylands Hospital, Adult Mental Health Services Brockway Road, Mount Claremont	**172**[47]
Joondalup Health Campus, Joondalup Mental Health Unit Shenton Ave, Joondalup	**47**[48]
Kalgoorlie Regional Hospital, Mental Health Inpatient Service Piccadilly Street, Kalgoorlie	**7**
King Edward Memorial Hospital, Mother and Baby Unit Loretto Street, Subiaco	**8**
Leschen Unit, Armadale Health Service Albany Highway, Armadale	**41**
Mercy Hospital, Ursula Frayne Unit Thirlmere Road, Mount Lawley	**12**
Rockingham Hospital, Mimidi Park Elanora Drive, Rockingham	**30**[49]
Selby Older Adult Mental Health Service Lemnos Street, Shenton Park	**32**[50]
Swan Health Service, Swan Valley Centre and Boronia Inpatient Unit Eveline Road, Middle Swan	**41**
TOTAL BED NUMBERS	**629**

43 Not all beds were necessarily open.
44 Albany Hospital mental health "G Ward" was closed on 1 May 2013 following the redevelopment of the hospital. Although the new mental health ward was open, it had not been authorised as at 30 June 2013.
45 The unit was authorised on 30 November 2012 and the number of beds increased from 10 to 14 beds on 7 May 2013.
46 Includes 8 beds on Plaistowe Ward that are funded by the Frankland Centre.
47 The number of beds at Graylands Hospital reduced as a result of the opening of Mabu Liyan Unit at Broome. Two beds were closed on Dorrington Ward, one bed was closed on Smith Ward, and one bed was closed on Montgomery Ward on 31 July 2012. A further 2 beds were scheduled to be closed in October 2012, however this did not occur. The bed numbers include 8 beds at Red Wing, Selby Older Adult Mental Health Service.
48 The number of beds on the open ward was increased by 5 beds from 16 August 2012 to 30 June 2013.
49 The 4 bed secure older adult ward was opened in February 2013.
50 One bed was closed as at 30 June 2013 as there was a single bed in a double room.

APPENDIX 2: Psychiatric Hostels Visited by Council[51]

Licensee, hostel name, and address	Bed Nos
Albany CSRU Albany Halfway House Association Inc. (licensee) Ballard Heights, Spencer Park, Albany	**11**
Burswood Care Burswood Care Pty Ltd atf Roshana Family Trust (licensee) 16 Duncan Street, Burswood	**31**
Casson Homes Inc. (licensee)	
Aitken House 55 View St, North Perth	**4**
Casson House 2-10 Woodville Street, North Perth	**92**
Woodville House 425 Clayton Road, Helena Valley	**25**
Devenish Lodge AJH Nominees Pty Ltd (licensee) 54 Devenish St, East Victoria Park	**41**
Franciscan House Meski International Pty Ltd (licensee) 16 Hampton Road, Victoria Park	**75**
Ngatti, Fremantle Supported Accommodation for Homeless Youth Life Without Barriers (licensee) 5-9 Alma St, Fremantle	**16**
Ngurra Nganhungu Barndiyigu Fusion Australia Ltd (licensee) 30 Onslow St, Geraldton	**14**
Pu-Fam Pty Ltd (licensee)	
St. Jude's Hostel 30-34 Swan St, Guildford	**52**
East St Lodge 53A and 53B East St, Guildford	**10**
Romily House Judith Balfe (licensee) 19 Shenton Road, Claremont	**70**
Rosedale Lodge David Wortley (licensee) 22 East St, Guildford	**0**[52]

51 Psychiatric hostels include group homes, CSRUs, and Community Options homes.

52 The number of beds was reduced from 27 to 20 by 19 September 2012, then to 15 beds by 3 October, 10 beds by 10 October, 5 beds by 31 October and was closed on 7 November 2012. Note the number of beds was originally 32 and was reduced to 27 on 31 March 2012.

Richmond Fellowship (licensee)

Anzac Tce Service 175 Anzac Tce, Bassendean	**3**
East Fremantle Service 56 Glyde Street and 58 Glyde Street	**8**
Bunbury CSRU 12 Jury Bend, Carey Park	**15**
Busselton CSRU Powell Court, Busselton	**10**
Hilton Service Units 1 and 2, 35 Oldham Crescent, Hilton	**6**
Kelmscott Community Options 25 Hicks Road, Kelmscott	**8**
Mann Way 4-6 Mann Way, Bassendean	**12**
Ngulla Mia 96 Moore St, East Perth	**34**
Queens Park Service 21-23 Walton Street, Queens Park	**10**
Westminster Service 32A and 32B Ullswater Place, Westminster	**5**

Roshana Pty Ltd (licensee)

BP Luxury Care 22 The Crescent, Maddington	**44**
Honey Brook Lodge 42 John St, Midland	**35**

Salisbury Home Legal Accounting and Medical Syndicate Pty Ltd and Calder Properties Pty Ltd (licensee) 19-21 James Street, Guildford	**35**

Southern Cross Care (WA) Inc. (licensee)

Bentley House 1182 Albany Highway, Bentley	**7**
Mount Claremont House 60 Mooro Drive, Claremont	**7**
Stirling House 4 and 6 Limosa Close, Stirling	**8**

St Bartholomew's House Inc. (licensee)	
Arnott Villas 20 Arnott Court, Kelmscott	**22**
Bentley Villas 1 Channon St, Bentley	**25**
Sunflower Villas 15 Limosa Close, Stirling	**25**
Swan Villas 91 Patterson Drive, Middle Swan	**25**
St Vincent de Paul Society (WA) Inc. (licensee)	
Vincentcare Bayswater House 65 Whatley Crescent, Bayswater	**6**
Vincentcare Coolbellup House 66 Waverly Road, Coolbellup	**4**
Vincentcare Duncraig House 270 Warwick Road, Duncraig	**4**
Vincentcare South Lakes House 9 Plumridge Way, South Lake	**3**
Vincentcare Swan View House 8 Wilgee Gardens, Swan View	**4**
VincentcareVincentian Village 2 Bayley St,m Woodbridge	**28**
Vincentcare Warwick House 39 Glenmere Road, Warwick	4
TOTAL BED NUMBERS	**838**

APPENDIX 3: Council of Official Visitors' Membership

Head of Council	Commencement	Expiry of Term
Debora Colvin	1 February 2007	31 March 2014 *(HOC from 1 April 2008)*
Official Visitors		
Sherril Ball	2002	7 April 2015 *(extended leave since January 2013)*
Denise Bayliss	7 March 2006	7 April 2015
Helen Bresloff-Barry	2 February 2010	7 April 2015
Adrienne Byrne	16 October 2012	7 April 2015
Donald Cook	2 February 2010	7 April 2015
Cecily Cropley	16 October 2012	7 April 2015
Alessandra D'Amico	1 February 2007	7 April 2015
Richard Desouza	2 February 2010	1 February 2013
Michael Dixon	18 January 2008	7 April 2015
Gerard Doyle	18 January 2008	7 April 2015
Mardi Edwards	16 April 2012	6 April 2014
Brian Evans	5 December 2011	6 April 2014
Margaret Fleay	2 May 2011	6 April 2014
Rodney Hay	1 February 2007	7 April 2015
Barbara Hewitt	5 December 2011	6 April 2014
Naka Ikeda	7 March 2006	7 April 2015
Norma Josephs	2 May 2011	6 April 2014
Kelly-Ann Letchford	2 February 2010	1 February 2013
Kerry Long	23 March 2005	7 April 2015
Ann McFadyen	7 April 2002	7 April 2015
Edana McGrath	22 July 1999	8 April 2013 *(resigned effective 31 July 2012)*
Melinda Manners	1 April 2007	7 April 2015 *(extended leave since August 2011)*
Gary Marsh	23 February 2010	7 April 2015
Bruce Morrison	2 February 2010	7 April 2015
Kate Nihill	16 October 2012	7 April 2015
Mary O'Reeri	27 February 2012	6 April 2014 *(resigned effective 6 February 2013)*
Graham Pyke	3 December 2009	7 April 2015
Sheila Rajan	7 April 2009	7 April 2015
Patricia Ryans-Taylor	3 December 2009	7 April 2015
Margaret Robinson	2 May 2011	6 April 2014
Kathleen Simpson	27 February 2012	6 April 2014
Jeff Solliss	7 April 2009	7 April 2015
Kelly Spouse	1 August 2009	7 April 2015
Helen Taplin	7 March 2006	7 April 2015
Catriona Were-Spice	14 August 2000	8 April 2013
Sally Wheeler	16 October 2012	7 April 2015
Suzanne Williams	5 December 2011	6 April 2014
Ian Wilson	2 May 2011	6 April 2014

APPENDIX 4: Official Visitors' Attendance at Meetings

	FULL COUNCIL MEETINGS		EXECUTIVE GROUP MEETINGS			
Official Visitor	Nov 2012	May 2013	Aug 2012	Oct 2012	Jan 2013	Mar 2013
Debora Colvin (Head of Council)	✔	✔	✔	✔	✔	✔
Sherril Ball	✔	Leave	✔	Apology	-	-
Denise Bayliss	✔	✔	✔	✔	✔	✔
Helen Bresloff-Barry	✔	✔	-	-	-	-
Adrienne Byrne	Apology	✔	-	-	-	-
Cecily Cropley	✔	✔	-	-	-	-
Don Cook	✔	✔	-	-	-	-
Alessandra D'Amico	✔	✔	-	-	✔	✔
Richard Desouza	✔	N/A	-	-	-	-
Mike Dixon	✔	✔	-	-	-	-
Gerry Doyle	✔	✔	Apology	Apology	-	-
Mardi Edwards	✔	✔	-	-	✔	-
Brian Evans	✔	✔	-	-	-	-
Margaret Fleay	✔	✔	✔P	✔P	✔	✔
Rodney Hay	✔	✔	-	-	-	-
Barbara Hewitt	✔	✔	-	-	-	-
Naka Ikeda	✔	✔	-	-	-	-
Norma Josephs	✔	✔	Apology	✔	-	-
Kelly-Ann Letchford	Leave	N/A	-	-	-	-
Kerry Long	✔	✔	-	-	-	-
Ann McFadyen	✔	✔	-	-	-	-
Melinda Manners	Leave	Leave	-	-	-	-
Gary Marsh	✔	✔	✔	✔	✔	✔
Bruce Morrison	✔	✔	✔	✔	-	-
Kate Nihill	✔	✔	-	-	-	
Mary O'Reeri	Apology	N/A	-	-	-	-
Graham Pyke	✔	✔	✔	✔	✔	✔
Sheila Rajan	✔	✔	-	-	-	-
Margaret Robinson	✔	✔	✔	Apology	Apology	✔
Patricia Ryans-Taylor	✔	Apology	-	-	-	-
Kathleen Simpson	✔	✔	-	-	-	✔
Jeff Solliss	✔	✔	-	-	-	-
Kelly Spouse	✔	✔	-	-	-	
Helen Taplin	✔	✔	✔	✔	Apology	✔
Sally Wheeler	✔	✔	-	-	-	-
Catriona Were-Spice	Leave	N/A	-	-	-	-
Ian Wilson	✔	✔	-	-	-	-
Suzie Williams	✔	Apology	-	✔P	✔	Apology
Donna Haney (Manager)	✔	✔	✔	✔	✔	✔
Michelle Galvez (Minute Taker)	✔	✔	✔	✔	-	✔

✔ attended n/a not appointed – not required to attend Leave (extended leave) ✔p proxiy

APPENDIX 5: State Records Commission Compliance Requirements

Section 19 of the *State Records Act 2000* requires all agencies to have an approved Record Keeping Plan that must be complied with by the organisation and its officers. The Council has a Record Keeping Plan which was established in 2004.

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

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

   An evaluation of the record keeping plan was completed in 2011–2012.

2. The organisation conducts a recordkeeping training program.

   Training regarding record keeping practices is provided for new employees as part of the induction program. An online record keeping awareness training program is also completed by employees.

   Official Visitors' Operations Manual covers record keeping requirements and this is reviewed annually and training is provided on an ongoing basis.

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

   The training program is reviewed annually to ensure its adequacy.

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

   The Code of Conduct Policy includes the roles and responsibilities of employees and Official Visitors regarding laws and policies. Official Visitors' induction training includes their record keeping responsibilities.

APPENDIX 6: Authorised Hospital Inspections

AUTHORISED HOSPITAL	TOTAL NUMBER INSPECTIONS (INFORMAL INSPECTIONS)	TIME OF INSPECTION		
		Weekdays 9am – 5pm	Weekdays 5pm – 9am	Weekends and Public Holidays
Albany Mental Health Unit	10 (18)	9(12)	(2)	1(4)
Alma Street Centre, Fremantle	48	42	4	2
Bentley Adolescent Unit	12(18)	9(15)	(2)	3(1)
Bunbury APU and PICU	23(16)	19(16)	2	2
Frankland Centre	12	10	1	1
Graylands Hospital	108	90	9	9
Joondalup Mental Health Unit	12	10	1	1
Kalgoorlie Mental Health Inpatient Service	12(17)	11(15)	1(1)	(1)
Leschen Unit, Armadale	48	40	4	4
Mabu Liyan Unit, Broome Hospital	7(12)	6(11)	1	(1)
Mills Street Centre, Bentley	48(12)	36(11)	4(1)	8
Mimidi Park, Rockingham	40(1)	36(1)		4
Mother and Baby Unit, KEMH	12	10	1	1
Selby Lodge	12	11		1
Swan Valley Centre and Boronia Unit, Swan District Hospital	24	20	2	2
Ursula Frayne Unit, Mercy Hospital	12	9	1	2
TOTAL	**440(94)**	**368(81)**	**31(6)**	**41(7)**

Note – Informal inspections are provided in brackets. Those hospitals with more wards get more visits as not all wards are inspected on the same visit.

APPENDIX 7: Psychiatric Hostel Inspections[53]

Licensed Hostel, Group Home, CSRU and Community Options Homes	Total Number of Inspections	TIME OF INSPECTION		
		Weekdays 9am to 5pm	Weekdays 5pm – 9 am	Weekends and Public Holidays
Albany CSRU	7	6		1
Burswood Care	6(1)	5	1	(1)
Casson Homes – Aitken House	5	4	1	
Casson Homes - Casson House	6	5	1	
Casson Homes - Woodville House	6	4	1	1
Devenish Lodge	6	5	1	
East St Lodge	7	5	1	1
Franciscan House	6	5		1
Ngurra Nganhungu Barndiyigu	6	5	1	
Ngatti Fremantle Supported Accommodation for Youth Homeless	6	5	1	
Richmond Fellowship – East Fremantle Service	6	5	1	
Richmond Fellowship – Anzac Terrace	6	5		1
Richmond Fellowship – Bunbury CSRU	6	6		
Richmond Fellowship – Busselton CSRU	6	5	1	
Richmond Fellowship – Hilton[52]	6	5	1	
Richmond Fellowship – Kelmscott CSRU	6	5	1	
Richmond Fellowship – Mann Way	6	5		1
Richmond Fellowship – Ngulla Mia	6(1)	5(1)		1
Richmond Fellowship – Queens Park	7	6		1
Richmond Fellowship – Westminster	6	5	1	
Romily House	7	7		
Rosedale Lodge[54]	1(5)	1(5)		
Roshana - Honey Brook Lodge	7	6	1	
Roshana - BP Luxury Care	8(3)	7(3)	1	
Salisbury Home	7	5	1	1
Southern Cross – Bentley House	7	5	1	1
Southern Cross – Mt. Claremont	7	6	1	
Southern Cross – Stirling House	6	5	1	
St Bartholomew's – Arnott Villas CSRU	5	4		1
St Bartholomew's – Bentley Villas CSRU	7	6		1
St Bartholomew's – Sunflower Villas	6	5	1	1
St Bartholomew's – Swan Villas	6	4	1	1
St Jude's Hostel	7	5	1	1
Vincentcare – Bayswater House	6	6		
Vincentcare – Coolbellup House	6	5		1
Vincentcare – Duncraig House	7	6	1	
Vincentcare – South Lakes House	6	5	1	
Vincentcare – Swan View House	6	5	1	
Vincentcare – Vincentian Village	7	6	1	
Vincentcare – Warwick House	6	5	1	
TOTAL	**247(10)**	**205(9)**	**27**	**15(1)**

Note – Informal inspections are provided in brackets.

53 Licensed psychiatric hostels includes group homes, CSRUs, and Community Options homes.
54 Hostel closed on 7 November 2012

APPENDIX 8: Total Consumers Contacted By Facility - 2004–2005 to 2011–2012

	NUMBER OF CONSUMERS[55]									No of beds
	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	
Albany Mental Health Unit	12	14	21	8	12	18	22	26	27	9
Alma Street Centre, Fremantle	88	107	95	112	96	95	126	113	98	64
Bentley Adolescent Unit	2	13	8	23	8	26	34	36	33	12
Bunbury APU and PICU	19	26	25	36	56	53	73	89	90	27
Frankland Centre	43	53	63	72	71	58	71	89	92	38
Graylands Hospital	330	299	376	384	279	326	379	424	454	172
Joondalup Mental Health Unit	19	20	35	18	18	50	44	52	50	47
Kalgoorlie Mental Health Inpatient Service	7	9	12	14	6	9	7	21	9	7
Leschen Unit, Armadale	36	45	53	80	66	72	104	88	86	41
Mabu Liyan Unit, Broome Hospital									27	30
Mimidi Park, Rockingham								39	68	30
Mills Street Centre, Bentley	58	117	96	80	57	71	101	111	99	76
Mother and Baby Unit, KEMH	0	0	0	4	5	3	2	3	4	8
Selby Lodge	2	6	3	5	8	6	7	13	7	32
Swan Valley Centre and Boronia, Swan	40	45	45	52	44	53	53	90	107	41
Ursula Frayne Unit, Mercy Hospital	6	4	6	5	4	11	14	13	10	12
Metropolitan clinics	54	58	58	58	42	22	31	54	61	-
Regional clinics	13	10	18	23	10	6	7	20	16	-
Psychiatric hostels	59	58	57	70	61	60	97	139	180	-
Other [56]	12	7	8	8	7	17	29	18	21	-

55 Source: Council's Visitor Tracking System database.
56 Includes consumers who are no longer involuntary but whose complaint arose while they were involuntary, involuntary patients being treated at non authorised mental health wards, by private psychiatrists, or on leave to general hospitals wards.

APPENDIX 9: Number and Percentage of Consumers, Authorised Beds and Number of Involuntary Patients by Facility

AUTHORISED HOSPITAL	NUMBER OF BEDS	% OF TOTAL AUTHORISED BEDS	NUMBER OF INVOLUNTARY INPATIENTS [57]	NUMBER OF COV CONSUMERS[58]	% OF TOTAL COV CONSUMERS
Albany Mental Health Unit	9	1.4%	30	27	2.1%
Alma Street Centre, Fremantle	64	10.2%	201	98	7.8%
Bentley Adolescent Unit	12	1.9%	37	33	2.6%
Bunbury APU and PICU	27	4.3%	128	90	7.1%
Frankland Centre	38	6.0%	Included in Graylands	92	7.3%
Graylands Hospital	172	27.3%	735	454	36.0%
Joondalup Mental Health Unit	47	7.5%	155	50	4.0%
Kalgoorlie Mental Health Inpatient Unit	7	1.1%	40	9	0.7%
Leschen Unit, Armadale	41	6.5%	156	86	6.8%
Mabu Liyan Unit, Broome Hospital	13	2.1%	34	27	2.1%
Mills Street Centre	76	12.1%	214	99	7.9%
Mimidi Park, Rockingham	30	4.8%	120	68	5.4%
Mother and Baby Unit, KEMH	8	1.3%	11	4	0.3%
Selby Lodge	32	5.1%	24	7	0.6%
Swan Valley Centre and Boronia Unit, Swan District Hospital	41	6.5%	189	107	8.5%
Ursula Frayne Unit, Mercy Hospital	12	1.9%	14	10	0.8%
TOTAL	**629**	**100%**	**2,088**	**1,261**	**100%**

57 Source: MHRB. Data represents the number of people who were made involuntary during the financial year and does not include people who are an involuntary inpatient following their CTO being revoked, an involuntary inpatient where the order (form 6) was made prior to 1 July 2012, long term patients on a form 9 or mentally impaired accused persons.

58 Source: Council's Visitor Tracking System database. Does not include residents of hostels and/or those attending clinics on CTOs.

APPENDIX 10: Total Consumers, New Consumers and Issues – 2003-2004 to 2012–2013[59]

FINANCIAL YEAR	NUMBER OF CONSUMERS	NUMBER OF NEW CONSUMERS	NUMBER OF COMPLAINTS
2003–2004	744	412	1,415
2004–2005	800	391	1,600
2005–2006	891	386	1,891
2006–2007	979	440	2,257
2007–2008	1,052	479	2,676
2008–2009	850	365	2,775
2009–2010	957	446	2,864
2010–2011	1,201	532	3,518
2011–2012	1,438	580	4,686
2012–2013	1,539	598	6,099

Note - The "number of complaints" was termed the "number of requests" until 2008-2009.

59 Source: Council's Visitor Tracking System database.

APPENDIX 11: Total Consumer Requests by Complaint

1. Issues requiring consultant or medical team input	2011/12	2012/13
1.1 Forms and explanation of rights. Includes forms not completed properly, time period expired, form not provided to consumer, rights not explained (oral and written – ss.156 to 159). For example "how long do I have to stay here", "they haven't told me why I'm here" and "they didn't explain my CTO".	237	374
1.2 Disagreement with involuntary status or diagnosis. Includes CTO. For example "I want to go home", "there's nothing wrong with me ", "I want to change my doctor".	409	559
1.3 Medication and treatment. Includes ECT.	286	421
1.4 Ground access and leave. For smoking related issues use code 2.1.	167	242
1.5 Transfer to another ward, hospital or clinic. Includes moving to an open ward and wanting/not wanting to transfer to another facility.	177	248
1.6 Access to consultant or medical team. Includes delays, insufficient staff, staff not available, monthly CTO review not done (ss. 164 and 75).	52	78
1.7 Other opinions. Includes requests for opinions, delays, or opinion not provided (ss.76, 111 and 112).	173	205
1.8 Phone, post or visitor rights and restrictions. Includes public phone not working, mobile/ laptop taken by staff, daily review of restrictions not done (inc. ss.166 to 169).	22	48
1.9 Seclusions and restraints. Includes not being given food, drink, or access to toilet, 15 min observations or 2 hourly authorisation by psychiatrist not documented, de-escalation techniques not used and post seclusion interview not completed (inc. ss.116 to 124). For rough treatment use code 9.2.	14	16
2. General issues		
2.1 Smoking.	58	69
2.2 Meetings. Includes facilitating a meeting of family and treating team (with or without Official Visitor attendance).	45	90
2.3 Personal possessions. Includes access to or loss of property and completion of property sheet (inc. s.165).	102	159
2.4 Physical environment. Includes temperature, access to courtyards and internet connection.	55	67
2.5 Food and beverages.	50	53
2.6 Financial matters. Includes costs, access to money and hostel boarding fees. For access to welfare officers use code 3.1 and liaison with the Public Trustee use code 8.1	91	184
2.7 Referral to another agency. Includes MHLC, Health Consumers' Council and Legal Aid.	99	132
2.8 Other hospital or supported accommodation issues.	327	346
2.9 Unable to contact consumer. Includes consumers who are discharged before OV is able to make contact	n/a	52
3. Allied services - access and quality		
3.1 Social workers, welfare officers, or case managers. Includes access, disagreement with decisions, wanting to go shopping and "who's feeding my dog?" For staff attitude issues use 9.4.	101	151
3.2 Occupational Therapy. Includes activities, lack of exercise, no outings and boredom.	30	48
3.3 Psychologist and other counseling services. Includes drug and alcohol support.	14	19
3.4 Other allied services. Includes non-health services such as Centrelink, Tenancy Advice and Silver Chain.	34	42
4. Physical health – access, delays or failure to diagnose		
4.1 Dental.	12	15
4.2 Podiatry.	3	9
4.3 Physiotherapy.	4	7
4.4 Dietician.	2	2
4.5 General Practitioner.	12	16
4.6 Other physical health issues. Includes x-rays, operations and tests.	53	74

5. Plans (care and discharge) and accommodation		
5.1 Care plans. Includes lack of consultation, no plan, plan not reviewed and failure to follow plan.	26	22
5.2 Discharge plans. Includes lack of consultation, no plan, plan not reviewed and failure to follow plan.	133	198
5.3 Accommodation. Includes unable to discharge due to lack of accommodation and wanting to move.	130	197
6. MHRB Hearing		
6.1 Request for a hearing. Includes requests without COV attendance.	503	483
6.2 Preparation for hearing.	334	391
6.3 Attendance at hearing.	223	226
6.4 Cancellation of hearing. If the hearing starts and is adjourned use code 6.6.	128	115
6.5 Medical report. Report not provided 3 days prior to the hearing.	9	21
6.6 Attendance at adjourned hearing.	9	2
6.7 Other MHRB. Any thing else related to the MHRB including 8 week and 6 monthly reviews (ss.138 and 139).	78	149
7. Regional issues – not covered elsewhere		
7.1 Transport. Includes PATS and RFDS.	0	4
7.2 Regional issue. Issue is unique to regional areas. Only use when issue is not identified elsewhere.	4	6
8. Mental Health Act and other legal issues		
8.1 Guardianship and administration. Includes liaison with Public Trustee or Public Advocate.	86	96
8.2 State Administrative Tribunal. Attendance at Guardianship and Administration hearings and MHRB appeals.	30	27
8.3 FOI and s.160 applications.	34	32
8.4 Criminal law and MIAR Board. Includes liaison and submissions and "when is my next court date?"	38	69
8.5 Voting. (ss.201 and 202)	0	4
9. Safety, dignity, privacy, and staff attitudes		
9.1 Safety. Includes feeling unsafe. Use for matters not included in code 10.	31	41
9.2 Rough treatment. Includes rough treatment by patients, residents, staff, police or guards. See also code 10.	31	37
9.3 Conflicts. Includes issues with other residents or patients, family member, and staff.	61	76
9.4 Dignity, privacy, and staff attitude. Includes ignoring consumers, entering rooms without knocking, confidentiality (s.206) and "staff treat me like I'm a child".	101	102
9.5 Cultural awareness. Includes lack of sensitivity, no interpreter and attending church.	9	7
9.6 Inappropriate location. Includes children on adult wards and people with autism or a disability on mental health wards.	7	5
10. Serious Issues		
10.1 Serious issues. Follow COV guidelines in the manual.	10	20
11. Office Use		
11.1 Request for a Visit. Office use only.	n/a	n/a
12. Compliments		
12.1 Compliments to staff and COV.	42	43
TOTAL	**4,686**	**6,099**

Appendix 12: Two Year Strategic Plan 1 July 2011–30 June 2013

Vision/Statement of Purpose:

To protect and promote the rights and quality of life, and advocate for and on behalf, of affected persons (as defined by the Act) who are using mental health services in Western Australia.

GOAL 1 - MHRB
To improve the Mental Health Review Board (MHRB) process for consumers.

Strategies to Achieve Goal

1.1 Continue to lobby for review of the MHRB process and legislative amendments to the Act as per the report and recommendations made by Head Of Council in May 2010.

1.2 Improve the level of representation of consumers at MHRB hearings.

1.3 Improve the standard of representation at MHRB hearings.

1.4 Improve consumers' access to, and the timeliness of, MHRB hearings.

1.5 Promote the right of consumers to natural justice and procedural fairness in hearings and endeavour to improve the observance of that right and in particular their right to:

- be provided with a copy of the medical report a reasonable amount of time in advance of the hearing (Council's position is a minimum of 3 days before)
- be given access to their medical file and any other documents made available to the MHRB as part of its deliberations.

GOAL 2 - SUPPORTED ACCOMMODATION
Broaden the range of supported accommodation options; improve the standards, safety and suitability of, and quality of care in, facilities inspected by Council (i.e. licensed private hostels, CSRU's and Community Options housing).

Strategies to Achieve Goal

2.1 Continue to lobby for a review of the sector.

2.2 Improve standards and the quality of care in facilities.

2.3 Improve Council's access to residents of supported accommodation facilities.

2.4 Encourage engagement with industry, Department of Housing and other stakeholders to explore housing options and opportunities.

GOAL 3 - LIFE AND CARE ON THE WARDS

To improve the quality of life and care on authorised hospital wards in accordance with consumers having the best care and treatment with the least restriction of their freedom and least interference with their rights and dignity (as per s5 Objects of the Act).

Strategies to Achieve Goal

3.1 Improve consumers' lives on the wards by highlighting and attempting to reduce unnecessary restrictions on their freedom and unnecessary interference with their rights and dignity.

3.2 Empower consumers to ensure that they have a say and are listened to regarding their care.

3.3 Improve Official Visitor accessibility to, and advocacy for, the most vulnerable consumers on wards:

- people "stuck on wards"
- the elderly
- children
- regional and remote patients being transferred and treated away from their home and family.
- indigenous and CALD consumers
- women and sexually abused and particularly vulnerable consumers on mixed gender wards
- consumers with an intellectual disability or an ABI.

3.4 Continue to lobby for consumers' rights to a truly independent "other opinion".

GOAL 4 – COUNCIL OPERATIONS

To improve Council's processes and procedures.

Strategies to Achieve Goal

4.1 Improve Council's processes and procedures for the collection and analysis of data, communication and access to information by Official Visitors.

4.2 Improve the quality and satisfaction of Official Visitor work.

4.3 Improve accessibility to Council by consumers, carers and other interested parties.

4.4 Put in place strategies to deal with an expansion of consumer numbers.

GOAL 5 – NEW LEGISLATION

To advocate for, and on behalf of, consumers in order to preserve, protect and improve their human rights in any relevant proposed legislative or other change.

Strategies to Achieve Goal

5.1 Ensure that Council has input to any reviews or draft legislation.

5.2 Continue to raise the need for protection of rights of, and advocacy for, voluntary patients, referred patients and patients on Hospital Orders as recommended by the Holman Review.

GLOSSARY OF ACRONYMNS

Act	Mental Health Act 1996
ABI	Acquired Brain Injury
AHPRA	Australian Health Practitioner Regulation Agency
BAU	Bentley Adolescent Unit
BPSD	Behavioural and Psychological Symptoms of Dementia
CAMHS	Child and Adolescent Mental Health Services
CCC	Corruption and Crime Commission
CNS	Clinical Nurse Specialist – usually the most senior nursing staff member in relation to a ward or wards
CMHS	Community Mental Health Service
CLMIA Act	Criminal Law (Mentally Impaired Accused) Act 1996
Consumer	An "affected person" as defined by s175 of the Act who can be assisted by an Official Visitor; individuals who do not come within this definition are referred to by various titles including patient, referred patient, voluntary patient or resident.
Council	Council of Official Visitors
CSRU	Community Supported Residential Unit
CTO	Community Treatment Order
DCP	Department for Child Protection
DOH	Department of Health
DSC	Disability Services Commission
ED	Emergency Department
EDAC	Ethnic Disability Advisory Council
FAP	Focus Area Person
FCMH	Forensic Community Mental Health
FCM	Full Council Meeting
HADSCO	Health and Disability Services Complaints Office
ICLS	Individualised Community Living Strategy
LARU	Licensing and Accreditation Review Unit
MHC	Mental Health Commission
MHLC	Mental Health Law Centre
MHRB	Mental Health Review Board
MIARB	Mentally Impaired Accused Review Board
NCH	New children's hospital
NMHS MH	North Metropolitan Health Service – Mental Health
NGO	Non-government organisation
OCP	Office of the Chief Psychiatrist
PCAC	Police Complaints Administration Centre
SAT	State Administrative Tribunal
UN Principles	United Nations Principles
WAAMH	Western Australian Association for Mental Health

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