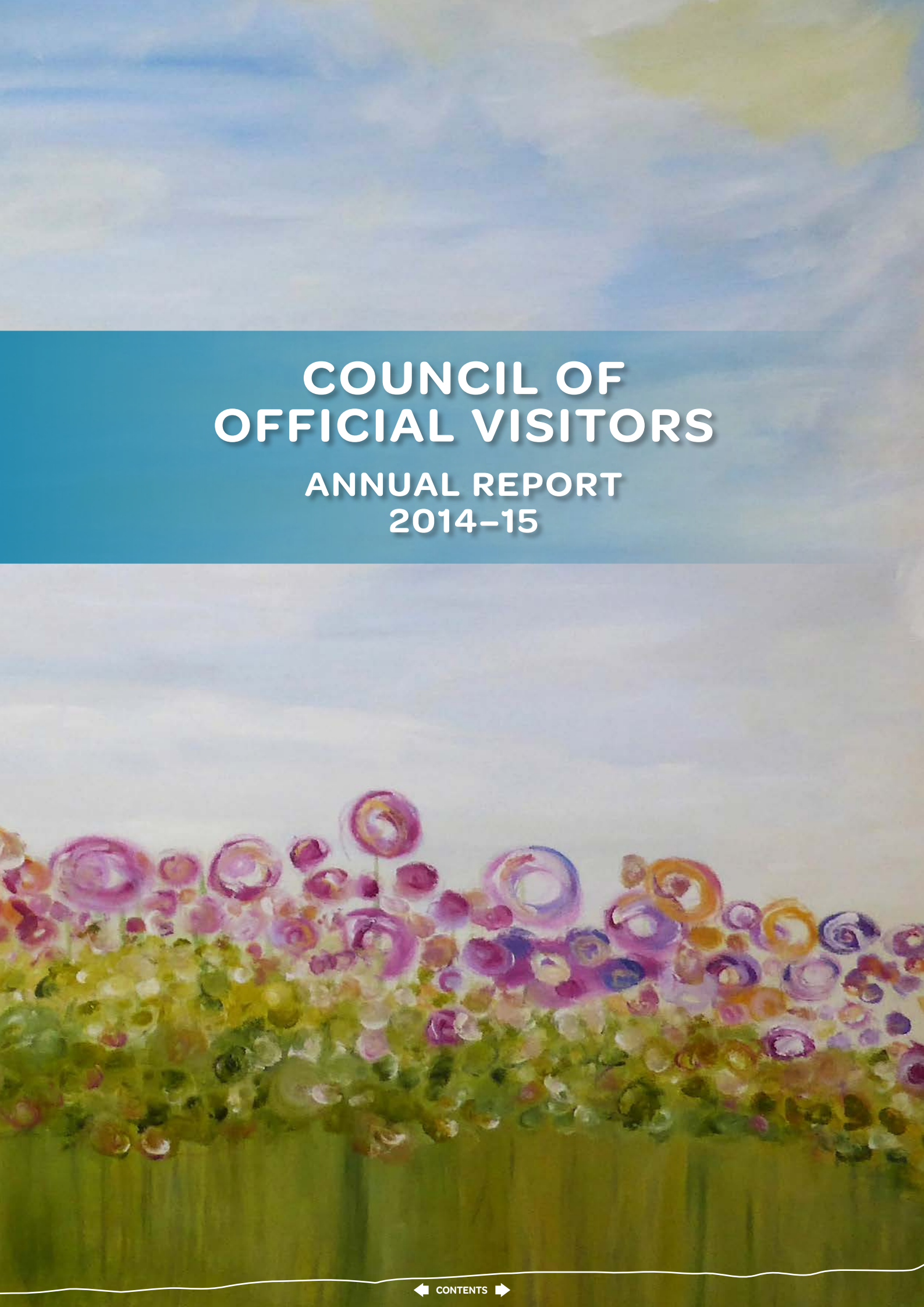

COUNCIL OF OFFICIAL VISITORS

ANNUAL REPORT 2014–15

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 2015.

As well as recording the operations of the Council for the 2014–2015 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

November 2015

Cover Image

The artwork on the front cover and throughout the Annual Report is by Macalister Walton. It is titled “Flourish” and reproduced with the kind permission of the artist.

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INTRODUCTION

In this, the last full year of operation of the Council of Official Visitors (Council), Official Visitors assisted 1,772 consumers. This was an increase of 10.6% over the previous year, and brings the increase in consumer numbers over the past six years to a massive 85.2%.

It has been a very busy year for Council for reasons other than the increased consumer numbers. Official Visitors conducted a number of surveys which are summarised in the report, including on sexual safety, treatment support and discharge plans, and length of stay on wards.

The length of stay report is particularly concerning as the survey found that on 30 June 2015, 11.2% of 578 authorised beds across Western Australia (WA) were occupied by people who had effectively been 'living' in hospital for a year or more. The issue of lack of varied and suitable supported accommodation in the community impacts on everyone: consumers trying to get in and out of mental health services; their carers and family members; mental health services' staff; and, the general public as people end up homeless or in prison. Building a strong network of community services requires action, supported by a firm commitment of funding to keep the current services going while new ones are built up, but it must be done. Everyone in WA will gain in the longer term. See Issue 2, Illustration 2 for a full report.

Council is unable to publish some data again this year due to delays in the implementation of its own as well as the Mental Health Review Board's new database systems. I have also chosen to remove Part 3 of the Annual Report. This sets out a summary of ongoing issues raised in previous annual reports by Council. As I will be providing a final Annual Report for Council after 30 November when the new Mental Health Advocacy Service (MHAS) takes over, I will insert it back into that report as a benchmark for the MHAS Annual Reports going into the future.

The increased call on Council services over the years in part stems from Official Visitors' ability to engage with, and gain the confidence and trust of, people who are involuntarily detained on wards. The independence of the Official Visitors and their approach to advocacy – which is to act according to the person's wishes and be fully person centred and consumer focused – has been integral to this and I thank each and every one of them for their dedication.

When the *Mental Health Act 2014* (2014 Act) becomes operational, the new MHAS which takes over from Council will have to contact 100% of all involuntary inpatients within seven days (and children within 24 hours) as well as people on a Community Treatment Order. There will be challenges in doing this, but as the newly appointed Chief Mental Health Advocate, I am pleased to be able to say that the approach to advocacy by Official Visitors will not be changing. Council's dedication to protecting consumers' rights and ensuring their voice is heard will therefore live on and indeed be expanded under the 2014 Act.

The writing of the Annual Report this year has been a joint effort so I would also like to acknowledge and thank Donna Ayriss, Council's Manager, Denise Bayliss, who was Deputy Head of Council until recently, Norma Josephs who stepped in as Deputy Head of Council after Denise retired, and Michelle Galvez, Council's Program Coordinator.

Debora Colvin

HEAD, COUNCIL OF OFFICIAL VISITORS

November 2015

"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."

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

Pursuant to s186 of the Act, Council must 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 or otherwise within 24 to 48 hours.

The functions of Official Visitors (s188 of the Act) are 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 any one of the following:

- 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 United Nations 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 (WA)
- the *"Licensing Standards for the Arrangements for Management, Staffing and Equipment: Private Psychiatric Hostels"* prepared by the Licensing and Accreditation Regulatory 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 United Nations 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 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 or 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 to 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 or 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, 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 and are partial to the consumer. The Official Visitor will tell the consumer their rights and options as well as consequences of taking particular actions and then will act according to the consumer's wishes. They do not make decisions for the consumer and are not counsellors, though they do need to be good listeners and sometimes act simply as a support person.

Where a consumer is not able to say what they want and the 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.

OPERATIONAL FRAMEWORK - REPORTING LINES

Official Visitors

The Council and its individual members are directly responsible to the Minister for Mental Health (Minister) 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 Annual 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 include the Clinical Director of the hospital or service concerned, the Chief Psychiatrist, the Mental Health Commissioner and, when warranted, the Minister).

Similarly with hostels, 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 with or contacts the Minister, the Mental Health Commissioner, the management teams of each of the authorised hospitals, as well as the Chief Psychiatrist, the Executive Directors of North and South Metropolitan and Country Mental Health Services, the President of the MHRB and various others from the government and non-government sectors involved in the protection of consumer rights and the provision of mental health services in WA. At these meetings, various significant and ongoing issues identified by 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 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 are employed by the Mental Health Commission under s65(2) of the *Public Sector Management Act 1994*.

The Manager (as the Executive Officer) is legislatively responsible for the Council records (ss183 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 2014–2015

A list of individuals who were members of the Council during 2014–2015 and their terms of appointment are contained in Appendix 3. Seventeen Official Visitors were reappointed following the expiry of their terms during 2014–2015 and one Official Visitor, who had previously worked as an Official Visitor, was appointed in the event that Council needs an extra or occasional Official Visitor in the metropolitan area between now and when the 2014 Act is proclaimed and Council is abolished. Two Official Visitors did not seek reappointment at the expiry of their term. As at 30 June 2015 therefore Council had 27 active Official Visitors plus Head of Council (down from 32 at the same time last year) with seven 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 form a panel for the purposes of that part of the Act. The Act is silent on who may be empanelled and the purpose of panels but individuals appointed to be members of a panel generally fall 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 were four panel appointments in 2014–2015:

- Megan Barnett, Disability Justice Service Manager, Disability Services Commission
- Patrick Langford, Manager Information Services, Mental Health Commission
- Marilyn Benn, Accreditation Canada, to accompany OVs on inspections
- Pierre Sauzier, Acting Project Officer, Council of Official Visitors.

COUNCIL MEETINGS

Full Council Meetings

Council usually holds two Full Council Meetings per year, however following the announcement that the 2014 Act was expected to commence on 30 November 2015, it was decided that a second meeting would not be scheduled; therefore only one Full Council Meeting was held in December 2014. This was combined with a training day and metropolitan and regional team 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 Full Council Meetings 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 teams (regional and metropolitan), Head of Council, Deputy Head of Council, and the Manager (non-voting).

During 2014–2015 the Executive Group held meetings in September, March and June. A summary of the Full Council and Executive Group meetings attended by Council members during 2014-2015 is contained in Appendix 4.

Country and Metropolitan Meetings of Council

Official Visitors are allocated to one of 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 Swan to Rockingham) based roughly on north, south, west and east geographical regions of the metropolitan area.

The four metropolitan and four regional teams met on 10 occasions which included one meeting which coincided with the Full Council Meeting. The Official Visitors met both separately in their teams and in combined sessions. The joint meetings were used to discuss issues identified by Official Visitors across the metropolitan or regional areas and for training. Nine of the 10 meetings with Official Visitors in regional areas were conducted by video link.

Access to appropriate care is a fundamental right and remains an ongoing issue in mental health, whether the care is in a hospital or in the community.

PART TWO

Visits, inspections, issues and outcomes in 2014-2015

The issues listed in this Part reflect the work conducted by Official Visitors during the year arising from their advocacy and inspection functions under the Act.

Individual Advocacy – Visits on Request (s186(c) of the Act)

Official Visitors assisted 1,772 consumers in 2014–2015. This was an increase of 10.6% over the previous year and brings the increase in consumer numbers over the past six years to 85.2%. Of the consumers assisted in 2014–2015, there were 1,492 involuntary inpatients, 64 were on a CTO and 202 were hostel residents.

The increased consumer numbers are consistent with the increase in the number of people put on a Form 6 or 9 involuntary order which rose by 3.8% from 2,072 to 2,151 (see Part 4 of this Report). The number of consumers who sought help from Official Visitors for the first time increased by 18% (to 774 consumers).

Council is once again unable to report on the numbers and types of complaints and issues raised by consumers. The existing 16 year old database system requires manual double entry which is extremely costly. In anticipation of a new database (ICMS) being in use from 1 July 2014, a decision was made early in 2014 to stop entering the complaint codes, however, ICMS is still not operational.

Monthly and Bimonthly Inspections (ss186 (a) and (b) of the Act)

In accordance with the Act, Official Visitors continued to inspect hospital wards monthly and psychiatric hostels every second month. The prime purpose of these visits is to ensure safety and suitability of conditions and make Official Visitors accessible to consumers as required by ss188(c) and (d) of the Act.

The inspections utilise questions based on particular 'focus areas' for staff and consumers. The focus areas are based on consumer rights (which include the Act, other legislation and various standards), known or suspected systemic issues, and the goals of Council's Strategic Plan. A list of the focus areas is provided in Appendix 11 and a copy of the Strategic Plan is at Appendix 12.

Letters are sent to the facilities after each inspection outlining any issues, as well as providing any positive feedback. Official Visitors follow up on previous issues raised using action lists. Most hospital facilities and many psychiatric hostel Licensees respond in writing to the inspection letters advising of changes made or giving explanations. This may be followed up by Head of Council in meetings or in further correspondence or inspections.

ISSUE 1 – ENSURING CONSUMERS KNOW THEIR RIGHTS (s188(a) of the Act)

Official Visitors are required to ensure that consumers have been informed of their rights. This is done in part by the monthly and bimonthly inspection process as well as when a consumer requests a visit.

Illustration 1 – Compliance with ss156 and 157 of the Act – Explanation of Rights

In December 2014 Official Visitors conducted inspection visits focusing on rights, which included a random medical file audit (with consumers' permission) and check of the admission packs handed out by hospital staff.

Under s156 of the Act, involuntary patients are to be told their rights orally and in writing. Admission packs are usually used by hospitals to provide the rights in writing. The packs were checked against Regulation 18 of the *Mental Health Regulations 1997* (Regulations). Some hospitals did not have admission packs, making it difficult to determine what written rights information was provided. In some other cases the admission packs did not address all the rights referred to in the Regulations.

Consumers were also asked whether they were told their rights, whether they knew their rights and whether they were given a copy of their Form 6, which is the order making them involuntary and which they must be given pursuant to s159 of the Act. Form 6 not being given to consumers was a major issue at one hospital. In a few other hospitals the problem was that consumers did not recall being given a copy of the Form 6 and the hospitals had no system for recording that it had been given to them.

Consumers commonly told Official Visitors that they did not know their rights or did not have a good understanding of their rights, even when there was documentation to say that their rights had been explained to them and admission packs provided. This reinforces the need to provide rights information throughout a person's stay in hospital as an involuntary patient.

Under s157 of the Act, involuntary patients are to be asked to specify a relative, friend, guardian or other person to whom a copy of the explanation of rights is to be given. While there have been improvements over the past few years, it remains the case that this section of the Act is often not met or at least the files do not record it as having been met. Under the 2014 Act, which is still to be proclaimed, this section has been strengthened.

The medical files were examined using a checklist which looked at the dates and timing on involuntary orders, to what extent rights had been explained to the consumer, and the seclusion and restriction forms. Only one major breach of the Act was detected in which a voluntary patient, who had been made involuntary, was examined for the purposes of the involuntary order by the treating psychiatrist, which was in breach of s30(6).

The outcome of the inspections was that some hospitals reviewed or undertook to review their admission packs and other processes. As one hospital wrote in reply to the inspection letter: "*The issue you identify regarding consumer rights is of concern and has been addressed promptly with staff being reminded of the requirement under the Act and CNS* (Clinical Nurse Specialist) *monitoring daily that this process is occurring and specifically that it is clear in the documentation if the patients were provided a copy of the Form 6.*"

ISSUE 2 – ACCESS TO CARE AND LEAST RESTRICTION OF FREEDOM (s188(b) of the Act)

Access to appropriate care is a fundamental right and remains an ongoing issue in mental health, whether the care is in a hospital or in the community. The main issues during the year were a lack of secure 'beds' in hospitals and in the community, and appropriate staffing. An extra 20 secure beds are expected to become available in the 2015–2016 year with the opening of the new Midland Hospital and Sir Charles Gardiner Hospital Mental Health Units. These extra beds will hopefully alleviate the current situation in Emergency Departments yet people remain on wards with nowhere to go. This creates bottlenecks, which are headaches for hospital administrators, harms the recovery of the people stuck on the wards, and is dangerous for the health of those who cannot be admitted in a timely manner.

Illustration 1 – Hospital Bed Pressures

Hospital bed pressures result in people waiting in Emergency Departments too long. Delays can be traumatising and mean a person can become more unwell, making the eventual admission longer. The bed pressures can also lead to children being admitted to adult wards, or people being discharged too soon to make way for others. 'Code yellows' are called across the state to warn services when the lack of beds reaches a particularly acute stage.

The number of available authorised beds increased by 24 beds from 598[1] beds in 2013–2014 to 622 beds in 2014–2015, with the partial opening of Fiona Stanley Mental Health Unit (20 of the 30 beds were opened by 30 June 2015) and the opening of the remaining four beds at the new Albany Mental Health Unit. However, in 2012–2013 there were 626 beds so this represents only a replacement of the beds lost the year before.

Council is not always made aware of Code Yellows but there were at least two during the year and October is always a difficult time for young people in the lead up to exams. On one day there were seven young people (aged under 18) sitting in Emergency Departments waiting for a bed in the Bentley Adolescent Unit. (This was prior to the opening of the new Youth Ward at Fiona Stanley Hospital which takes young people aged 16–24). As a result two children were held on adult wards at this time. Official Visitors checked on the children to ensure that the Child and Adolescent Mental Health Service (CAMHS) Guidelines for children held on adult wards were being followed including being nursed on a one-on-one "special" at all times. The admissions to adult wards in both cases were very short.

Being stuck in the Emergency Department can be a traumatising and degrading experience. One patient told their Official Visitor that they spent three days in the corridor directly in front of the nursing station where they had no privacy and, when they were assessed and interviewed by psychiatrists and doctors, their responses could be heard by everybody who was in the vicinity. The patient said that they felt "*violated*" by the experience. When they asked to be moved to a private location, they were "*pumped (with medication) to calm me down*". A relative of the patient eventually spoke up on the patient's behalf, but was told it was none of their business. The patient believed this experience had a negative effect on their recovery journey, heaping trauma on a situation that was already fraught.

Council wrote to the hospital concerned on behalf of the patient and asked if Emergency Department staff had been trained in 'trauma informed care'. The Medical Co-Director responded saying that: "*The unavailability of mental health beds results, as in this patient's case, in a prolonged stay in an inappropriate environment which has the potential to be traumatising to some. The Emergency Department staff and mental health staff appreciate the impact that this has on our mental health patients and are equally concerned about the issue. Every effort is made to alleviate the discomfort and distress to the patient. Bed availability however continues to remain an ongoing issue which is state wide.*" The hospital apologised to the patient and their relative and said staff would be reminded of their conduct when dealing with patients and consumers.

1 See Appendix 1 to this Annual Report. 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.

Illustration 2 – Access to Appropriate Accommodation and Care in the Community

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

Across the 15[2] mental health units (comprising 578 authorised beds), there were 65 consumers in hospital for a year or more. This represents 11.2% of the authorised beds in those units across the state that were occupied by people who had effectively been 'living' in hospital for a year or more. This increased to 15.9% of authorised beds being taken up by consumers for six months or longer; and 22.0% of authorised beds being taken up by consumers who had been on the ward for 90 days or longer at the 15 units that participated.

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

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

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

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

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

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

2 Information from two facilities with 39 authorised beds was not available.

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

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

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

Hospital 5: This facility reported 20 consumers who had been admitted for 90 days or longer, four of whom had been admitted for one year or longer. No consumers required accommodation as at 30 June 2015. The facility commented that short-term community supported accommodation and ongoing long-term accommodation were required to discharge long term consumers.

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

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

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

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

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

Illustration 3 – Right to Least Restrictive Care – Consumers Stuck in Forensic Services

As in previous years, Official Visitors supported a number of consumers this year who were being detained in the Frankland Centre, even though they had finished their sentence or the charges had been dropped or found unproven. Frankland is WA's most secure authorised hospital designed for 'forensic' patients, that is, those on remand or in jail. Keeping a consumer in the Frankland Centre in such circumstances is not complying with the Objects of the Act as it does not represent the least restriction of their freedom. It also delays access to care for people in jail.

Applications were made to the MHRB in each case for referral to another authorised hospital ward. In several cases the applications were successful, with orders being made that the patient be moved out of Frankland. However they were not complied with as there was either no bed available in another authorised hospital or the receiving hospital put up other arguments as to why they should not take the consumer. In one case the consumer was moved to another authorised hospital, spent one night there, and was then moved back again in an apparent dispute between the two hospitals. Head of Council also became involved in discussions with the respective heads of service. Eventually the consumers were discharged from Frankland to other hospitals.

Official Visitors also became aware of consumers remanded to the Frankland Centre by the Courts for several weeks who were then made voluntary by the treating psychiatrist but had to stay in Frankland despite the fact that they no longer met the detention criteria under the Act. In such cases the person may be detained on remand elsewhere and are taking up sorely needed beds in the Frankland Centre.

Illustration 4 – Access to Psychiatrists and Medical Staff

A common complaint by consumers is lack of access to their psychiatrist, who is the one person (apart from the MHRB) who can make them voluntary or grant them access off the ward. From the Official Visitors' perspective, this and other types of staff shortages on wards, raise both rights issues and concerns about the safety and suitability of the ward.

Metropolitan wards

In January and February, Council was advised of medical staff shortages in two facilities. In one case the hospital decided to close five beds for a number of days rather than incur the risks inherent in staff shortages.

Of particular concern were ongoing issues at a metropolitan hospital which had featured in last year's Annual Report due to concerns about the lack of psychiatrists and the safety and suitability of the ward[3]. Council had been told that two new psychiatrists would be starting in the second half of 2014, but by September 2015 one had already resigned and the other doctor would not in fact be registered as a psychiatrist until January 2015 (which eventually took until April 2015), leaving (once again) only one psychiatrist instead of three for 30 patients.

We asked what the contingency plan was. The answer came back that it had been '*problematic*' to maintain the full complement of psychiatrists, that locums would be used and that, while the facility was funded for three psychiatrists, the "*minimum staffing level of Consultant Psychiatrists in recent times has been two and that patient care has not been compromised*". Council once again made the point that stressed staff can lead to mistakes and that Official Visitors raising rights issues on behalf of consumers were being told by facility staff that overwork and "*other priorities*" were the reason.

3 See page 13, Illustration 2.

Subsequently in February 2015 Official Visitors again learned that the facility would be back to one psychiatrist, this time for four weeks – a locum from another state. The issue came up in several MHRB hearings and complaints by consumers. The MHRB agreed with one of the consumers that, looking at their medical file, it appeared the consumer had "*barely seen a doctor for a month*".

Indeed it was the case that the medical files showed that one patient had not seen any doctor for two weeks or a psychiatrist for nearly four weeks; another patient had seen a doctor the day before the MHRB hearing, but had not been seen by any medical staff in the seven days prior to that (and the time before that was also seven days). In checking the files, the legibility of doctors' names and writing was also raised.

The response from the Clinical Director was that the facility would only be reduced to one psychiatrist for two weeks (not four weeks) and that the patients complaining had been seen a number of times by junior doctors (registrars) and their cases discussed at the multidisciplinary team meetings. This explanation ignored the issue that the patient who was being detained wanted to see the psychiatrist, who they see as the expert, and who is the only person with the power to make them voluntary.

A meeting with management followed and it was agreed that:

1. consumers need to know what to expect by way of the regularity with which they can expect to see medical officers and their psychiatrists
2. doctors' notes on the files need to be legible and clearly identify the name and position of the author
3. doctors' reports need to be given to the patient three days before a hearing and a member of the medical team needs to be responsible for explaining the context of the report to the patient.

Council maintains a watching brief in relation to this facility.

Regional wards

In last year's Annual Report we reported shortages in Albany and Kalgoorlie due to recruiting difficulties and the lack of availability of adequately trained staff. This issue continued over a year later. In Kalgoorlie a Clinical Director was recruited from overseas but we were then advised in June 2015 that the person had withdrawn so recruiting had to start all over again.

In Albany the new Mental Health Unit was authorised and opened with 12 beds on 26 July 2013, but the four secure beds did not open for another 18 months (on 23 February 2015). Official Visitors were told in July 2014 that staffing of the secure unit had been "*delayed by the State Government recruitment freeze*". In August 2014 Council was told that a key issue, and the only remaining obstacle, to opening these beds was the lack of availability of adequately trained staff.

Illustration 5 – Access to Social Workers, Welfare Workers and Other Clinicians

People who are suddenly detained have no time to prepare for time away, for example to pack clothes, make arrangements for pets or the payment of bills. Therefore social workers and welfare workers are crucial in helping reduce the trauma of being detained. While on the wards, patients also use welfare workers to get them cash so that they can purchase necessities, buy treats in the kiosk or cigarettes. Without such workers, nurses are asked, which raises safety risks as they have to leave the ward. If nurses refuse, consumers can become desperate – in one case the consumer was giving a voluntary patient their ATM card and PIN. Social workers also take responsibility for finding accommodation for those consumers with no home and in some cases for negotiating with landlords to maintain leases.

In October 2014 Council wrote to one metropolitan hospital raising concerns that the number of welfare officers had been reduced from 1.5 FTE to only 0.5 FTE and that in February 2015 the number of social workers would be reduced from 2 FTE to 1 FTE. At the time Council understood there were 12 homeless patients in the facility, few of whom had family or other support. In December we were told that they were recruiting for the vacant welfare officer position and attempting to provide temporary staff in the interim and had started work on recruiting for another social worker to fill an anticipated vacancy in February. In June 2015 the situation improved with 2 FTE social workers active on the wards.

The Kalgoorlie Mental Health Unit has no allied health workers at all – an issue which has been repeatedly raised by Official Visitors.

At other facilities complaints of boredom by consumers usually means no, or not enough, allied health workers.

Illustration 6 – Access to Care and Council's Submissions on the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025

The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025 (the Plan) aims at "*achieving system wide changes to meet the needs of all Western Australians over the next 10 years, to support the sectors in meeting these needs and towards improving outcomes for consumers, their families and carers.*"

Council responded to the Plan in its submission[4] in March 2015. We acknowledged that the overall premise was commendable, but stated that Council would not support the Plan without extra funding in place as the consumers assisted by Official Visitors were likely to be the ones most disadvantaged by the proposed changes. Our submissions then noted a number of 'glaring omissions' from the Plan, including:

- the needs of long term patients 'stuck' on wards, or who are considered to be 'revolving door patients', with multiple issues, often including cognitive impairment. The length of stay survey referred to in Illustration 2 above evidences this need for 'safety nets' for people with chronic, serious mental illness and/or in lower socio-economic or rural areas because of their heavy reliance on general practitioners (GPs)
- research into ways of reducing medication side effects and/or better medication options
- innovative approaches to workforce issues
- system navigation and helplines.

Council awaits the outcome of the revised Plan.

ISSUE 3 – RIGHT TO RESPECT AND DIGNITY (s188(b) of the Act)

Respect and dignity issues are a common feature of complaints by consumers and often reflect the culture of the ward and/or stressed staff. Apart from consumers having a right to be treated this way, it will reduce re-traumatisation on the wards, enhance recovery and lead to a calmer ward environment. To quote a couple of consumers:

- *"If you want consumers and carers to be easier to work with, treat us with a bit of kindness"*
- *"We are not looking for cure, just looking for humane treatment."*

4 Council's submission can be read at www.coov.org under "Publications" then "Submissions".

Some examples of cases dealt with this year are set out below.

Illustration 1 – Psychiatrist Behaviour

A locum psychiatrist put up his middle finger in the 'f*** you gesture' to a patient while standing in the nurses' station. Complaints were made and an investigation followed. The patient was apologised to and the doctor's appointment at the hospital ended.

Illustration 2 – Security Officer Behaviour

- Security officers were seen (by other patients on the ward and an Official Visitor) laughing and enacting a 'high five' gesture while returning from the end of the corridor after a restraint which resulted in the female patient being injected. The Official Visitor complained to the Nurse Director who met with the Security Guards and got their agreement that the behaviour was 'completely out of order'.

- An Official Visitor overheard security officers (in a different facility) talking while leaving a secure ward, saying "*It's a f***ing psych ward mate. Fancy seeing f***ing fruitloops in a psych ward*", and laughing. The hospital Co-Director responded saying that they had spoken to both the site and area security managers who were appalled by the comments and would be raising the issues with the security team. Subsequently the Area Head of Security met with the Head of Council and advised that he had introduced mental health specific training in an endeavour to change the culture.

Illustration 3 – Nurse Behaviour

- A patient told their Official Visitor they had been treated like a child and told to "*go to their room*" before being put in seclusion. The nurse told the Official Visitor that he had made a joke (as a bit of an ice breaker) and that it had "*escalated a little*". He also said that the consumer was not put into seclusion but had spent some periods of "*open time out*" in the seclusion side room as a de-escalation technique. The Official Visitor pointed out that these time out periods were not being documented as seclusions would be and that referring to an adult being given "*time out*" could appear to be condescending and treating them like a child. The nurse conceded that the consumer wanted to be and should be treated with more dignity and respect. The consumer said they were satisfied that the nurse had listened to their complaints and did not "*want to cause trouble*" by taking it further.

- A consumer complained to their Official Visitor about a sore toenail. The Official Visitor could see that the nails were very long (up to 10mm) and the nail on the big toe appeared to be rising up slightly. A request was made to nursing staff to have the nails cut as the consumer could not physically do it themselves. Four days later nothing had happened. Nursing staff told the Official Visitor that they were not allowed to cut toenails. The Official Visitor then spoke to the senior nurse in charge of the wards and was told that it was hospital policy that nurses did not cut toenails. The Official Visitor explained that the patient's nails were so long it could cause her harm, especially when sleeping, but this did not result in a change of response. The Official Visitor then asked if she could cut them herself and was told that she could. She cut off the offending toenail and advised nursing staff that the patient appeared to have a fungal infection. Head of Council raised the issue complaining about the policy and that patient-centred care appeared to be missing on the ward. Council was assured that there was no such policy and that a number of nurses were going to be trained in 'foot care'.

Illustration 4 – Hospital Policy

Consumers with a history of self-harming were being made to stay all day in 'rip proof' gowns and eat with their fingers. The unattractive and not very comfortable gowns made the patients stand out amongst other patients and visitors to the ward, and were demeaning. There were lengthy discussions. While acknowledging the duty of care issues, other hospitals had processes to safely allow the use of cutlery, and did not insist that patients wear rip proof gowns all day long. The hospital agreed to review practices and ultimately agreed to change their policies.

ISSUE 4 – RIGHT TO HAVE THE LAW FOLLOWED AND STANDARDS MET (s188(b) of the Act)

It goes without saying that consumers have the right to have the law followed and standards met, particularly when people are being detained and required to take medication against their will. Many of the issues dealt with by Official Visitors involve advocating for such rights and standards to be met. Below are some examples.

Illustration 1 – Seclusion Practices

The Chief Psychiatrist's quarterly report into seclusions noted: "*In 2013 a United Nations report (United Nations Human Rights Council, 2013) called for a ban on the seclusion, confinement and restraint of people experiencing psychological or intellectual disabilities. The report, although not legally binding in Australia, states the practice of seclusion and restraint from a human rights perspective is no longer acceptable. It is widely accepted that the use of seclusion and restraint do not meet the human rights principles (United Nations Human Rights Council, 2013). The use of restrictive practices is reported to cause distress to both patients and carers and can negatively impact on a patient's recovery process (McSherry, 2013)*"[5].

Complaints about seclusion are far less frequent now than a few years ago due to changing practices in authorised hospitals. However, issues still emerge. There is a danger of complacency as the Chief Psychiatrist's data suggests that seclusion rates have increased again since 2013–14[6]. The average rate of seclusion for the first half of 2014–2015 was 6.46 events per 1,000 bed days. In 2013–2014 it was 5 events per 1,000 bed days. Official Visitors check the seclusion registers on every visit and the June 2015 inspection focused on this issue.

- At one hospital consumers were regularly being told they had to stay in a 'side-room', which was otherwise known as the seclusion room. This was not being recorded as seclusion, however if they attempted to leave the room, the door was being locked. The seclusion register was also not being consistently used on one of the wards, as required by the Act, and on another ward staff could not locate a seclusion register. Official Visitors spent time educating staff on the Act, management undertook to ensure that staff were all aware of patient rights and a seclusion register was re-established.
- In another hospital, the seclusion register showed a consumer had been secluded every day for seven days for extremely lengthy periods of up to 20 hours. The Official Visitor was told that the consumer was in fact free to leave the seclusion room during the periods recorded but longer times were recorded in the register because the seclusion was not ceased (officially) by the doctor. In other words, the register was not

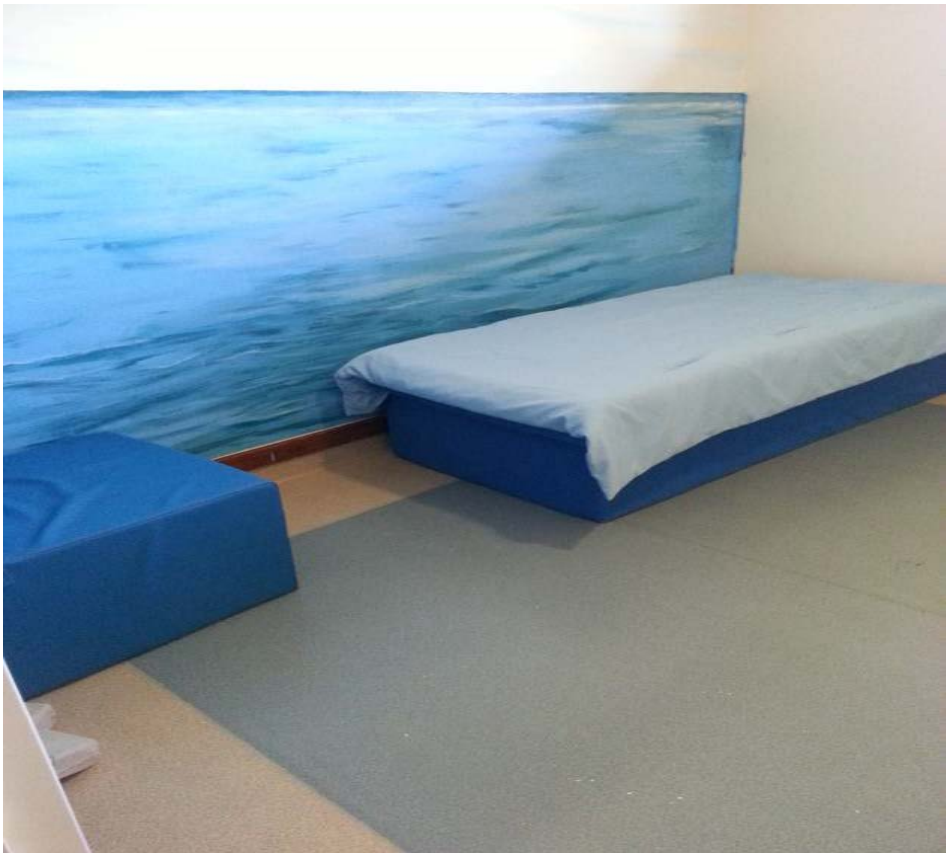
5 Office of the Chief Psychiatrist, Seclusion and Restraint Quarterly Report April 2014-June 2014 (p3).
6 Office of the Chief Psychiatrist, Seclusion and Restraint Quarterly Report April 2014-June 2014.

accurate. Apparently the ward had difficulty getting doctors to attend every two hours[7] to review the seclusion authorisation (as is best practice) especially at night, so had longer seclusion authoristions made. Apart from making it difficult for the Official Visitor to check what in fact had happened, the register distorts the ward's seclusion figures which have to be reported on nationally.

- In another hospital where issues with seclusion records had previously been raised, an inspection of the 10 most current seclusion records noted that:
  - there were several instances of medical officers not signing the form to record that they had carried out patient reviews as required
  - a staff note and initial of the time that seclusion was concluded was frequently overlooked
  - in one instance the outcome of seclusion had not been completed.

  Previously it had been proposed that junior medical staff be given additional training in the completion of seclusion records. The response from the hospital on this occasion was that their quarterly audits on seclusion practices had not included compliance with documentation but would now do so.

- Seclusion rooms are usually windowless with pale, bare walls (sometimes with graffiti scratched into them) and nothing else except a mattress on the floor. One hospital took a creative approach to making their seclusion room more attractive and calming. In September 2014 Official Visitors took a photo[8] of the seclusion room and as at June 2015 the room remains in a similar condition:



7 There is no time limit for seclusion orders under the Act but when the the 2014 Act comes into operation, the time allowed will be limited to 2 hours.

8 The Chief Psychiatrist's Operational Directive 0253/09 prohibits the use of photographic equipment in mental health facilities, however Official Visitors obtained permission to take the photo.

Illustration 2 – Treatment, Support and Discharge Plans

Treatment, Support and Discharge Plans (TSD Plans) are a key requirement for, and element of, patient care under the National Standards for Mental Health Services[9] and DOH policy. Whenever a consumer raises complaints about their care, an Official Visitor will ask the consumer if they have a copy of, or have been involved in, their Plan, and will check to see if it is being followed, regularly reviewed or if it could be amended to enhance the consumer's recovery.

The 2014 Act will further impose a legislative requirement that the treatment, care and support provided to all involuntary patients must be governed by a TSD Plan, that preparation of the Plan involve the patient, carers and others, and that a copy must be given to them. The Official Visitors' May inspection therefore focused on trying to set a benchmark of how TSD Plans are currently being done in authorised hospitals. Ward staff were asked questions in line with the wording of the 2014 Act and a random selection of three TSD Plans were checked (with consumer consent).

Results of the inspection are listed below.

- Forty inspection reports were completed. In relation to involving consumers and family in the preparation of the Plan, staff talked about involving consumers who were '*well enough*' and family *'with the patient's permission'*. It wasn't clear how either the consumer or carers were involved, and many staff indicated that they were usually more involved with planning nearer to discharge – even though nearly all said adherence to the TSD Plan commenced as soon as possible after admission.
- Almost all staff said the Plan was reviewed weekly at clinical review meetings/multidisciplinary team meetings, but there was little reference to inviting consumers or families to such meetings. Documentation of the Plan was said to be primarily by nursing staff.
- The majority of staff also said they did not give consumers a copy of the TSD Plan including the discharge summary. Reasons given included:
    - concerns regarding confidentiality if patients leave paper work on ward where others can read it
    - forms had been designed for staff not patients
    - *"Many of the young people do not want a copy. They may feel there is greater privacy for them if it is kept on the file away from other patients"*
    - Poor literacy skills of patients
    - *"Patients are too unwell and Plans have a lot of personal information on them and usually end up in the rubbish bin or on the floor"*
    - *"I would say 80% of patients do not want a copy of their care Plan or consultation form"*
- Hospitals have not developed a uniform way of indicating if a patient has been given a copy of a TSD Plan or refused to accept it.
- Staff indicated that the majority of families do not receive a copy of the TSD Plan.
- Compliance with requirements for regular review of TSD Plans, particularly in relation to longer term consumers, were low or variable.

9 Standard 10.4.8.

- A Discharge Summary is usually provided to the GP and community mental health services but not to the patient, their carer or other agencies involved with the person's care and support in the community.
- Consumers indicated that they were reviewed by their doctors, however, for the most part did not appreciate that there was a documented TSD Plan on their medical file. Besides an admission pack, they said they received little documentation or information.
- Bentley Hospital was the exception. Patients on Wards 7 and 8 were said to be reviewed regularly by their doctor and allocated nurse with the person in attendance. The outcomes of the review are documented by the nurse on a Care Consultation Form and signed by the patient. This is an excellent step towards consumers feeling more involved in their care Plan. It also means there is clear evidence of meetings if the consumer does have a memory issue.
- Another example of best practice was the Bentley Adolescent Unit which has a My Progress Form through which the patient identifies what they want to work on each week.
- Consumers who were nearer discharge or involved in finding accommodation were clearer about their TSD Plan.

A summary of the findings is below.

- While authorised hospitals have documented TSD Plans for each patient, they must work hard to meet their obligations under the 2014 Act which requires active involvement of the patient and their personal support person.
- Official Visitors observed a concerning resistance to giving consumers copies of TSD Plans which extends in some cases to information about the consumer's diagnosis and treatment.
- An increased sense of purpose and responsibility was evidenced where Official Visitors did observe consumers being actively involved in their care planning. Active involvement by the consumer included signing off on it and receiving a copy.
- Authorised hospitals will also have to develop better processes for providing the consumer with documentation and proving that it has been provided.

Illustration 3 – Restriction of Rights

Under the Act consumers' rights to visitors and to make telephone calls or correspond by post may be restricted or denied if the psychiatrist considers it in the interest of the consumer to do so. Such restrictions can only be made by a psychiatrist and must be reviewed daily by a psychiatrist. It is a common source of complaint by consumers.

In one case a consumer had their rights to make phone calls restricted for six days, and ward staff could not explain why the restrictions were being continued. The hospital form had been signed each day but no reasons were given and nothing else could be determined from the consumer's file. The Official Visitor was told that the restriction was made initially because of a concern that the consumer would spend too much money making multiple calls. The Official Visitor argued that the original order could have been less restrictive, for example, five calls a day, or to send texts only or, as was eventually agreed to, to use the ward phone and have access to their phone contact numbers to do so.

Illustration 4 – Other Opinions

The right to another opinion under the Act is one of the two most important rights under the Act (the other being the right to a review by the MHRB). The request can be made by a consumer at any time and does not have to be in writing. The other opinion must be provided by a psychiatrist who has not previously considered the matter. The Chief Psychiatrist's Operational Directive sets out the process and states that it would be preferable for the opinion to be obtained from a psychiatrist who is not employed by the mental health service which is providing care and treatment for the consumer. In reality, however, almost all other opinions are provided by another psychiatrist in the same hospital. The perception of independence is therefore compromised.

Other difficulties include that the other opinion is not set up to take place on a particular date and time. It tends to be done when the psychiatrist is next on the ward. This makes it difficult for the consumer to prepare and severely limits their ability to have an Official Visitor or family member support them in the interview with the doctor or to discuss the outcome (noting that the other opinion is not provided to the consumer in writing either, though this will change under the 2014 Act).

Council has been advocating for many years for a process to be established to allow the Operational Directive to be followed, and continues to do so. In September 2014 Head of Council provided an Options Paper to the Mental Health Bill Implementation Review Group[10] which set out a range of alternatives including a roster system between hospitals and health services and a survey and register of private psychiatrists. The DOH has now proposed a Model for Further Opinions under the 2014 Act and it is hoped that the access to truly independent other opinions will be possible when the 2014 Act is proclaimed.

Apart from the difficulty of getting another opinion from a psychiatrist who the consumer perceives to be independent, a number of other issues arose during the year, as outlined below.

- Identifying a psychiatrist who can provide a culturally appropriate other opinion – there is no list that can be used to identify such psychiatrists.
- Hospital staff requiring the consumer to put a signed request in writing which is not required under the Act, can be difficult for the consumer, and delays the other opinion.
- A psychiatrist gave the other opinion without having met with the consumer. The Australian Health Practitioner Regulation Agency is investigating.

The benefit of the other opinion being done well is illustrated by a 'good news story' involving a consumer and their carer where both were extremely anxious about the consumer being on a particular medication, the severity of the side effects and apparent lack of effectiveness. The other opinion was obtained from a psychiatrist from outside the hospital. She met with the consumer and their carer and gave them both plenty of time to raise their concerns. After reviewing the notes the psychiatrist said she could recommend two options. She then canvassed the options with the consumer and carer who were a party to the decision, which was to stay on the medication for a bit longer to see if it would work, but to cease most of the other medications which the consumer was on (which were substantial).

10 A large committee, chaired at the time by Judy Edwards and more recently Eric Ripper, comprising representatives from various stakeholders (MHC, DOH mental health area services, consumers and carers, WA Association of Mental Health, MHRB) to advise the Mental Health Commissioner on the implementation of the Mental Health Bill (later the 2014 Act).

ISSUE 5 – SAFETY AND SUITABILITY OF THE WARD (s188(c) of the Act)

The Act requires that Official Visitors inspect places where people are detained, cared for or treated under the Act, and ensure that these places are kept in a safe and suitable condition. Safety and suitability considers the environmental, physical conditions of the ward as well as other matters such as sexual and physical safety.

Illustration 1 – Issues with Mixed Wards and No Female Only Ward

Last year's Annual Report drew attention to the fact that WA no longer has a female only ward and the potential trauma that having to share a ward with men can cause women who have experienced sexual abuse, some older women, and women from different ethnic backgrounds. It remains the case that there is no female only ward in WA (although there is one male only ward). Once again Council was made aware of a number of cases involving sexual activity on mental health wards as outlined below.

- A mixed ward had only one woman, who was found in a sexual encounter with another consumer. She was moved to another hospital only to find herself once again the only female on the ward. She was then put on a one-on-one "special", with a nurse constantly by her side. The original ward was maintained as a male only ward for a couple of weeks because it was considered unsafe for women.
- Following an issue raised by Council last year about a ward at Graylands Hospital which had nine male beds and six female beds, hospital management reversed the beds so that there were more women on the ward. Graylands also has a male only ward so it has some ability to manage those male consumers who, because of their illness, can become a risk for women on a ward, but other hospitals do not.
- A male consumer was found in a female consumer's bedroom in the early hours of the morning. The male consumer was placed under one-on-one nursing care and later transferred to the male only ward. Council was told the male consumer had been risk assessed but there had been no concerns. When Council asked how this could happen, we were told the matter was being investigated.
- Official Visitors took several complaints from a female consumer about male consumers walking around naked. The response from the hospital was: *"Unfortunately in mental health environments some patients can present with very challenging behaviours, often due to their mental state at the time. In the face of such behaviour, clinical staff will attempt to counsel, redirect or divert a patient…this type of behaviour is challenging for our staff to manage."*

Illustration 2 – Sexual Safety and Gender Sensitive Policies and Procedures

In November 2014 Council's monthly inspection focused on sexual safety and gender sensitivity on mental health wards. During the inspection Official Visitors were asked to make observations and speak with staff about their awareness of preventative strategies, how they would handle incidents should they arise, and the aftercare required. Fourteen sites across WA were visited, resulting in 35 reports for a range of mental health wards including acute, elderly, rehabilitation and one adolescent ward.

Due to the sensitive nature of the subject, only a small number of consumers were approached. Issues raised by consumers included:

- feeling uncomfortable when consumers are naked on the ward
- feeling unsettled due to the noise of other consumers particularly at night
- not understanding the night checks done by nursing staff
- wanting the bathrooms and toilets to be single gender
- wanting to lock their bedroom doors from the inside.

Staff identified the biggest risks to consumers' sexual safety as follows:

- mixed genders, particularly when ward design is not suitable
- the 12 to 18 year old age group being particularly vulnerable
- high acuity of consumers
- inadequate staffing levels
- ward areas which are out of direct line of sight
- rehabilitation wards where there is more opportunity for relationships to develop between consumers
- predatory behaviours and disinhibition of consumers
- vulnerable people with cognitive impairment or dementia who were unable to protect themselves
- staff handover times when there are less staff to monitor consumers
- no designated areas for male or female consumers
- inability to separate two consumers onto different wards when there is only one secure ward
- inability for consumers to be able to lock bedrooms doors at night, so that the consumer can exit freely but others cannot enter unless they have a key.

Processes around identifying risk were varied. Twenty-eight staff spoken to said a consumer's risk of vulnerability was considered at the initial intake and "*if vulnerability is flagged, a further screening process is triggered*". Twenty-four staff said consumers were assessed for risk of offending only after being admitted to the ward. When asked where the risk was documented, responses were also varied including the admission assessment form, management handover sheets, care plans and on PSOLIS[11].

Actions taken when consumers are displaying disinhibiting or predatory behaviours or have the potential to be victimised included: one to one specialling of consumers; developing a specific behavioural management plan; ensuring consumers are dressed appropriately; placing consumers under regular observations; observation of consumer movements in and out of wards; discussing concerns at staff meetings; alerting the consultant; counselling victims and predators; trying to make corridors gender specific; ensuring that the consumers are in a direct line of sight and allocated specific bedrooms; allocating gender specific nursing staff. Staff told Official Visitors that they do not receive specific training on sexual safety and gender sensitivity but believed it would be helpful, particularly if it focused on preventative strategies.

11 The DOH database for psychiatric patients.

Observations by Official Visitors

Only 24 out of the 46 mental health wards were noted as having bedroom door locks that could be locked by the consumer from the inside (and opened by staff from the outside). Such locks would prevent other consumers from entering bedrooms uninvited while being able to be overridden by staff from the outside, making the consumer feel safer. This would be a relatively inexpensive measure that would improve the sexual safety and reduce anxiety for vulnerable consumers.

A number of wards have male and female bedrooms side by side rather than being located in separate corridors, and many wards do not have single gender defined areas or a separate space on the ward available for women.

There is no overriding policy in the WA mental health system that deals specifically with sexual safety in terms of prevention. There is a policy titled *"Responding to Allegations of Sexual Assault Disclosed Within a Public Mental Health Facility 2012"* but this is after the fact. As at November 2014, Armadale Health Service Leschen Unit was the only service to have a specific preventative policy on sexual safety.

Although it appeared to be generally accepted that sexual behaviour was not allowed on most mental health wards in WA, there was little evidence of consumers being told about expected behaviour on wards. Providing consumers with both written and verbal information about expected behaviour, which is in line with the ward and/or service policy, would clearly establish the boundaries of physical contact. Information about personal sexual safety would also empower vulnerable consumers by providing them with information about mechanisms of self-protection and options if exposed to a sexual incident.

Mental Health Service Responses

In response to the inspection, NHMS MH wrote acknowledging three common areas for improvement:

- development of a policy to promote gender sensitivity, sexual safety and help prevent sexual aggression
- training and education for staff on gender sensitivity and sexual safety
- clear information for consumers regarding sexual safety.

Council was advised that they had discussed these issues with the OCP to facilitate the development and implementation of best practice guidelines for all WA Mental Health Services. They said the OCP was planning to develop such guidelines in 2015 which would assist in promoting sexual safety for consumers.

Armadale Hospital advised it was sourcing lock specifications for staged implementation on its wards. Fiona Stanley Hospital management said a sexual safety environment audit was being scheduled regularly. The CAMHS advised that they had organised a group to meet to begin the development of guidelines, policies and staff training on sexual safety and gender sensitivity.

Illustration 3 – Bathroom Doors not Giving Privacy

In August 2014 Official Visitors raised concerns about the lack of shower doors or curtains on a shared female bathroom on a mixed ward, and a shared male bathroom on a male only ward. Three female consumers also complained that: one toilet had no door; another toilet door was broken and could not lock; and, there was a hole that other people could see though. At the time male consumers were using the female side hallway to access a courtyard because the other courtyard was being painted. The consumers also said that water pressure for the shower was too low and the shower did not have hot water either. Several female consumers did not have a shower over that weekend.

An Official Visitor contacted the hospital's engineering department and a new toilet door was installed but it was still not lockable and the shower recess remained without curtains or doors. Council wrote to the hospital and sought urgent rectification.

Two months later the situation remained unchanged. In October Council was advised that new shower doors had been designed to meet anti-ligature requirements but they were awaiting a costing.

Some months later new prototype doors were installed in the women's showers and the shower curtains put back up in the male showers and toilets (as an interim measure). A meeting with hospital management was held as the doors to the female showers were still clearly unacceptable; too much could be seen from the hallway and the toilet doors could not be locked to stop someone walking in on the consumer. Management agreed.

Eventually, 11 months later new doors and locks were installed which allowed privacy and some dignity.

Illustration 4 – Other Safety Issues

While involuntary patients are put on to wards for their own safety and the safety of others, the wards themselves are not always a safe place to be. Examples of reports in from Official Visitors during the year are outlined below.

- While the Official Visitor was on the ward she witnessed the consumer she was visiting being punched in the head by another patient, in front of a doctor and two nurses. The other patient then walked outside. Two nurses went and talked to the assailant and then came in to the nurses' station while the Official Visitor went out to talk to the consumer. Among other things, the consumer complained that no-one came and asked him how he was or checked him out. The Official Visitor spoke to nursing staff about this and then to the consumer's psychiatrist as this was the third time in three weeks that the consumer had been assaulted.
- A consumer in a wheelchair was assaulted by another unwell patient. On raising the issue the Official Visitor was told the ward needed some "*urgent reconfiguration*". They said they were discussing some changes and that they would be escalating the discussion as it involved another treating team.
- While on leave in the hospital grounds a consumer was assaulted by a patient who had been discharged only 48 hours earlier (and who was readmitted after this assault). The consumer who was assaulted had to have stiches.
- A consumer was pushed down stairs by another patient on the ward without warning or provocation. The assailant had done this previously to other patients and was meant to be on '15/60 minute line of sight observations' at the time. The consumer who was assaulted was moved to another ward.
- A consumer who told their Official Visitor that they had spent nine days waiting for a bed in the Emergency Department was finally admitted and placed on 15/60 observations by nursing staff. While in a small TV room another patient came up and punched the consumer in the face and head several times. The attack was only stopped after the consumer screamed out and staff eventually made their way to the TV room. The consumer's nose was broken.
- The assaults are not always done by patients. A nurse pulled a consumer out of their wheelchair when they would not stand up. The consumer usually used a walking stick but this was not allowed on the ward. A disciplinary investigation is underway.
- An Official Visitor who was leaving a hospital facility came across a patient near the busy road on the edge of the campus looking distressed and stopped to talk to them. The patient who was on unescorted ground access was thinking of throwing themselves onto the road. The Official Visitor stayed talking to the patient and eventually managed to get assistance. The patient had previously attempted suicide and was a voluntary patient.

- Sadly, Official Visitors were made aware of a number of suicides this year by consumers – some completely while still a patient and others shortly after discharge. In one case Council wrote to the Director General of the Department of Health and the Chief Psychiatrist to raise concerns as to whether the patient, who lived alone, should have been discharged. The Official Visitor had been assisting the consumer in the days prior to discharge and the patient had expressed concerns about being unsure about her discharge plan. Official Visitors had also had comments made to them by staff on two wards about pressure to discharge patients. The Chief Psychiatrist replied explaining that an internal review would be conducted under the auspices of the WA Review of Mortality protocols, a Root Cause Analysis would follow, and the matter would be reported to the Coroner. He said the pressure to discharge patients who have not fully recovered due to a shortage of beds required further investigation which he would be doing with the hospital management.
- An Official Visitor happened to be visiting a ward when a patient was discovered not breathing by nursing staff. The Official Visitor remained on the ward for the following hour due to concerns that all the ward staff had become involved in the incident and no one had been left to monitor patients or deal with their distress as they quickly became aware that something serious had happened to another patient. Council wrote to the hospital with a full report by the Official Visitor querying the safety and suitability of the ward during that period of time. The question was why some staff had not been directed to stay with patients, given that there was an influx of staff from other areas of the hospital to deal with the patient. At one stage a nurse had asked the Official Visitor to answer any phone calls in the nursing station. It seemed to Council that the incident had not been managed safely. The hospital responded saying, "*The manager responsible asserts that throughout the incident, staff were deployed appropriately.*"

Illustration 5 – Environmental Conditions

Each year Official Visitors conduct an environmental audit of hospital wards with follow-up check inspections some months later. The environmental condition of the ward can go a long way to helping someone feel safe and comfortable so that they can concentrate on their recovery, or it can do the opposite and perhaps even further traumatise the person. Issues dealt with this year in the audit and as a result of consumer complaints are outlined below.

Courtyards: The Courtyards and outdoor areas have inadequate furniture, shade, vegetation and recreational equipment (this complaint does not apply to newer wards or where there has been a recent renovation). For a person locked on a ward for several weeks at a time with up to a dozen or more unwell strangers, the outdoor areas are vital to their wellbeing and recovery.

Cleanliness: For the most part the standard of cleanliness was adequate, however, mould in showers and shower recesses in some hospitals was noted in the audit along with the need to regularly clean toilet and shower vents.

Lack of storage for patients: Except for some of the newer wards, the storage for patients' belongings is inadequate. As well as having a right to possessions, it is the Council's position that patients need access to adequate storage, including a locked facility for important or valuable items, given the long length of stay for many mental health patients.

Bed comfort: Beds remain a major issue in some hospitals. Patients say they are too high, too hard and/or the sheets don't fit. Some patients remove the mattress and put it on the floor to sleep on. Hospitals have agreed to replace the beds but progress is slow and meanwhile patients are not getting a good night's sleep. As sleep is an important component to recovery this remains a serious outstanding issue.

Curtains: Most bedroom windows do have curtains or blinds but, when broken they often do not get fixed in a timely manner. This has the potential to create privacy or sleep issues.

Air conditioning and heating: In older and even newer hospitals Official Visitors receive many complaints about the heating and cooling systems. Hospital stays can be unwelcome and being either too hot or too cold compounds consumers' discomfort. It is also concerning that on some wards consumers are not able to voice that they are uncomfortable. Staff have usually endeavoured to address the situation by repeatedly involving the Engineering Departments. Perhaps this continual issue points to ensuring the best systems are put in place when buildings are being designed.

Security: There were a couple of incidents where the doors are not working and there were delays in having them repaired causing security concerns. Also, Official Visitors were told in a couple of wards that the CCTV cameras were set up in areas not used at night by patients and would be better transferred to corridors that patients do use.

Telephones: It is essential that all wards have a free telephone so patients can contact significant others, their lawyer or advocate. Delays in installing and repairing telephones continue to occur. This is not acceptable particularly as some wards refuse to allow patients to keep their mobile phones.

Access to cool water: On some wards patients do not have access to an internal water fountain. Instead pitchers of water are placed on tables throughout the day. Besides being unhygienic, pitchers can be thrown and have the potential to cause harm.

Televisions: On authorised mental health wards the only televisions provided are in lounge or communal areas. Consumers complained about the time it took on several wards for televisions to be repaired or replaced. As boredom is a constant complaint by consumers, this is also unacceptable.

Information racks: The majority of wards have information racks but some are only available in the airlock at the entry to the ward and therefore not readily available to the consumer and often complaint forms are not available.

ISSUE 6 – PSYCHIATRIC HOSTELS – RIGHT TO PROPER CARE (s188(b) of the Act)

Psychiatric hostel residents may request visits from Official Visitors and inspections of these visits are conducted every second month pursuant to Ministerial direction. This year there were 854 beds in licensed private psychiatric hostels in WA which are visited by Official Visitors, four less than last year due to the closure of one small hostel. A full list of the hostels can be found in Appendix 2. The facilities range widely in style, size, standard of accommodation and care, and level of funding (some are run by not-for-profit nongovernment organisations and some by 'for-profit' entities). In this Annual Report they will all be referred to as hostels. There are a number of recurring issues arising for hostel residents who were assisted by Official Visitors as illustrated below.

Illustration 1 – Lack of High Support Accommodation – Ageing and Physical Care Needs

An ageing population and the general poor health experienced by people with severe and chronic mental illness combine to cause issues amongst hostel residents which affect both the consumer and fellow residents. Hostel staff do their best to deal with these issues but they miss out on extra funding, and often do not get sufficient support from other services. Commonwealth services are usually denied the resident because they live in a hostel which gets funding from the MHC (albeit minimal funding in many cases).

As one hostel Licensee wrote in what is a typical example[12]:

> *"The resident has become a high needs resident and does not meet our program criteria. Their cognitive function is decreasing and their bladder control is minimal. The community mental health service is aware and has applied for an ACAT* (Aged Care Assessment Team) *assessment. An OT assessment has shown a significant decrease in their functional levels. The DSC has refused funding/services. This resident now requires well over four hours' support each day in order to maintain any level of cleanliness. Staff frequently find the resident soaked in urine. The resident is unable to self-catheter and forgets to change their pads. Staff assist by washing the resident's bedlinen, clothes and prompting the resident to shower. The resident has lived here since early 2009... No suitable accommodation can be found for the resident... Staff do the best they can until such time as we can be sure the resident will be suitably housed."*

As another hostel Licensee wrote in relation to incontinence issues:

> *"Defecation has always been an issue. Reasons presented to us by a psychiatrist for this behaviour include:*
>
> - *high dosage medications*
> - *behavioural – this can be hard to change*
> - *unexpressed anger*
> - *desired behaviour*
> - *psychosis – this can result in regress into defecation if not controlled.*
>
> *The psychiatrist concluded, 'One would be totally naïve if one thinks that it can be fixed.'"*

In the second case Head of Council became involved and spoke to the community mental health service to get more support for the hostel in dealing with the issues.

Illustration 2 – Report on Hostels

In October 2014 Council reported on the support for residents of private psychiatric hostels by Community Mental Health Services (CMHS) to the Minister for Mental Health, the Director General of the DOH and the Commissioner for the MHC. It followed bimonthly inspections of hostels by Official Visitors earlier in 2014[13] and reported on information from hostel residents, hostel staff, and community mental health service staff about the support for residents and the consequences of transferring care from the community team to GPs.

It noted significant disparities affecting hundreds of residents of the larger, old style hostels (termed 'for-profit hostels' in the report) as they do not receive the same level of monitoring and coordination of care from CMHSs as other hostel residents. The inequity was compounded by substantial differences in funding provided by the MHC: 'for-profit hostels' receive on average $8,758 per resident, per year, compared with between $58,758 and $170,110 per resident, per year for other staffed residential services, based on 2012/2013 funding.

The report recommended a review of the funding for hostels and CMHSs, improving access to GPs and addressing gaps in care, and improving understanding of the roles and responsibilities of hostels and CMHS through service level agreements. The objective is to remove discrimination and improve equity of access to support services and outcomes for hostel residents.

12 The quote has been amended to remove any reference to the person's identity.
13 Reference was made to the findings in the 2013-14 Annual Report at pp 19-20.

Mental Health Commissioner, Timothy Marney, submitted the following response.

1. In relation to the request for a review of the way in which for-profit hostels are funded: The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025 (the MHS Plan) "articulates the current discrepancies in the WA mental health system and prioritises housing ...as well as investment in community support and community bed based services. As part of the MHS Plan's implementation, the MHC will review current services purchased to ensure alignment with the MHS Plan."

2. In relation to the request for a review of MHC funding to CMHS for the support of hostel residents, the MHC was undertaking a review of the funding for 'non-admitted mental health services' which, it is envisaged, would allow for a more transparent, coordinated approach. The review is exploring options for ongoing clinical psychiatric support outside CMHS.

3. In relation to the request to support hostel residents by other community services funded by the MHC, reference was made to working with an agency to implement a training strategy to up-skill staff within hostels in basic contemporary practices of recovery, social inclusion and community engagement. This would include the development of pathways to inclusive community opportunities for hostel residents and mentoring arrangements to support hostels. There was also reference to assistance with care plans and discussion with Partners in Recovery agencies.

4. In relation to improving hostel residents' access to GPs, this was recognised as an issue and is being discussed with the DOH.

5. In relation to the call for service level agreements between CMHS and hostels, this was also recognised as an issue and said sample templates had been made available. They are considering mandating the recommendation.

The Director General of DOH, Professor Stokes, replied referring to his report on the *"Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia"*. He noted that he had made three recommendations specifically relevant to hostel residents and their access to health support, care planning and treatment. He said the Office of Mental Health would be following through on those recommendations which included the development of service level agreements or MOUs between CMHS and hostels. Professor Stokes also suggested that the MHS Plan provided the MHC with an opportunity to review, remodel and realign its contracted services including hostels.

Illustration 3 – Access to Partners in Recovery and the National Disability Insurance Scheme

Council continued to devote time and resources to promoting and helping hostel residents access Partners in Recovery (PIR) and the National Disability Insurance Scheme (NDIS) in order to improve the quality of their care and access to recovery oriented services. This included attending various meetings with PIR providers and NDIS staff as well as taking them into hostels and promoting them to residents.

It is early days and Official Visitors' experience with PIR has been varied. Marlene and Stewart have kindly agreed to share their experience which, apart from being a 'good news story', reflects the journey that many people have to tread.

Marlene and Stewart's story (so far)

MARLENE'S STORY

I grew up in Forrestfield. I got married when I was about 30 and had my daughter a couple of years later. I am now 50.

My marriage lasted about 10 years and then I was a single parent until my daughter moved to her father's when she was 12.

At aged 45, I developed paranoid schizophrenia. I was experiencing paranoia: thoughts that the TV was talking to me; thoughts that people were talking about me and stuff like that.

When I became unwell, I was admitted to Graylands by my friend, who I was sharing with at the time. I was in Graylands for about three weeks. While I was there, they found me accommodation in a hostel. So, I moved there from Graylands.

Not long after living there, the staff realised that I still wasn't very well and they referred me to another Psychiatric Hospital. I was in there for about a month where they got my medications right – I have been stable ever since then. I was at this hostel for about three years, when they moved me to another hostel because they didn't know how to deal with my emphysema. During my time there, I was hospitalised pretty much monthly because of this. Since I've been at my current hostel, it's reduced, but I have been admitted to hospital twice in the last month.

The staff here are mostly OK, but the food is often not too good. There are a lot of various types of stews which you can't usually eat.

I still have a pretty good relationship with my ex in that we are friendly when we meet. He is storing all of my furniture. My relationship with my daughter is not what I would like. She doesn't visit me very often – I think that it's because she doesn't like visiting me at the hostel. She didn't like visiting me at the last one either. Also, she doesn't have her driving license yet and has to rely on her father. I got a phone call from her on Mother's Day, but she said that she was too busy to visit me. I haven't seen her for a year.

In late March, I met with the manager of the hostel with my Official Visitor about my finances and needing some underwear, which, by the way, I still don't have. This is apparently a breach of Regulations. However, the manager did suggest accessing NDIA (National Disability Insurance Agency) for Stewart, who is a close friend and me.

Before I met Stewart, I had been pretty bored because there's not much to do at the hostel. I spent a lot of time lying in bed. But, since we've been friends, we spend quite a bit of time together: talking; going shopping; going to the movies; and, generally enjoying each other's company.

After the discussion with the hostel manager, my Official Visitor and I went and saw Stewart. Stewart and I decided that we wanted to share a house to live in. From there, our Official Visitor got applications from NDIA, and helped me fill in my sections. She also provided instructions for the hostel manager on what my GP and their OT needed to provide in reports. The hostel manager arranged these. Denise then took all the forms to NDIA. She then attended an appointment with me with the NDIA lady, Wendy, on 15 June. From there, a draft plan was developed and then the Official Visitor, Stewart and I met with Wendy on 1 July to finalise both Stewart's and my plans.

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I was approved Service Coordination to help me find accommodation; to access counselling to help me learn to be more assertive; to access employment and to access a computer course. I have also been granted funding for 10 hours per week support in the home (including cooking, cleaning, shopping, budgeting, attending appointments etc.).

The whole process has been pretty good really and only took a couple of months once our Official Visitor took the forms in.

I chose Mental Illness Fellowship of WA (MIFWA) to be both my Service Coordinator and Service Provider. The Official Visitor has asked MIFWA to also refer me to Partners in Recovery to see if they can fund or get a computer for me.

I'm hoping that by getting support through NDIA funding, I will be able to get back in the groove. I have become sort of institutionalised and haven't done any cooking, cleaning, budgeting or food shopping for five years now. I feel like I've lost these skills.

I also want to learn how to use a computer and to get a job in a nursery for two or three days a week. I don't have any qualifications in horticulture, but I have done a lot of gardening in the past.

MIFWA staff arranged a viewing of a three-by-two unit on 27 July for Stewart and me which we loved. We filled in the rental application the next morning with the help of Brad from MIFWA and we should be moving in in about three weeks.

Between us, Stewart and I have enough furniture to fill our new home. But, we will probably need kitchen appliances – I can't remember what's in my boxes that are stored at my ex's.

I'm hoping that once I'm in my own home, my daughter will feel comfortable enough to visit me and that our relationship will improve.

I'm looking forward to the future now.

July 2015

STEWART'S STORY

I was born in Scotland in 1954. When I was 16, I decided that I couldn't handle living in Glasgow anymore and moved to Australia. I didn't know anyone when I arrived.

I got married when I was 18 and have three adult children and three grandchildren. I worked on the mines from 1976 doing 12.5 hour shifts. In 2003, I went fishing in Onslow with my brother-in-law. On the way back to the mine, my brother-in-law noticed that I was holding my head and asked me what was wrong. I said that it felt like there was a tension band around my head. This lasted for quite a while. I was also feeling high, like I was invincible.

Anyway, I went and saw a doctor who arranged to have me flown back to Perth for an assessment. I was in Joondalup ED where a psychiatrist came to see me. It was then that the Bipolar Affective Disorder diagnosis was made. I continued working on the mine until 2011 when I accidentally overdosed on my lithium medication and nearly died. I was on life support in Joondalup Hospital for four days.

I was admitted to the Joondalup Mental Health Unit from the ED and was there for around six months.

My marriage dissolved after about 16 years, mainly because of my illness.

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I've been briefly married twice since my first divorce. You make some stupid decisions when you're manic!

Between first being diagnosed and having to stop working, I was seeing another private psychiatrist on a regular basis.

It was while I was in hospital in 2011/2012 that I again had the previous psychiatrist treating me. He arranged for me to live at the hostel that I'm in now. If I hadn't moved to a hostel, I still would have been in hospital. I've been here for about 2.5 years. When I moved in, it was supposed to be 'this will do for now', but how long is 'for now'? I'm still here. For the first six months, I didn't like it, it didn't grab me. And then I thought to myself, it's only me that can change things. But I just didn't know which way to turn. I went to a self-help group. But it made me feel worse. I went again the following week, but half way through the meeting, I walked out because they were making me feel sick.

However, I met Marlene, who also lives at the hostel about six months ago. Since then, things have been better. We spend time together: go shopping; do errands; go to the movies; have the occasional drink at the local pub; and, generally spend a lot of time together. We're good for each other. Before I met Marlene, I would go to the shops, but pretty much nowhere else.

I now see the original psychiatrist every three months in his private practice. Early on, my daughter rang his rooms and told them that I couldn't afford to pay private rates. Fortunately, he responded that he would be happy to bulk bill me, which I'm very grateful for. He knows me so well. I also see the GP who comes fortnightly to the hostel as needed.

I have some sort of neurological disorder which is still un-diagnosed. I'm waiting for an appointment with a neurologist. But the symptoms are unsteadiness, numbness of my feet; tingling in my hands and a sharp, cold pain up the sides of my legs and constant shaking. It looks like Parkinson's, but apparently it isn't. I use a cane and have the occasional fall. I also have emphysema and early dementia, which I didn't know about until I read the report that my doctor wrote for the NDIA application!

It was actually the manager of the hostel who raised the issue of NDIA with my Official Visitor. She then met with Marlene and me, and we decided that we should share a house in the community. My Official Visitor then ran with the NDIA application process. She helped me fill in my form and got the hostel to arrange the reports from my psychiatrist, GP and their OT. The process has been very good. I had two interviews with NDIA people and a draft plan was then developed by them. My Official Visitor was at my next meeting, along with Marlene to discuss the draft plans for both of us and my Official Visitor negotiated a greater level of support for me.

The funding approved for me was for my Service Coordinator, who I chose to be Mental Illness Fellowship of WA (MIFWA), to find accommodation; and to link me with physiotherapy and podiatry to help with my neurological disorder. It also provides me with five hours per week domestic support and the like which will also be provided by MIFWA. Because Marlene and I will be sharing accommodation, we will be able to combine the level of domestic support provided to both of us: 15 hours per week in total. My Official Visitor has also asked MIFWA to refer me to Partners in Recovery to see if they can arrange some reading glasses for me.

My hope with the NDIA funding support is that I will be able to be independent again.

With the help from MIFWA, Marlene and I have found a really nice unit in Midland which is well appointed and well located. We'll be moving in in a few weeks. Marlene and I have enough furniture and it's just up to MIFWA to help us to arrange a furniture removalist and to get it all set up. We both love gardening and are looking forward to establishing a potted garden in the courtyard, which is a good size.

July 2015

Illustration 4 – Financial Issues

Hostel residents can be in a very vulnerable position in relation to finances as many have limited funding and it is often controlled by hostel staff.

- Queries raised by residents of one hostel caused Council to inquire into the handling of residents' finances by reference to Standard 4 of the *"Licensing Standards for the Arrangements for Management, Staffing and Equipment"* (Licensing and Accreditation Regulatory Unit (LARU) Standards). Several meetings were held with the bookkeeper and then the hostel manager. A report was prepared in July 2014 and posted on 1 August 2014 with a covering letter stating that the hostel had 10 days to raise any concerns with the report before it would be sent to LARU. The report highlighted that of the 11 sub-standards, three were not complied with, one was not fully complied with and two were not always observed. In addition, a resident had asked for extra money from their Public Trustee Officer which was approved, but it was not noticed by the bookkeeper when it was paid into the hostel Licensee company account. It was some time before it was discovered and passed on to the resident. Although many attempts were made to have our concerns responded to, the hostel management's response to the report was not received until March 2015 and hence Council's report had already been sent to LARU. Although most issues raised in the report have now been addressed, Council is not totally satisfied with the response and will continue to monitor the situation.
- In another case there was a happy ending. A resident was in arrears with their board and lodging by $945. The hostel managed all their finances and had halted their cigarettes and spending money. The Official Visitor negotiated a $10 per week 'allowance' and got a statement of payment from the hostel and Centrelink (which sends payments direct to the hostel Licensee). The resident had recently moved hostels. It turned out that the previous hostel Licensee had transferred a pension amount of $951 after the resident left them into the resident's bank account without advising the resident. The resident had not checked as they assumed the account was empty (as it usually was) and the bank hadn't been informed of the change in address so no statements had been received. The resident was very relieved to be debt free and their spending money and cigarettes were reinstated by the hostel.

Illustration 5 – Auditor General's Recommendations

On 25 June 2014 the Auditor General published a report following an inquiry into *"Licensing and Regulation of Psychiatric Hostels"* which involved the Mental Health Commission (MHC), LARU in the Department of Health, and Council. The Auditor General recommended that there should be improved coordination and cooperation between the agencies. This resulted in the formation of an interagency group which enables issues to be raised for discussion. There have been six meetings in 2014–2015 during which the terms of reference were agreed, system wide developments were monitored and reported upon, and major issues relating to psychiatric hostels were discussed.

ISSUE 7 – SAFETY AND SUITABILITY OF PSYCHIATRIC HOSTELS (s188(c) of the Act)

It goes without saying that hostels need to be safe and suitable. There is a licensing regime conducted by LARU and funding provided by the MHC. Many, if not most, hostel residents are on a disability pension and up to 87.5% of the pension goes on payment to the hostel owner. Some of the issues dealt with this year by Official Visitors relating to safety and suitability are highlighted below.

Illustration 1 – Staff Could not be Found

Hostel Licensees are required by regulation[14] to ensure that a supervisor is present at the hostel at all times. While an Official Visitor was on site at a hostel late one afternoon a resident threatened to hurt themselves, saying several times over that they had 'had enough' and just wanted to get a knife. While this was going on a second resident told the Official Visitor that they wanted to go to hospital and asked for help. The Official Visitor was unable to find any staff and other residents told her that they had not seen the hostel supervisor for several hours.

Following Council's policy in relation to threats of harm, the Official Visitor contacted the Head of Council and calls were made to the local community mental health service and the hostel Licensee. A short while later it was confirmed that the supervisor was on site. One resident was taken to hospital. A meeting was held with the Licensee. Council was told that the supervisor had been present the whole time 'in her room' and perhaps the Official Visitor had not recognised her. A number of concerns were raised and discussed and some new practices put into place at the hostel.

Illustration 2 – Residents Confined to their Rooms

In another hostel, residents were confined to their villas once the 'day shift' had gone home at 4pm because there was only one night supervisor. Official Visitors said there were long term residents who could not name the last time they went anywhere after four o'clock in the afternoon. The hostel rules did not allow them to visit one another and there was no communal social area where visitors or family could meet up. The issue was raised with LARU as Licensees are required to have sufficient staffing.

Illustration 3 – Poor Conditions Generally

Ongoing concerns in relation to the conditions in one hostel and the poor relationship with the Licensee led Council to empanel a person who had worked for Accreditation Canada for 25 years for an independent opinion. The outcome was that the Accreditor agreed with concerns raised by Official Visitors. The MHC, LARU and the Minister were advised and given a copy of the report (which was also sent to the Licensee).

Extracts from the report include the following:

> "Doors are kept locked and staff needed to be called for both entry and exit, although we were told residents could hop a fence or could leave by walking around the back, so the locks appeared to be more for monitoring visitors than containing residents.
>
> The majority of the residents were found wandering, what appeared to be aimlessly, on a concrete patio area at the side of the building, many smoking, many carrying water/pop containers and a few sitting looking lonely and sad."

Comments noted in the report included:

- The smell outside rooms 44, 45 and 46 was "*absolutely outrageous and no one should have to live in that area or walk past that area*".
- There was one area where laundry was being dried and obviously, due to the smell, was being aired and had not been washed.

14 Regulation 8 of the *Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997*.

- Residents complained about not always having hot water and in one area a tap had been dripping so the whole tap had been removed.
- There were no hand sanitisers anywhere and there was no evidence that hand washing was taking place prior to eating.
- Corridors were extremely dark particularly on the main floor and the runners, carpet over carpet, were bunched in several areas creating a tripping hazard.
- Several windows in corridors had curtains that did not fit. Rips in curtains were visible from the outside and one window in the upstairs had no screen.
- Resident beds in double rooms and one triple room were very close together leaving very little personal space.

Meetings with the Licensee and LARU followed. Some small improvements have been made and Official Visitors continue to try to work with the hostel Licensee despite claims by the Licensee that they are being bullied and singled out by Council.

Nevertheless, there are several hostels where conditions are exemplary. For example, at one hostel, residents were highly complimentary of the maintenance program and upgrades to the facility and pointed out new furniture.

Illustration 4 – Food Issues

For people living in hostels, often the only thing to look forward to is their next meal – it is the main pleasure for people who are already so disadvantaged. Official Visitors have observed the following at some hostels.

- Food is often cold. This is sometimes because there are two 'shifts' for dining, as dining rooms are not large enough for all residents. The second 'shift' gets cold food. At one hostel it was served and left for 15 minutes before being given to residents.
- At one hostel, supper consists of pre-mixed coffee and a biscuit. The issue is that it is pre-mixed with no choice but to have coffee with sugar and milk. Those who do not drink coffee have nothing. The menu says that tea, coffee and milo is available.
- In another hostel, morning tea is hot chocolate and afternoon tea is coffee with cream and sugar added, served in plastic cups. During the inspection it was noted there were four soda crackers and four plain biscuits at each table of four.
- At another hostel, various types of stews are served sometimes up to four times per week. Several residents stated that they are usually inedible and that they often do not eat at that mealtime.
- Regulation 10(b) of the *Hospitals (Licensing and Conduct of Psychiatric Hostels) Regulations 1997* states that "residents receive fresh fruit or juice daily". This is often not the case. In several instances fruit is kept in the kitchen and is not freely available to residents. In most cases cordial is served as a replacement for juice.
- Often, the meal that is provided does not reflect that which is on the menu.

As a result of Council's reports and interventions, some of these practices have ceased. Nevertheless, Council continues to monitor all hostels in this regard because we are aware that some will fulfil their obligations for a while and then lapse into their previous practices.

On a positive note, at one hostel, several residents commented on how good the food was, with one describing it as being '*tops*'.

ISSUE 8 – HELPING RESOLVE COMPLAINTS (ss188(d) and (e))

Much of Official Visitors' work is helping consumers resolve complaints. They will usually first attempt to resolve a complaint by dealing directly with the treating team and ward or hostel staff. Sometimes however the complaint needs to be reported or investigated. Official Visitors may help consumers to write up the complaint, or draft it for them. Part of this process involves telling the consumer their rights in relation to the issue, the options they have and consequences (for example the formality of the process, time taken etc.).

Working out the complaint processes in mental health can be difficult as each Area Health Service does things slightly differently. Council has long complained about delays in responding to complaints (or even acknowledging them), poor quality responses and lack of procedural fairness and transparency in the investigation process.

At a systemic level Council took on two initiatives in 2014–2015 in an endeavour to improve complaints processes for consumers (and carers) – a survey about complaints processes and becoming party to a Mental Health Complaints Partnership Agreement between the Health and Disability Services Complaints Office (HaDSCO), the DOH, the OCP and the MHC.

Illustration 1 – Complaints Survey

Official Visitors conducted a survey on complaints processes in authorised hospitals during their monthly inspections in October 2014. Staff and consumers were asked about their knowledge of complaints processes. Official Visitors also made their own observations about the availability of information on the wards about how to make a complaint. The questions were devised with input from staff at the HaDSCO.

The survey results reflected an inconsistency in information on wards about how to make a complaint and complaint handling, and almost no knowledge of the role of HaDSCO which is the statutory body for handling complaints relating to health and disability services in Western Australia (WA). One third of the 93 consumers spoken to said they did not know how to go about making a complaint. Council also has concerns about the quality of complaint handling on some wards where complaints were not passed on or not investigated appropriately.

Most hospitals responded positively to the survey results which were sent individually to each hospital (in many cases almost immediately) by making sure there were posters and pamphlets put on the wards.

The Minister congratulated the Council *"on a timely piece of work, which evidences the need for the changes contemplated in the* Mental Health Act 2014 *in reference to complaints about mental health services".*

Illustration 2 – Mental Health Complaints Partnership Agreement

Working through the mental health complaints system is extremely complex and at times very frustrating – and that is just for Official Visitors who are not struggling with a severe mental illness or locked on a ward. The Health and Disability Services Complaints Office has been written into the 2014 Act with a view to improving complaints processes, which has long been a source of complaint in itself by both consumers and their carers.

Head of Council therefore actively engaged with HaDSCO through the year. This included empanelling a HaDSCO staff member so that they could get a better understanding of what mental health patients experience,

especially the disempowerment that comes from just being locked up on a ward. Head of Council also accepted an invitation to be part of a Mental Health Partnership working group comprising representatives from Council, HaDSCO, the Office of Mental Health, the OCP, LARU and Corporate Governance division of the DOH and the MHC. The results of the Complaints survey referred to above were shared with the members of this group.

The aim of the group is to establish a multiagency agreement aimed at making access to mental health complaints processes easier. The partnership was signed on 12 August 2015 and launched by the Minister for Mental Health.

ISSUE 9 – ASSISTING WITH MENTAL HEALTH REVIEW BOARD AND STATE ADMINISTRATIVE TRIBUNAL APPLICATIONS AND HEARINGS (s188(g))

Official Visitors assist consumers to make applications to the MHRB and support them in the ensuing hearings and periodical reviews of their involuntary status. Official Visitors also support people in State Administrative Tribunal hearings, primarily those where an application has been made to appoint a guardian or administrator.

It is a goal of Council's Strategic Plan to:

- improve consumers' access to representation by lawyers and Official Visitors at MHRB hearings
- improve the standard and quality of representation at MHRB hearings
- promote and protect the right of consumers to natural justice and procedural fairness in hearings and endeavour to improve the observance of that right, in particular their right to:
    - be provided with a copy of the medical report in a reasonable amount of time in advance of the hearing (Council's position is a minimum of three days before); and
    - be given access to their medical file and any other documents made available to the MHRB as part of its deliberations

Illustration 1 – Supporting Consumers in Mental Health Review Board Hearings

In the 10 months from 1 July 2014 to 30 April 2015[15], 38.4% of consumers were represented at MHRB hearings with 22% supported by an Official Visitor and 16.4% represented by a Mental Health Law Centre (MHLC) lawyer. This is a small improvement on the previous year. However, given that 10 years ago only 14.5% of consumers were represented at hearings, there has been significant improvement over time.

It does mean that 61% of consumers were unrepresented in hearings (although some may have had the support of a carer, friend or other advocate).

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. Having access to such a list would lead to increased representation and rights protection because it would allow Official Visitors to visit consumers to check that they know about the hearing and understand what it involves, including their rights to contact the MHLC for legal representation and/or to have an advocate, family members and/or other friends attend the hearing. It is hoped that there will be some changes in this regard under the 2014 Act.

15 Due to the implementation of a new database the MHRB were only able to provide data from 1 July 2014 to 30 April 2015 for the 2014-2015 financial year. Comparisons of the number of hearings cannot be made between 2014-2015 and previous years because data reported for all other years were for a 12 month period.

Table 1: MHRB Representation – MHRB Data				
Year	Completed hearings	Number and percentage of hearings involving Council	Number and percentage of hearings involving the MHLC	Percentage represented by MHLC and Council
2004–2005	1,203	6.7%	7.8%	14.5%
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	214 / 21.8 %	123 / 12.5%	34.3%
2013–2014	1,117	257 / 23%	143 / 12.8%	35.8%
2014–2015[16]	994	219 / 22%	163 / 16.4%	38.4%

Illustration 2 – Mental Health Review Board Survey

Council carried out a survey between 1 June and 30 September monitoring the timeliness and content of medical reports for MHRB hearings and attendance by treating psychiatrists at the hearings. Official Visitors and MHLC lawyers were asked to complete the survey for each hearing that they attended.

The majority of hearings were at Graylands Hospital (and the numbers at some other hospitals were very low). Overall, only 22 (30%) of the 73 reports were made available to the consumer, their lawyer or their Official Visitor, three days prior to the hearing. Indeed 44% were not available until the day of the hearing. In those cases where the medical report was available prior to the day of the hearing, only 33% of consumers said their psychiatrists had discussed the report with them. This is unacceptable and a breach of the consumer's right to natural justice[17].

The results of the survey in regard to attendance by psychiatrists was also disappointing, with only 42 (58%) of the 73 hearings surveyed being attended by the treating psychiatrist. Attendance by Frankland Centre psychiatrists was particularly poor with the treating psychiatrist being in attendance on only four (33%) of the 12 hearings.

Based on the results of the survey, the content of medical reports was addressed reasonably well by psychiatrists at most hospitals with a few exceptions.

- Of the 73 medical reports surveyed, s4 of the Act was complied with in 93% of cases.
- Seven of the 73 reports (9.6%) failed to address all four (mandatory) criteria of s26 of the Act, five of which were by the Frankland Centre.
- A treatment plan was not noted in seven of the 73 reports.
- Section 137 of the Act requires the MHRB to consider any medical and psychiatric history of the consumer and their social circumstances – two and eight reports respectively failed to address these issues.

16 The data reported is for a ten month period from 1 July 2014 to 30 April 2015 only. Comparisons of the number of hearings cannot be made with previous years' figures as the data reported for all other years were for a 12 month period.

17 It is Council's position that medical reports relied on by the MHRB should be made available to the consumer and any representative at least three days before the hearing (as is required by Regulations in some other states) and that the psychiatrist should discuss the report with the patient before the hearing (instead of the Official Visitor or their lawyer having to take the patient through the report for the first time). Council is also of the view that the psychiatrist should attend the hearing, or be available by telephone, and that the reports should address all the criteria required by s26 of the Act to be met before a person can be made involuntary as well as the matters required to be considered by the MHRB in s137 of the Act.

It is a goal of Council to "promote and protect the rights of consumers to natural justice and procedural fairness in hearings and endeavour to improve the observance of that right".

PART THREE

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 2014–2015 compared with the previous year's figures (provided in brackets), such as:

- number of consumers assisted by Council: **1,772 (1,602): 10.6% increase**
- number of new consumers (i.e., consumers making their first contact with Council): **774 (656): 18.0% increase.**

Data obtained by Council from the DOH and the MHRB (see Table 2 below) however shows decreases in the number of involuntary inpatient orders, the number of people put on orders and the number of involuntary inpatients, yet an increase in the number of people contacting public mental health services, the number of voluntary inpatients and the number of people put on involuntary orders for the first time, as outlined below.

- number of involuntary inpatient orders to detain a person under the Act (as reported by the MHRB): **2,753 (2,621): 5.0% increase**
- number of people put on a Form 6 or 9 involuntary inpatient order (as reported by the MHRB): **2,151 (2,072): 3.8% increase**
- first time on a Form 6 (i.e., first time made an involuntary inpatient in Western Australia (WA), as reported by the MHRB): **979 (909): 7.7% increase**
- involuntary inpatients (as reported by the DOH): **2,000 (2,388): 16.2% decrease**
- mental health inpatients (voluntary and involuntary as reported by the DOH): **17,528 (15,647): 12.0% increase**
- people who contacted public mental health services (as reported by the DOH): **60,023 (56,350): 6.5% increase**
- mental health patients discharged from general DOH wards (as reported by the DOH): **10,293 (9,915): 3.8% increase.**

We are unable to provide the number of CTOs issued this year due to database issues at the MHRB.

CONTENTS

Table 2: Mental Health Consumer Data from Council, DOH and MHRB									
Year	No. of people who asked for visits by Council	No. of involuntary inpatients[18] (DOH data)	No. of people put on a form 6 involuntary inpatient order[19] (MHRB data)	No. of involuntary inpatient orders (form 6) issued[20] (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[21] (MHRB data)	No. of mental health inpatients (voluntary and involuntary)[22] (DOH data)	No. of mental health patients discharged from general DOH wards[23]	No. of people who contacted public mental health services[24] (DOH data)
2004-2005	800	2,587	2,151	2,752	NA	970	11,602	7,460	37,951
2005-2006	891	2,354	2,026	2,535	NA	951	11,655	7,728	39,872
2006-2007	979	2,419	1,976	2,315	NA	827	12,100	8,176	40,776
2007-2008	1,052	2,349	2,013	2,486	NA	771	12,190	8,273	40,836
2008-2009	850	2,268	1,897	2,397	NA	843	12,842	8,851	43,048
2009-2010	957	2,417	2,128	2,688	922	907	13,638	9,459	45,148
2010-2011	1,201	2,525	2,141	2,690	930	923	14,728	10,298	48,305
2011-2012	1,438	2,429	2,094	2,628	1,069	844	15,892	11,436	51,064
2012-2013	1,539	2,543	2,084	2,627	890	826	16,989	12,176	54,280
2013-2014	1,602	2,388	2,072	2,621	909	883	15,647	9,615	56,350
2014-2015	1,772	2,000	2,151	2,753	979	889	17,528	10,293	60,023

18 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 was reported to Council on 12 August 2015 by DOH and may be subject to change. Data reported by Council in previous years has been updated by DOH with the exception of 2004-2005.

19 Source: MHRB. Data represents the number of people made involuntary during the financial year (form 6 or 9). If multiple involuntary inpatient orders were made during the year, the individual is counted once. This does not include people who were an involuntary inpatient where the order (form 6) was made prior to 1 July 2014 (except where a form 9 was made during the financial year) or mentally impaired accused persons. Some of the data reported by Council in previous years has been updated by MHRB.

20 Source: MHRB. Data represents the number of involuntary inpatient orders made during the financial year and does not include people who were an involuntary inpatient where the order (form 6 or 9) was made prior to 1 July 2014 (except where a form 9 was made during the financial year) or mentally impaired accused persons. A person may be counted more than once if multiple involuntary orders are made in the same financial year. Some of the data reported by Council in previous years has been updated by MHRB.

21 Source: MHRB. This represents the number of new CTOs and the number of CTOs made on discharge of a detained person during the year. Data for the 2014-2015 year are for the period 1 July 2014 to 30 April 2015 only.

22 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 also includes separations from Hospital in the Home Mental Health. This data does not reflect multiple discharges as individuals are counted once during the financial year. Data was reported to Council on 12 August 2015 by DOH and maybe subject to change. Data reported by Council in previous years has been updated by DOH with the exception of 2004-2005.

23 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 2014-2015. People may have been voluntarily or involuntarily treated as a mental health patient. Data reported by Council in previous years has been updated by DOH with the exception of 2004-2005.

24 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 was reported to Council on 12 August 2014 by DOH and subject to change. Data reported by Council in previous years has been updated by DOH with the exception of 2004-2005.

ANALYSIS OF CONSUMER DATA

Numbers of Involuntary Patients

The MHRB data shows the number of people subject to an involuntary inpatient order increased by 79 (or 3.8%) and the number of involuntary orders increased by 132 (or 5.0%) in 2014–2015. It appears that demand for mental health services also increased (based on the number of people contacting public mental health services), more mental health patients were discharged (both voluntary and involuntary and those from general wards) and the number of people assisted by Official Visitors increased. In fact, all the statistics (Council's figures and those obtained from both the MHRB and the DOH) show increases regarding involuntary detention with the exception of the number of people discharged from hospital who were involuntary at some point during their stay which showed a significant decrease of 16.2% in 2014–2015 and follows a decrease the previous year of 6.1%.

The number of people subject to multiple involuntary inpatient orders during the year (i.e., an indication of the rate of return to hospital) also increased and is the highest it has been for the past 10 years. In 2014–2015 there appeared to have been 602 people subject to multiple orders based on MHRB data, up from 549 and 543 the previous years.

The number of people being subject to an involuntary inpatient order for the first time also continues to increase. In 2014–2015 there were 979 people subject to an involuntary order for the first time in WA, and this figure increased 7.7% from the previous year (from 919) and 2.1% from the year before (from 890). This is consistent with the number of new consumers that Council assisted which increased 18.0% this year and these increases are concerning apparent trends.

Increases in Council's Consumer Numbers

As can be seen from Appendix 10, Council's consumer numbers increased significantly in 2014–2015 (by 10.6%) which follows years of successive increases. This is consistent with the increase in the number of people made involuntary (increase of 3.8%). The fact that the number of consumers asking Council for help increased, therefore reflects ongoing demand that is higher than that reflected in the 10.6% increase.

While Council has a very high 'rate of return' from consumers, there was also a significant increase in the number of people approaching Council for the first time (increased by 18.0% to 774 new consumers).

The number of people on a CTO asking Council for help increased slightly.

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 (1,492) followed by hostel residents (202) and then people on a CTO represented as being treated in regional and metropolitan clinics (64).

Graylands Hospital remains the single biggest source of hospital consumers (342) but the number of consumers at Graylands Hospital decreased significantly, almost certainly reflecting the closure of beds in that facility. There were significant increases in the number of consumers seeking Council assistance at Fremantle, Bentley, Armadale, Rockingham and Kalgoorlie hospitals[25].

25 See Appendix 9.

ANALYSIS OF ISSUES AND REQUESTS

During 2013–2014 Council was advised that a new database system would be up and running by 1 July 2014 and a decision was made to stop coding complaints. Council remains unable to access information on the types of complaints made to Official Visitors to inform its operations or report on complaints. The old computer system has resulted in double handling of information by office staff and ineffective procedure. If a computer system that can handle the requirements of the 2014 Act is not implemented before 30 November 2015, however, the new Mental Health Advocacy Service (MHAS) is at high risk of breaching its statutory obligations and it will incur high and unnecessary administrative costs in trying to do so.

BUDGET AND RESOURCING ISSUES

Council was allocated a budget of $1,907,360 for the 2014–2015 financial year and expended $1,916,322 according to figures provided by the MHC[26]. This was 0.8%[27] increase on expenditure compared to the previous year and $8,962 (0.5%) over budget.

Payments to Official Visitors were $1,279,536 in 2014–2015 which is 66.8% of Council's total expenditure, and represents an increase of 7.7% (or $91,404) compared to the previous year's payments to Official Visitors. This increase is more than explained by the 10.6% increase in consumer numbers and the opening of Fiona Stanley Hospital in February 2015. Head of Council's workload also increased in the past two years due to her involvement in preparation for the implementation of the 2014 Act.

The remainder of Council's expenditure was for administration costs (33.2% or $636,786) which has decreased both as a percentage of total expenditure and in terms of the actual amount due to 'one-off' expenses incurred in 2013–2014 for additional office accommodation. There continued to be extra costs associated with administration to cope with the duplication of work created by a 16 year old computer system (a system that has not met Council's operational needs for many years). Despite years of development work on a new computer system, as at 30 June 2015, the implementation of a new computer system was again postponed. This has impacted on Council's ability to monitor trends and effectively deploy its resources.

Council has reported in previous years about the lack of regular financial expenditure records which continue to be a problem in managing Council's finances.

Remuneration of Official Visitors

Official Visitors are entitled to remuneration as determined by the Minister for Mental Health (s180 of the Act) and the last increase in remuneration was effective from 1 July 2014. The rates are as follows:

- Head of Council: full day $504; half day $336
- Official Visitors: full day $336; half day $231.

The MHC is required[28] to report the individual cost of remunerating board and committee members in its annual reports. In 2013–2014 the remuneration was incorrectly reported, with several payments overinflated. Corrections are being published in the Commission's 2014–2015 annual report.

26 Council was not provided with information by the MHC to verify these figures.
27 Council's expenditure for 2013-2014 was revised down from $1,912,360 as reported in the 2013-2014 Annual Report, to $1,900,077.
28 See Premier's Circular 2010/02 – State Government Boards and Committees.

The remuneration structure of half and full day sittings is based on payments for government board members, but does not reflect the way Official Visitors work which is highly operational. Council has Official Visitors who work almost full time hours which is more cost effective for Council. Their hours, however, include weekends and evenings and they do not get sick leave, over-time rates or holiday leave. Official Visitors must supply their own phones, computers and transport. Their work load is erratic and they are not paid for travel time (except when travelling between facilities). Many do not claim the costs of phone calls, parking fees or things like printing documents from their home computers and Executive Group members cannot be paid for additional work they undertake to fulfil their role and cannot be paid at a higher rate, despite taking on increased responsibility.

The MHAS, which will replace the Council, under the 2014 Act, will allow considerably more flexibility than is currently available including the ability to retain senior mental health advocates who can take on supervisory and administrative work.

Administrative Support

Council's support staff continues to struggle to keep up with the administrative workload of supporting Official Visitors as both consumer numbers and the number of facilities to be inspected continue to increase. Consumer numbers have risen each year since 2008–2009 and have increased 85.2% in the past six years.

An independent report produced in September 2010 said Council needed two extra FTE and this was prior to the major increases in consumer numbers. In 2011 Council settled for one new staff member (taking it to four FTE) while calling for a new database which it expected would reduce some of the administrative handling of reports. In the meantime Council has used temporary staff and, as already noted, complaints coding was stopped during 2013–2014 as another cost cutting measure.

Electoral Act Requirements

a) As required under the *Electoral Act 1907* s175ZE(1), during 2014–2015 the Council expended the following in relation to the designated organisation types:

b) advertising agencies: nil

c) media advertising organisations: $2,635 (paid to Adcorp)

d) market research organisations: nil

e) polling organisations: nil

f) direct mail organisations: nil.

STRATEGIC PLAN 2013–2015

Council's Strategic Plan aims to focus Council's attention on issues of concern to Official Visitors within the parameters of the legislative functions. The Strategic Plan is complemented by a year by year operational plan which uses activities such as the focus areas for the monthly inspection visits, Official Visitor training, Head of Council advocacy and Council processes and procedures to carry out the strategies listed to achieve the goals.

The goals for Council have not changed significantly over the past few years and Council was expecting to have changed into the new advocacy service by now. At its May 2013 Full Council Meeting Council therefore agreed to another two year plan, pending the introduction of the 2014 Act, in very similar terms to the previous two year strategic plan. A copy of the Plan is provided in Appendix 12.

The goals reflect the issues of greatest concern to Official Visitors, which are:

1. to improve the MHRB process for consumers
2. to improve the variety, and standards, safety and suitability, of supported accommodation facilities inspected by Council (i.e., licensed hostels, Community Supported Residential Units (CSRUs) and Community Options housing) and the quality of care and recovery oriented services provided to residents of these facilities
3. 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)
4. to improve Council's processes and procedures
5. to ensure, protect and improve the observance of consumers' human rights and quality of care in any relevant proposed legislative or other change.

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 President of the MHRB, the executive directors of North Metropolitan Mental Health Services and various South Metropolitan authorised hospitals, the clinical and nursing directors of metropolitan authorised hospitals, staff of the MHC and the LARU.

Other meetings attended by Head of Council during the year included meetings with the Mental Health Commissioner, the Acting Commissioner for Children and Young People, the Principal Solicitor and Manager of the MHLC, the Chairman of the MHLC Board, the NDIS Manager, and other agencies and people including Consumers of Mental Health WA and HaDSCO, and some hostel Licensees. At these meetings, Head of Council gathers and shares information and raises issues of concern and/or advocates for specific changes both on behalf of individual consumers and at a systemic level.

Mental Health Bill 2013 Implementation Committees and Consultations

Head of Council is a member of the Mental Health Bill Implementation Reference Group and the Mental Health Advocacy Services Working Group. She has nominated representatives from Council to participate on the Mental Health Bill Education Steering Committee and the Chief Psychiatrist's Approved Forms Working Group.

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:
- South Metropolitan Health Service, Mental Health Strategy and Leadership Unit, Mental Health Seminars 2014 – *"Improving the System for Mental Health Consumers: The Intersection of Official Visitors and Hospital Staff"*
- Partners in Recovery Network
- Health and Disability Services Complaints Office staff
- WA Society of Jewish Jurists and Lawyers – medico-legal conference
- Polytechnic West

- Swan Valley Centre – student nurses
- Mental Health Commission Evaluators – induction training
- Criminal Law Mentally Impaired Accused forum on 27 October 2015 – *"Seeking Change in the Legislation"* (panel member)
- Richmond Fellowship – *"Leading Change in Mental Health"* (panel member)

Official Visitors also gave presentations to:

- Richmond Fellowship – Bunbury CSRU, Busselton CSRU and Queens Park Service
- St Bartholomew's Arnott Villas
- Graylands Hospital's Academic Hour
- Medical staff at Fiona Stanley Hospital
- Allied and nursing staff at Sir Charles Gairdner Hospital
- Fremantle Hospital – Doctors' education session
- Alma Street Centre – ward staff.

Official Visitor Training

Full day training sessions are provided to Official Visitors usually twice per year and training is scheduled the day before the Full Council Meeting so that regional Official Visitors can also attend. In addition, Council invites speakers to team meetings with regional Official Visitors taking part by video link. In anticipation that Council will cease to exist in November 2015, June training was cancelled.

The December 2014 Full Council Meeting training included:

- a workshop on *"Trauma Informed Care: What Every Official Visitor Needs to Know"* by Kerry Hawkins, Recovery Consultant
- a presentation titled *"Implementation of the Stokes Review Recommendations and Preparation for the new Mental Health Act"* by Kingsley Burton, A/Executive Director, Office of Mental Health, Department of Health
- a presentation on peer support work at CAMHS by Beverly Robinson, Senior Project Officer and Sheriden Carlson, Peer Support Worker CAMHS
- a 'hypothetical' scenario chaired by Justice David Parry with lawyers from the Mental Health Law Centre and Official Visitors
- a presentation on the new Disability Justice Centre by Megan Barnett, Disability Justice Manager, Disability Services Commission.

Other training provided during the year included:

- August 2014 – Sandy Boulter, Mental Health Law Centre – patient records
- September 2014 – Susan Moir and Sandra Labuschagne from the Office of the Auditor General (OAG) – OAG's role and findings from a hostel enquiry
- October 2014 – Leanne Pech and Trish Heath, Commission for Children and Young People – Handling complaints from young people
- February 2015 – Kingsley Burton, Acting Executive Director of Office of Mental Health – Implementation of the Stokes Review recommendations and preparation for the 2014 Act

- March 2015 – Louise Cefalo, Acting Quality Assurance Officer, Mental Health Commission – Quality management framework for community managed organisations
- May 2015 – Greg Gordon, Clinical Nurse Specialist, Drug and Alcohol Office – Addiction and DAO services
- May 2015 – Sara Visser, Richmond Fellowship Fremantle – Partners in Recovery referral process
- attendance by some Official Visitors and Council support staff at various seminars and workshops including the following:
  - The MHS – The Mental Health Services Conference 2014[29]
  - "*Professional Development Day*" by the Mental Health Review Board
  - *"First responders suicide prevention"* forum by the Mental Health Commission
  - "*Cultural Competency Training for mental health professionals and the non-profit sector*" by the Ethnic Disability Advocacy Centre
  - *"Trauma, Culture and Mental Health"* in the "Let's Talk Culture" series by the Western Australian Association of Mental Health
  - *"Capacity"* by the Office of the Chief Psychiatrist
  - *"Capacity: the 2014 Act"* by the Mental Health Review Board and included a number of speakers and topics including: Matthew Howard SC on consent/capacity; Margaret Doherty from Mental Health Matters 2 on the 2014 Act; and John Pinnington on de-escalation techniques
  - *"Shared Decision Making – Prescribing Medication to Enable Recovery"* by Richmond Fellowship
  - *"Suicide Prevention"* by Wesley Life Force
  - *"Linking the Housing Sector with Social Service"* by Richmond Fellowship
  - *"Nutrition and Mental Health: a review of the evidence"* by South Metropolitan Health Service, Mental Health Strategy and Leadership Unit
  - *"Trauma Informed Practice"* by Richmond Fellowship
  - *"Trauma Informed Practice & Person-Centred Risk and Safety"* by Richmond Fellowship
  - *"Rebuilding life with Mental Health Challenges: From therapy to education"* by Richmond Fellowship, Albany
  - *"Mental Health First Aide"* by Partners in Recovery, Albany
  - *"A Common Vision for Recovery"* by Richmond Fellowship
  - *"Introduction to Recovery Approach – Recovery in a World Context"* by Richmond Fellowship
  - *"Making Real Connection – who am I to help you"* by Richmond Fellowship
  - *"Eating Disorders Forum"* by Bridges Eating Disorder Association of Western Australia Inc.
  - *"Leading Change in Mental Health"* by Richmond Fellowship
  - *"Governance in Recovery Focused Services"* by Richmond Fellowship
  - *"The Power of Information: Driving organisational performance through effective information management"* by the Institute of Public Administration Australia WA
  - *"NDS and NDIA Information Forum"* by the National Disability Services Western Australia.

29 Official Visitors received financial support to attend the conference through a subsidy from the Western Australian Association for Mental Health.

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 this 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. Official Visitors are also required to declare any disqualifying interests (see s178 and Schedule 3 of the Act) for 2013–2014. No disqualifying interests were identified.

Complaints Regarding Official Visitors and Council Operations

There were eight complaints received during the year with two complaints from consumers, one from a parent of a consumer and five by mental health services staff. There was also one ongoing complaint from the previous financial year by mental health services staff. Although Council has a Complaints Policy (a copy of which can be found on the website under 'Other Publications') and an official complaints form, most of the complaints were not made formally but by telephone or by email.

- A consumer complained that his request for a visit by an Official Visitor was not acted upon. Review of Council's records and inquiries made of Official Visitors who may have been on the ward at the time failed to find any reference or knowledge of the request. This was explained to the consumer but an apology was also provided.

- A hostel resident telephoned and spoke to Head of Council complaining that her Official Visitor was not helping her, had done nothing for her, and that Council's service was not giving her the support she needed. Head of Council explained the complaint options and suggested a change of Official Visitor. The complaint was not pursued formally and the consumer was allocated a different Official Visitor.

- The parent of a consumer reported that their (adult) son had told them that an Official Visitor had spent the night with them. There was no Official Visitor by the name given by the parents. Urgent investigations showed a person who had been a patient at the same hospital as their son had told him that he was an Official Visitor. The patient had been on an open ward and visited the son while he was on a locked ward. The parent was reassured and accepted that the person had not been an Official Visitor.

- A nurse complained about Council's support for patient bedrooms being open during the day. Head of Council spoke to the nurse concerned about Council's approach but a resolution was not reached. The complaint was not pursued formally.

- A psychiatrist complained about an Official Visitor's style of communication just before and during a family meeting. Council offered either an external investigator or Deputy Head of Council (who had not worked directly with the Official Visitor who was the subject of the complaint) to investigate the matter. The doctor accepted the Deputy Head of Council as the investigator and she conducted interviews with the parties who attended the meeting. She and Council's Manger subsequently met with the Official Visitor and the doctor to discuss the preliminary findings. While there were some differences in facts, or at least recall of the facts, all parties acknowledged that miscommunication had occurred. The Official Visitor was counselled and some areas for improvement by the medical staff were also noted.

- A psychiatrist complained to an Official Visitor about two issues relating to her advocacy for a consumer. One issue was resolved following receipt of advice from the OCP confirming the content of the advocacy; the other issue was resolved by discussion between the Official Visitor and the doctor.

- A Clinical Director complained to Head of Council about a letter sent to the Australian Health Practitioner Regulation Agency on behalf of a patient complaining about a second opinion. Concerns were raised about a change of approach by Official Visitors and that the matter had not been raised first with the Clinical Director. It was made clear that the consumer chose this option. It was acknowledged that perhaps the consumer could have been persuaded to initially raise the matter with the Director but ultimately Official Visitors act according to the consumer's wishes.

- A Clinical Director complained about an Official Visitor's behaviour, including that he had allowed a consumer's lawyer to see the consumer's medical file. Discussions were held with Head of Council. The patient had consented (in writing) to information sharing with the lawyer. There were various matters in dispute about the patient's care. Council offered to retain an independent investigator but the offer was not taken up.

- In the case of an ongoing complaint by mental health service staff referred to in last year's Annual Report, options were canvassed with the complainant to follow up the matter, but they chose not to pursue the matter.

Appendix 1: Authorised Hospitals

Hospital name, mental health ward and address	No of beds authorised[30]
Albany Regional Hospital, Albany Mental Health Unit Hardie Road, Albany	**16**[31]
Armadale Health Service Leschen Unit Albany Highway, Armadale	**41**
Bentley Adolescent Unit Mills Street, Bentley	**12**
Bentley Hospital and Health Service, Mills Street Centre Mills Street, Bentley	**76**
Broome Health Campus, Mabu Liyan Unit Robinson Street, Broome	**13**[32]
Bunbury Regional Hospital **Acute Psychiatric Unit (APU) and Psychiatric Intensive Care Unit (PICU)** Bussell Highway, Bunbury	**27**
Fiona Stanley Hospital Mental Health Unit[33] Murdoch Drive, Murdoch	**20**
Frankland Centre, State Forensic Mental Health Services Brockway Road, Mount Claremont	**38**[34]
Fremantle Hospital and Health Service, Alma Street Centre Alma Street, Fremantle	**64**
Graylands Hospital, Adult Mental Health Services Brockway Road, Mount Claremont	**136**
Joondalup Health Campus, Joondalup Mental Health Unit Shenton Avenue, Joondalup	**47**
Kalgoorlie Regional Hospital, Mental Health Inpatient Service Piccadilly Street, Kalgoorlie	**6**[35]
King Edward Memorial Hospital, Mother and Baby Unit Loretto Street, Subiaco	**8**
Rockingham Hospital, Mimidi Park Elanora Drive, Rockingham	**30**
Selby Older Adult Mental Health Service Lemnos Street, Shenton Park	**32**
St John of God Mt Lawley Hospital, Ursula Frayne Unit Thirlmere Road, Mount Lawley	**12**
Sir Charles Gairdner Hospital, Mental Health Unit[36] Verdun Street, Nedlands	**0**
Swan Health Service, Swan Valley Centre and Boronia Inpatient Unit Eveline Road, Middle Swan	**44**[37]
TOTAL BED NUMBERS	**622**

30 As at 30 June 2015.

31 Albany Mental Health Unit opened with 12 beds on 26 July 2013 and an additional 4 beds were opened on 23 February 2015.

32 Mabu Liyan Unit is a 14 bed unit, however, one bedroom is used as a seclusion room.

33 Fiona Stanley Hospital Mental Health Unit was authorised on 23 December 2014 and opened on 3 February 2015. As at 30 June 20 beds had been opened in the 30 bed unit.

34 Includes eight beds that are on Hutchison ward at Graylands Hospital that are funded by the Frankland Centre.

35 Kalgoorlie Regional Hospital, Mental Health Inpatient Service is a 7 bed unit, however one bedroom is used as a seclusion room.

36 Sir Charles Gairdner Hospital, Mental Health Unit was authorised on 29 May 2015, however no beds were open as at 30 June 2015.

37 Includes two permanent over-census beds.

Appendix 2: Private Psychiatric Hostels[38]

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)	
Casson House 2-10 Woodville Street, North Perth	92
Woodville House 425 Clayton Road, Helena Valley	25
Devenish Lodge AJH Nominees Pty Ltd (Licensee) 54 Devenish Street, East Victoria Park	41
Franciscan House Meski International Pty Ltd (Licensee) 16 Hampton Street, Burswood	75
Ngatti, Fremantle Supported Accommodation for Homeless Youth Life Without Barriers (Licensee) 5-9 Alma Street, Fremantle	16
Joondalup Mental Health Sub-Acute Service Neami Limited (Licensee) 22 Upney Mews, Joondalup	22
Ngurra Nganhungu Barndiyigu Fusion Australia Ltd (Licensee) 30 Onslow Street, Geraldton	14
Pu-Fam Pty Ltd (Licensee)	
St. Jude's Hostel 30-34 Swan Street, Guildford	52
East St Lodge 53A and 53B East Street, Guildford	10

38 Private psychiatric hostels include group homes, CSRUs, and Community Options homes. Bed numbers are as at 30 June 2015.

Romily House **70**
Judith Balfe (Licensee)
19 Shenton Road, Claremont

Richmond Wellbeing Incorporated (Licensee)[39]

- **Bunbury CSRU** **15**
  12 Jury Bend, Carey Park
- **Busselton CSRU** **10**
  Powell Court, Busselton
- **Kelmscott Community Options** **8**
  25 Hicks Road, Kelmscott
- **Mann Way** **12**
  4-6 Mann Way, Bassendean
- **Ngulla Mia** **34**
  96 Moore Street, East Perth
- **Queens Park Service** **10**
  21-23 Walton Street, Queens Park
- **Westminster Service** **6**
  32A and 32B Ullswater Place, Westminster

Roshana Pty Ltd (Licensee)

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

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

Southern Cross Care (WA) Inc. (Licensee)

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

39 Richmond Fellowship of Western Australia Incorporated changed their name to Richmond Wellbeing Incorporated on 27 May 2015.

St Bartholomew's House Inc. (Licensee)

Arnott Villas 20 Arnott Court, Kelmscott	**22**
Bentley Villas 1 Channon Street, Bentley	**25**
Cannington Accommodation Unit 73A & B Mallard Way, Cannington	**6**
Medina Accommodation Unit 61 Ougden Way, Medina	**6**
Midland Accommodation Unit 7A & 7 B George Street, Midland	**6**
Sunflower Villas 15 Limosa Close, Stirling	**25**
Swan Villas 91 Patterson Drive, Middle Swan	**25**

St Vincent de Paul Society (WA) Inc. (Licensee)

Vincentcare Bayswater House 65 Whatley Crescent, Bayswater	**6**
Vincentcare Coolbellup House 66 Waverly Road, Coolbellup	**0**[40]
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 Street, Woodbridge	**28**
Vincentcare Warwick House 39 Glenmere Road, Warwick	**4**
TOTAL BED NUMBERS	**854**

40 Vincentcare Coolbellup became vacant on 3 March 2015 and officially closed on 19 May 2015.

Appendix 3: Council of Official Visitors' Membership

Head of Council	Commencement	Expiry of Term
Debora Colvin	1 February 2007	2 April 2017 *(HOC from 1 April 2008)*
Official Visitors		
Sherril Ball	2002	7 April 2015 *(Extended leave since January 2013)*
Denise Bayliss	7 March 2006	2 April 2018
Donald Cook	2 February 2010	2 April 2018
Cecily Cropley	16 October 2012	2 April 2018
Alessandra D'Amico	1 February 2007	2 April 2018
Michael Dixon	18 January 2008	4 April 2016
Gerard Doyle	18 January 2008	4 April 2016
Maxine Drake	1 April 2014	2 April 2017
Mardi Edwards	16 April 2012	2 April 2017
Margaret Fleay	2 May 2011	2 April 2017
Barbara Hewitt	5 December 2011	2 April 2017
Naka Ikeda	7 March 2006	2 April 2018
Norma Josephs	2 May 2011	2 April 2017 *(Extended leave since 13 June 2015)*
Kerry Long	17 March 2015	2 April 2018 *(Extended leave since 17 March 2015)*
Shelley McClellan	22 October 2013	4 April 2016
Ann McFadyen	7 April 2002	2 April 2018
Sandra McKnight	1 April 2014	2 April 2017
Melinda Manners	1 April 2007	2 April 2018 *(Extended leave since August 2011)*
Gary Marsh	23 February 2010	2 April 2018
Vlasta Mitchell	1 April 2014	2 April 2017
Bruce Morrison	2 February 2010	2 April 2018
Trinette Murphy	27 May 2014	2 April 2017
Kate Nihill	16 October 2012	7 April 2015 *(Resigned effective 20 May 2015)*
Kaylee Oberg	22 October 2013	4 April 2016 *(Extended leave since 15 December 2014)*
Graham Pyke	3 December 2009	2 April 2018
Sheila Rajan	7 April 2009	2 April 2018
Patricia Ryans-Taylor	3 December 2009	2 April 2018
Matthew Scurfield	1 April 2014	2 April 2017 *(Extended leave since 29 June 2015)*
Kathleen Simpson	27 February 2012	2 April 2017
Jeff Solliss	7 April 2009	2 April 2018 *(Extended leave since 24 December 2013)*
Kelly Spouse	1 August 2009	2 April 2018
Jennifer Stacey	22 October 2013	4 April 2016 *(Extended leave since March 2015)*
Helen Taplin	7 March 2006	2 April 2018
Peter Upton-Davis	1 April 2014	2 April 2017
Sally Wheeler	16 October 2012	2 April 2018
Ian Wilson	2 May 2011	2 April 2017

Appendix 4: Official Visitors' Attendance at Meetings

	Full Council Meetings	Executive Group Meetings	
Official Visitor	12 December 2014	19 March 2015	18 June 2015
Debora Colvin *(Head of Council)*	✔	✔	✔
Jennifer Stacey	✔	-	-
Sherril Ball	Extended Leave	-	-
Denise Bayliss	✔	✔	✔
Cecily Cropley	✔	✔	✔
Don Cook	✔	-	-
Alessandra D'Amico	✔	✔	✔
Matthew Scurfield	✔	-	-
Mike Dixon	✔	-	-
Gerry Doyle	Extended Leave	-	-
Mardi Edwards	✔	✔	-
Maxine Drake	✔	-	-
Margaret Fleay	✔	✔	✔
Rod Hay	Extended Leave	-	-
Barbara Hewitt	✔	-	-
Naka Ikeda	✔	-	-
Norma Josephs	✔	✔	-
Sandra McKnight	✔	-	-
Kerry Long	NA	-	-
Shelley McClellan	✔	-	✔P
Ann McFadyen	✔	-	-
Melinda Manners	Extended Leave	-	-
Gary Marsh	✔	-	-
Vlasta Mitchell	✔	-	-
Bruce Morrison	✔	-	-
Trinette Murphy	✔	✔	✔
Kate Nihill	✔	-	-
Kaylee Oberg	Apology	-	-
Graham Pyke	✔	✔	✔
Sheila Rajan	Apology	-	-
Patricia Ryans-Taylor	Apology	-	✔
Kathleen Simpson	✔	-	-
Jeff Solliss	Extended Leave	-	-
Kelly Spouse	✔	-	-
Helen Taplin	✔	✔	✔
Sally Wheeler	✔	-	-
Ian Wilson	✔	-	-
Peter Upton-Davis	✔	-	-
Donna Haney (Manager)	✔	✔	✔
Michelle Galvez (Minute Taker)	✔	✔	✔

✓ - attended NA – not appointed - not required to attend ✓P – proxy

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 to ensure their employees comply with the Record Keeping Plan. The following compliance information is provided.

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

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

2. The organisation conducts a recordkeeping training program.

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

   Official Visitors' Operations Manual covers recordkeeping 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 recordkeeping responsibilities.

Appendix 6: Authorised Hospital Inspections

AUTHORISED HOSPITAL	TOTAL NUMBER OF INSPECTIONS (INFORMAL INSPECTIONS[41])	TIME OF INSPECTION		
		Weekdays 9am – 5pm	Weekdays 5pm – 9am	Weekends and Public Holidays
Albany Mental Health Unit	12 (22)	10 (21)	1 (1)	1
Alma Street Centre, Fremantle	48 (5)	40 (5)	4	4
Bentley Adolescent Unit	12 (14)	11 (10)	1 (2)	(2)
Bunbury Acute Psychiatric Unit and Psychiatric Intensive Care Unit	24 (8)	20 (8)	2	2
Frankland Centre	12	11	1	
Graylands Hospital	108	90	9	9
Fiona Stanley Hospital Mental Health Unit[42]	15 (3)	13 (3)	2	
Joondalup Mental Health Unit	12	10	1	1
Kalgoorlie Mental Health Inpatient Service	12 (24)	10 (23)	1	1 (1)
Leschen Unit, Armadale	48	40	4	4
Mabu Liyan Unit, Broome Hospital	12 (23)	9 (22)	2 (1)	1
Mills Street Centre, Bentley	48 (14)	40 (9)	4 (3)	4 (2)
Mimidi Park, Rockingham	48	40	4	4
Mother and Baby Unit, KEMH	12	11	1	
Selby Lodge	12 (1)	10	1 (1)	1
Swan Valley Centre and Boronia Unit, Swan District Hospital	24 (3)	20 (3)	2	2
Ursula Frayne Unit, St John of God Mt Lawley Hospital	12	10	1	1
TOTAL	**471 (117)**	**395 (104)**	**41 (8)**	**35 (5)**

Note: informal inspections are provided in brackets.

41 Those hospitals with more wards get more visits as not all wards are inspected on the same visit.
42 Fiona Stanley Hospital Mental Health Unit was authorised on 3 December 2014 and opened on 23 February 2015.

Appendix 7: Private Psychiatric Hostel Inspections[43]

LICENSED HOSTEL, GROUP HOME, CSRU AND COMMUNITY OPTIONS HOMES	TOTAL NUMBER OF INSPECTIONS	TIME OF INSPECTION		
		Weekdays 9am– 5pm	Weekdays 5pm – 9am	Weekends and Public Holidays
Albany CSRU	6	6		
Burswood Care	6	5	1	
Casson Homes – Casson House	6	5	1	
Casson Homes – Woodville House	6	6		
Devenish Lodge	6	5	1	
East St Lodge	6	5	1	
Franciscan House	7	6	1	
Joondalup Mental Health Sub-Acute Service	7	7		
Ngurra Nganhungu Barndiyigu	6	5		1
Ngatti Fremantle Supported Accommodation for Youth Homeless	6	2	4	
Richmond Fellowship – Bunbury CSRU	6	5	1	
Richmond Fellowship – Busselton CSRU	6	5	1	
Richmond Fellowship – Kelmscott CSRU	6	5	1	
Richmond Fellowship – Mann Way	6	5	1	
Richmond Fellowship – Ngulla Mia	6	5	1	
Richmond Fellowship – Queens Park Service	6	5	1	
Richmond Fellowship – Westminster Service	6	5	1	
Romily House	6	5	1	
Roshana – Honey Brook Lodge	7	6	1	
Roshana – BP Luxury Care	6	5	1	
Salisbury Home	6	5	1	
Southern Cross – Bentley House	6	5	1	
Southern Cross – Mt. Claremont	6	5	1	
Southern Cross – Stirling House	6	4	1	1

43 Private psychiatric hostels include group homes, CSRUs, and Community Options homes.

St Bartholomew's – Arnott Villas CSRU	6	5	1	
St Bartholomew's – Bentley Villas CSRU	6	5	1	
St Bartholomew's – Cannington Accommodation Unit	6	4	1	1
St Bartholomew's – Medina Accommodation Unit	6	5		1
St Bartholomew's – Midland Accommodation Unit	6	6		
St Bartholomew's – Sunflower Villas	6	5	1	
St Bartholomew's – Swan Villas	6	6		
St Jude's Hostel	6	5	1	
Vincentcare – Bayswater House	6	6		
Vincentcare – Coolbellup House	4	4		
Vincentcare – Duncraig House	6	4	1	1
Vincentcare – South Lakes House	6	5	1	
Vincentcare – Swan View House[44]	6	4	1	1
Vincentcare – Vincentian Village	6	4	1	1
Vincentcare – Warwick House	6	6		
TOTAL	**235**	**196**	**32**	**7**

44 Vincentcare Coolbellup became vacant on 3 March 2015 and officially closed on 19 May 2015.

Appendix 8: Total Consumers Contacted By Facility 2004-2005 to 2014-2015

	Number of Consumers[45]											
	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	No. of Beds[46]
Albany Mental Health Unit	12	14	21	8	12	18	22	26	27	38	35	16
Armadale Hospital Leschen Unit	36	45	53	80	66	72	104	88	86	102	130	41
Bentley Adolescent Unit	2	13	8	23	8	26	34	36	33	22	29	12
Bentley Hospital Mills Street Centre	58	117	96	80	57	71	101	111	99	102	133	76
Broome Hospital, Mabu Liyan Unit									27	31	34	13
Bunbury APU and PICU	19	26	25	36	56	53	73	89	90	116	98	27[47]
Fiona Stanley Hospital Mental Health Unit											17	20[48]
Frankland Centre	43	53	63	72	71	58	71	89	92	99	92	38[49]
Fremantle Hospital, Alma Street Centre	88	107	95	112	96	95	126	113	98	159	205	64
Graylands Hospital	330	299	376	384	279	326	379	424	454	366	342	136
Joondalup Mental Health Unit	19	20	35	18	18	50	44	52	50	58	68	47
Kalgoorlie Mental Health Inpatient Service	7	9	12	14	6	9	7	21	9	9	23	6
KEMH, Mother and Baby Unit	0	0	0	4	5	3	2	3	4	1	5	8
Mimidi Park, Rockingham								39	68	122	154	30
Selby Older Adult Mental Health Service	2	6	3	5	8	6	7	13	7	18	10	32
St John of God Mt Lawley, Ursula Frayne Unit[50]	6	4	6	5	4	11	14	13	10	12	9	12
Swan Valley Centre and Boronia, Swan	40	45	45	52	44	53	53	90	107	104	108	44
Metropolitan clinics	54	58	58	58	42	22	31	54	61	46	48	
Regional clinics	13	10	18	23	10	6	7	20	16	10	16	
Psychiatric Hostels	59	58	57	70	61	60	97	139	180	175	202	854
Other[51]	12	7	8	8	7	17	29	18	21	12	14	

45 Source: Council's Visitor Tracking System database.

46 Number of beds as at 30 June 2015.

47 Kalgoorlie Regional Hospital, Mental Health Inpatient Service is a 7 bed unit; however one bedroom is used as a seclusion room.

48 Fiona Stanley Hospital Mental Health Unit was authorised on 23 December 2014 and opened on 3 February 2015.

49 Includes eight beds that were originally on Hutchison ward at Graylands Hospital that are funded by the Frankland Centre.

50 Mercy Care was renamed St John of God Mt Lawley Hospital on 5 May 2014.

51 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, Number of Beds and Number of Involuntary Patients by Facility

AUTHORISED HOSPITAL	NUMBER OF BEDS	% OF TOTAL AUTHORISED BEDS	NUMBER OF COUNCIL CONSUMERS 2013–2014[52]	NUMBER OF COUNCIL CONSUMERS 2014–2015[53]	% OF TOTAL COUNCIL CONSUMERS 2014–2015
Albany Mental Health Unit	16	2.6%	38	35	2.3%
Armadale Hospital Leschen Unit	41	6.6%	102	130	8.7%
Bentley Adolescent Unit	12	1.9%	22	29	1.9%
Bentley Hospital Mills Street Centre	76	12.2%	102	133	8.9%
Broome Hospital Mabu Liyan Unit,	13	2.1%	31	34	2.3%
Bunbury Hospital APU and PICU	27	4.3%	116	98	6.6%
Fiona Stanley Hospital Mental Health Unit	20	3.2%	Not opened	17	1.1%
Frankland Centre	38	6.1%	99	92	6.2%
Fremantle Hospital Alma Street Centre	64	10.3%	159	205	13.7%
Graylands Hospital	136	21.9%	366	342	22.9%
Joondalup Mental Health Unit	47	7.6%	58	68	4.6%
Kalgoorlie Mental Health Inpatient Unit	6	1.0%	9	23	1.5%
KEMH Mother and Baby Unit	8	1.3%	1	5	0.3%
Mimidi Park, Rockingham	30	4.8%	122	154	10.3%
Selby Lodge	32	5.1%	18	10	0.7%
St John of God Mt Lawley Hospital Ursula Frayne Unit	12	1.9%	12	9	0.6%
Swan District Hospital Swan Valley Centre and Boronia Unit	44	7.1%	104	108	7.2%
TOTALS	**622**	**100%**	**1,359**	**1,492**	

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

Appendix 10: Total Consumers and New Consumers 2003-2004 to 2014-2015[54]

FINANCIAL YEAR	NUMBER OF CONSUMERS	NUMBER OF NEW CONSUMERS
2003–2004	744	412
2004–2005	800	391
2005–2006	891	386
2006–2007	979	440
2007–2008	1,052	479
2008–2009	850	365
2009–2010	957	446
2010–2011	1,201	532
2011–2012	1,438	580
2012–2013	1,539	598
2013–2014	1,602	656
2014–2015	1,772	774

54 Source: Council's Visitor Tracking System database.

Appendix 11: Inspection Focus Areas

MONTH	HOSPITALS	PRIVATE PSYCHIATRIC HOSTELS [55]
July 2014	Consumers' feedback regarding rights	Individual care plans and access to services
August 2014	Follow up outstanding issues and admission process	Individual care plans and access to services
September 2014	Quality of life and weekend visit	Group consultation – residents' feedback regarding rights
October 2014	Complaint processes	Group consultation – residents' feedback regarding rights
November 2014	Sexual safety and gender sensitivity on wards	Group consultation – access to other services
December 2014	Rights	Group consultation – access to other services
January 2015	Environmental audit	Administration of finances
February 2015	Safety and security (evening or night visit)	Administration of finances
March 2015	Recovery	Weekend visit and environmental audit
April 2015	Diversity responsiveness	Weekend visit and environmental audit
May 2015	Treatment, support and discharge plans	Safety and security – evening/ night visit
June 2015	Restraint and seclusions	Safety and security – evening/ night visit

55 Includes Group Homes, CSRUs and Community Options Homes. Hostels are required to be inspected bimonthly.

Appendix 12: Two Year Strategic Plan 1 July 2013 to 30 June 2015

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.

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

Strategies to Achieve Goal

1.1 Continue to advocate for improvements to the MHRB process under the current Act and have input into the Mental Health Bill as per the report and recommendations made by HOC in May 2010.

1.2 Improve consumers' access to representation by lawyers and Official Visitors at MHRB hearings.

1.3 Improve the standard and quality of representation at MHRB hearings.

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

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

TWO YEAR GOAL 2 - SUPPORTED ACCOMMODATION
To improve the variety and standards, safety and suitability of supported accommodation facilities inspected by Council (i.e., licensed hostels, CSRUs and Community Options housing) and the quality of care and recovery oriented services provided to residents of these facilities.

Strategies to Achieve Goal

2.1 Continue to lobby for a review of the sector including the governance, oversight, and quality assurance of supported accommodation facilities.

2.2 Continue to raise issues and advocate for improved standards and quality of care in facilities including access to community and other services aimed at recovery by residents.

2.3 Maintain, and endeavour to improve, accessibility to Official Visitors by residents of supported accommodation facilities.

2.4 Continue to advocate for a wider variety of, and more, supported accommodation.

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 *Mental Health 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 acquired brain injury.

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

TWO YEAR 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 OV work.

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

4.4 Put in place strategies to be responsive to an expansion of consumer numbers.

TWO YEAR GOAL 5 – NEW LEGISLATION

To ensure, protect and improve the observance of consumers' human rights and quality of care in any relevant proposed legislative or other change.

Strategies to Achieve Goal

5.1 Continue to ensure that Council has input to any reviews and draft legislation.

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

5.3 Continue to raise the need for an independent inspection service as well as an advocacy service.

5.4 Prepare for a new Mental Health Act and the changes it brings.

GLOSSARY OF ACRONYMNS AND TERMS

2014 Act	Mental Health Act 2014
Act	Mental Health Act 1996
CMHS	Community Mental Health Service
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
DOH	Department of Health
DSC	Disability Services Commission
GP	General Practitioner
HaDSCO	Health and Disability Services Complaints Office
LARU	Licensing and Accreditation Regulatory Unit
MHC	Mental Health Commission
MHLC	Mental Health Law Centre
MHRB	Mental Health Review Board
NDIS	National Disability Insurance Scheme
Minister	Minister for Mental Health
OCP	Office of the Chief Psychiatrist
OAG	Office of the Auditor General
PIR	Partners in Recovery

Council of Official Visitors
Unit 1, 18 Harvest Tce, West Perth WA 6005
Post (no stamp required): Reply Paid 84455, West Perth 6005
T: (08) 6234 6300 or 1800 999 057
F: (08) 9226 3977
E: info@coov.org
W: www.coov.org