COUNCIL OF OFFICIAL VISITORS

2007–2008

ANNUAL REPORT

Artwork produced through the Creative Expression Unit at Graylands Hospital.

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Minister for Mental Health
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Dear Minister

In accordance with section 192(3) of the *Mental Health Act 1996* I submit for your information and presentation to Parliament the Annual Report of the Council of Official Visitors for the financial year ending 30 June 2008.

As well as recording the operations of the Council for the 2007–2008 year the report reflects on a number and range of issues that continue to affect consumers of mental health services in Western Australia.

Yours sincerely

Debora Colvin
HEAD
COUNCIL OF OFFICIAL VISITORS

October 2008

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INTRODUCTION

YEAR IN REVIEW 2007–2008

The Council's direct work with consumers continued to grow in 2007–2008. A total of 2676 requests for contact with the Council were received from 1052 consumers during 2007–2008. This is an increase of 18.6% in the number of requests received from the previous year and a 7.4% increase in the number of consumers. There was nearly a 13% increase in the number of Mental Health Review Board hearings attended by Official Visitors with consumers.

Highlights of the year included the opening of three Community Supported Residential Units (CSRU's) in Albany, Busselton and Geraldton and the first of the Community Options houses in Kelmscott. However, a further 10 beds were closed in the Mills Street Centre at Bentley Hospital and other beds in authorised hospitals remained closed. Many people remain "stuck" for months and even years on secure wards with nowhere else to go and the CSRU and Community Options housing is unlikely to change their plight. Some of these people have cognitive impairments such as an acquired brain injury rather than a mental illness. Urgent action is needed for these groups of people.

It is the case that despite the extraordinary commitment and the advocacy skills of Council's Official Visitors and the similar commitment of many people working in the mental health system, there remain serious issues and concerns about the protection and enforcement of the rights of people with a mental illness.

Under the current legislation, Council only sees those people who have been made involuntary or who reside in a licensed psychiatric hostel. However, this year, Official Visitors have seen beds shaped like bananas because they should have been replaced long ago and paper stuck on windows instead of curtains in an adolescents' ward; they have been to a hostel and dealt with the stench of urine and sight of encrusted faeces and vomit because no cleaning had been done for days apparently because the hostel could not get staff; they have heard about a consumer who was physically held down by several nurses for up to 2 hours; they have been told about a patient who was seriously injured while being put into seclusion but who did not get treatment for 20 hours and then required an operation to fix the injury; and they have heard about consumers being moved regularly from bed to bed and locked ward to open ward and back again, sometimes late at night, as hospital management grapples with the problem of bed shortages. The Health Department's smoking ban has also presented a new range of issues for Official Visitors to deal with.

While conditions in some facilities have improved this year, much still needs to be done. The consumers seen by Official Visitors tend to stay locked up in hospital for weeks, often months and sometimes years. Their physical surroundings are therefore very important.

Stigma remains an issue – while some mental illness has "come out of the closet" such as depression, many other forms of mental illness remain the object of myth and suspicion. As noted by one Official Visitor, you do not see flowers or "get well balloons" on mental health wards, indeed you do not see many visitors at all and the design and rules of many wards do not encourage visitors.

Apart from advocating for consumers, the Council was also active in other areas:

- producing a Charter of Rights for hostel residents;
- considering and adopting a new Position Statement in relation to smoking; and
- reviewing and writing a report to the Minister on issues with the Mental Health Review Board process from a consumer perspective, particularly in relation to the content and timeliness of doctors' reports resulting in the Minister asking Head of Council to convene and chair, and Council to administer, a committee to look into the issues raised.

In addition, Council engaged an outside party to review Council's operations. While generally highly commending Council's work, some 37 recommendations were made including that current and future resourcing be determined as a matter of urgency noting that any further growth would require new systems, additional resources and a new governance system.

All these matters are discussed in more detail elsewhere in this Report.

It is the case that the work of Official Visitors can be difficult, prolonged and carried out in adverse circumstances. The day-to-day commitment, flexibility and fortitude of each Official Visitor along with the administrative staff who support them must be acknowledged.

The Council also owes much to the contributions of Catherine Stevenson, the Council's inaugural Executive Officer who moved to the country in December 2007 after 10 years with the Council and Dr Judyth Watson who retired as Head of Council in April 2008.

Catherine's professionalism, energy and efficiency were greatly relied on over the past decade as the Council expanded from 15 Official Visitors to 41, and 192 consumers a year to 979. She had an encyclopaedic knowledge of the Mental Health Act and her ability to champion the effects of the conditions, care and treatment experienced by our clientele in the many and varied facilities that we visit ensured the Council's continued high standing in the Mental Health Community.

Judyth continued her lifelong commitment to human rights and protecting those who are most vulnerable, guiding the Council in the development of a strategic plan in 2003 and providing a new dimension furthering the cause of refugees and indigenous communities affected by Mental Illness. We also thank Judyth for her warmth, compassion and spirit. She was a formidable advocate and took every opportunity to argue for better care, treatment and conditions for our clientele.

I would also like to take this opportunity to thank the many people who have given their time to come and speak to Official Visitors at various educational sessions throughout the year.

PART ONE

THE LEGISLATIVE AND OPERATIONAL FRAMEWORK

LEGISLATIVE FRAMEWORK

The Council of Official Visitors (the Council) was established in accordance with the *Mental Health Act 1996* (the Act), Part Nine, sections 175 - 192. The Minister for Health appoints people from the general community to be Official Visitors in accordance with section 177 of the Act.

OPERATIONAL FRAMEWORK

The functions and responsibilities of the Council of Official Visitors are prescribed in Part Nine of the Act.

The major responsibility of the Council's members (Official Visitors) is to ensure that "*affected persons*", as defined in section 175 of the Act, are aware of their rights and that those rights are observed. This includes monitoring the quality of care provided to ensure that it is of the highest possible standard. The Official Visitors also have a responsibility to undertake a complaint management role for "*affected persons*".

"*Affected person*", under the Act (section 175), includes:

- an involuntary patient, including a person subject to a Community Treatment Order;
- a mentally impaired 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 licensed private psychiatric hostel; and
- any other person in an institution prescribed for the purposes of the section by the regulations.

The Council is required to ensure that an Official Visitor or panel visits each hospital authorised under section 21 of the Act at least once per month and each licensed private psychiatric hostel at the direction of the Minister for Health (currently at least once every 2 months). In practice, most hostels are visited every month, alternating formal with informal visits. The Vincentcare, Richmond Fellowship and Casson Homes shared houses (when occupied), and the Busselton, Geraldton and Albany CSRU's are visited every two months.

The Council has maintained its active visiting programme, visiting twelve authorised hospitals and twenty-eight licensed private psychiatric hostels, including group or shared houses and three new Community Supported Residential Units in Busselton, Albany and Geraldton, and the first of the Community Options houses in Kelmscott. (Casson Homes two shared houses in North Perth remained vacant during 2006–2007). The facilities visited by the Council are listed at Appendices 1 and 2.

An "*affected person*" or another person on their behalf (section 189 of the Act) can request a visit from an Official Visitor. A visit is then arranged as soon as is practicable (section 186(c) of the Act). The Council aims to respond within a maximum time of 48 hours. Requests can be made in writing or via telephone or personal contact. As already noted there were 2676 requests in 2007–2008. Further details are provided in Part 3 of this report.

REPORTING LINES

Official Visitors

The Council and its individual members are directly responsible to the Minister for Health. Any Official Visitor, or person on a panel, who considers that the Minister for Health or the Chief Psychiatrist should consider a matter, may make a report to that person (section 192 of the Act). The Head of Council is required to make a report to the Minister for Health at the end of each financial year on the activities of the Official Visitors and the Minister is to table this report in Parliament (sections 192(3) & 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 very serious or systemic issue, it is taken to the Head of Council. Head of Council will then draft a letter or call for a meeting, or telephone, appropriate parties such as the Clinical Director of the hospital or service concerned, the Chief Psychiatrist and/or Head of the Mental Health Division and, when warranted, the Minister for Health. In addition, the Head of Council meets regularly with the Mental Health management teams of each of the authorised hospitals, as well as with the Chief Psychiatrist, the Director of the Mental Health Division and various others involved in the provision of Mental Health Services in WA, both from the government and non-government sector. At these meetings various ongoing issues identified by Official Visitors are raised and discussed with the Council seeking a response resulting in action.

Executive Officer & Other Staff

The Council's Executive Officer and other office staff are public servants (as per section 182 of the Act) and employed by the Department of Health to assist in the administration of the Council under the Act (section 182). The Executive Officer is legislatively responsible for the Council records (sections 183 and 184) and taking requests from affected persons for visits by Official Visitors (section 189) and further 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 section 186 of the Act.

COUNCIL COMPOSITION 2007–2008

A list of individuals who were members of the Council during the 2007–2008 financial year and their terms of appointment are contained at Appendix 3. Fifteen individuals were reappointed following the expiry of their terms during 2007–2008. There were 9 resignations or retirements.

Sheila Stephens retired, having served the Council since July 1999. Particular thanks go to her for all the work she has done over the years to improve the plight of regional consumers.

As already mentioned, Head of Council, Dr Judyth Watson also retired after 5 years. Lawyer Debora Colvin, who had been appointed as an Official Visitor in February 2007, resigned as an Official Visitor to become Head of Council on 1 April 2008. Six other individuals resigned from the Council during this time due to personal commitments. The contributions to the Council of all of these people are greatly appreciated.

PANEL APPOINTMENTS

Section 187 of the Act allows the Council to appoint 2 or more persons, at least one of whom is an Official Visitor, to be a panel for the purposes of that Part of the Act. Individuals appointed to be members of a panel would generally fall into the following categories:

1 **Expert/Consultant** – appointed when issues arise and direct access to professional or expert advice during a visit or contact is required and members of the Council do not have the required expertise.

2 **Interested community members** – appointed when members of the community seek a greater understanding of the role of the Council.

There were 3 panel appointments in 2007–2008 one of which was an interested community member. The Council's previous Executive Officer, Catherine Stevenson, was also empanelled twice: to assist in the Council's annual May training and Induction Programme for Official Visitors and to also provide assistance with comment on the proposed Broome Psychiatric Unit.

COUNCIL MEETINGS

The Council held 4 Full Council meetings in 2007–2008. All meetings had a professional development focus as well as bringing together country and metropolitan Official Visitors to report, discuss and decide on various issues including position papers and the Functional Review of the Council. A brief summary of those meetings is as follows:

- Presentations on working with Indigenous consumers were given at the August 2007 meeting;
- Council's 10th birthday party celebrations were held at the November 2007 meeting including inviting back former Official Visitors and Head of Council Stuart Flynn;
- In February 2008, Joe Calleja, the Chief Executive of the Richmond Fellowship gave a presentation on the work of this non-government organisation and its approach to the "recovery" model.
- In May 2008, newly appointed Official Visitors participated in a three-day induction and training programme. Previously appointed Official Visitors attended some of these sessions and the Full Council Meeting was held on the last afternoon of the programme followed by a workshop on case studies led by some of the more Senior Official Visitors. The training sessions of interest to all Official Visitors included presentations on managing aggression, how to prepare for and present at a Mental Health Review Board hearing, and sessions on Official Visitors' recording and reporting responsibilities.

Country and Metropolitan meetings of Council

Official Visitors are divided up into two groups in the metropolitan area, based on the North and South Metropolitan Mental Health Area Services (nominally called A and B group by the Council), and three groups in the country based on where there are authorised hospitals: South West, Lower Great Southern and Goldfields.

Each regional based group met monthly and the 3 regional groups met together prior to each Full Council meeting to discuss and share issues of mutual concern and interest. Reports from each group were also given at the Full Council Meeting.

The Metropolitan groups also met, both separately and in a combined session, on the third Thursday of every month except when there were Full Council meetings. The joint meetings were used to discuss issues identified by Official Visitors such as concerns about the Mental Health Review Board process, the impact of the smoking ban and Council's complaint classification system.

Sub-committees

There are two sub-committees:

1. the Executive Group, comprising representatives from each of the sub-groups of the Council (regional and metropolitan), Head of Council and the Executive Officer; and
2. the Focus Area Group.

The Executive Group met monthly except when there were Full Council meetings, with Country members attending by means of tele-conference. It acts as the decision making body for the Council between Full Council Meetings and is to ensure effective communication between the Executive, the Full Council and all Official Visitors.

The Focus Area Group meets on an ad hoc basis and via email to draft the formal inspection report forms which are used by Official Visitors when carrying out inspections of authorised hospitals and hostels and group homes.

A summary of the meetings attended by Council members during 2006–2007 is contained at Appendix 4.

BUDGET

The Council was allocated a budget of $815,027 for 2007–2008. Expenditure for the year totalled $942,051 of which 65% accounted for the costs of Official Visitors and 35% for administration and support (see summary at Appendix 5). Members of the Council are entitled to remuneration (section 180 of the Act). The remuneration rates for members of the Council were last reviewed and increased as from July 1st 2006.

There was again this year increased activity by Official Visitors as reflected in the 18.5% increase in consumer requests. However the costs were also substantially increased by a formal review of the Council by consultant John Kirwan and the change in the Executive Officer and Head of Council as in each case there was an overlap of duties to allow proper handover.

RECORDS MANAGEMENT

In accordance with the *State Records Act 2000,* section 19, the Council has developed a record keeping plan governing the management of all its records. Refer to Appendix 6 for the statement of compliance with State Records Commission Standard 2, Principle 6.

PART TWO

THE RIGHTS OF PEOPLE WITH A MENTAL ILLNESS

It is the job of the Council and its Official Visitors to ensure that the rights of *"affected persons"* are observed. Those rights are derived from:

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

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

- the *National Standards for Mental Health Services* - 12 Guiding Principles adopted by Australia in December 1996 which were built on the UN resolution, to guide policy development and service delivery in each of the States;

- *the Mental Health Act 1996* WA (the Act) which accords a set of legal rights to consumers in WA that protect them;

- the *Licensing Standards for the Arrangements for Management, Staffing and Equipment: Private Psychiatric Hostels* prepared by the Licensing Standards and Review Unit of the Department of Health as regulated by the *Hospitals and Health Services Act* 1927; and

- standards set by the Office of the Chief Psychiatrist including *Standard in Care Outcomes in Licensed Psychiatric Hostels.*

In order to ensure that the rights are observed and that affected persons have been informed of their rights, Official Visitors have the power, amongst others, to inspect consumers' medical records (with their consent) to check whether rights have been observed, including that explanations of their rights have been given verbally and in writing to the individual.

Statutory rights provided by the Act to "affected persons" include the following:

- A prescribed procedure to order involuntary status in hospital or community (Part 3, Division 1);
- A requirement that information about rights and a written explanation be given to them and another person of their choosing every time an order is made (sections 156 and 157);
- A requirement that they be given a copy of the order when made, varied, cancelled (section 159);
- The right to access personal records (with potential restrictions) (section 160);
- The right to have access to personal possessions (section 165);
- The right to have access to letters (section 166);
- The right to have access to a telephone (section 167);
- The right to have access to visitors (section 168) (with procedures to be followed if any of sections 166–168 are denied);
- The right to request and receive an opinion from another psychiatrist (sections 76, 111);
- The right to assessment and review by a psychiatrist (sections 37, 43, 49, 50, 164);
- The right of access to an Official Visitor (section 189);
- The right to review by the Mental Health Review Board – periodic and requested (sections 138, 139, 142); and
- Specified requirements in relation to the authorisation and recording of seclusion and mechanical bodily restraint (Part 5, Divisions 8 & 9).

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

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

THE ISSUES - WHEN THE RIGHTS OF PEOPLE WITH A MENTAL ILLNESS HAVE NOT ALWAYS BEEN OBSERVED

The following issues represent a selection of the matters that have been brought to the attention of Council by means of complaint, or following inspections, visits and reports from Official Visitors.

Some of the complaints have breached the Act; others may not have breached the Act but certainly detract from the right to dignity and respect and do not appear in keeping with the objects of the Act, in particular section 5(a) that the person receive "*the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity"*.

All of them involved *"affected persons"* (referred to in this section as consumers) and are the proper (statutory) concerns of the Council and its Official Visitors.

In each case the Council and/or an Official Visitor initiated correspondence and/or meetings because of the potential of the complaints and observations to impinge on the rights of the complainant and potentially on other mental health consumers.

ISSUE 1: RIGHT TO ANOTHER (SECOND) OPINION

General observations and comment: It is the right of an involuntary patient to request another opinion as provided by section 111 of the *Mental Health Act 1996*. In-patients are not required to write their request: they need only ask and make it known to a staff member personally or through another person such as an Official Visitor. The Council has a Position Paper regarding the legal requirements for the protocols and procedures to ensure that individuals can access this right to what is known colloquially as a 'second opinion'.

Illustration 1: A female in-patient asked an Official Visitor to request a second opinion for her. This was conveyed to a nurse but, on inquiry two days later the Visitor was told by both a nurse and a doctor that the opinion should be asked for in writing and this was why it hadn't been attended to.

Action: Despite the Visitor's explanations to staff, the request had not been dealt with 4 days later, so the Council contacted executive staff at the unit to emphasise that requests need not be written and that any such requirement was an unnecessary barrier for involuntary patients. Concern was stated that if this is practice at the unit, it was likely that other verbal requests had not been acted on. We also asked that, if this were practice, there should be an urgent policy review and stated that, if this was not policy of the unit, then education should be provided to all nursing staff to rectify the practice.

Status: Both the Programme Manager and the Head of Clinical Services responded. The Manager stated that the process of requesting a second opinion was to be subject to an internal quality process and also that the woman had decided to ask for a second opinion from a private practitioner rather than another in service consultant. The Service Head confirmed that a memo had been distributed to all clinical and administrative staff reminding them that requests for a second opinion do not need to be written, that no barriers should be put up for patients wanting to exercise this right, and that verbal requests required a prompt response.

***Illustration 2*:** At another inpatient unit the Official Visitor was told by a consumer that her request for a second opinion had not been carried through as she needed to complete a 'form'. On inquiry two nurses told the Visitor that there was a form in use because 'this is a hospital and you know hospitals run on paper'. She was also told that if she made the request on behalf of a patient then she too would need to complete the form.

Action: The Council raised this matter with the Manager of the unit. She clarified that the woman had then been offered another opinion but declined it.

Status: Because of the issues raised by the Official Visitor that could detract from a person's right to another opinion, a Professional Development update for staff in relation to facilitating a request for a second opinion was implemented.

ISSUE 2: PHYSICAL RESTRAINT

Illustration: There was concern expressed to the Council about a practice, said to be increasing, at Graylands Hospital about the continued physical restraint (ie holding a consumer down), for up to two hours. This could involve four nurses and the restraint was said to be part of management plans.

Action: The Council sought to clarify whether this practice had developed and if so how it might have been incorporated into management plans. We made the point that it would be likely to have an adverse impact on care and compromise patient dignity and their sense of safety. We raised the question as to whether this form of restraint could meet any definition of mechanical restraint in the Act because, if not, then statutory protections and records are not required. We also suggested that it would be difficult to find a legal basis for this type of intervention and raised a number of questions.

Status: It was acknowledged by the hospital that the "practice of holding a consumer down for extended periods was not normal practice". However an example was given of one person who had been very agitated and at serious risk of self harm before restraint. Protocols are governed by the hospital's policy on the management of aggression. It was said that only one consumer was frequently restrained in this way – though the Council had been told by anonymous staff that others had also been restrained in the same manner. Consumers are advised of such inclusions in their management plan for dealing with arousal. These interventions are authorised by their treating psychiatrist. De-briefing of the person and staff is part of the procedure.

The hospital agreed to seek advice on physical restraint from the Chief Psychiatrist. The Council also wrote to him to ask about the legal status of this kind of intervention and whether there is any indication of its clinical efficacy. It was also proposed that, apart from an emergency, it not be endorsed through incorporation into a behaviour management plan.

The Office of the Chief Psychiatrist conducted a Review of Seclusion, Physical Restraint and Mechanical Bodily Restraint in October 2007. As at 30 June 2008 Council was waiting to hear the outcome of that review.

ISSUE 3: VOLUNTARY/INVOLUNTARY STATUS ISSUES

Illustration 1: In 2006 the Mental Health Review Board (MHRB) ordered that a patient remain involuntary but be released on a Community Treatment Order (CTO) in 10 days. Investigations by the Council showed that she was not actually released onto the CTO for 13 days. The matter was confused because a second CTO was apparently issued by the medical team.

Action: In last year's Annual Report it was noted that the Council had confirmed the original order with the President of the MHRB and asked a number of questions of the Head of the clinical service and also asked the MHRB what procedures were in place to ensure that orders of the MHRB such as "*To be discharged on a CTO within 10 days*" are complied with. We also asked what action the Hospital takes if an order of the MHRB can not be followed within the designated period due to unforeseen circumstances (e.g. problem with accommodation) and what advice is provided to the MHRB. At the time of last year's report the matter was still unresolved after 9 months.

Status: After further follow up of the matter in early October 2007 Council was advised by the MHRB that the practice of ordering that a patient be released onto a CTO in a set number of days time was uncommon. As a result there was no formal monitoring process in place. Council was assured however that Board staff would from now on monitor compliance

Illustration 2: Council received complaints from 2 consumers who did not know whether their (CTO) had lapsed or not and, if they had, whether it was a deliberate decision by the clinic administering the CTO or an oversight. There is no requirement under the Act for the consumer to be told when a CTO is lapsing.

In the case of the first consumer she contacted the Mental Health Review Board who told her that the CTO had lapsed. She was therefore no longer obliged to continue to attend the clinic for appointments. Two weeks later a doctor and nurse from the clinic turned up at her home unannounced. The consumer had a friend visiting at the time who did not know about her illness. The consumer asked the clinic staff not to talk about the CTO as it was embarrassing and her friend could hear the conversation. Despite this the clinic nurse continued to talk to her for another 10 minutes and the following day, based on that conversation, the consumer was put back on a CTO.

In the case of the second consumer he was subjected to needless anxiety about whether he was within his rights to not attend the next clinic appointment.

Action: The Council has spoken to the Chief Psychiatrist about the issue of consumers not being formally advised when a CTO had lapsed. He advised that there are no plans to change the legislation to provide for notice being given. He noted that the date the CTO lapses is stated on the original order.

Comment: Council's view is that many people misplace the original order but even if the date was stated in that order, consumers still do not know whether the failure to arrange a new CTO is simply an oversight or whether it was intentional. This raises communication issues with clinic staff. The Council is continuing to advocate for change in this regard and is also planning other strategies to better inform consumers who are on CTOs and to make the Council and Official Visitors more accessible to people on CTOs. Council is aware that a study by the Office of the Chief Psychiatrist found that a substantial proportion of people on CTOs were not being given information in relation to what it means to be on a CTO, access to the Council and the right to a second opinion.

ISSUE 4: PATIENTS WITH COGNITIVE IMPAIRMENTS ADMITTED TO SECURE UNITS

General observations and comments: The following illustrations are provided to highlight the problem of mental health wards, and in particular acute care secure wards, being used to care for people who, in Council's view, should not be in those wards but for whom there is no other alternative because of the lack of appropriate facilities for them in WA. While this issue is not new, it is of growing concern to the Council along with the "ghosts on the ward" (referred to in Issue 5 below) and none of the current Health Department funded initiatives appear to be capable of resolving it.

In some cases the consumer was involuntary; in other cases they were not, which meant that, though they were being held on a locked ward, they were without the protections available under the *Mental Health Act* including access to Official Visitors to advocate on their behalf.

Besides the people whose circumstances have been outlined below, there are numbers of people at Graylands who have an Acquired Brain Injury as well as many elderly men and women who are not involuntary patients but who are nursed on secure (locked) wards. This issue has been raised in previous Annual Reports. The physical and rehabilitative needs of such individuals cannot be properly met; further their behaviour demands the attention of nursing and other staff to the extent that the people with a mental illness might have their care compromised.

Illustration 1: A nurse approached an Official Visitor to express concern, and that of colleagues, that a nine year old child had been admitted to the Bentley Adolescent Unit (BAU). The child's condition is a rare and fatal inherited disorder, its early signs taking the form of personality and behavioural deterioration. The child had been transferred from Princess Margaret Hospital because a new medication regime was needed. The child's behaviour was said to be too challenging to be managed at the children's hospital. However the BAU Centre staff said the child was too young to be properly cared for in a unit where it has been agreed the lower age should be 13 or 14 years old.

Action: The Council agreed that this child was inappropriately admitted to the BAU and expressed concern to various clinicians and Departmental Heads. The Official Visitor maintained regular contact with the child and the child's mother before the child was able to go home for care. (See also Issue 6 below)

Illustration 2: A unit admitted a man diagnosed with advanced Huntington's Disease. This was intended to be a short term arrangement but after three weeks an appropriate facility had still not been found. The man needed special nursing, but because of his aggression, up to six nurses had been injured and had taken time off work. The consequence was that some beds had to be closed in order to sustain staffing and meet this person's needs.

Action: Both the Official Visitor to whom this situation had been reported by nursing staff and the Council approached the Chief Psychiatrist and other senior staff but to no avail. Nearly 6 weeks later, as at 30 June 2008, the consumer remained in hospital.

Illustration 3: A woman was admitted to a metropolitan unit with a disputed diagnosis - according to nurses – of a mental illness when she was known to have an intellectual disability and epilepsy. She might also have an autistic disorder. There were complex social issues involved as well, related to accommodation. Because of her behaviours the open ward at the hospital needed to be locked thus not only inconveniencing people coming and going but also restricting the rights of voluntary and involuntary patients on the ward.

Action: The Official Visitors and the Council spoke to the hospital's clinical director and also suggested that the feasibility of a formal Guardianship Order be explored and tried to advocate for her but, because of a range of social circumstances, this was very difficult. A second opinion was also organised. Eventually she was made voluntary which meant that the Council could no longer advocate for the consumer.

Illustration 4: A young man with an acquired brain injury and memory loss had been more than ten weeks in a secure ward when an outside advocacy agency asked for Council assistance on his behalf. In that time he had had no ground access as he was often restless and agitated. His family was trying to provide whatever support they could and there were efforts made by his clinical team to find suitable accommodation. The ward was unable to provide him with the type of therapy he requires and the general conditions on the ward were not suitable.

Action: Because of the provisions of the *Mental Health Act* in relation to access to records by an Official Visitor requiring consumer consent, and advice by the Office of the Chief Psychiatrist that the consumer could not consent, the Council was limited in its ability to assist until the matter of Guardianship was clarified. In the interim period the Council referred the matter to another advocacy organisation and once the Guardian was appointed Council was then able to undertake its role with this consumer. Since then the Council has continued to work with the consumer's family in an effort to obtain better care and to find him alternative accommodation – he remained on the ward as at 30 June 2008.

ISSUE 5: SHORTAGES OF ACUTE ADULT INPATIENT BEDS & GHOSTS ON THE WARDS

General observations and comments: There continues to be shortages of acute adult inpatient beds. The shortage is caused in part by staffing issues. For example, in April 2008 the Mills Street Centre advised that it was closing 10 beds due to staff shortages. They have not been re-opened.

Lack of housing accommodation also continues to be an issue despite the opening this year of three Community Supported Residential Units (CSRUs) and the first of the Community Options homes. Council understands that approximately 40% of patient beds are taken up by patients who are healthy enough to leave but who remain in hospital waiting for accommodation

Further compounding the bed shortage is the fact that almost every secure mental health ward in the authorised hospitals visited by Official Visitors contains 2 or 3 consumers with very complex mental health issues who have been living there for many months, sometimes over a year. This is in addition to the patients with cognitive impairments referred to in Issue 4 above. These consumers are sometimes called "ghosts on the wards" by Official Visitors because they have been on the ward for such a long time; they don't want to be there; the hospitals don't want them there; but there is nowhere suitable for them to go.

Apart from the issue of other patients having to wait longer in Emergency Departments for a bed and the specific issues highlighted below, Council is concerned that secure wards do not have the therapy or programs in place for such consumers as they are designed to care for the acutely ill, short term patient.

It is also concerned about the number of patients turned away by hospitals and the pressure on medical teams to send some consumers home, perhaps before they are ready, simply to free up a bed. "Hotbedding", as it is known to Official Visitors, continues in most facilities as does the regular use of "leave beds" as consumers are regularly moved around from bed to bed and ward to ward while staff try to accommodate new patients, all of which is very unsettling and stressful for consumers who are already dealing with a serious illness.

Council is further concerned that the current housing initiatives (the building of Community Supported Residential Units (CSRUs) and Community Options houses) will not be a solution for the "ghosts on the wards" because they will never "qualify" for such housing, as their needs require a much higher level of staff to resident ratio than is to be funded and/or these consumers need to be living in a secure unit.

Illustration 1: From time to time the admission of "civil" patients to the maximum-security inpatient psychiatric hospital (Frankland Centre), run by the State Forensic Mental Health Services, has been the source of complaint both from patients and from family members who deem the Centre as inappropriate ward accommodation. The Centre assesses and cares for people who come from the courts and prisons either on remand awaiting trial or following conviction. While there have been no reports to Council in the past year, there continue to be "civil patients" on Frankland because there is apparently nowhere else for them to go.

Action: Official Visitors advocate for any such patients to be transferred to other wards when asked. These people have either "done their time" or had their charge dismissed or withdrawn but they remain involuntary under the *Mental Health Act*. As civil patients they are entitled to a bed in another ward which may, for example, be in an unlocked ward or where they can have ground access – all of which is denied to them while they remain in Frankland. It is also more difficult for family and friends to visit because of the security arrangements.

Status: Unresolved: the Council will continue to monitor and lodge patient complaints and to advocate when asked.

Illustration 2: A consumer who is not a forensic patient continued to be nursed in the forensic mental health unit, the Frankland Centre, principally because the consumer had a history of threatening and intimidating behaviour to others, including staff. The history, health status and case were complex. At one stage it was planned that the consumer be moved into Graylands hospital in a ward with special renovations and using security guards. The consumer remained in Frankland because there was no suitable placement outside.

Action: The Council's Official Visitors provided ongoing advocacy for the consumer and attended Mental Health Review Board hearings with the consumer and facilitated other meetings. Along with nurses and others, the Council had misgivings about the accommodation plans after renovations were completed in one ward and using security guards because the consumer would be effectively isolated from other people and the security guards would not have the proper training.

Status: As at 30 June 2008 the consumer remained a civil patient on Frankland and Council's negotiations were continuing.

Illustration 3: A parent complained that her son in Graylands was moved 7 times in 4 weeks including on one occasion at near to midnight.

Action: The matter was taken up with Graylands' Management who admitted that investigation of the patient's medical record showed that there were 6 moves since admission, and at least 3 were because of bed shortages. Council was told that the patient's record would be marked "not to be moved again unless for therapeutic reasons". Council was also reassured that the consumer's treating team had remained the same throughout the moves.

Illustration 4: A consumer approached an Official Visitor to complain that he had been moved so that a new patient could be accommodated: he said the move compromised his treatment and his safety and had also complained through the hospital's structures. This consumer was now in office space with a floor based mattress, no cupboard or storage space, no easy access to a toilet and paper had been stuck on a window to afford some privacy. The potential to detract from an individual's rights to privacy and dignity is very real in the circumstances.

Action: A letter was sent from the Head of Council to the Operations Manager of the Unit about this particular complaint and also re-stating the Council's view that admission of extra patients can only have a negative impact on all consumers and staff, particularly when no attempt is made to provide dignity and privacy.

Status: See below.

Illustration 5: Only five days after Council had received the individual complaint above, another Official Visitor made several adverse observations including:

- the census was an extra three patients 'over count' in the ward referred to above,
- in her view there were two in this ward who needed to be in a secure (locked) ward but no beds were available; one of them was so ill that a special nurse was needed;
- interview rooms and group rooms had mattresses on the floor (no cupboards and paper at windows) so were effectively de-commissioned for their intended purpose;
- the mattresses in the interview rooms of one ward could be seen from the ward entry;
- other lounge or therapy rooms were also de-commissioned for group use as they were used by staff for interviews of patients and others had access to walk through during an interview;
- staff numbers had not increased to care for more people; and
- two consumers approached the Official Visitor to complain about the accommodation arrangements.

Action: Again a letter was sent to the Operations Manager to emphasise that the Council cannot condone the arrangements made for extra admissions as it has a negative impact on the dignity, confidentiality and privacy of all persons in the ward.

Status: Due to 10 beds being officially "closed" as a result of staff shortages at the Mills Street Centre, apparently mattresses on the floor are no longer being used. In reality sometimes only 6 or 7 beds are actually closed as the others are being used when they are "over the count" from time to time.

Comment: Council recognises that sometimes extra patients have to be accommodated and it understands that it is normally done in a discrete way and for a minimum time. It is unthinkable that extra general hospital patients in an ophthalmic unit or a cardiac unit would be nursed on mattresses on the floor and the Council claims that this practice could contribute to the stigmatising of psychiatric patients.

ISSUE 6: THE BENTLEY ADOLESCENT UNIT

General observations and comment: The Council has had, and continues to have, a number of concerns about the design, maintenance and cleaning of the Bentley Adolescent Unit (BAU) as well as the mixture of ages on the ward. The BAU is the only authorised hospital ward in the State catering for children and adolescents. The secure side of the BAU is best described as looking and feeling like a prison, despite the attempts of staff to make it seem more friendly. There is also no reasonable outdoor area for children on this side of the unit. We know from discussions with consumers and their parents that arrival at the BAU is a shock. Already reeling from the impact of a mental health diagnosis and associated issues, these children are placed into a confined environment which during the course of this year did not even include proper beds, curtains, or shower privacy. Despite this Official Visitors are regularly told that there is a waiting list for the unit. In Council's view a plan to replace the BAU is urgently needed.

Illustration 1: Although the BAU is stated to provide services to adolescents aged 14-18, Official Visitors report regular admissions of 11, 12 and 13 year olds and one child as young as 9 years old. The concern is that impressionable pre-adolescent children are mixing with older teenagers on the ward.

Action: Official Visitors continue to advocate on behalf of all consumers in the BAU. The Council has also raised its concerns with the hospital arrangement, the Chief Psychiatrist, the Mental Health Division and the Minister. The problem remains that the BAU is the only acute care mental health facility for adolescents or children of any age and as currently designed it is impossible to separate the consumers by age.

Illustration 2: For some time the Council has advocated and agitated for improvements to the cleaning and maintenance needs in the BAU. The Council's unresolved and increasing concerns were not about the care, but about the shabby rooms, broken furniture and almost complete lack of day by day and longer term maintenance. Faded paper substituted for curtains on windows open to the street, bent bed frames best described as "banana beds" and worn mattresses and half-mast shower curtains contributed to the general shabbiness and coldness of the Centre.

Initially no-one from the hospital management was able to say whether orders had been placed for new fittings. Then we were told the curtains were on order but months passed and they still had not arrived. We were told that bed replacements were not included in the local budgets.

Even though the Family at Work facility next door to the BAU is not an authorised ward (they are collectively known as the WAY Centre), as it shared the building and some services, the Council inspected it too to establish whether there was any difference between them. There was little to no difference with both units presenting in a negative light.

Action: Various staff members had requested attention to these issues but seemingly without success. The Council then brought them to the attention of the Executive in meetings or through correspondence, again to no avail. When no improvements were forthcoming the Council undertook a detailed inspection. This eventually resulted in sending a report to the Minister that suggested he might like to visit personally in order to frame an urgent response. This he did in early April together with the Executive Director of the Mental Health Division and the Head of Council. Shortly thereafter the curtains arrived and new beds were ordered. (When the new beds arrived towards the end of June they were appreciatively described by one consumer as "hell sic"!)

Status: The condition of the BAU remains of concern to the Council although the hospital management has advised that it intends to set up a working group to see what can be done to improve the overall ambiance of the unit. It remains that:

- furnishings on the locked side especially, in the lounge area, are sparse and dull making it cold and uncomfortable;
- it took months for the broken TV to be replaced;
- a second Playstation 2 unit is needed for consumers on the locked side and more games for the unit on the unlocked side; and
- the garden is in bad need of a tidy up to make it more inviting.

Comment: The Council and its Official Visitors are distressed that it too often takes their intervention to have the repair and maintenance needs acknowledged by various levels of staff: these needs, we claim, should not require outside intervention, but be identified by regular audit and then attended to. It is also an indication of the stigma of mental health that the BAU, unlike Princess Margaret Hospital, is not the regular recipient of donations and grants to improve the unit and its facilities.

ISSUE 7: CLEANING AND MAINTENANCE

***General observations*:** Cleaning and maintenance of wards continues to be a frustrating issue for the Council. Many, if not most, of the patients on mental health wards in authorised hospitals spend many weeks living on those wards so it is important that they be clean, comfortable and inviting as they become a temporary, and sadly in some cases more or less a permanent, home. As has been repeatedly pointed out by Council in Annual Reports the environs are such that the stigma associated with mental illness will be reinforced and augmented when patients and their families experience these ward facilities. We claim that the shabby surrounds, the unclean ward areas, the cold showers and uncomfortable beds are a signal that this is "good enough" for people with a mental illness.

Illustration 1: For well over a year the bathroom areas at the Alma Street Centre have been the subject of many complaints from patients and their families as well as from Official Visitors. Widespread mould, filthy windows and air vents have made some people reluctant to use the showers. Last year the Council reported that cleaning of ward areas also required an urgent review and patients have continued to complain especially about light fittings and windows and curtains that need replacement.

Action: The Council raised these concerns repeatedly in person and by correspondence with senior staff.

Status: Hospital management advised that they had reported Council's concerns to the engineering department who were costing an external contractor to come in and clean the vents and light fittings. The bathrooms on the ward concerned were also awaiting an engineering inspection. Council was further advised that the windows were cleaned twice yearly but they would ask that they be cleaned as a matter of priority on the next visit.

Comment: While hospital staff continue to accept these conditions for their patients and for their own working space, it means that resolution and a permanent solution will not be found.

Illustration 2: The Council has long reported that too often the wards and bathrooms at Graylands Hospital are unclean, in need of various repairs and upgrades. Mostly these reports took far too long to be acted on or solutions were temporary with the same problems recurring. The Council's concern is that these environs may be unsafe and can detract from the rights to dignity and privacy.

Action: It was decided to visit and inspect all wards on the Graylands campus with the exception of Ellis Ward and the Frankland Centre in order to establish whether the facility was "safe and otherwise suitable" (section 188(c) of the *Mental Health Act*). Based on the Act and the National Standards for Mental Health Services a schedule was arranged and extensive inspections were done by two Official Visitors and the Head of Council. The following is not a complete and detailed list of observations but these do set out a large number of patients' complaints and Official Visitors' observations as well as requests from nursing staff to the Council to assist them in their efforts to get change.

General cleanliness: In three wards one was greeted by noxious smells either from the bathrooms, lavatories and/or damp carpets. Water drained from two showers into a central ward area; stainless steel toilet bowls were reminiscent of disgracefully kept public toilets; toilet seats were missing and mould was obvious in several bathrooms. Almost every ward had stained and dirty (cleanable) surfaces on floors and tables, including dining tables. Almost all ceilings, light fittings and skylights needed a thorough clean. The outdoor areas on the whole were unkempt and littered with broken chairs and cigarette butts.

Infrastructure: The general environs are old and reflect a time when the emphasis was custodial. Because of the architecture and planning of various ward spaces, privacy cannot be guaranteed; the water in the

ancient pipes takes minutes to flow hot and the bedrooms are not heated as it was claimed that heaters would be a risk to safety. There were countless examples of the neglected or old infra structure needing attention, including the installation of new washing machines and a contemporary alarm system.

Patient facilities: These are worn and shabby. Beds and bedding are a frequent cause for complaint, being uncomfortable and hard, sometimes with thread bare cotton blankets. In one 21 bed ward only 7 comfortable chairs were provided and in an 8 bed unit there were only 2 lounge chairs: most were in need of repair throughout the hospital. It was almost impossible to find functional drawers and cupboards to provide some sense of personal security for belongings.

Seclusion rooms: Almost all resembled a desolate prison cell and all are in need of a thorough clean and paint. It is understandable that many individuals who are secluded assess their experience as punitive.

A full report was sent to the Minister, the Chief Psychiatrist, the Executive Director of the Division and Graylands' senior staff. It was pointed out that the problems fell into roughly two categories, one being very old infra structure in all of the wards, the other being the inability of staff to bring their influence onto these matters that have been brought to them continually either through correspondence or in meetings. The Council asked the minister to request the Director General to plan and budget for the refurbishment of all wards and to upgrade plumbing infrastructure

Status: The Minister responded promptly and laid out a list of improvements due to be made at Graylands with an allocated budget. The Clinical Director also responded with a list of related matters that were being finalised. These included a daily programme of cleaning, a monthly environmental audit, replacement of floor coverings, streamlining of a maintenance and replacement system, replacement of all ward robes in one ward and a review by the engineering department of priority maintenance work on every ward. Council is pleased to report that these badly needed improvements have slowly been, and are continuing to be, implemented. Meanwhile the Council continues to draw deficits to the executive of the hospital and press for urgent change especially in cleaning and maintenance needs.

ISSUE 8: OUTDOOR AREAS FOR WARDS

General observations and comment: On the whole outdoor areas at secure units are drab and in need of imaginative renovation including all weather protection. These are critical spaces for involuntary patients especially when they need to reflect, walk and find privacy. The Council continues to receive complaints about the spaces at Armadale and Joondalup in particular, as well as the Bentley Adolescent Unit, and brings experience from there to any agenda concerning the planning of new units and upgrading of existing units, emphasising that the design and size of outdoor areas can contribute directly to the nature of the therapeutic environment they are aiming for.

> ***Illustration 1:*** The courtyard at the unit of Kalgoorlie Regional Hospital is small and has 'invited' a few consumers to try to climb the fence where it meets a wall on to a roof in order to leave. This year one woman's attempt resulted in a fractured leg and while others have suffered less severe injuries or are returned by local police, the area's design is itself a hazard. Any attempt to leave is even less safe after dark and/or when people are drowsy with medication.

***Action*:** The local Official Visitors have documented their concerns about the nature of the courtyard and the risk posed. Council contacted the Chief Psychiatrist who arranged an engineer's inspection. The Head of Council met on site with local executive staff to discuss options to improve suitability and safety, one suggestion being to fit and assess an alarm system. It was also deemed vital that any changes to the fence did not make the area look like a prison. Improved risk of absconding assessment was also instituted.

Status: It is acknowledged that a more suitable and larger courtyard is available nearby and can provide a suitable space for Indigenous consumers. However people from this ward must be escorted there, whereas they can readily access the existing ward courtyard. Council does not want a prison like environment and endorses individual risk assessment so that preventive measures can be taken.

Illustration 2: The amenity of the outside area of Ward 5.1 at the Alma Street Centre (ASC) means that a large part of the space is unusable for its patients. The area is shabby and in need of repair, damage having apparently been caused by building contractors during work on Ward 4.3 some years ago.

Action: This issue has been raised at every Council liaison meeting for over two years yet until very recently and, despite reassurances, no plan for the work has been made.

Status: A commitment has been made to attend to the area in the financial year 2008-2009

ISSUE 9: ACCESS TO PENS AND PENCILS

Illustration: Official Visitors have been agitating for a very long time about the practice on the secure ward at Armadale hospital of refusing to allow consumers to have pens and pencils. Instead consumers are forced to ask nurses for something to write with and then are given stubby pencils on the grounds that the pens or pencils could be used as a weapon. The practice continued despite hospital management assuring Council that it was not accepted practice.

Action: Letters were written and the issue has been brought up with hospital management

Status: As at 30 June the practice remained although hospital management have said the practice is not authorised by the hospital and that they agree it is demeaning to provide consumers with the stub end of a pencil and expect them to write correspondence with this.

ISSUE 10: COMPLAINTS PROCESS AND SERIOUS ALLEGATIONS

General observations and comment: In each of the illustrations listed below serious and disturbing allegations were made by consumers. Apart from concern about the complaint itself, in each case Council is less than satisfied with the complaints process of the respective services. In Council's view there is no consistency in the way complaints are dealt with and a number of the mental health services need to improve their complaints management system. It is incumbent on all public hospitals to implement an effective complaints management system with the aim to improve the quality of its care.

Illustration 1: A consumer was secluded on six occasions in as many days apparently for attempts to abscond and for the consumer's own safety. This consumer, aged over 60 and weighing 54kgs, complained about having been "manhandled" by 5 nurses applying undue force during transfers to the seclusion room. Skin injuries and minor lacerations were obvious and nurses had dressed them.

Action: The consumer lodged a written complaint with the ward staff, but two weeks later had not received a response. Council had also written asking to be kept informed of the outcome of the investigation into the complaint. The consumer complained about not being treated with dignity or respect and wanted a review of procedures and a letter of apology. In the meantime the Official Visitor queried the need for so many seclusions and the manner in which the seclusions had been effected having confirmed that the consumer had been secluded on six occasions. The Operations Manager was written to when three weeks had passed without a response.

Eventually after further inquiries, Council was told that the matter had been resolved "at ward level". This was contrary to the advice of the consumer to the Official Visitor. It was also Council's view that a complaint as serious as this, involving the action of ward nurses and potential assault, should never be allowed to be resolved at ward level. Further discussions were held with the hospital management. As a result the hospital advised that it would be changing its procedures so that any matter said to have been resolved at ward level would be followed-up by a letter sent to the patient clarifying that the complaint had been resolved at ward level and inviting them to contact the hospital if that was not the case. A letter in these terms was sent to the consumer.

Status: While Council welcomes the change made it remains dissatisfied that a complaint of this seriousness should be dealt with at ward level and as at 30 June was intending to write back to the hospital to ask that the policy be further amended so that any complaint against ward staff be immediately referred to the Clinical Nurse Director.

***Illustration 2*:** Last year the Council reported a similar complaint from another consumer that had been delayed in its investigation. It had also been investigated without interviewing the consumer or asking staff for statements, because this would have incurred "further delays in responding to the complaint".

Action: Despite reassurances that procedures were changing, we asked the Chief Psychiatrist to investigate further, in particular to address the adequacy of the inquiry procedures into the original complaint.

Status: The service advised the Chief Psychiatrist that a number of "quality actions" had since been implemented and agreed that the initial investigation would have benefited from interviews with staff and patients, that the delay in responding to a serious complaint was not acceptable and that the outcome has been a Register of Complaints aimed at better tracking the management process.

Illustration 3: A young woman asked an Official Visitor to hear her complaint that a male nurse had and was continuing to behave inappropriately towards her. Though distressed she gave lucid and unchanging accounts of her allegations. She wanted to transfer out of the unit where she had been admitted.

Action: The Council took the matter to the Director of Nursing asking that it be investigated and that the consumer be moved immediately to another hospital (which she was). Further we advised the woman that she should engage the services of a solicitor. She was supported through the harrowing interview process by the Official Visitor. Eventually Council received a letter advising that the allegations against the nurse had been investigated by the service in which he is employed. Council was told that the complaints against him were not upheld "due to lack of evidence" although he was counselled about "ethical and professional standards pertaining to nursing staff". Council was not satisfied that proper process has been followed in relation to such a serious allegation and, with the Mental Health Law Centre, has sought further information about the process and conduct of the investigation and raised the issue with the Office of the Chief Psychiatrist. The Official Visitor continues to be available for the complainant should she need to contact her.

Status: As at 30 June 2008, Council awaits a further response from the Health Service.

Illustration 4: A consumer was hurt while being put into seclusion. He complained his leg had been broken during the initial restraint and seclusion at 1500 hours. He was released at 1700 hours. No treatment was provided during this time. He was later put back into seclusion at 1830 hours still complaining about his leg. He was visited a few times after this by a doctor but it was not until the following afternoon that he was taken to SCGH where it was confirmed that his neck of femur was broken and he was operated on a short time later.

Action: Council raised the issue by letter with the service on 9 April. The consumer also filed a written complaint form.

Status: As at 30 June 2008 neither Council nor the consumer had received any response. Council is continuing to follow-up with the service.

ISSUE 11: BARRIERS TO ACCESS BUILDINGS AND SERVICES

***Illustration 1*:** The difficulty for consumers with coexisting physical disability/morbidity at Graylands Hospital was reported last year as an unresolved issue. One man said that because he is wheelchair bound, he is prohibited from participating in outings arranged by the Occupational Therapist. An Official Visitor established this to be so, the reason given being that the transport of wheelchairs and walking frames on the bus posed a potential hazard.

Action: The Council wrote to say this decision was hard to understand as elderly people who use chairs and frames are able to take similar bus trips.

Status: Almost one year after lodging the complaint on behalf of this person the Council was told that the Executive Committee of the hospital had approved the use of a maxi-taxi for wheelchair bound patients to participate in outings etc and a review of needs and resources was done with a view to alleviating the problem.

Illustration 2: From time to time the Council continues to receive complaints from physically impaired consumers about difficult access to the bedroom areas of Plaistowe and Hutchison wards which are on the first floor of the building. They are advised to use the stairs to access their bedrooms as the lift was not available to be used.

Action: The Council continues to ask for arrangements to be made to facilitate use of the lift for passengers.

Status: It is of concern to the Council that a public hospital does not have facilities which ensure disability access as required by legislation or that the building design is unable to be changed. This situation can only become more acute when the needs of an ageing population are taken into account.

ISSUE 12: MURCHISON WARD AT GRAYLANDS

General observations and comment: A substantial component of the work of Official Visitors is on behalf of the long term consumers who reside in this ward. The environs contribute to the problems reported and observed, as does the turnover of staff. The Council has continued to take up matters related to clinical governance that can impact adversely on the quality of life and potentially on the rights of the residents all of whom have either an enduring mental illness or an Acquired Brain Injury. A government sponsored programme to provide community based accommodation through Community Options housing is a welcome initiative, however, it has taking much longer than anticipated to implement and it now seems that many of the consumers may not be suitable for discharge to these facilities. Alternative accommodation is required.

In the meantime, the Council is pleased that, after several years of its advocacy, all consumers residing in this ward will be provided with specially designed and lockable cupboards in this year and that efforts are being made to ensure they can get television reception in their bed rooms (a challenge because of the nature of building materials and ward architecture). Council also welcomes recent initiatives of the ward Clinical Nurse Specialist to give consumers more activities including visits to the zoo, Henley Brook and other places along with a monthly planner of activities such as an "Italian Day" with staff and consumers working together in the preparation, cooking and eating of Italian food.

Illustration 1: Ward environment: although the ward is old and shows its age with the lay out and general need for repair, the Council has raised many objections to clear examples of a need to clean. For instance there has frequently been urine and too often faeces and vomitus deposited and ignored on the floor: it is walked through and adds to the air of neglect. The Council finds this deplorable and distressing.

Action: The need for a cleaning team to respond to these conditions as they arise has been pointed out to the executive on several occasions in meetings and by letter. Further the need to manage the behaviour of the 'culpable' consumers is clear.

Status: Although there is always a response to match the Council's complaints and requests it is never long before the same issues arise again so Council will continue to watch for and advocate about this issue.

Illustration 2: Certain patient behaviour can readily be linked to the state of the ward. In the presence of Official Visitors a man and woman walked out into the grassed area and passed urine. It was distressing that no-one, other residents and staff included, took any notice of this anti-social behaviour. A nurse was asked on this occasion whether this was usual behaviour and it was confirmed to the Official Visitors who were told there "are others". It was/is the Council's view that this unnecessary behaviour robs all the people in the ward of their dignity because it was not acknowledged as aberrant behaviour. It also confirmed the Council's view that nurses effectively make themselves unavailable because they have to be summoned from behind a locked glass door to unlock the lavatories when people need them.

Action: The Council wrote to the Heads of the Area Services and of Clinical Services to point out that we would argue that the separation of nurses and patients is a remnant of custodial care and does not reflect the kind of care directed to rehabilitation and socialisation. It was suggested that nurses should circulate among patients and engage them in meaningful activities, one being regular toilet visits in order to respect the rights of all patients in this ward.

Status: Graylands carried out an investigation, which came up with some responses and proposed changes. Council was advised that it was agreed that the problems might not arise if nursing staff engaged more with patients, a problem compounded by the fact that Murchison had a low staff to patient ratio. The Nurse Director was to meet to discuss these issues and to review nursing staff allocation and service delivery.

Illustration 3: A new clinical psychologist was appointed with one of the priorities being to review and update behaviour management plans. There was a commitment to engaging patients in the development of these plans. However there were some examples of plans that seemed as if they could not achieve their goals.

Action: Through the Clinical Director the Council commended the ward and also pointed out some concerns about consequences of certain behaviours being unclear and also about the lack of timely rewards for positive behaviours.

Status: It is acknowledged that where there are staff shortages and changes, timely rewards and application of consequences makes it difficult to use behaviour management plans to their capacity.

Comment: The Council claims that effective plans made with the person involved should have the potential to contribute to the rights of the individual.

Illustration 4: Seclusion practices at Murchison can be an informal practice where individuals' behaviour is managed by isolating them, but not in the seclusion room, for a period of time and avoiding the requirements of the legislation. This arises from time to time when an Official Visitor might find the person on a routine visit. For instance one man was observed seated but confined in a room with the door shut. His behaviour had been threatening and he kept pushing an alarm bell. A woman was told to remain in a room because of her threatening behaviour

Action: The Official Visitors pointed out to the staff in each instance that the people were secluded because they were unable to leave the area. The staff claimed in each case that they were using 'time out' procedures. As this is a recurring problem the Council reported to the Chief Psychiatrist.

Status: This form of controlling unacceptable behaviour is in direct breach of the Mental Health Act as seclusion is to be authorised, recorded and reported as such. The Clinical Nurse Specialist was informed about the observations and undertook (again) to remind staff of their obligations to patients as required by the legislation.

Illustration 5: The Clinical Governance Review done in this ward in late 2005 by the Chief Psychiatrist is yet to have all of its recommendations implemented. The Council has always asked that it be appraised of all responses and Review updates are generally on the agenda of our liaison meetings with the hospital executive. However the Council is critical of the length of time taken to implement the recommendations and concerned that many of the matters raised before the Review continue to be problematic (see above).

Action: The Council again wrote to express our concerns to both the Chief Psychiatrist and to the hospital. It was suggested that the implementation of recommendations be supervised by a specialist in organisational change. We said that both organisational and cultural change is necessary and that the Council wanted to discuss a realistic approach to be supported by all stake holders to ensure that the residents of Murchison Ward are treated with dignity.

Status: This proposal and approach was not accepted and implementation of the necessary changes moves slowly through a number of allocated committees.

ISSUE 13: NURSING ATTITUDES

Illustration 1: The Council was concerned about the implications of a nurse having made a successful application for a Violence Restraining Order against a patient who was a person for whom the Council was advocating. The nurse was offered a transfer to another ward and declined but did transfer later.

Action: The Council was most concerned about this action which it considered to be unnecessary and unhelpful. More than twenty questions were asked of the Clinical Director and the Chief Psychiatrist including why the nurse had felt it necessary to take such action.

Status: The Council was assured by the Clinical Director that the patient's mental health had not been compromised by the nurse taking out the VRO. It was suggested that the nurse was new to the health service and had not appreciated what other supports could be put into place before taking out the VRO. Further there is no knowledge that staff have applied for similar orders in similar circumstances. Such an action by a nurse in a mental health service indicates that there is a need for more comprehensive induction encompassing safety and supports available to protect both staff and patients.

Illustration 2: A consumer complained she had been raped by another patient on the ward. The consumer was then put into the secure ward against her wishes even though the other patient had been discharged. Ward staff told the Official Visitor that the consumer was being kept on the locked side because she was disinhibited (all the wards at this hospital were mixed). The general implication was that the consumer was a danger to other patients rather than the other way around. There were also other related concerns about the way issues involving this consumer were being handled.

Action: Head of Council called the Clinical Director of the unit who agreed to talk to staff about their attitude.

Status: Council awaits the finalisation and launch of a draft Health Department document titled "*Responding to a Disclosure of an Allegation of Sexual Assault within a Mental Health Service*" which may assist staff to respond effectively and appropriately in cases like this. It also commends an NSW Health Department document titled "*Guidelines for the Promotion of Sexual Safety in NSW Mental Health Services*".

ISSUE 14: USE OF SECURITY GUARDS IN MENTAL HEALTH UNITS

Illustration: Last year the Annual Report noted that there had been a series of complaints about the use and attitudes of security guards at Kalgoorlie Mental Health Unit. It was a concern that it might take 2 or 3 hours for a response from the external guards, and further that these guards had not been trained to meet the needs of a mental health unit, having been seconded from a general security guard workforce. As a result the Hospital introduced short training sessions and requested that a trained security guard be available at all times on the hospital site. The Council was not confident that this particular matter had been resolved, though was given assurances that steps were being taken to clarify roles and functions

Status: While there have been no further complaints this year, the hospital continues to use security guards.

ISSUE 15: ACCESS TO CLINICAL AND ALLIED HEALTH SERVICES

General Observations and comment: As a matter of principle the Council will always advocate for involuntary detained patients who complain that they have not been seen by their Psychiatrist, as their treatment may not comply with the Act's objective (section 5 (a)) that treatment and care be provided "*with the least restriction of their freedom…*".

As in previous years the Council continues to receive complaints about lack of access to a range of services in both metropolitan and country services. Consumers complain time and again to Official Visitors of the unrelenting boredom on the wards, particularly on weekends. Complaints about lack of access to the Consultant Psychiatrist are also common and Council has approached the Chief Psychiatrist to ascertain how regularly consumers should be interviewed by the Consultant Psychiatrist (as distinct from a member of the "treating team").

Council is also aware that a number of services (again both in the metropolitan and country regions) have spent most of this year looking and waiting for staff to arrive including Clinical Directors, Consultant Psychiatrists, Occupational Therapists, Social Workers and Nurses.

The good news this year was that Kalgoorlie now has its own resident Psychiatrist who consults daily at the unit. Last year the unit was relying on fly-in and fly-out consultants. However Kalgoorlie continues to have no Psychologist or Occupational Therapist (though the hospital has approved an increased staffing ratio to enable nursing staff to help deliver some of the OT programs themselves) and no regular or easy access to the hospital's Social Worker due to the workload of the hospital patients. Security staff continued to be used at this hospital.

Residents in hostels do not fare any better (see below).

Each year the Council takes its concern to the Office of the Chief Psychiatrist and the Mental Health Division about the unmet needs of people in hospitals as well as for the residents in Licensed Private Psychiatric Hostels.

Status: The Government commitment to improving this situation across the sector is welcome, although for many reasons it is likely to be some time before the promised recruitment of medical, nursing and allied health professionals is accomplished. Extra incentives are needed to encourage staff to country regions. The Council will continue to monitor individual complaints and to advocate for improved service levels.

ISSUE 16: RIGHT OF CITIZENS TO VOTE IN ELECTIONS

Illustration: There is a civil and political right to vote in elections accorded to adult citizens of this country. The Council shares its concerns with the President of the Mental Health Review Board and the Chief Psychiatrist that people with long term mental illness can be excluded from their right to vote in Federal and State elections because either they are not enrolled to vote or they may be assessed as not having the capacity to vote (sections 201 – 203 of the Act). They may not know of the right to appeal a decision of incapacity.

There was a Federal Election in November 2007, before which many parties made an extra effort to ensure that hospital in-patients would be able to vote if at all possible. However it is of concern that many people at Graylands were possibly denied participation because the local Electoral Division did not deem it necessary to provide a mobile polling booth. Postal applications were offered.

The State Electoral Commission had previously advised that Graylands Hospital would be considered a declared special institution and a mobile polling team would visit the Hospital prior to the next State election for enrolled and absentee voters.

Action: The Council entered into correspondence with the Returning Officer at the Curtin Division prior to the Federal Election being called in November 2007, to be informed that he would assess how well or otherwise the provision of postal votes to eligible people in the hospital was handled. We reported that there was some delay between the Division receiving Postal Vote applications and sending the ballot papers: the hospital's welfare workers provided assistance to ensure people could vote. Some patients, following a risk assessment, were taken to a local booth to vote, but this was far from satisfactory.

The Council therefore asked for reconsideration of the Division's decision not to provide a mobile booth prior to the next Federal election, pointing out that mobile booths visited the mental health units at Fremantle, Armadale, Bentley and Albany for instance and in some cases the hospital itself was a community booth on the day of the Election.

Status: In March 2008 Council was advised by the Australian Electoral Commission that it would not commit to a mobile voting booth at the next election despite also acknowledging that 6 voters received their papers too late to vote. The Council's interest is to ensure that people with capacity can exercise their right to vote and that people in a mental health facility receive the same consideration as do people in a general or maternity hospital. Council will therefore continue to argue for a mobile voting facility.

ISSUE 17: LICENSED PRIVATE PSYCHIATRIC HOSTELS

General Observations and comment: The licensed private psychiatric (LPP) hostel sector comprises a range of facilities from small suburban houses accommodating 3 to 5 people, to custom built cluster housing developments and older, larger facilities with up to 84 residents. Some are managed by not for profit organisations and some as business enterprises.

The opening this year of the first Community Supported Residential Units (CSRU's) in Geraldton, Albany and Busselton and the first Community Options House in Kelmscott totalling 43 new beds (though due to staffing issues Kelmscott was not fully operational as at 30 June 2008), is welcomed by the Council.

The Council's Official Visitors have the statutory authority and function to inspect LPP Hostels and to ensure that:

1. the rights of residents are observed; and
2. LPP Hostels are "kept in a condition that is safe and otherwise suitable".

(*Mental Health Act 1996* (MH Act) sections 188 (b) and (c))

Typically residents of LPP hostels have chronic and enduring mental illness. As a result they can be quite vulnerable and it is not uncommon for LPP hostel residents to be in situations where that susceptibility can be exploited or where they are patronised or treated like children in regards to personal decision making. Residents are usually loathe to complain about their living conditions, perhaps because there are few options for those who need communal accommodation as well as each person being known to the Licensee. Official Visitors will either provide advocacy for the resident to the Licensee or take the matter up as a systemic or environmental problem rather than an individual one.

In order to assist Official Visitors a 10 point Charter of Rights for hostel residents was drafted during the year to be used as a guide when visiting LPP hostels. It is accompanied by notes for the Official Visitors that summarise the range of legislation and standards that apply to LPP hostels so that Visitors can ensure that individual rights are protected. The Charter states that every resident of a LPP hostel has the right**:**

1 To ask an Official Visitor to visit and to discuss concerns or make a request or complaint;

2 To have a Residential Agreement with the Licensee. This should include a statement as to how personal monies are to be managed and audited;

3 To live in accommodation that meets the needs of residents and the expectations of the community. The environs should be safe, comfortable and home-like and meet regulatory requirements;

4 To have access to clothing, laundry, food and drinks and medication management that meets required standards;

5 To personal privacy and space, and to be treated with dignity, compassion and respect;

6 To the full and effective use of his/her personal civil, legal, religious and consumer rights;

7 To live without discrimination, violence, intimidation, harassment, exploitation, abuse or neglect;

8 To be treated and accepted as an individual, and to have individual preferences respected and taken into account;

9 To make informed decisions and informed choices, (including the choice of personal GP and dentist and the right to find alternative accommodation) and

10 To have access to services and activities which are generally available in the community, including to individuals who live with a physical disability.

A decision was also made to allocate Official Visitors to specific LPP hostels in an effort to make Official Visitors more familiar and accessible to residents and allow them to try to work with hostel licensees to improve conditions for the residents.

Illustration 1*: *Physical conditions: Official Visitors reported on a Saturday morning, amongst other major concerns about cleanliness, that the bathrooms on all floors were filthy with an overpowering stench of urine, faecal matter encrusted on toilets and vomit in one sink. In addition the floors generally were filthy, dining room tables had gone uncleaned and there were general concerns about the health of hostel residents. This condition prevailed until Monday afternoon when it became apparent that the 40 bed hostel was being left with only one staff member to do everything on the weekend including providing meals which meant that the hostel was not being cleaned from Friday morning to Monday morning.

Action: Meetings were called with the Manager and Licensee to try to address the issues. The Official Visitors made it clear that the hostel had to be cleaned on the weekends and could not be allowed to go 2 days without cleaning. Given the number of residents and the age of the bathrooms, it was felt that they should be cleaned twice a day or at least have spot checks carried out during the day. The hostel Manager explained they had difficulties getting staff. Official Visitors came up with a number of practical suggestions in relation to cleaning and meeting the needs of residents in these discussions. It should be said that this is not strictly the role of Official Visitors but out of concern for the day to day needs and rights of residents a lot of commitment was made by the Council.

There were also meetings with the hostel outreach team attached to the Mills Street Centre in an effort to ensure that appropriate medical, social and recreational services could be provided on an individual basis. Subsequently the local authority was also contacted and responded with an inspection and advice about obligations for kitchen and food hygiene practices.

Status: A great deal of Council attention has been paid since this incident in trying to improve the rights of the residents of this hostel with efforts going into attempts to work with the Licensee to improve the environs and services. Some renovations have been made to the bathrooms, cleaning has improved (though the Council would like to see a lot more improvement), a dietician was brought in by the hostel to advise on menu planning, the provision of cold water was introduced during summer months and there have been some other improvements.

***Illustration* 2: *Right to autonomy and privacy*:** A number of residents from a second hostel complained that their mail from the Public Trustee had not been delivered and also that possessions had been taken from their rooms. Some residents claimed that they do not receive their mail for some time after it arrives at the Hostel and that on occasion it has been opened. The complaints had been taken up from time to time by Official Visitors with the Licensee but to no avail.

Action: The Head of Council and the Executive Officer met with senior representatives of the Public Trustee to convey our concerns and try to clarify whether the claims had any substance. It was their view that privately addressed letters they send – which could contain private information or ask urgent questions should arrive within two days. The Council wrote to the Licensee with a number of questions about hostel policy and practice in relation to receipt and distribution of residents' correspondence.

Status: The Licensee sent a step by step response to our questions, explaining that many residents were incapable of managing their correspondence and that he will continue to manage it as has been done for the 'last 25 years without complaint'.

Illustration 3: Right to autonomy and privacy: For some years the Council has asked this Licensee to provide locks for resident bedroom doors and/or their bedroom furniture, but with little success. Again several residents have complained that property and money go missing from their room and it is not uncommon for a resident to disturb someone going through their possessions. It is a standard of the licensing requirements that hostel residents be able to lock their room or a cupboard.

Status: The Licensee again responded to our requests by stating that while some residents do now have a locked cupboard, the Council and its representatives do not understand the nature of the residents and the difficulty of monitoring them – impossible he said, behind locked doors. He denied that money or property has been reported stolen but items are "often misplaced or borrowed, not necessarily stolen". He pointed out that 'we are not hotels where one would use swipe cards'.

Comment: It is disappointing that such outmoded views of chronic mental illness limit individual capacity and autonomy. (In fairness this is not the only hostel opposed to enabling a person to secure at least their belongings through providing a locked door or cupboard).

Illustration 4: Access to clinical and allied health services: Difficulties getting access to clinical services, both GP and psychiatric, is commonly experienced by hostel residents. In some cases GPs will no longer visit the hostel and there are transport and other difficulties in getting to the doctor's surgery. In the case of at least one hostel, the Mental Health Nurse from the local treating clinic has advised that he is acting as a pseudo GP dealing with general health issues as well as mental health issues. In the case of another hostel, a resident had not seen a psychiatrist for many months until an Official Visitor provided assistance and contacted the local clinic. Access to dentistry treatment also remains a major concern. Access to social workers and recreational and rehabilitation activities are also virtually non-existent in some hostels unless regular transport is provided by the Licensee.

Action: Official Visitors continue to advocate on an individual basis.

ISSUE 18: MENTAL HEALTH REVIEW BOARD HEARINGS

General Observations and comments: For the past 3 years the Council has run a project designed to increase the number of consumers with representation and support at Mental Health Review Board (MHRB) hearings either by Official Visitors or lawyers from the Mental Health Law Centre (MHLC). The purpose of the hearings is for the Board to review the treating psychiatrist's decision to keep the consumer involuntary and/or in hospital or on a Community Treatment Order. This year Official Visitors were requested to attended 384 MHRB hearings in comparison with 340 last year and 163 the year before that. (See Part 3 of this report for more information)

At the hearings the consumer faces a panel of 3 people, (a lawyer, psychiatrist and community member). The consumer's Consultant Psychiatrist sometimes attends, however it is more usual for a Psychiatric Registrar or Senior Medical Officer to attend, and he or she usually provides a written report on the consumer to the MHRB stating their reasons for refusing to make the consumer voluntary. Most consumers find the MHRB hearing very intimidating and Official Visitors hear from consumers all the time that it is a "kangaroo court" or a waste of time attending.

In April 2008 Official Visitors met to discuss a number of concerns they had with the process, primarily revolving around the content and timeliness of doctors' reports. Discussions were also held with the MHLC who confirmed that they had similar concerns. As a result a letter was sent to the Minister and the MHRB calling for an ad hoc committee to be established to consider those concerns and looks at ways of overcoming some of the issues.

The concerns include the late provision of reports (sometimes only an hour before the hearing) with the Official Visitor or Mental Health Law Centre Lawyer having to show the report to the consumer just before they go into the hearing. Reading the report can be very distressing to the consumer who has little or no time to compose him or herself before going into the hearing. In addition Official Visitors are concerned about the hearsay statements repeated as fact over and over again on the medical files, sometimes going back many years, which then reappear on medical reports. In some cases where consumers have been involuntary for some time, the same medical report appears to have been used over and over again.

The Minister for Health responded by asking Head of Council to convene and chair, and the Council to administer, a committee to look into the issues raised. Representatives of the Health Department, MHRB and the Mental Health Law Centre will take part.

Illustration 1: The Community Treatment Order (CTO) status of a man in a non-metropolitan clinic was to be assessed by the MHRB by tele-conference. An Official Visitor accompanied him. However, the hearing was conducted by telephone (not a conference phone) via an on site nurse. No psychiatrist's report was available when the review started.

Action: The Official Visitor complained to the nurse and then to the Council about the conduct of the hearing. She added that the psychiatrist's report was conveyed by phone to the Board and in turn through the nurse to the consumer and herself. Further the Official Visitor made other observations:

- The signage to the clinic was poor and made it hard for people to find it.
- Although the next two hearings that day would be done without the consumers attending them, it was assumed they would be conducted in a similar way.
- The tele-conference equipment had been on order for six months.

The Head of Council wrote to the President of the Board to suggest that the process was unfair and that the Board should probably have adjourned the hearing. A letter was also sent to the Regional Director asking when the equipment would be installed and recommended that clear directions to the clinic were required.

Status:

1. The status of the man was confirmed at hearing and he remained on a CTO.
2. The Regional Director assured Council that until new equipment was installed later in the year, consumers would be offered a review at another Regional clinic. As signage was originally located to be "informative but discrete" it was to be reviewed by a senior staff member and made visible at all times
3. The President made enquiries with the Panel and listened to the tape recording of the hearing. He concluded that the hearing was not procedurally fair and an offer was made to the consumer to convene another hearing (not taken up). It was emphasised that if a telephone conference needed to be held, a conference phone must be used and all in attendance should hear what is said at all times and be able to communicate with other participants to be consistent with the Act (section 113).

ISSUE 19: BAN ON SMOKING IN DEPARTMENT OF HEALTH FACILITIES

A ban on smoking in all Department of Health facilities including mental health units, wards and clinics was imposed from 01 January 2008. This caused great concern in the sector as tobacco is an acknowledged source of comfort to many people with a mental illness. Although definitive W.A. data are not available, in 2000 SANE Australia estimated that smoking is three times more prevalent among people with mental illness than in the general population. Others report that between 75% and 90% of patients with a mental illness smoke.

As stated in the 2006-2007 Annual Report, previously Council had agreed to support the Health Department's smoking prohibition with the proviso that it not be imposed on involuntary patients in locked wards until any problems associated with implementation in open wards were resolved.

In May the Council revisited this position following a review of the current position by Official Visitors based on their observations and what they had been told by staff and consumers. The result of that review was a new Position Statement and a letter to the Minister for Health about the impact of the smoking prohibition.

In particular, the Council told the Minister that it was concerned about:

1. consumers being put into seclusion or denied privileges such as ground access because they were caught smoking;

2. particularly vulnerable consumers selling valuable personal items to buy a single cigarette;
3. a proposal by Graylands' hospital that they withhold patients' own money where they were "repeat offenders" so that they could not continue to purchase cigarettes on the cigarette "black market" which is apparently thriving at this hospital – Council warned Graylands that they did not have the legal right to do this and that it would be an infringement of consumers' rights;
4. aggressive behaviour associated with nicotine withdrawal resulting in a consumer staying longer in a secure ward than would otherwise have been necessary and the consequent impact on the shortage of acute beds;
5. the extra aggression associated with nicotine withdrawal leading to added stress on staff with the resultant impact of more staff resignations and/or stress leave when the system is already having to cope with double and sometimes triple shifts and bed closures due to lack of staff;
6. the danger of consumers sitting in the gutter on the side of the road to smoke (so that they were officially off Health Department property) where they could be injured by a passing car;
7. the danger of consumers hanging around bus-stops to smoke, or disappearing into the bush or open spaces, often in the darkness;
8. visitors not being allowed to take bags onto the ward in case they are smuggling cigarettes which is an infringement of the rights of other people; and
9. the general distress being caused to very unwell consumers who are already having to deal with a serious illness as well as being locked up against their will for weeks or months with other very unwell people and having to try to give up a very serious addiction all at the same time.

The Position Statement on Smoking agreed to by the Council and sent to the Minister as a result of these concerns states that:

- the Council supports the WA Smoke Free directive for voluntary consumers;
- Official Visitors will support consumers who are trying to give up smoking and wish to comply with the smoking ban;
- the Council opposes the WA Smoke Free directive for involuntary consumers (and provided the rationale as noted above);
- the Council advocates for the creation of safe designated smoking areas on the basis of duty of care by the Department of Health (where consumers are responsible for the cleaning of the areas to avoid issues of staff passive smoking);
- Official Visitors will not actively assist Department of Health staff to enforce the ban on smoking by reporting breaches of the ban;
- Official Visitors as appointees of the Minister for Health will not intentionally undermine the implementation of the smoking ban and will not supply voluntary or involuntary patients with cigarettes and/or lighters; and
- Official Visitors will actively monitor and report any incidences of infringement of rights that occur as a result of the implementation of the smoking ban.

The Position Statement will be reviewed in December 2008.

In responding to the Council's letter, the Minister has re-stated the Government position on its determination to reduce smoking. The Council recognises that aim but as advocates for patients continues to argue that any actual problems should have been resolved before imposing the ban onto involuntary patients in locked wards and that asking people to give up a very serious addiction when they are acutely ill, is likely to be fraught with difficulty.

ONGOING ISSUES THAT REQUIRE REMEDY

The issues listed below have been raised in the Council's Annual Reports from 1997 onwards and remained unresolved during 2007–2008. If these issues were to be addressed the Official Visitors believe that the quality of life for people with acute, as well as enduring, illnesses will be improved.

LEGISLATION

1998–1999

1 Definition of "affected person" – Mental Health Act 1996, Section 175

Amend the Act to enable Council to attend to voluntary patients, including children, referred persons and individuals subject to a Hospital Order under the Criminal Law (Mentally Impaired Accused) Act 1996.

2007–2008

The rights and dignity of voluntary consumers can also be breached and the Council continues to be asked for a range of assistance by individuals who we cannot help. The Council anticipates that forthcoming legislation will establish the authority for it to be able to deal with their complaints.

2 Consumer access to personal records – Mental Health Act 1996, Sections 160 & 161

The Act allows for a "suitably qualified other" person to access a consumer's medical record on his/her behalf if it is determined that the consumer should not have this access. The Chief Psychiatrist's restriction of "suitably qualified other" ONLY to psychiatrists should be reviewed as a matter of urgency to allow the appropriate involvement of other professional groups. The Chief Psychiatrist has received advice that legal practitioners cannot withhold information from their clients. Therefore the restriction to psychiatrist for "suitably qualified others" will remain.

2007–2008

Council claims that amendment to the legislation is still required.

3 Medical Treatment May Be Approved by the Chief Psychiatrist – Mental Health Act 1996, section 110

The Chief Psychiatrist has delegated this power to the Heads of Mental Health services and states that this allows for the distinction between "authoriser" and "prescriber". In Council's view guidelines must be developed regarding the use of the Chief Psychiatrist's delegated authority to approve medical treatment.

2007–2008

There must be a separation between the psychiatrist who may prescribe non-psychiatric medical treatment and the psychiatrist who consents to the giving of non-psychiatric medical treatment, e.g. contraception. The Council cannot think of any other medical field where a prescribing doctor also provides consent to the prescription/treatment. This should be made clear in the legislation.

2004–2005

1 Debate Regarding Use of Provisions of the GUARDIANSHIP AND ADMINISTRATION ACT 1990 rather than the MENTAL HEALTH ACT 1996

The Council had reservations about a number of proposals accepted by Government in response to the review of the Mental Health Act 1996

Illustration 1 – Review Rec. 3.9: *This recommendation proposes an amendment of the Criminal Code so that a person who detains an individual without a diagnosed mental illness but with a degenerative brain disease (eg dementia) admitted to an authorised hospital, is not liable to section 337 of the Code. The recommendation also allowed a guardian to consent to detention which raises concerns. Mental health legislation provides a framework for the detention of individuals meeting section 26 criteria and provides protections and rights for them which would not apply where a guardian has consented.*

Illustration 2 – Review Rec. 5.3: *This recommendation proposes that voluntary psychiatric patients must either give informed consent to treatment or a have a guardian who can give consent. The guardianship legislation would need amendment to* this *end. It has been established practice that persons with a mental illness who do not or cannot consent to essential treatment are treated under the provisions of the Mental Health Act as involuntary patients. One of the protections established by the Act is the right to review. Although a guardianship order can be reviewed by the SAT, the decisions of the guardian cannot be independently reviewed. The appointment of a guardian to consent to psychiatric treatment does not provide the safeguards of the Mental Health Act.*

Illustration 3 – Review Rec. 5.10: *This recommendation proposes that a supervising psychiatrist be empowered to consent to medical treatment on behalf of an involuntary patient or mentally impaired accused person who is in an authorised hospital. The prime purpose of mental health legislation is to provide psychiatric treatment, not other medical treatment. In that instance it would be appropriate for a guardian to be appointed to consent to non-psychiatric treatments.*

2007–2008

Council is waiting to see the draft legislation.

FOR PEOPLE ADMITTED TO AUTHORISED HOSPITALS

1997–1998

1 The outside area at Joondalup Mental Health Unit secure ward *has always been inadequate. The outdoor area should be extended to an appropriate size and configured to enable access to the garden.*

2007–2008

The extensions to the hospital are in progress. The area is bigger but Council has concerns about the height of the walls. The position will be reviewed when the extensions are completed.

1998–1999

1 The impact of overcrowding in authorised hospitals

There is an URGENT need to increase the number of places in step-down facilities for transition from hospital to community. No progress as yet; and there is anecdotal evidence that individuals are readmitted to acute units because there are no other options. We urge the Office of Mental Health (OMH) to re-assess the number of beds required to ensure that enough acute as well as step-down beds are available. More beds of all types are required for children and adolescents.

2007–2008

The W.A. Mental Health Plan and its 12 key initiatives aim to address and rectify problems inherent in the sector, including bed numbers. However funding was not forthcoming for all 12 initiatives and even it had been, the quantum of need for acutely ill people as well as for community based supported accommodation inevitably means that complaints about overcrowding will continue for some years. The Council has actively supported plans for community based supported accommodation and is delighted that people are gradually being housed including in non metropolitan areas. However there remain a significant number of people in hospital wards who cannot leave because there is no where for them to go. Council is also concerned that there are two groups of acutely unwell consumers (including those with acquired brain injury and other cognitive impairments) who are being treated in mental health secure wards but who will not qualify for the new CSRU and Community Options initiatives of the Health Department. These people are likely to be left languishing in the acute hospital wards without appropriate care and reducing the care levels available to other mental health consumers.

2 Lack of system wide policies that have a direct impact on consumers

Depending on the hospital or service, consumers are likely to be subject to different rules and expectations. For example, there are no sector wide policies in relation to searches of the person, use of video surveillance and the use of mobile telephones, among other issues. Such policies when developed by Office of the Chief Psychiatrist (OCP) and/or OMH need to reflect any associated legislative requirement.

2007–2008

Consumers and members of the Council continue to comment that they experience/observe differences between services.

3 "Second" opinions

Consumers must be offered a range of options that ensure that second opinions are independent of the treating team and, if requested of the treating service. The OCP has issued an Operational Circular stating that it is "desirable" that second opinions are independent of the treating team and 'whenever possible the opinion arranged should be seen to be independent' (Council emphasis).

The effect for consumers of the implementation of this Operational Circular requires monitoring.

2007–2008

The Council contends that the right to a "second" or other opinion must be independent. Complaints that applications must be written have continued to be made this year. Of equal concern has been delays in getting second opinions and getting truly independent second opinions, contributed to at least in part by the shortage of Consultant Psychiatrists in some facilities. The Council utilises its position statement on other opinions as derived from the Act, for its use and for the information of Official Visitors. A separate position statement includes protocols for individuals treated by Community Treatment Order. The Position Statement says that Consumers must be provided with a range of options to include:

- an opinion from another psychiatrist from within the authorised hospital where they are currently detained; or
- an opinion from a psychiatrist in private practice; or
- an opinion from a psychiatrist, who is employed by another public mental health service.

The advantages and disadvantages of the options listed above (timeliness, costs and degree of independence) should be explained to consumers so that they may make as informed a decision as possible. Arrangements for the provision of the opinion must be instigated within 1 normal working day of the receipt of the request for the opinion.

1999–2000

1 Facilities for children and adolescents

A contingency plan is urgently required for occasions when all beds are full at the Bentley Adolescent Unit (BAU) at the WAY Centre attached to Bentley Hospital.

Further in 2005–2006: *Apart from the 12 beds at the BAU there are no beds for children and adolescents who need involuntary treatment. If inpatient treatment is imperative, young people will be admitted to adult units. In November 1999 the Council first raised concerns regarding the procedures in place to deal with the situation when the BAU is at capacity and when an adolescent patient requires admission to an authorised hospital. In May 2000 the Council was advised that a draft contingency plan was to be developed as well as action to improve referral pathways.*

2007–2008

Problems continue with children ranging in age from 9 to 17 years being treated at the BAU. In addition this year the Council has seen the BAU be allowed to get run-down with banana beds and paper on windows instead of curtains. (See Issue 6 above.) It is Council's view that the BAU should be replaced because the design of the building is inappropriate to house children and adolescents - it looks and feels like a prison, has insufficient outdoor area and it requires younger children to mix with teenagers. The Council understands that a contingency plan as part of the WA Mental Health Plan is also yet to be completed while meanwhile Official Visitors are regularly told that there is a waiting list of children for the BAU.

Council is aware that a new committee called the Infant, Child, Adolescent & Youth Mental Health Services (ICAYMHS) Executive Group has been established following on from a Review of Child & Adolescent Mental Health Services in Western Australia by Professor Barry Nurcombe in July 2007. Professor Nurcombe's report identified a number of serious gaps in both funding and the provision of mental health services to this age group. The ICAYMHS Executive Group is to develop a mental health plan and review the current policy.

The Council therefore looks forward to seeing improvements during 2008–2009.

2 Human relations and need for intimacy

These issues require urgent attention if individuals are to be appropriately rehabilitated and socialised. Staff training is required, especially in relation to their acceptance that needs for physical, emotional and spiritual intimacy are universal.

2007–2008

Some progress has been made but there are still facilities where patients have to ask to use the phone and then sit outside the nurses' station with little or no privacy. Council's position statements on Access to Telephone and Access to Visitors can contribute in a small way to ensuring that these needs can be protected.

3 Often no access to on-site gyms, or to exercise equipment etc.

Increase access to on-site gyms and to equipment (bikes, balls etc). Access to physical exercise opportunities varies between hospitals and wards.

2007–2008

Little if any change since first reported. In particular consumers complain that weekends are especially difficult because of the lack of scope for any physical activity. Boredom is a very common claim made to Official Visitors. Usually the equipment is available but not the staff.

2001–2002

1 Design of facilities

The Council noted that they, consumers and providers should be invited to participate in planning renovations and new units to ensure a consumer perspective is considered in design. The Council has been asked to comment on proposed renovations for a small number of facilities. Unfortunately with few exceptions, this input still may not be incorporated. Among other matters, the standard and provision of facilities for visitors, outdoor areas and telephone access differ between acute units.

2007–2008

Council welcomes the policy of the Mental Health Division to include consumers, and where appropriate, carers and other advocates (including Council representatives) as members of the many planning groups for the development of the W.A. Mental Health Plan. Not only Council representatives, but other members of various planning committees have found our Position Papers (e.g. Translating Rights into Authorised Hospital Design, Access to Telephones and Access to Visitors) useful as a checklist of many issues that should be considered at design stage. As reported in Part 3 of this Report, Council was invited this year to comment during the planning process for the new Broome Mental Health Unit.

2002–2003

1 Access to Allied Health Professionals/Multi-disciplinary team

All consumers should have access to a multi-disciplinary team of professionals to ensure that they receive an holistic approach to their treatment. The Council continues to raise this matter with the MHD and OCP.

2007–2008

While the W.A. Mental Health Plan aims to recruit and retain numbers of allied health professionals, slow progress is being made and the deficits are very obvious in both metropolitan and regional units.

2 Need to improve opportunities for socialisation for people with a long term illness

As a matter of priority, individualised socialisation and slow stream rehabilitation programmes for long-stay hospital patients should be developed and implemented. There has been some slow improvement. A range of basic human needs must be provided for.

2007–2008

The opening up of the first Community Options home in Kelmscott and the John Milne Centre at the Mills Street Centre, Bentley are the welcome beginnings of change in relation to this issue but much more needs to be done. Council has also been very pleased with efforts made recently at Murchison House by the new CNS (see Issue 12 above).

3 Specific areas for visitors are inadequate or non-existent in many inpatient facilities

Any new inpatient facilities, particularly secure units, should incorporate designated visitors' areas into their design. Existing units should be refurbished to accommodate designated visitors' areas. The dedicated facilities available for individuals to receive visitors in private vary between inpatient facilities and wards within those facilities. Most often there are none.

2007–2008

Consumer and advocate membership of planning committees should go some way to ensure that these needs are addressed in new facilities. The Council's position paper "Access to Visitors" has been a useful tool to put to designers and architects that visiting spaces are incorporated into plans for new and refurbished units: it has been very rewarding to have been able to influence plans for new unit designs and indeed at times to have persuaded designers to change.

2003–2004

1 Hospital Emergency Departments (ED) and the management of people with a mental illness

It was of concern to the Council that practices had developed to manage access to acute beds, not the clinical needs of each patient. Undue lengths of time in the ED and use of mechanical and/or chemical restraints were noted. It was acknowledged that the pressure on beds is a sector wide issue compounded by the lack of intermediate care beds.

2007–2008

Although there have been some improvements in relation to treatment in Emergency Departments, Council continues to hear about people kept in ED for days (up to 7 days). The pressure on beds also has an impact at the other end of the patient chain: for example, hot bedding with patients being moved from ward to ward (at Graylands in particular though also some of the other hospitals as patients are shuffled from the secure to open ward and then back again) plus the regular use of leave beds and discharging patients to unauthorised hospitals. While such strategies may be considered efficient use of beds, for patients it can mean great instability at a time when they are already under a lot of stress and so compromise their care.

2 Indigenous services

It was noted that there is a desperate need for a range of new initiatives in indigenous mental health services so that the health and associated needs of people from metropolitan, rural and remote areas of the State can be better met and understood and their care individualised.

2007–2008

Last year the Council welcomed the range of initiatives planned to meet the needs of indigenous people in the W.A. Mental Health Plan and stated it would participate in any consultative processes established for this purpose, however, there has been no progress in the past 12 months of which Council has been made aware. (The Council has two Official Visitors who are indigenous Australians).

3 People with Acquired Brain Injury (ABI)

Secure mental health units are being used as a solution to concerns about safety in general medical wards. It is the Council's view that this particular small but growing group of individuals with challenging and aggressive behaviours should be treated in a specialised service. They need skilled and trained staff and appropriate long term accommodation.

2007–2008

This issue remains a serious and growing problem. Speaker after speaker raised the plight of people with ABI at the Disability & Justice Conference held in Perth in November 2007 but it remains that such people are being placed in mental health units because there is nowhere else for them to go. The Council remains concerned about the treatment being received by people with an ABI, whether their rights are respected, and the impact on staff and other mental health consumers.

4 Mental Health Review Board hearings: medical staff attendance and/or reports

Two hearings had to be adjourned because medical staff did not attend. When, for whatever reason, medical staff are unable to attend a hearing or do not present a report to the Board, there is a perception by the patient that fairness and justice are compromised.

2007–2008

Unfortunately there remain occasional instances of non-attendance by medical personnel and medical reports are nearly always provided only a few hours before the hearing. Almost always they have not been made available to the consumer. Council wrote to the Minister for Health about a range of concerns about the MHRB process and he has asked the Head of Council to convene and chair, and the Council to administer, an ad hoc committee made up of representatives from the Health Department the MHRB and the Mental Health Law Centre to consider the issues. For more information see Issue 18 above.

2004–2005

1 Right of capable persons to exercise their right to vote

An involuntary patient at Graylands Hospital contacted the Council to say he wanted to vote in the State election. He had been deemed incapable of exercising his right to vote by a psychiatrist (sections 201 & 202 of the Act). The Council arranged for an urgent MHRB hearing (section 203 of the Act) the day prior to the election and the decision was overturned. This example and the transport provisions made for electors at Graylands raised a number of matters about a citizen's right to vote and the organisation of these arrangements for people hospitalised with mental illness. Any other hospital of this size would be provided with an appropriate service for its patients. The Council was surprised to learn that only 2 long term patients at Graylands were enrolled to vote in order to exercise a basic political right.

2007–2008

The situation has improved from the perspective of State elections, but not Federal elections. For further information see Issue 18 above.

2 Low representation of individuals at Mental Health Review Board hearings

Research was undertaken to establish why so few individuals have representation or support when their status was reviewed by the Mental Health Review Board (MHRB). The Council has continued to aim for providing support to more consumers at MHRB hearings but with limited success. The aim of the research was to use the study's results to assist the relevant agencies to review, and if necessary, revise their procedures for disseminating information about their role and services and to improve representation.

2007–2008

Council has, through ongoing efforts, managed to increase the amount of representation and continues to explore ways of more effective contact with consumers in regard to exercising their right to representation and support as well as all their other rights. For more detail see Part 3 of this Report.

3 Cigarette smoking in authorised hospitals

The Council had pointed out that the prohibition of cigarette smoking within 5 metres of the doors to government buildings and 10 metres of air conditioning units was having a direct and negative impact on consumers, especially those confined to secure wards. The matter of who controls cigarette smoking, and for what purpose, is complex but the Council claims that individuals should be able to, and encouraged to, manage their own smoking habit. Control can adversely affect the decision making rights of individuals. Besides the clear implications for health, there are safety concerns for the smoker and for others.

2007–2008

The Department of Health's smoking prohibition took effect from 1January 2008. In Council's views the prohibition has led to a number of problems and Council has, in its Position Statement agreed on this year, proposed designated smoking places. For further information see Issue 19 above.

2005–2006

1 Advising "Another Person" of the Patient's Rights – Mental Health Act 1996, section 157

Advising "another person" (section 157) of the rights explained to a patient (section 156) is not always completed by the clinician whereas Official Visitors confirm that an explanation of rights is generally provided to patients. Unless denied by the patient concerned, the Official Visitors check case notes in authorised units to ensure that an individual has been informed of his/her rights as an involuntary patient as per section 156 and that a record is made. Authorised units utilise a range of reminders, stickers, labels, signatures and colour codes for staff for that purpose. Clearly, because of illness, there can be a delay or a clinician needs to repeat explanations at a later date.

Under the Act section 157 specifies that a copy of the explanation …. is to be given to another person. …defined in context of: "A person to whom the explanation is to be given is to be asked to specify a relative, guardian, friend, or other person to whom a copy of the explanation is to be given, and a copy of the explanation is to be given to the person specified.". In most hospitals there was no provision for recording that this explanation has been followed. The Council has asked all Clinical Directors/Managers to attend to this requirement.

2007–2008

Official Visitors have continued to follow up on these records in hospital but implementation remains inconsistent.

2 Neglect of dental health, hygiene and treatment

The Council of Official Visitors is perturbed by the continuing complaints related to timely access to dental treatment for both long term consumers and acute involuntary patients and has raised the concerns of Official Visitors about the neglect of dental hygiene of all consumers with a long term illness to the Mental Health Division for many years. Inevitable effects of this neglect must be that food cannot be enjoyed, that nutritional status is compromised and that there are other adverse impacts on physical health and self esteem.

The Minister had responded to our advocacy by assuring the Council that additional funding would be sought in order to "significantly increase free dental service provision through the Graylands Hospital Dental Clinic for consumers who are currently in hospital or reside within psychiatric hostels".

A commitment was also given to training for nursing and hostel staff in the promotion of dental health to this client group: the training will be developed in conjunction with the Director of Dental Health Services. The proposal for an audit may be considered.

2007–2008

The Graylands Hospital Dental Clinic has expanded and this is welcomed but Official Visitors continue to be told that hostel residents in particular have little or no access to dental care. A range of initiatives require implementation and ongoing effort between all stakeholders, including in the hostels and supported housing sector.

FOR PEOPLE SUBJECT TO COMMUNITY TREATMENT ORDERS

2003–2004

1 Community Treatment Order issues

Instances of breaches and potential breaches of the Act were cited as they related to complaints received from consumers subject to Community Treatment Orders.

2006–2007

The Council has drawn attention in previous years to instances where consumers are put in a position where they could unwittingly breach the conditions of their order .This year issues have also arisen in relation to the lapsing of CTOs (see Issue 3 above). The Council asks clinic staff to provide a letter from the Council for every person on a CTO and Mental Health Review Board staff send letters to consumers due for a review of their status. A study by the Office of the Chief Psychiatrist, however, revealed that the majority of people on CTOs were not being given information in relation to what it means to be on a CTO, access to the Council and the right to a second opinion. Because people on a CTO are treated out of clinics it is difficult for the Council to make itself accessible. In the latter months of this year Council therefore changed its approach by visiting selected clinics in an effort to better reach these vulnerable consumers. For further information see Part 3 of this Report.

FOR PEOPLE RESIDENT IN LICENSED PRIVATE PSYCHIATRIC HOSTELS

1998–1999

1 Minimal health care and support services provided to residents of psychiatric hostels

Services have continued to be reduced through inadequately funded Government programmes, reinforcing the isolation of hostel residents from main stream health services. Some services are rationed by the providers, whilst others including transport to appointments, are reliant on the licensee making arrangements as required. A concerted campaign is needed to inform and remind providers about the physical health needs of hostel residents and to ensure that General Practitioners and other health professionals provide services under newly introduced Medicare arrangements. Although Official Visitors take up these matters case by case, it is clear that more global management is required, including by processes initiated by the Mental Health Division and the Office of the Chief Psychiatrist. From Council experience, individuals need to be assessed, and their needs identified for access to a range of services including:

- those provided by allied health professionals;
- community based recreational services; and
- socialising activities.

2007–2008

In general the great deficiencies outlined above remain and indeed have probably worsened as in some cases GPs no longer visit clinics and hostel licensees struggle to get staff. Many unmet physical and dental health needs are clear to the Official Visitors and others who visit hostels and respond to resident requests. Improvements should be a priority for the entire sector. See also Issue 17 above.

2 Licensing standards in licensed private psychiatric hostels required

The Council welcomed the introduction of standards for hostels and a three year process of implementation from 01 January 2004. Council argued that the reports of standards that are monitored and audited by the Licensing Standards and Review Unit (LSRU) should be subject to procedures to facilitate publicly accessible reporting.

2007–2008

Issues with licensing standards remain both in terms of their implementation (or lack thereof) by licensees but also their interpretation and usefulness. Council understands a review (which is now overdue) is planned by the Health Department.

3 Lack of facilities and privacy in licensed hostel bathrooms and toilets

Residents should be confident that soap and plugs are available in bathrooms (Hospital Act regulations) and that shower and lavatory doors are opaque and lock (Licensing Standards).

2007–2008

These continue to be ongoing issues of concern for residents and the Council in a number of hostels. In some instances there is potential for a neglect of hygiene especially where cleanliness of bathrooms and lavatories is compromised. In one hostel the rates were put up at the same time as residents started to receive basic provisions such as soap and toothpaste as required by the Licensing regulations. Residents therefore considered that they were getting something extra for the higher fees but in fact the Licensee had been in breach of the regulations.

4 Bedrooms and wardrobes in psychiatric hostels don't always ensure privacy and security

All bedrooms should have doors that can lock and wardrobes that are lockable. A master key, available to the shift supervisor should any problems arise, should alleviate the concerns that prevent individuals being able to secure their possessions.

2007–2008

Complaints from residents continue and Official Visitors continue to raise such issues.

5 Few residents of licensed psychiatric hostels have a resident agreement with the licensee

A resident agreement should, among other requirements, detail the rights and responsibilities of the resident and the owner/licensee. These are a crucial component of the licensing arrangements and Council argues that ***all*** *hostels should enter into an agreement with* ***all*** *its residents.* Further in 2004–2005: *The Public Trustee has developed an agreement to be provided by the Hostel proprietor to people at the time of their admission. The document complies with and reflects the standards required by the Department of Health's Licensing Standards and Review Unit.*

2007–2008

Based on a survey of hostels this year, most residents now have a residential agreement. Council will continue to monitor the situation to ensure that this condition of the licensing standards is met by all hostels.

2005–2006

1 Medication costs: inequities

There are some instances where policy operates differentially on residents of licensed private psychiatric hostels. Residents who have moved from one hostel to another in another health service area have been charged for medications when they were formerly provided at no cost. The Council has argued that a sector wide policy about charges for prescribed medications should apply. The current practice is in our view an inequity especially as hostel residents are a vulnerable group with little to no discretionary money.

2007–2008

Council understands that the situation remains unresolved. The Council maintains its position that medications should be provided from hospital pharmacies at no cost to the individual.

2 Aging of the population of Licensed Private Psychiatric Hostels

It is clear to any observer that many men and women have clear physical signs of ageing and/or physical disability. It has long concerned the Council that a hostel might not be the most appropriate accommodation for people with unmet physical needs. The issue was highlighted due to the closure of two hostels in 2005–2006. It was a source of anxiety to several advocates including the Council that several elderly people due to leave their residence had not had their needs assessed. Some assessments were done during the closure process but these would have been difficult to do (for most individuals) with no baseline against which to compare.

2007–2008

The Council continues to recommend to both the Chief Psychiatrist and the Mental Health Division that Aged Care Assessment Team (ACAT) assessments for all older psychiatric hostel residents be undertaken and the Council recommends that all hostel residents over 60 are examined and assessed by a psycho-geriatric team. The Council will be proposing that a requirement for such an assessment be included in the reviewed Licensing Standards.

PART THREE

STRATEGIC PLAN 2007–2008 AND OTHER ACTIVITIES

OVERVIEW OF STRATEGIC PLAN

The strategic plan for 2007–2008 was a further extension of the three year strategic plan developed back in 2003, with some modified targets. The Council originally agreed to an 18 month extension of the plan to 31 December 2007 in anticipation of the new Mental Health Act, however the drafting of that legislation was delayed yet again and so a further extension was agreed to 30 June 2008.

The prime aims of the strategic plan were to increase the number of consumers on Community Treatment Orders (CTOs) and living in hostels and group homes who received assistance from Official Visitors (OVs) and to increase the number of consumers who are represented in Mental Health Review Board (MHRB) hearings by either Official Visitors or lawyers from the Mental Health Law Centre. Although the strategic plan effectively remained as it had done for the previous 5 years, three new strategies were employed during the course of the year:

- Firstly, it was decided that a new approach needed to be taken to hostels and group homes in order to be more effective in getting changes and improvements made in the living conditions of some hostels and to make Council more accessible to the consumers. As a result, teams of Official visitors were allocated to specific hostels. This approach would allow the residents to get to know the Official Visitors better and the Official Visitors to build a relationship with hostel and group home staff in order to work together with them with a view to improving the conditions of the hostel or group home where it was felt this was necessary.
- Secondly, it was also decided that a new approach was needed to reach people on CTOs who are treated out of Mental Health Clinics. A survey of a select number of clinics was therefore carried out with Official Visitors attending the clinics with the aim of explaining the Council's role, ascertaining the numbers of CTO consumers that Clinics are responsible for, and whether and how CTO consumers' rights are upheld under the *Mental Health Act*. Letters were sent to other clinics requesting phone interviews and presentations were made to several clinics. This work is continuing.
- Thirdly, towards the end of this reporting year it was agreed by Official Visitors that the value of the Mental Health Review Board (MHRB) project which was aimed at making sure consumers knew their rights and encouraging them to have representation at the hearings, seemed to have run its course. There are a number of reasons for this, which are discussed further below. Official Visitors also reported dissatisfaction with the MHRB process and concern about the impact it has on consumers (see Issue 18 in Part 2 of this Report). It has therefore been decided to abandon the MHRB project for next year and a new approach to dealing with MHRB issues has been taken. Official Visitors will however continue to ask ward staff about consumers who have MHRB hearings pending and to offer their services to consumers.

QUANTITATIVE TARGETS & RESULTS

The following targets applied for the period 1 July 2007 to 30 June 2008:

- increase by 30% the number of consumers on Community Treatment Orders (CTOs) who receive assistance from the Council;
- increase by 15% for both people on CTOs and inpatients the number of requests for Official Visitors' attendance at Mental Health Review Board (MHRB) hearings;
- increase by 10% the total number of hostel/group home residents who receive assistance from the Council; and
- increase by 10% the total number of "*affected persons*" who receive assistance from the Council.

TABLE 1: PROGRESS TOWARDS REACHING STRATEGIC PLAN TARGETS TO 30 JUNE 2008			
	01/07/05–30/06/06	**01/07/06–30/06/07**	**01/07/07–30/06/08**
Increase by 30% the number of consumers on CTO who receive assistance from Council			
Metropolitan	58	58	58
Non-Metropolitan	10	18	23
TOTAL	**68**	**76**	**81**
Increase by 15% (both for CTO and hospital based consumers) request for attendance by Official Visitors' at MHRB hearings			
Involuntary Inpatients	136	294	334
CTO	27	46	50
TOTAL	**163**	**340**	**384**
Referral to the Mental Health Law Centre by Official Visitors for representation at MHRB			
Number of referrals	Not recorded	**24**	**32**
Increase by 10% the total number of hostel/group home residents who receive assistance from the Council			
TOTAL	**58**	**57**	**70**
Increase by 10% the total number of "*affected persons*" who receive assistance from the Council to 30 June 2008			
	01/07/05–30/06/06	**01/07/06–30/06/07**	**01/07/07–30/06/08**
TOTAL	**891**	**979**	**1052**

In summary and as can be seen from the table:

- The number of consumers on CTOs receiving assistance has increased only slightly (6.6%) so the 30% target was not met. While the distribution of open letters to consumers from the Council forwarded by the MHRB and community clinics continues, Council has started to look at other ways of making itself more accessible to these consumers.
- Requests for Official Visitors' attendance at MHRB hearings have again increased from 340 to 384 (or 12.9%, falling just short of the target) but there has been a noticeable slowing down in the second half of the year. It is believed reasons for this include the larger number of longer stay consumers on the wards and the "revolving door" that many consumers seem to spend their time passing through.

- The number of direct referrals to the Mental Health Law Centre (MHLC) by Official Visitors (where the consumer stated they wished legal representation at a hearing) was reported for the first time last year. A total of 32 such referrals occurred which is an increase on last year (24). This does not include consumers who stated that they wished MHLC assistance but chose to contact the service themselves.
- Hostel residents – the number of residents who received assistance has increased markedly this year from 57 to 70 (or 22.8% easily surpassing the 10% target). This figure is based on individual residents who requested assistance and for whom a report has been filed. It is believed that having "hostel teams" had led to the increased numbers but also the change in emphasis by Council to try to improve overall living conditions in hostels will have in fact benefitted more residents than reflected in the figures.
- Overall numbers – the number of affected persons who received assistance and the number of requests continue to increase by about the same amount as the previous year. The number of consumers increased by 73 (or 7.45%) and the number of requests increased from 2257 to 2676 (or 18.56%).

QUALITATIVE TARGETS

The Strategic Plan listed 3 key activity areas. The **first key activity area** was to address the rights and quality of life of "*affected persons*" i.e.:

- the rights and quality of life of involuntary patients in hospitals;
- the rights and quality of life of hostel residents; and
- the rights and quality of life of people with a Community Treatment Order.

In relation to these matters, to the end of the year 2007–2008, using the knowledge and information acquired from the formal inspections of hospital wards, hostels and group homes and the MHRB focussed visits, including the extra visits to secure wards, we are confident that the increased activity has meant that many more involuntary patients are made aware of their rights provided by the *Mental Health Act 1996,* although we have no quantitative data to support our claim.

The **second key activity area** continues the commitment to achieve an annual professional development plan for Council members. This is continuing to progress with a learning component structured into each Full Council meeting.

The **third key activity area** aimed to raise the profile of the Council In this regard the extra efforts made in appointing hostel teams and visiting clinics will have raised awareness of the Council by consumers. In addition Council took part in a number of consultations, conferences and presentations.

INSPECTION VISITS

The Act specifies that each authorised hospital must be visited by an Official Visitor or panel at least once in each month. In addition the Minister, in accordance with the Act section 186(b), has directed that an Official Visitor or panel should visit designated licensed psychiatric hostels at least once every two months. In practice most are visited each month.

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

Appendices 7A and 8A contain summaries of the inspection visits to authorised hospitals and licensed private psychiatric hostels by the time and day of the week. As in previous years the vast majority of inspection visits occurred without notice, as provided for by section 190(2) of the Act, however, consumers are provided with services in hospitals and hostels 24 hours per day, seven days per week. To ensure that visits are conducted at times other than Monday to Friday 9.00 am - 5.00 pm the Council set the following targets for formal inspection visits to occur outside usual working hours:

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

During 2007–2008 the Council conducted 29.8% of formal inspection visits to authorised hospitals and 18.24% of such visits to psychiatric hostels outside these hours. The Council therefore slightly exceeded the target set for authorised hospitals, however the Council did not meet the set target in relation to visits to licensed private psychiatric hostels outside these hours (see Appendix 9). This has been raised with the Council members.

Authorised Hospitals

The practice of having a specific focus for each monthly hospital inspection continued in 2007–2008. The inspection visits provide an opportunity for consumers to raise questions, concerns or compliments directly with the Official Visitors. The following focus areas were made the subject of inspection forms used by Official Visitors when visiting both authorised hospitals and hostels and group homes:

- Rights – Statutory
- Rights - Human (*ref Australian Charter of Human Rights)*
- Access to Medical Records and Information (s.160 and s.161)
- Furnishings
- Christmas and New Year Celebrations
- Medical
- Food & Beverages
- Therapy
- Clinic Visits
- Privacy
- Statutory Rights and Hostel Regulations

All authorised hospitals were visited each month with a total of 266 formal inspection visits (see Appendix 7A). Not all wards of the larger hospitals were visited each month. These wards were visited on a rostered basis, usually once every two or three months. However part-way through the year it was decided by Council that all secure wards should be inspected monthly and this will continue next year.

In addition to the formal monthly visits, the regional hospitals (Albany, Bunbury and Kalgoorlie) were generally visited at least one other time each month on an informal basis. Visits did not occur if, at the time of the planned visit, there were no involuntary patients in the unit or all who were there were currently being assisted by an Official Visitor.

A process of informal visits to metropolitan authorised hospitals that do not have Council mailboxes also continued. The focus of these visits was primarily to provide consumers with information regarding their rights, in particular to review by the MHRB. A total of 101 informal visits to authorised hospitals occurred during 2007–2008 (see Appendix 7B).

Licensed Private Psychiatric Hostels

There were 145 formal inspection visits to licensed private psychiatric hostels (see Appendix 8A). As in previous years the formal visits had a particular focus area. A number of the smaller group homes did not receive a visit every second month due to an office error caused by changes in staff but that position has been rectified to ensure that every licensed facility is visited every second month.

The practice of informal visits on a bi-monthly basis to the licensed private psychiatric hostels also continued. The group or shared houses operated by Richmond Fellowship and Vincentcare did not receive these informal visits. Appendix 8B contains a summary of the informal visits to licensed private psychiatric hostels by the time and day of the week.

CONSUMER CONTACTS

Total Individual Contacts

The Council knows that a large number of involuntary patients in hospital and the community do not access its services. It is not possible to establish the proportions of consumers who did contact us against the total of involuntary patients, nor the numbers of individuals who contacted us over more than one episode (admission or order made under the Act). This information would be useful for future planning.

During 2007–2008 a total of 2676 requests for contact with the Council were received from 1052 consumers (see Appendix 10). While the number of consumers increased by 73 there was an 18.56% increase in requests received compared to 2006–2007 (see Appendices 13A and 13B). These requests resulted in 2325 visits by Official Visitors to consumers and a further 3499 telephone calls by the Council office either to or on behalf of the consumers as reported by the Official Visitors (see Appendix 12). In addition there would have been many more phone calls made to consumers by Official Visitors using their private phones, which calls are not recorded.

For 2006–2007 it was decided to report on attendance by Official Visitors at State Administrative Tribunal hearings related to the *Guardianship and Administration Act 1990*. Official Visitors act either as a support person or lay advocate for these individuals. Official Visitors attended 10 such hearings during 2007–2008.

Authorised Hospitals and Licensed Private Psychiatric Hostels

As in previous years the largest number of consumers from any one service with whom the Council had contact during 2007–2008 were the 456 consumers receiving treatment at Graylands Hospital (see Appendices 10 and 11A). This large proportion of contacts from Graylands Hospital has been consistent since the Council was established. This was an increase of 17 on last year or nearly 4% of the overall 7.4% increase in numbers although in fact it reflects a slight decrease in terms of percentages of beds to consumer contacts.

The other substantial increases in numbers of consumers contacting Council this year were at Armadale and Alma Street hospitals and, as previously noted, from the hostel resident population. There were notable decreases in numbers of consumers requesting assistance from Joondalup and Albany hospitals and a mild increase at Bunbury over the previous year; otherwise most facilities were fairly stable in terms of the numbers of consumers requesting assistance from Council (see Appendices 10, 11A,11B, 13A and 13B).

Based on figures provided by the Mental Health Division, Graylands Hospital site (including the forensic beds associated with the Frankland Centre) has approximately 35% of the authorised beds in the State. Consumers from Graylands Hospital (including Frankland Centre) once again accounted for a greater proportion of the total consumers contacting the Council for assistance at 43.4%.

Graylands Hospital was the only facility where the proportion of total consumers contacting Council

exceeded by any significant amount the percentage of authorised beds in that facility. For the most part, the proportions were less. The only other hospitals where the percentage of the number of requests for assistance exceeded the percentage of beds held, were Armadale and Kalgoorlie hospitals (see Appendix 11B).

The Council had contact with a small number (8) of individuals from "Other" facilities/services. This included "*referred*" individuals in Emergency Departments and non-authorised mental health units and involuntary inpatients on leave from authorised hospital to another hospital.

Community Mental Health Services

Consumers treated by Community Treatment Orders (CTOs) at Community Mental Health clinics remain the most difficult group of "*affected persons*" for the Council to contact. Council is acutely aware that most consumers treated by CTO throughout the State have no contact with us. Our concern remains to ensure that their rights are observed. At any one time there can be between 250 and 300 consumers subject to a CTO within the State. Based on current figures the Council is likely to only have contact with about 3% of these individuals.

As already stated, there was a very small increase in the number of consumers on CTOs requesting assistance from the Council this year (see Appendices 13A and 13B and Table 2 above). Of the total of 81 consumers, there were 23 consumers based in regional areas. Some of those individuals were from health service areas without an authorised hospital and therefore without local Official Visitors. These individuals were provided with assistance via telephone from metropolitan based Official Visitors. A number had been inpatients in Perth hospitals with contact from Official Visitors, who were then discharged back to their homes in regional areas.

The strategy of asking community mental health services to provide letters of introduction from the Council to consumers on CTOs continued during 2007–2008. The Mental Health Review Board also assisted in forwarding letters of introduction from the Council to those people on CTOs for whom a MHRB hearing was being scheduled. In addition visits to selected clinics were made in an effort to improve Council's accessibility to consumers on CTOs. Further strategies are planned for 2008-2009.

Mental Health Review Board – Levels of Representation

The *Mental Health Act 1996* provides the right to both requested reviews and, following an initial review within eight weeks of admission, a series of periodic reviews by the Mental Health Review Board (MHRB). It also provides the right to have assistance in preparing one's case for review, to support during this time and to either support from Official Visitors or legal representation from the MHLC before the MHRB. The major function of Official Visitors is to ensure that the rights of "*affected persons*" are observed. This includes the right to information about review and to support prior to and at review.

For the last four years the Council's strategic plan has aimed to increase the number and proportion of consumers supported at MHRB hearings by a set target each year. The history of the attempts can be traced through previous Annual Reports.

The issue for the Council is how the increases made in the past couple of years can be maintained for the benefit of all patients in all authorised hospitals; and a further challenge for the Council is to increase our contacts with people treated by a CTO especially at the time/s that their status is reviewed by the MHRB.

TABLE 2: OFFICIAL VISITOR REQUESTS FOR AND ATTENDANCE AT MENTAL HEALTH REVIEW BOARD HEARINGS 2007–2008 COMPARED TO 2006–2007			
	01/07/06 TO 30/06/07	01/07/07 TO 30/06/08	% INCREASE
Requests for OV attendance at MHRB	REQUESTS / ATTENDANCES		
TOTAL	436/340	495/384	13.5% / 12.9%

Analysis of consumer contacts

A summary of the issues raised by consumers is contained at Appendices 15A and 15B. Issues are categorised based on the consumer's view of the matter, with the major issue raised being the one categorised and recorded. The Council continued to utilise the same categorisation of complaints and issues as in previous years (though this will change next year).

The largest group of requests during 2007–2008 was associated with the *Mental Health Act 1996* category (38.5%), including Mental Health Review Board applications and attendance.

Apart from 19.4% of requests which have been listed as "unable to be determined", the next single biggest category of requests was "Access" and, in particular discharge or transfer arrangements. As most consumers usually tell Official Visitors they want to leave hospital, many requests are categorised as 1.6 or "discharge arrangements".

During the past few months of the 2007–2008 year, a review of the classification system used to produce Appendix 15A was carried out. The classification system is based on an earlier version of a general complaints classification system used by the Health Department. As such it is not specific to mental health issues which means it is difficult to use consistently or in a way that truly reflects all the issues. Due to funding constraints the system will continue to be used in 2008-2009 (with some limited modifications) but plans are underway to investigate and obtain funding for a new system for the following year.

It is important to note also that approximately nine percent (9.45%) of complaints related to quality of care including inadequate or wrong treatment and rough treatment and almost three percent of complaints related to an absence of caring or lack of courtesy by staff and privacy issues.

OTHER ACTIVITIES

Liaison with Services

As already referred to regular meetings between the Head of Council and Executive Officer with the Chief Psychiatrist, Executive Director of the Mental Health Division, Area Clinical Directors and management at the authorised hospitals in the metropolitan area were held throughout 2007–2008. Opportunities were taken to meet with regional service managers this year in all three regions where there is an authorised unit as well as in Geraldton where a CSRU had opened. Relevant matters are taken to these meetings, advocating both on behalf of individual consumers and also for systemic change.

Meetings were held also with a variety of government and non-government agencies with whom the Council has contact and shares areas of concern, including for instance, the Mental Health Law Centre, Mental Health Review Board, Health Consumers Council, the Public Advocate and the Public Trustee.

Consultation processes / requests

Council representatives continued their participation in a number of sector committees throughout 2007–2008, including:

- **Mental Health Advisory Group; now the Mental Health Review Group:** The Head of Council continued her membership of the Mental Health Advisory Group, chaired by the Director General of Health.
- **Seclusion and "Time Out" Committee:** An Official Visitor represents the Council at this cross sector committee, a sub-committee of the Mental Health Network Coordinating Group, established in response to the findings of the Council's survey related to the use of Seclusion and "Time Out".
- **Chief Psychiatrist Advisory Group on Electroconvulsive Therapy (CPAG on ECT):** The purpose of this group is to provide advice and recommendations from time to time to the Chief Psychiatrist on the future developments of best practice and monitoring of ECT in Western Australia. An Official Visitor attends as required.
- **Smoke Free Coordination Group:** The Head of Council is a member of this group. The group reviews research findings from elsewhere, identifies potential problems and planned the sector wide implementation.
- **Kalgoorlie Hospital:** A local Official Visitor was invited to participate in the Hospital's Smoke Free Focus Group meeting/s planning for their smoke free implementation. A similar arrangement was made for **Graylands Hospital.**
- **Office of Health Review (OHR):** A follow up meeting was held to discuss complaints management in the public mental health sector.
- **Mills Street Centre, Bentley:** An in depth Review of the Centre was undertaken for accreditation and Council was asked to take part in the Review.
- **Evaluation of the Smoke Free WA Health System Policy:** An Official Visitor was interviewed as part of the North Metropolitan Area Health, Mental Health's three month evaluation.
- **Office of the Chief Psychiatrist's review of Graylands Hospital:** A number of Official Visitors were interviewed by the OCP team working on this review.

The Council has also continued to participate in policy development and advocacy at local and systemic levels including:

- **Proposed changes to the *Mental Health Act*:** The Head of Council and Executive Officer met with the Department of Health (DOH) and other sector staff who are instructing the Parliamentary draftsman, in anticipation of the Bill being finally drafted. It was of concern to the Council and others that a statutory form is to be prepared for almost every eventuality of persons to be deemed involuntary amounting to more than 50 forms.
- **Patient First Booklet:** The Council was dismayed that a public system wide brochure to encourage informed patient participation in their care did not address the issues relevant to people who have a mental illness. The Council wrote to the Department of Health in June 2007 about the issue. A response received in December 2007 advised that a meeting had been held as a result of which it had been agreed that the Mental Health Division would be producing an addendum to the Patient First Booklet for release in early 2008. However the Council understands that this has not eventuated.
- **Departmental Review of Interpreter Services:** The Council provided a submission for this review commissioned by the Health Department.

- **Human Rights Act: proposals for legislation**: The Council responded to the proposals with a submission and attended a meeting to discuss the recommendations made to the Attorney General. Our submission focussed on how and whether such legislation would further protect or perhaps adversely affect people with a mental illness.
- **Care Coordination draft policy**: The Council commented on a draft response to the challenge of improving coordination of care for people with serious mental illness and other complex psychosocial needs. The purpose of the policy paper was to develop a model to put the COAG Care Coordination Principles into practice in WA.
- **Alleged Sexual Assault Guidelines:** The Council was requested to respond to the decision of the Mental Health Network to develop these protocols. We emphasised that neither the Council nor ward staff should engage in deciding whether the complaint had veracity and that they should all be received with an offer to refer to the police. Council has since been provided with a draft copy of the guidelines but understands that they remain waiting to be "legalled" by the Health Department's lawyers.

Building consultations

Last year the Council prepared a Position Statement on Translating Rights into Authorised Hospital Building Design that has proved to be useful and often quite effective when needing to advocate for future patients in new buildings at the planning stage. The statements are derived from the *Mental Health Act* and National Standards and based on a practice perspective that acknowledges that building design can have beneficial (or adverse) effects on patients' rights.

The Head of Council and the Executive Officer have met with clinicians and architects to discuss the following plans and raised concerns for patient rights as required.

- **Rockingham Hospital proposed inpatient units: amended design.** Following the summary of issues in last year's Report it is pleasing to state that there was a positive outcome when revised plans for a functional unit were accepted. The Council had been most concerned that the design of the buildings included, in our view, an inevitable breach of rights under current legislation (when a new Act is contemplated to improve patient rights), design features that would compromise patient and staff safety, and that current Australian guidelines and standards were not met. The Council claimed that the design was not therapeutic and was already dated.
- **Joondalup expansion and redevelopment:** Again following consultations the Council was pleased to support revised plans with a secure family courtyard that should address some of the problems with space.
- **Proposed Fiona Stanley Hospital:** The Head of Council met with a small sub group of the planning committee to be briefed on the mental health unit plans and to take the opportunity to outline the advantages of translating design so as to protect rights as far as is possible.
- **Broome Mental Health Unit: I**n May this year a planning committee from the Broome Unit asked to meet with Council representatives to discuss draft plans for the new unit. As it was considered that there would probably be a number of shared issues between Kalgoorlie and Broome in relation to inpatient units, an Official Visitor from the Council's Goldfields team initially met with the planning committee. Subsequently the Council's former Executive Officer, Catherine Stevenson, who had drafted Council's Position Statement on Translating Rights into Authorised Hospital Building Design, was empanelled to assist the Kalgoorlie Official Visitor and Head of Council prepare detailed comments and suggestions on the plans. Council understands that those comments have been well received and some changes made.

Presentations to Community Groups

Council representatives, as nominated, provided presentations to the following groups on the role, powers and functions of the Council.

- Albany TAFE students – Official Visitor
- Australian Association of Social Workers: Symposium on Mental Health; proposed changes to the *Mental Health Act* and likely impact on functions of the Council – Executive Officer
- Avro Consumer Advisory Group – Official Visitor
- Graylands Hospital: Staff of Hutchison ward – Executive Officer
- Marr Moodijt Aboriginal College students: re mental health legislation – Executive Officer and Official Visitor.
- Geraldton CSRU (Community Supported Residential Unit) – Official Visitors.
- Mental Health clinics in Fremantle, Perth (Inner City) and Subiaco – Official Visitors.

Position Statements

The Council undertook the consideration and drafting of two new position statements this year:

1. *Ten Point charter for hostel residents;* and
2. *Position Statement on Smoking*.

More information about the positions statements can be found in Issues 17 and 19 of Part 2 of this Report.

The Council's previously adopted position statements that underpin its work, remain in place and include:

- *Access To Second Opinions – Community Treatment Orders, Mental Health Act 1996* (section 76);
- *Access To Telephone, Mental Health Act 1996* (section 167);
- *Access To Visitors, Mental Health Act 1996* (section 168);
- *Closed Circuit Television (CCTV) Monitoring in Inpatient Units*;
- *Electroconvulsive Therapy and Informed Consent*;
- *Management of Consumers' Tobacco Products by Facility Staff; and*
- *Translating Rights into Authorised Hospital Design*.

Position Statements are usually reviewed every two years. Copies of all the Council's position statements are available from its office.

Professional Development Activities

The Council endeavours to ensure that all Official Visitors, metropolitan and regional, are provided with appropriate training and development opportunities to enable them to carry out their functions efficiently and effectively. The Full Council meetings incorporate a professional development component including the use of external speakers as appropriate.

As in previous years an orientation programme was provided to members of the Council during 2007–2008. This served to both familiarise newly appointed Official Visitors to their role and responsibilities and acted as a refresher course for more experienced Official Visitors. The programme again ran over three days and incorporated a meeting of the Full Council as well as training sessions on preparation for, and advocacy in, a MHRB hearing by the Mental Health Law Centre, managing aggression, Official Visitors' recording and reporting responsibilities and a workshop on case studies led by some of the more Senior Official Visitors.

In addition the following sessions were attended by the Executive Officer, Head of Council, and/or selected Official Visitors:

- **Disability & Justice conference –** this was sponsored by the Office of the Public Advocate, the Office of Crime Prevention, Department of Corrective Services, Department of the Attorney General, Western Australia Police, Department of Health and the Disability Services Commission to highlight the growing challenge for the criminal justice system in responding to people with a decision-making disability—such as mental illness, intellectual disability, brain injury or dementia.
- **Mental Health Community Network Open Space Forum** – this was the first in a series of Open Space forums run by the Mental Health Division. The aim of this forum, which was open to the public and advertised widely, was to ask the question: "What can we ALL do to better the mental health of ALL West Australians?"

Meetings in London

As the Head of Council, Dr Judyth Watson, was completing leave in London, she took the opportunity to stay on for two days to meet with representatives of three agencies that have related functions and/or interests to those of the Council of Official Visitors. They are registered charities and not statutory agencies, one being the Sainsbury Centre for Mental Health, the other MIND, a national and community based mental health organisation and a local MIND group.

Each has programmes for forms of advocacy - the focus of each meeting. The aim of each meeting was to exchange information between colleagues and to explore how the Council in WA might be able to improve and augment our advocacy functions.

Information regarding the current (1983) and anticipated (2007) *Mental Health Act* for England and Wales was outlined at both meetings, each agency expressing concern about a proposal to increase powers to detain patients and for the first time introduce a Community Treatment Order as a form of discharge arrangement. The proposed 2007 legislation has provisions for advocacy similar to those accorded to the Official Visitors in WA but there is disappointment that these will not be enacted until "later".

The Mental Health Act Commission based in Nottingham sounds to have some-what similar functions to the Council and is the statutory regulator of health and social care for all persons treated for a mental illness. It monitors how the Act is used and collects statistics regarding the use of the Act. There are visiting powers but very few Visitors, known as Commissioners, who are based in Regions: a recent review has examined the care of detained patients in England and Wales. The Commission does not presently have an advocacy function.

1 The Sainsbury Centre for Mental Health (SCMH) was established in 1985 with a core grant for research and development and to identify best practice in the field. The aim of the SCMH is to improve the quality of life for people with severe mental health problems in the UK: its philosophy is one of social inclusion and social justice. It works to influence policy and improve practice in public services through research, analysis and development and is affiliated to the Institute of Psychiatry at King's College London. Its two main programmes are in employment so as to establish equal opportunities in the labour market and also a prisons and mental health programme, especially focussing on people with a mental illness who should not be in prison.

2 MIND National is the leading mental health charity that develops policy, lobbies Government and each 6 months runs campaigns, disseminating information targeted through its many networks of members (e.g. ethnic, rural). MIND conducts research which is mostly qualitative; has 180 workers and 200 local MIND associations. The organisation has just received £180 million for a four year campaign to reduce stigma.

3 MIND City and Hackney (MC&H) is one of the local associations with one programme operating from the Centre for Forensic Mental Health in Hackney. It has developed advocacy services over three branches of local services viz. the community, the Homerton Hospital and the Forensic Centre. For a large constituency there are five paid advocates with volunteer advocates coordinated across the hospital and community sector. Seclusion procedures were briefly discussed and it was acknowledged that there are 'difficulties' at the Hospital - with complaints of tranquilliser use and 'man-handling' and evidence that patients see the process as punishment. The main issues that people bring to their advocate have been categorised and found to differ between community based, hospital and forensic patients.

The issue of the times though for patients and advocates is that of a proposed ban on smoking to be implemented on July 1st 2008. A project officer for MC&H is employed one day a week. The agency has taken a very strong stand in support of patients and is keeping a watching brief on a legal case to be heard by the British High Court. A patient from a high security forensic unit has been given legal aid to lodge his complaint against the ban. His lawyers using European law which guarantees respect for privacy and family life are arguing that the hospital is this patient's home. He has been joined with three more complainants. The Council sent this information to the Minister.

A number of relevant reports, briefing and policy papers are now in the Council's library and relevant copies were sent to the Director of the Mental Health Division, the Chief Psychiatrist, the Inspector of Custodial Services and to other services.

A recent Project Report: *With us in mind: service user recommendations for advocacy standards in England. Findings of Mind's Advocacy Standards Project [n.d.]* will be useful for the Council's teaching sessions. A copy of briefing notes from the Mental Health Alliance in England and Wales to inform the House of Lords on the place of advocacy was later sent to the Council.

These two meetings could contribute to the impetus and ideas for the future work and direction of the Council. This might mean for example that:

- the Council distinguishes categories of complaint and requests from different treatment centres in the sector;
- the Council elaborates on its understandings of advocacy;
- the Council inform the Minister of the English case appealing the smoking prohibition ;
- the Council advocates in the sector for possible trial and/or application of the 'Care Programme Approach' audit tool [to monitor, assess and evaluate care planning] for those patients who are repeatedly detained under the Act; and
- the Council also asks applicable and relevant questions regarding certain forensic patients.

The meetings and the literature were both useful means of appreciating the importance for patients of the statutory powers and functions of the Official Visitors as advocates that exist in WA. A fuller version of this section was provided as a Report to the Official Visitors as well as to various clinical services' directors.

QUALITY ASSURANCE

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

Review of Council Operations – the Kirwan Review

As part of the quality assurance process, Council engaged an external consultant, Mr John Kirwan, to conduct a review of the operations of the Council, to assess the potential impact of the announced changes to the *Mental Health Act*, and to make recommendations for consideration by the Council, the Department of Health (DOH) and the Minister for Health.

The terms of reference for the review were:

1. An analysis of current operations – statutory and non-statutory.
2. To look at options for alternative ways of operating including an organisational structure that would best meet the needs of the Council to ensure that it performed all of its functions effectively and efficiently including considering the administrative support offered and required, and the roles of and relationships between the Head of Council and Executive Officer.
3. An analysis of the impact of anticipated changes:
    a. consequent on the new legislation; and
    b. financial and other resource implications for administrative purposes.

The review, conducted over a 4-week period from mid-July 2007 to mid-August 2007, consisted of almost 30 semi-structured confidential interviews with Official Visitors, the Head of Council and Executive Officer, DOH internal stakeholders and external stakeholders. There was also a desktop review of relevant literature and information including the submissions and working papers of the 2003 Holman Review of the *Mental Health Act 1996* and *Criminal Law (Mentally Impaired Accused) Act 1996* (including the Government's response), Council strategic and operational information and information from other jurisdictions in Australia and overseas.

The result was a 45 page document and 37 recommendations which are listed further below. Key findings included that:

- The current operations of the Council, including the support of patients before the Mental Health Review Board (MHRB) are well regarded - it is seen as an efficient representative and advocacy service.
- Within the health system in Western Australia (WA), the Council and the role of an Official Visitor (OV) holds a unique and valued place as custodians and advocates for citizens whose rights have been affected through their involuntary admission as a patient.
- OVs have statutory powers that are rare and allow unfettered access to citizens in government and non-government health services and in community settings across WA. In an era when governments and government bureaucracies are actively seeking community engagement in the pursuit of quality health services, the Council offers a well-established mechanism.
- The Council undertakes valued system-wide initiatives that, while not currently core business of the Council, have contributed to improvements in policy and patient care and could, if the resources were available, initiate and participate in developing a stronger prevention and promotion focus. Several external stakeholders identified a range of areas where they would value Council input and involvement, including in the development of models of care, facilities development and redevelopment, and staff training.
- There is support for a more system-wide and progressive role for the Head of Council in representing the Council with a particular focus on improving patient outcomes and on problem solving using an evidence-based collaborative approach.
- While the Council has received regular increases in resources to meet increased demand, there are concerns that it is reaching a stage where any further growth will require new systems, additional resources, a new governance system including enhanced and more functional accommodation and work areas for the Head of Council and for the OVs, and a new database system to assist day-to-day operational efficiency. This included a strong case for the development of a modern e-based data system for the Council that is user friendly and that allows the OVs and Council staff to capture, enter and access data in a timely manner.

- The Minister, as the person responsible for and to whom the Council reports, is exposed to some risk because of the Council's small resource base and its reliance on the corporate knowledge, skills, ability and personal commitment of present and former OVs and staff, in particular the Head of Council and Executive Officer.
- Should the Council remain at its current level of activity and resourcing, the current organisational structure would be viable only for the short term. With the new Mental Health Act and the expansion of the role of the Council, there will be an increase in workload and complexity, possibly by up to 200%. To address these changes, there needs to be a new governance regime and organisational structure.

Recommendations

1. That current and future resourcing be determined as a matter of urgency.
2. That the Council develop a communications strategy that explains the role, outcomes and operations of the Council to the broader health system, and includes regular updates in mainstream health communications such as Healthview, and that the Council seek DOH support to upgrade the web site to make it easier to access the Council website.
3. That the Council address the numbers of patients that do not access the Council.
4. That, should the Council be granted additional resources, the lack of national KPI's or outcome statements relating to the role of the OV be addressed at a national level through the Minister and the COAG process.
5. That initiatives be explored by the DOH and the Area Health Services to establish appropriate understanding of the role of the Council, including attendance by OVs at relevant training and development opportunities and conferences at the health service level, and joint training with the main stakeholders (e.g. Mental Health Division).
6. That the existing reporting and recording system of OV activities be reviewed and a business case be developed for an upgraded system to improve internal efficiencies and deliver higher quality reporting and recording of Council activities.
7. That the Council document its accommodation needs, and discuss those needs with the DOH so that they can be factored into the DOH's accommodation planning process.
8. That the Council request the Mental Health Division to identify all agencies involved with mental health patients in the Government and non-government sectors together with their respective roles and responsibilities, to achieve clarity of purpose and a reduction in duplication and overlap.
9. That the Council develop a human resources framework for OVs and staff that particularly addresses recruitment, retention, and staff/professional development.
10. That the Council, the Mental Health Division, and the OCP agree on protocols for involving the Council in strategic planning, facilities planning, identification of system-wide problems and potential solutions, and other associated initiatives.
11. That the DOH's Mental Health Division be asked to identify all the relevant datasets held by agencies such as the DOH, Council and MHRB, that an agreed data linkage protocol be established, and that there be an annual collaborative review of the data leading to an identification of relevant trends and other system-wide issues.
12. That the Council and the Manager of the Mental Health Information System within the Information Collection and Management area of Health System Support agree on a standard monthly reporting regime to keep the Council informed of the level and location of activity.
13. That the Council, with support from DOH, develop an annual risk management assessment and plan as part of the annual strategic planning process.

14. That a Members of Parliament briefing kit be development for the Minister to distribute for their information to all Members of the WA Parliament and for WA members of the Federal Parliament, with the kit including information that can be used in electoral offices.

15. That resourcing be requested from the DOH (either in the submission addressing the whole of DOH impact of the new Mental Health Act or in the normal DOH budget process) for a review to scope the data system needs and to develop a suitable new data system for the Council.

16. That, if resources are available, a new integrated e-based recording and reporting system be developed and implemented. If resources are not available, a risk analysis review of the current systems should be requested from DOH.

17. That the new data system be capable of being linked to other data sets (e.g. MHRB) to provide high quality data for the Minister.

18. That, with expanded scope, new functions, and increased workload, the Council provides the Minister with monthly reports on key outcome areas.

19. That a change management plan and process be established to assist the transition from the existing to the new model, taking into account concurrent changes in location/office, new business systems, increase in the numbers of OVs and staff, and new management and governance arrangements, with appropriate union consultative change requirements being adhered to.

20. That the Council request the Mental Health Division to identify areas of potential unmet need in respect to the expanded scope of the Council.

21. That, following the quantification of unmet need and with the data available following the implementation of Recommendations 11 and 12, the Council request that a standing committee be convened by the Mental Health Division to identify and address the protection of the human rights of patients who do not exercise their statutory rights under the *Mental Health Act*.

22. That the range of options canvassed (from no change, to changing the Head of Council from a sessional statutory position to an employed statutory position) be considered by the Minister, together with the resultant impact on the role of the Executive Officer.

23. That funding be increased to enable the Council to increase the number of OVs, Council staff, and operating expenditure.

24. That the Council be permitted an increase in resourcing before the new Mental Health Act is implemented to allow the changes to be well established and to avoid problems from a surge in demand.

25. That the Council be resourced to appoint two new Level 6 officers, an officer responsible for research, evaluation and policy development, and an officer responsible for training (both internal and external to the Council), data, communications, and quality improvement.

26. That there be an orderly transition from the current governance model to the one adopted by the Minister.

27. That a formal evaluation strategy be established following the consideration of this report, with a person from outside the Council and the mental health stakeholder group undertaking the evaluation.

28. That the system-wide range of responsibilities and functions of the Council be expanded to include policy development and the provision of advice.

29. That DOH undertake a data mapping review of all existing data sets in use in the mental health area so that all stakeholders are aware of available data sets that can be used to improve effectiveness and efficiency.

30. That an annual forum on data hosted by DOH reviews data, trends and directions, so allowing all stakeholders, particularly the Council, to use the data to inform strategic plans, KPI's and reports to the Minister.

31. That the Council through the Mental Health Division seek approval from the WA Country Health Services and the Metropolitan Area Health Services to invite OVs to attend relevant Health Service training and induction programs, and other local initiatives.

32. That the Council hold an annual Council conference involving all key stakeholders, and, if possible, inviting key eastern states OVs to attend.

33. That the Council host an annual meeting with the Patient Advocates from the hospitals to increase awareness of respective roles and responsibilities.

34. That the Council seek advice from the Mental Health Division as to the efficacy of OVs making visits to Health Service emergency departments.

35. That, unless such a paper already exists, the Council request DOH to have a short paper commissioned on the opportunities and threats arising from demographic changes, and strategies that should be considered by the Council.

36. That the Council seek resources for a review and upgrading of its communications systems.

37. That there be an annual presentation by Council to the State Health Executive Forum (SHEF) on the activities, achievements and issues addressed by the Council.

Following on from the Kirwan Review a paper examining the governance options was circulated to and commented on by Official Visitors. In summary the responses were that**:**

- The positions of Head and Executive Officer should be kept separate.
- The Head of Council and the Official Visitors must remain independent of the Department of Health in order to retain autonomy for the Council of Official Visitors.
- A deputy Head of Council is needed.
- The Executive Officer's position should be upgraded and attract a higher salary.
- More administrative support is required for Official Visitors and therefore more administrative staff are required.
- The need for an increased budget is recognised.
- New premises are urgently needed.
- More strategic and policy advice for Official Visitors is needed.
- Better collection and collation of data is needed.
- The capacity and skills of Official Visitors can be used for various in house training and development and also for policy and extra Council committee work.
- Expertise and skills will still be needed to be brought in for some areas such as training and database development.

Using the responses of Official Visitors and the recommendations of the Kirwan Review, a Business Case was put to the Department of Health in November 2007 for increased funding and staffing levels. The Business Case is based on a two staged approach: the first phase seeks increased funding to meet immediate needs; the second phase refers to the impact of the proposed new legislation when Council's role will be expanded greatly by being made responsible for all mental health consumers, both voluntary and involuntary. Council awaits the outcome of that application.

Complaints Classification

A review of the Council's complaints classification system (as presented in appendix 15A) was also undertaken this year by a working party of Official Visitors. The categories used derive from a Health Department classification system (since updated by the Health Department) and it is not specific to mental health which makes it difficult to use by Official Visitors and reduces the level of accuracy and usefulness of the data. The working party was unable to change the item headings and numbers and ideally a new computer system is required. In the meantime, however, work was done to give Official Visitors better guidance on the use of the headings in order to better promote consistency.

Codes of Conduct and Ethics

The Council has adopted a Code of Ethics and a Code of Conduct that bind all its members. Copies of these Codes are available from the Council's office.

Complaints Regarding Council Operations

No complaints were received.

PRIORITIES FOR 2008–2009

A new one year interim Strategic Plan was developed for 2008–2009 pending the introduction of the proposed new Mental Health Act and increased funding and resources sought in a Business Case submitted to the Department of Health in November 2007. The Business Case relies in large part on the findings and recommendations of the Kirwan Review (referred to above). Council is awaiting the outcome of the application and so is limited in the meantime by current funding constraints.

The goals listed in the 2008–2009 Strategic Plan are set out below. Within each goal are a number of practical strategies for achieving those goals. (A full copy may be obtained from Council's office.)

GOAL 1 To operate the Council in accordance with the legislative requirements of the *Mental Health Act.*

GOAL 2 To increase the accessibility of the Council to, and contact with, affected persons who are living in hostels and group homes.

GOAL 3 To increase the accessibility of the Council to, and contact with, affected persons who are on Community Treatment Orders (CTOs).

GOAL 4 To improve the Mental Health Review Board process for affected persons.

GOAL 5 To plan for the changes which will be brought in by the new Mental Health Act, in particular, in relation to the COV being responsible for voluntary patients and a Youth Advocate.

GOAL 6 To better capture and utilise the information gathered by OVs.

GOAL 7 To establish better COV procedures and protocols.

GOAL 8 Raise the profile of the Council.

The Strategic Plan continues to build on two of the three qualitative goals of the previous Strategic Plan, namely to increase the accessibility of Council to people on CTOs and in licensed psychiatric hostels.

In relation to the fourth goal, to improve the representation of consumers in Mental Health Review Board hearings, Council has decided to continue to try to increase representation while also aiming to improve the overall experience of the process for consumers.

In addition, the Strategic Plan begins the process of trying to implement some of the recommendations made in the Kirwan Review, especially in relation to information and data collection, the use of the website and better promotion of the role of the Council. However, unless and until significantly improved resources are provided, the Council will not be in a position to implement many of the recommendations.

APPENDIX 1

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

Albany Regional Hospital
Albany Mental Health Unit
Hardie Road, Albany

Fremantle Hospital and Health Service
Alma Street Centre
Alma Street, Fremantle

Armadale Health Service
Leschen Unit
Albany Highway, Armadale

Bunbury Regional Hospital
Acute Psychiatric Unit (APU) and Psychiatric Intensive Care Unit (PICU)
South West Mental Health Service
Bunbury Health Campus, Bunbury

Graylands Hospital
Adult Mental Health Services
Brockway Road, Mount Claremont
Including the **Frankland Centre** (State Forensic Mental Health Services)

Selby Older Adult Psychiatry Service (Selby Lodge)
Lemnos Street, Shenton Park

Kalgoorlie Regional Hospital
Mental Health Inpatient Service
Piccadilly Street, Kalgoorlie

King Edward Memorial Hospital
Mother and Baby Unit
Loretto Street, Subiaco

Joondalup Health Campus
Joondalup Mental Health Unit
Shenton Ave, Joondalup

Bentley Hospital and Health Service
Mills Street Centre
Mills Street, Bentley

Mercy Hospital
Ursula Frayne Unit
Thirlmere Road, Mount Lawley

Swan Health Service
Swan Valley Centre & Boronia Inpatient Unit
Eveline Road, Middle Swan

APPENDIX 2

Licensed Private Psychiatric Hostels

As per *"Functions of the Council of Official Visitors Direction 2005"*, 21 June 2005
superseded by *"Functions of the Council of Official Visitors Direction 2006"*, 24 October 2006
superseded by *"Functions of the Council of Official Visitors Direction 2007"*, 22 December 2007

Albany Halfway House Association Inc.	
***Albany CSRUs**	Ballard Heights, Spencer Park, Albany
**Licensed 13.12.2007*	
Burswood Hostel	16 Duncan Street Burswood
Casson Homes	
***Aitken House**	55 View Street North Perth
**Vacant as of March 2006*	
Casson House	2–10 Woodville Street, North Perth
Woodville House	425 Clayton Road, Helena Valley
Devenish Lodge	54 Devenish Street, East Victoria Park
Dudley House	24 Dudley Street, Midland
Franciscan House	16 Hampton Road, Victoria Park
Fusion Australia Limited	
Ngurra Nganhungu Barndiyigu CSRUs	
Licensed 14.11.2007	Onslow Street, Geraldton
Honey Brook Lodge	42 John Street, Midland
Richmond Fellowship	
	56 Glyde Street, East Fremantle
	58 Glyde Street, East Fremantle
	4–6 Mann Way, Bassendean
	23 Walton Street, Queens Park
***CSRUs**	Unit 5, 1 Powell Court, Busselton
**Licensed 19.02.2008*	
***Community Options**	85 Hicks Road, Kelmscott
**Licensed 4.06.2008*	
Romily House	19 Shenton Road, Claremont
Rosedale Lodge	22 East Street, Guildford
St Jude's Hostel	26 & 30–34 Swan Street, Guildford
Salisbury Home	19-21 James Street, Guildford
Vincentcare	
***Bassendean House**	1 North Street, Bassendean
**Closed 13.03.2008*	
Bayswater House	65 Whatley Crescent, Bayswater
House	66 Waverley Road, Coolbellup
Duncraig House	270 Warwick Road, Duncraig
South Lakes House	9 Plumridge Way, South Lake
Swan View House	8 Wilgee Gardens, Swan View
***Vincentian Village**	2 Bayley Street Woodbridge
**Licensed 25.02.2008*	
Warwick House	39 Glenmere Road, Warwick

APPENDIX 3

COUNCIL OF OFFICIAL VISITORS 2007–2008 MEMBERSHIP

Head of Council	**Expiry Date of Term**
Dr Judyth WATSON ***Retired 31.03.2008***	*31 March 2008
Ms Debora COLVIN ***Appointed 01.04.2008***	*31 March 2011

Official Visitors	
Mr Bruce AMBROSIUS	01 February 2009
Dr Michael ANDERSON	01 February 2009
Mrs Sherril BALL	01 February 2011
Ms Denise BAYLISS	01 February 2009
Ms Leanne CANNON	01 February 2009
Ms Geraldine CHANDLER	01 February 2010
Ms Debora COLVIN ***Resigned 07.03.2008***	*01 February 2009
Ms Alessandra D'AMICO	01 February 2010
Mrs Marie DAVIES	01 February 2010
Mr Michael DIXON	01 February 2011
Mr Gerard DOYLE	01 February 2011
Ms Gillian EVANS	01 February 2009
Mr Adrian GAVRANICH	01 February 2011
Mr Rodney HAY	01 February 2010
Mrs Naka IKEDA	01 February 2009
Ms Kirsten JOHNSTON	01 February 2011
Mr Damian JOLLY	01 February 2011
Mrs Denise KAY	01 February 2010
Mrs Kerry LONG	01 February 2011
Mrs Ann McFADYEN	01 February 2009
Ms Edana McGRATH	01 February 2011
Mrs Melinda MANNERS	01 February 2010
Miss Sophie MOUNSEY ***Resigned 21.12.2007***	01 February 2009*
Mr Geoffrey MURPHY ***Resigned 21.10.2007***	01 February 2009*
Mrs Maria Luz NOÉ	01 February 2009
Mr Sean O'CONNELL ***Resigned 26.04.2008***	01 February 2011*
Ms Val O'TOOLE	01 February 2009
Mrs Theresa PIPER	01 February 2011
Mrs Josie SCATA ***Resigned 21.02.2008***	01 February 2011*
Mr Leslie SCHULTZ	01 February 2009
Ms Maggie SPEIRS ***Resigned 09.01.2008***	07 April 2009*
Mrs Sheila STEPHENS ***Retired 22.02.2008***	07 April 2008*
Ms Margaret STOCKTON ***Resigned 31.07.2007***	01 February 2008*
Ms Helen TAPLIN	01 February 2011
Mrs Judith TAYLOR	01 February 2010
Mrs Kathryn TONCICH	01 February 2010
Ms Catriona WERE-SPICE	01 February 2011
Mrs (Angela) Leonie WILSON	01 February 2011
Ms Brooke WITHERIDGE	01 February 2010

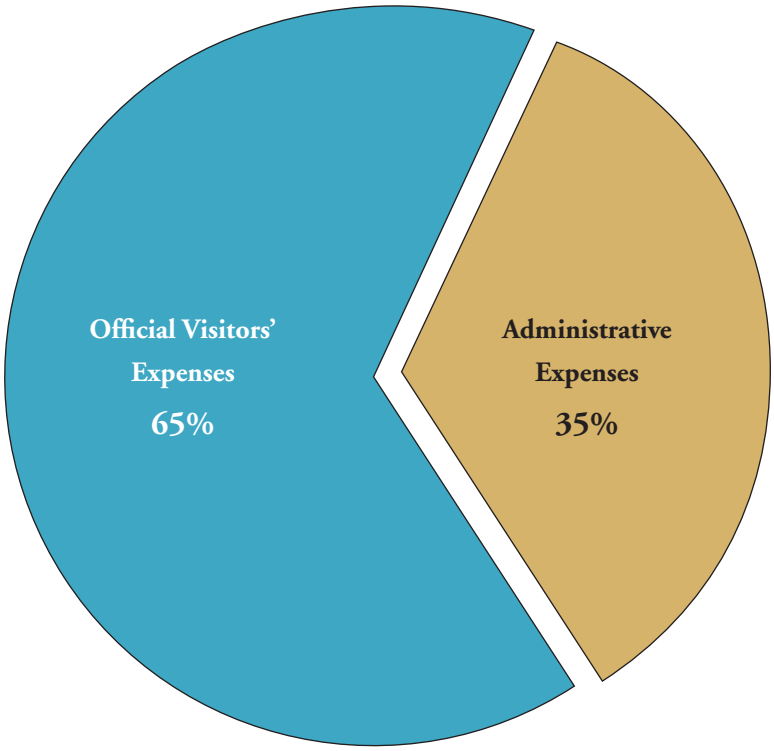
APPENDIX 4

COUNCIL OF OFFICIAL VISITORS' MEETINGS ATTENDANCE 2007–2008

OFFICIAL VISITOR	FULL COUNCIL		EXECUTIVE GROUP	
	Present	Apologies	Present	Apologies
Dr Judyth WATSON (Head of Council)	3	0	5	0
Ms Debora COLVIN (Head of Council from 1.04.2008)	4 (3 as OV, 1 as HoC)	0	3	0
Mr Bruce AMBROSIUS	4	0	2	1
Dr Michael ANDERSON	4	0		
Mrs Sherril BALL	3	1	7	1
Ms Denise BAYLISS	2	2		
Ms Leanne CANNON	4	0	1 proxy	0
Ms Geraldine CHANDLER	3	1		
Ms Alessandra D'AMICO	4	0		
Mrs Marie DAVIES	4	0		
Mr Michael DIXON	1	0		
Mr Gerard DOYLE	1	0		
Ms Gillian EVANS	3	1	3	0
Mr Adrian GAVRANICH	4	0		
Mr Rodney HAY	3	1	1	0
Mrs Naka IKEDA	4	0		
Ms Kirsten JOHNSTON	1	0		
Mr Damian JOLLY	2	0		
Mrs Denise KAY	4	0	3	2
Mrs Kerry LONG	3	1	5	1
Mrs Ann McFADYEN	4	0		
Ms Edana McGRATH	3	1	2 (1 proxy)	0
Mrs Melinda MANNERS	2	2		
Miss Sophie MOUNSEY	1	1		
Mr Geoff MURPHY	1	0		
Mrs Maria NOÉ	4	0	6	1
Mr Sean O'CONNELL	2	0		
Ms Val O'TOOLE	2	2		
Mrs Theresa PIPER	4	0	4	1
Mr Leslie SCHULTZ	4	0		
Ms Maggie SPEIRS	1	1		
Mrs Sheila STEPHENS	4	0	3	0
Ms Margaret STOCKTON	0	0		
Ms Helen TAPLIN	4	0		
Mrs Judith TAYLOR	4	0	2 (proxy)	0
Mrs Kathryn TONCICH	4	0		
Ms Catriona WERE-SPICE	4	0		
Mrs Leonie WILSON	3	1	1 (proxy)	0
Ms Brooke WITHERIDGE	4	0		

APPENDIX 5

CHART - SUMMARY OF EXPENDITURE 2007–2008



The Council's expenditure for the 2007–2008 financial year was $942,051. As required under the *Electoral Act 1907* section 175ZE (1), during 2007–2008 the Council expended the following in relation to the designated organisation types:

(a) advertising agencies: nil;

(b) market research organisations: nil;

(c) polling organisations: nil;

(d) direct mail organisations: nil; and

(e) media advertising organisations: $2,316.98

APPENDIX 6

STATEMENT OF COMPLIANCE WITH STATE RECORDS COMMISSION – STANDARD 2, PRINCIPLE 6

QUESTION 1: Whether the efficiency and effectiveness of your record keeping systems has been evaluated or alternatively when such an evaluation is proposed?

The efficiency and effectiveness of the Council of Official Visitors record keeping system were evaluated in June 2008.

QUESTION 2: The nature and extent of record keeping training programme conducted?

Record keeping training is conducted with Council's administrative staff on an as needed basis.

QUESTION 3: Whether the efficiency and effectiveness of the record keeping training programme has been reviewed or alternatively how this is planned to be done?

The review of training programme is carried out by the Executive Officer following specific training sessions.

QUESTION 4: Assurance that the organisation's induction program addresses employee roles and responsibilities in regard to their compliance with the organisation's record keeping plan?

Council of Official Visitors induction programme provides one to one training about the record keeping plan and its role and importance relating to employee roles and responsibilities.

APPENDIX 7A

AUTHORISED HOSPITAL FORMAL INSPECTIONS BY HOSPITAL & TIME & DAY OF INSPECTION 2007–2008

AUTHORISED HOSPITAL	TOTAL NUMBER OF INSPECTIONS	TIME OF INSPECTIONS		
		Mon–Fri 9 am–5 pm	Mon–Fri 5 pm–9 am	Sat / Sun / Pub Hol
Albany Regional Hospital – Mental Health Unit	12	4	4	4
Alma Street Centre	26	11	2	13
Armadale Health Service – Leschen Unit	34	24	4	6
Bunbury Acute Psychiatric Unit & Psychiatric Intensive Care Unit	18	11	4	3
Graylands Hospital – including Frankland Centre	52	42	3	7
Joondalup Mental Health Unit	12	11	0	1
Kalgoorlie Mental Health Unit	12	9	2	1
KEMH – Mother & Baby Unit	12	8	1	3
Mercy Hospital, Ursula Frayne Unit	12	10	1	1
Mills Street Centre	36	20	8	8
Selby Lodge	12	12	0	0
Swan Health Service Boronia Unit & Swan Valley Centre	28	23	0	5
TOTAL	**266**	**185**	**29**	**52**

*There has been an increase in the number of Inspection Visits to some facilities from 2007–2008 as at the February 2008 Full Council Meeting it was agreed to inspect all locked wards each month.

APPENDIX 7B

AUTHORISED HOSPITAL INFORMAL VISITS BY HOSPITAL & TIME & DAY OF INSPECTION 2007–2008

AUTHORISED HOSPITAL	TOTAL NUMBER OF INFORMAL VISITS	TIME OF VISIT		
		Mon–Fri 9 am–5 pm	Mon–Fri 5 pm–9 am	Sat / Sun / Pub Hol
Albany Regional Hospital	10[1]	8	2	0
Bunbury Acute Psychiatric Unit & Psychiatric Intensive Care Unit	20[2]	14	4	2
Joondalup Mental Health Unit	12	12	0	0
Kalgoorlie Mental Health Unit	11[3]	10	0	1
KEMH – Mother & Baby Unit	0[4]	0	0	0
Mills Street Centre Ward 6 & WAY Centre	24	20	0	4
Swan Health Service Boronia & Swan Valley Centre	24	20	0	4
TOTAL	**101**	**84**	**6**	**11**

1 No informal visits occurred in July or August 2007
2 Due to mailboxes being installed in both the APU and PICU this has resulted in an increase in the number of informal visits
3 No informal visits occurred in December 2007
4 No informal visits occur to KEMH Mother and Baby Unit

APPENDIX 8A

LICENSED PRIVATE PSYCHIATRIC HOSTEL FORMAL INSPECTIONS BY HOSTEL & TIME & DAY OF INSPECTION 2007–2008

LICENSED PRIVATE PSYCHIATRIC HOSTEL	TOTAL NUMBER OF INSPECTIONS	TIME OF INSPECTIONS		
		Mon–Fri 9 am–5 pm	Mon–Fri 5 pm–9 am	Sat / Sun / Pub Hol
*Albany Halfway House CSRUs *Licensed 13.12.2007.* *Visits commenced March 2008*	1	1	0	0
Burswood Psychiatric Hostel	6	5	1	0
Casson Homes – *Aitken House **No residents*	0	0	0	0
Casson House	6	6	0	0
Casson – Woodville House	8	8	0	0
Devenish House	8	5	0	3
Dudley House	8	8	0	0
Franciscan House	9	7	0	2
Fusion – Geraldton CSRUs **Licensed 14.11.2007* *Visits commenced April 2008*	2	2	0	0
Honey Brook Lodge	8	8	0	0
Richmond Fellowship – 6 Mann Way, Bassendean	5	5	0	0
Richmond Fellowship – CSRUs Powell Court, Busselton **Licensed 19.02.2008* *Visits commenced March 2008*	1	1	0	0
Richmond Fellowship – 56 & 58 Glyde Street, East Fremantle	6	4	2	0
Richmond Fellowship – Community Options 85 Hicks Road, Kelmscott **Licensed 4.06.2008*	0	0	0	0
Richmond Fellowship – 23 Walton Street, Queens Park	4[5]	3	0	1
Romily House	7	4	0	3
Rosedale Lodge	8	6	0	2
St Jude's Hostel	10	8	0	2
Salisbury Home	8	5	0	3
Vincentcare – *Bassendean House **13.03.2008 No longer licensed*	3	3	0	0
Vincentcare – Bayswater House	4[5]	4	0	0
Vincentcare – Coolbellup House	4[5]	3	0	1
Vincentcare – Duncraig House	6	5	0	1
Vincentcare – South Lakes House	5[5]	1	4	0
Vincentcare – Swan View House	8	6	2	0
Vincentcare – Vincentian Village Woodbridge **Licensed 25.02.2008* *Visits commenced March 2008*	4	3	1	0
Vincentcare – Warwick House	6	5	0	1
TOTAL	**145**	**116**	**10**	**19**

5 A changeover in office staff resulted in these facilities not being visited bimonthly. As soon as this oversight was identified visits to these facilities occurred.

APPENDIX 8B

LICENSED PRIVATE PSYCHIATRIC HOSTEL INFORMAL VISITS BY HOSTEL & TIME & DAY OF VISIT 2007–2008

LICENSED PRIVATE PSYCHIATRIC HOSTEL	TOTAL NUMBER INFORMAL VISITS	TIME OF VISIT		
		Mon–Fri 9 am–5 pm	Mon–Fri 5 pm–9 am	Sat / Sun / Pub Hol
*Albany Halfway House CSRUs *Licensed 13.12.2007.* *Visits commenced March 2008*	2	2	0	0
Burswood Psychiatric Hostel	5	3	2	0
Casson House	7	6	1	0
Casson – Woodville House	5	4	1	0
Devenish House	7	6	0	1
Dudley House	4	4	0	0
Franciscan House	4	4	0	0
Fusion – Geraldton CSRUs *Licensed 14.11.2007.* *Visits commenced April 2008*	0	0	0	0
Honey Brook Lodge	4	4	0	0
Richmond Fellowship – CSRUs Powell Court, Busselton *Licensed 19.02.2008.* *Visits commenced March 2008*	0	0	0	0
Romily House	5	4	0	1
Rosedale Lodge	4	4	0	0
St Jude's Hostel	5	3	0	2
Salisbury Home	6	4	1	1
TOTAL	**58**	**48**	**5**	**5**

APPENDIX 9

PERCENTAGE OF FACILITY FORMAL INSPECTIONS BY TIME & DAY OF INSPECTION 2004–2005 TO 2007–2008

FINANCIAL YEAR	FACILITY TYPE	TIME OF INSPECTIONS (% OF TOTAL)		
		Mon–Fri 9 am–5 pm	Mon–Fri 5 pm–9 am	Sat / Sun / Pub Hol
2004–2005	Authorised Hospitals	55.45%	20.45%	24.1%
	Licensed Private Psychiatric Hostels	50.5%	33.3%	16.2%
2005–2006	Authorised Hospitals	66%	15.3%	18.7%
	Licensed Private Psychiatric Hostels	64.5%	13.8%	21.7%
2006–2007	Authorised Hospitals	70%	11.8%	18.2%
	Licensed Private Psychiatric Hostels	70%	13%	17%
2007–2008	Authorised Hospitals	**70.2%**	**10.98%**	**18.82%**
	Licensed Private Psychiatric Hostels	**81.76%**	**7.06%**	**11.18%**

*The Council has identified a trend of visiting facilities Mon–Fri 9am to 5pm. Official Visitors are working on strategies for 2008–2009 to ensure a more even spread of visits.

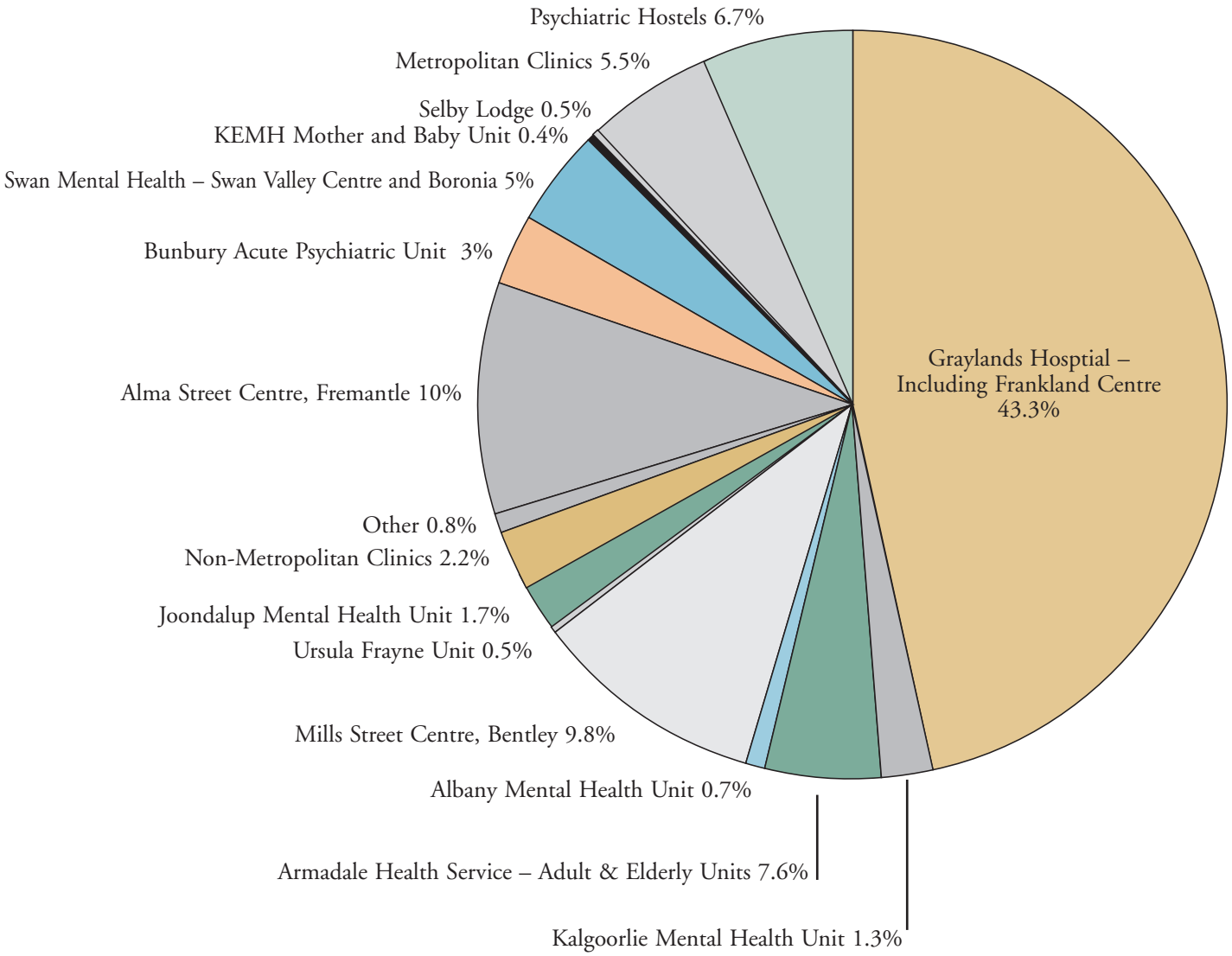
APPENDIX 10

NUMBER OF CONSUMERS AND REQUESTS BY FACILITY 2007–2008

FACILITY	NUMBER OF CONSUMERS CONTACTED	NUMBER OF REQUESTS RECEIVED
Albany Mental Health Unit	8	23
Alma Street Centre, Fremantle	112	243
Armadale Health Service – Leschen Unit	80	192
Bunbury Acute Psychiatric Unit & Psychiatric Intensive Care Unit	36	77
Graylands Hospital – including Frankland Centre	456	362
Joondalup Mental Health Unit	18	32
Kalgoorlie Mental Health Unit	14	20
KEMH – Mother & Baby Unit	4	9
Mercy Hospital – Ursula Frayne Unit	5	13
Mills Street Centre, Bentley	103	239
Selby Lodge	5	12
Swan Health Service – Swan Valley Centre & Boronia	52	126
Metropolitan Clinics	58	150
Non – Metropolitan Clinics	23	53
Psychiatric Hostels	70	117
Other [6]	7	7
Private Practice	1	1
TOTAL	**1052**	**2676**

APPENDIX 11A

PERCENTAGE[7] OF TOTAL CONSUMERS BY FACILITY 2007–2008



APPENDIX 11B

PERCENTAGE OF TOTAL CONSUMERS PER FACILITY CONTACTING COUNCIL COMPARED TO PERCENTAGE OF AUTHORISED BEDS BY FACILITY 2007–2008

AUTHORISED HOSPITAL / FACILITY [8]	NUMBER OF BEDS	% OF TOTAL AUTHORISED BEDS IN WA	% OF TOTAL CONSUMERS CONTACTING COUNCIL (Total consumers by facility)
Albany Regional Hospital	9	1.5%	(8) 0.8%
Alma Street Centre	66	11.2%	(112) 10.6%
Armadale Hospital	43	7.3%	(80) 7.6%
Bunbury Regional Hospital	39	6.6%	(36) 3.4%
Graylands Hospital – including Frankland Centre	206	34.97%	(456) 43.4%
Joondalup Health Campus – Mental Health Unit	31	5.3%	(18) 1.7%
Kalgoorlie Regional Hospital	7	1.2%	(14) 1.3%
KEMH – Mother & Baby Unit	8	1.36%	(4) 0.4%
Mercy - Ursula Frayne Unit	12	2.04%	(5) 0.5%
Mills Street Centre	86	14.6%	(103) 9.8%
Selby Lodge	48	8.15%	(5) 0.5%
Swan Districts Hospital	34	5.77%	(52) 4.9%
TOTAL	**589 beds**		
Other (Clinics / Hostels)	0	N/A	(159) 15.1%

APPENDIX 12

CONTACTS WITH CONSUMERS BY FACILITY 2007–2008

FACILITY [1]	NUMBER OF CONSUMERS CONTACTED	CONTACT TYPE					
		VISIT	PHONE CALL	LETTER	MHRB [9] ATTEND.	G & A [10] ATTEND.	REFER[11]
Albany Mental Health Unit	8 (0.76%)	20	24	0	3	0	0
Alma Street Centre – Fremantle	112 (10.65%)	208	360	6	37		2
Armadale Health Service – Leschen Unit	80 (7.60%)	169	356	6	41	2	3
Bunbury Acute Psychiatric Unit & Psychiatric Intensive Care Unit	36 (3.4%)	124	48	0	14	0	0
Graylands Hospital – including Frankland Centre	456 (43.35%)	1150	1474	15	169	4	14
Joondalup Mental Health Unit	18 (1.7%)	23	31	0	7	0	0
Kalgoorlie Mental Health Unit	14 (1.3%)	19	9	0	4	0	0
KEMH – Mother & Baby Unit[8]	4 (0.38%)		15	0	0	0	0
Mercy Hospital – Ursula Frayne Unit	5 (0.48%)	18	24	0	2	1	0
Mills Street Centre – Bentley	103 (9.8%)	264	421	5	34	0	9
Selby Lodge	5 (0.48%)	7	12	1	2	0	0
Swan Health Service – Swan Valley Centre & Boronia	52 (4.9%)	97	149	6	21	1	1
Metropolitan Clinics	58 (5.5%)	36	296	4	39	1	2
Non-Metropolitan Clinics	23 (2.2%)	11	73	4	7	0	0
Psychiatric Hostels	70 (6.7%)	174	199	4	3	1	1
Other (including Private Practice)	8 (0.8%)	2	8	0	1	0	0
TOTAL	**1052**	**2325**	**3499**	**51**	**384**	**10**	**32**

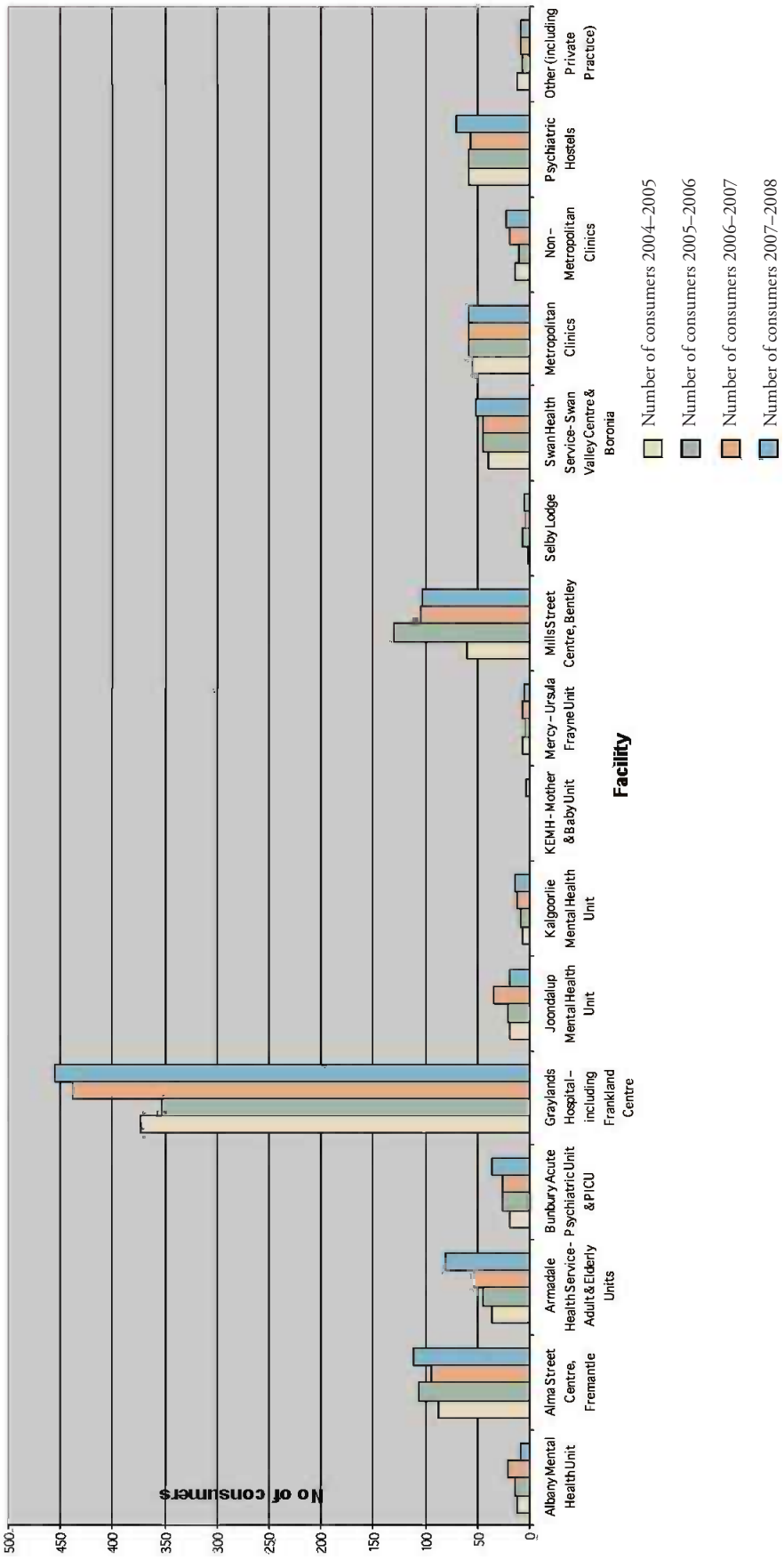
8 KEMH – Mother & Baby Unit visits commenced in June 2007
9 MHRB – Mental Health Review Board
10 G & A – Guardianship and Administration (State Administrative Tribunal)
11 Referral to Mental Health Law Centre for representation at Mental Health Review Board hearing

APPENDIX 13A

TOTAL CONSUMERS CONTACTED BY FACILITY 2004–2005 TO 2007–2008

FACILITY	NUMBER OF CONSUMERS			
	2004–2005	2005–2006	2006–2007	2007–2008
Albany Mental Health Unit	12	14	21	8
Alma Street Centre, Fremantle	88	107	95	112
Armadale Health Service – Leschen Unit	36	45	53	80
Bunbury Acute Psychiatric Unit & Psychiatric Intensive Care Unit	19	26	25	36
Graylands Hospital – including Frankland Centre	373	352	439	456
Joondalup Mental Health Unit	19	20	35	18
Kalgoorlie Mental Health Unit	7	9	12	14
*KEMH – Mother & Baby Unit	0	0	0	4
Mercy Hospital– Ursula Frayne Unit	6	4	6	5
Mills Street Centre, Bentley	60	130	104	103
Selby Lodge	2	6	3	5
Swan Health Service - Swan Valley Centre & Boronia	40	45	45	52
Metropolitan Clinics	54	58	58	58
Non-Metropolitan Clinics	13	10	18	23
Psychiatric Hostels	59	58	57	70
Other (including Private Practice)	12	7	8	8
TOTAL	**800**	**891**	**979**	**1052**

GRAPH–TOTAL CONSUMERS CONTACTED BY FACILITY 2004–2005 TO 2007–2008



APPENDIX 14A

TOTAL CONTACTS WITH CONSUMERS 2003–2004 TO 2007–2008

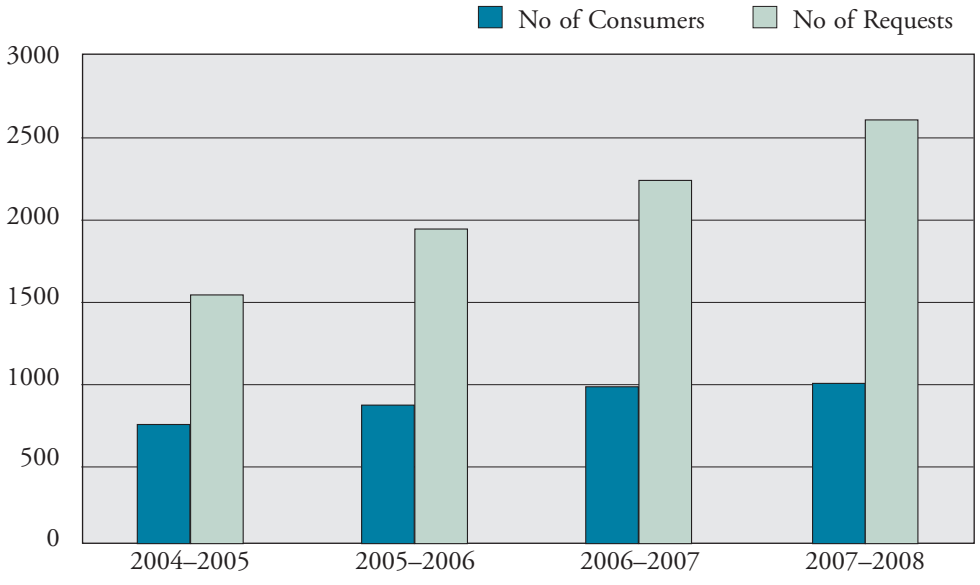
FINANCIAL YEAR	NUMBER OF CONSUMERS (# Requests)	CONTACT TYPE					
		VISIT	PHONE CALL [12]	LETTER	MHRB ATTEND.	G & A ATTEND.	REFER [13]
2003–2004	744 (1415)	1234	2149	84	109	0	Not reported
2004–2005	800 (1600)	1329	2551	127	83	1	Not reported
2005–2006	891 (1891)	1560	3201	93	81	0	Not reported
2006–2007	**979 (2257)**	**2028**	**3317**	**63**	**171**	**5**	**24**
2007–2008	**1052 (2676)**	**2325**	**3499**	**51**	**384**	**10**	**32**
% increase – 2006–2007 to 2007–2008	**6.9% (15.6%)**	**12.8%**	**5.2%**	**- 23.5%**	**55.6%**	**50%**	**25%**

12 This statistic only refers to telephone calls to and from the Council office. It does not include the hundreds of calls made by Official Visitors from their own phones.

13 Referral to Mental Health Law Centre for representation at Mental Health Review Board hearing

APPENDIX 14B

TOTAL CONSUMERS CONTACTED AND REQUESTS RECEIVED 2004–2005 TO 2007–2008



APPENDIX 15A

TOTAL CONSUMER REQUESTS BY ISSUE CATEGORY– ALL FACILITIES 2007–2008

1.	ACCESS	NUMBER
1.1	Delay in Admission or treatment	8
1.2	Waiting list delay	3
1.3	Non-attendance	0
1.4	Inadequate or no service	23
1.5	Refusal to admit or treat	3
1.6	Discharge or transfer arrangements	370
1.7	Access to transport	1
1.8	Physical access/entry	2
1.9	Parking	0
	Subtotal (%[14] TOTAL[15])	**410 (15.3%)**

2.	COMMUNICATION	NUMBER
2.1	Inadequate information about treatment options	30
2.2	Inadequate information on services available	16
2.3	Misinformation or failure in communication	20
2.4	Failure to fulfil statutory obligations	7
2.5	Access to records	12
2.6	Inadequate or inaccurate records	3
2.7	Failure to provide interpreter	1
2.8	Certificate or report problem	0
	Subtotal (% TOTAL)	**89 (3.32%)**

3.	DECISION MAKING	NUMBER
3.1	Failure to consult consumer	20
3.2	Consent not informed	8
3.3	Consent not obtained	16
3.4	Private/public election	0
3.5	Refusal to refer or assist to obtain a second opinion	5
	Subtotal (% TOTAL)	**49 (1.83%)**

4.	QUALITY OF CARE	NUMBER
4.1	Inadequate diagnosis	33
4.2	Inadequate treatment	152
4.3	Rough treatment	26
4.4	Incompetent treatment	13
4.5	Negligent treatment	4
4.6	Wrong treatment	25
	Subtotal (% TOTAL)	**253 (9.45%)**

5.	COSTS	NUMBER
5.1	Inadequate information about costs	3
5.2	Unsatisfactory billing practice	1
5.3	Amount charged	0
5.4	Overservicing	0
5.5	Private health insurance	0
5.6	Lost property and/or reimbursement	18
	Subtotal (% TOTAL)	**22 (0.8%)**

6.	PRIVACY / CONSIDERATION / DISCOURTESY	NUMBER
6.1	Inconsiderate service/lack of courtesy	26
6.2	Absence of caring	21
6.3	Failure to ensure privacy	4
6.4	Breach of confidentiality	3
6.5	Discrimination	2
6.6	Discrimination of public consumer	1
6.7	Sexual impropriety	3
6.8	Sexual transgression or violation	2
6.9	Assault	6
6.10	Unprofessional conduct	1
	Subtotal (% TOTAL)	**69 (2.6%)**

7.	GRIEVANCES	NUMBER
7.1	Inadequate response to a complaint	9
7.2	Reprisal following a complaint	0
	Subtotal (% TOTAL)	**9 (0.34%)**

8.	OTHER	NUMBER
8.1	Administrative practice	62
8.2	Catering	16
8.3	Facilities	28
8.4	Security	24
8.5	Cleaning	6
8.6	Fraud/illegal practice	3
	Subtotal (% TOTAL)	**139 (5.2%)**

9.	*MENTAL HEALTH ACT 1996*	NUMBER
9.1	Mental Health Review Board Application	495
9.2	Mental Health Review Board Attendance	384
9.3	Second Opinion Request (not 3.5)	68
9.4	*Mental Health Act 1996* Information	73
9.5	*Mental Health Act 1996* Non-Compliance (not 2.4)	3
9.6	SAT[16] Appeal Application/Process	8
9.7	SAT (review of MHRB [52]) Attendance	0
	Subtotal (% TOTAL)	**1031 (38.5%)**

10.	*CRIMINAL LAW (MENTALLY IMPAIRED ACCUSED) ACT 1996*	NUMBER
10.1	Mentally Impaired Accused Review Board	3
	Subtotal (% TOTAL)	**3 (0.11%)**

11.	UNABLE TO BE DETERMINED	NUMBER
11.1	Unknown/Undetermined	518
	Subtotal (% TOTAL)	**518 (19.4%)**

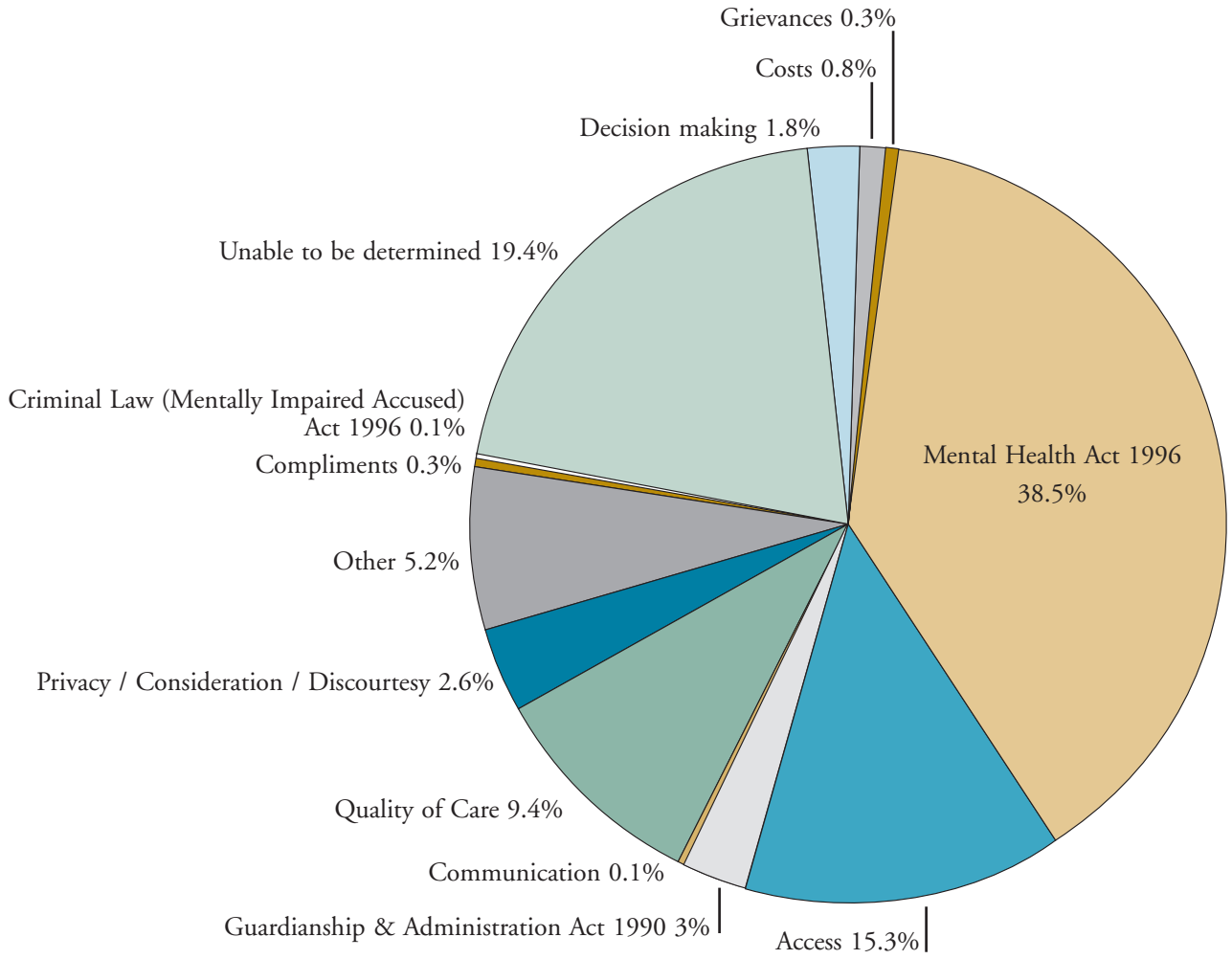
12.	COMPLIMENTS	NUMBER
12.1	Compliments	4
	Subtotal (% TOTAL)	**4 (0.15%)**

13.	*GUARDIANSHIP AND ADMINISTRATION ACT 1990*	NUMBER
13.1	Information on processes	26
13.2	SAT[16] Attendance (Guardianship & Administration Act)	10
13.3	Public Trustee	44
	Subtotal (% TOTAL)	**80 (3%)**

14 Rounded value
15 Total Requests = 2676
16 State Administrative Tribunal

APPENDIX 15B

CHART–PERCENTAGE[17] OF CONSUMER REQUESTS BY ISSUE CATEGORY–ALL FACILITIES 2007–2008



17 Rounded value