Hon Helen Morton MLC
MINISTER FOR MENTAL HEALTH

In accordance with section 192(3) of the Mental Health Act 1996 I submit for your information and presentation to Parliament the Annual Report of the Council of Official Visitors for the financial year ending 30 June 2012.

As well as recording the operations of the Council for the 2011–2012 year the report reflects on a number and range of issues that continue to affect consumers of mental health services in Western Australia.

Debora Colvin
HEAD, COUNCIL OF OFFICIAL VISITORS

October 2012
Cover Image


© Marion Treasure 2010.

Exhibited at the 11th Annual “Open Minds - Open Doors” Art Exhibition by the Alma Street Centre and DADAA Inc.

The imagery is included in the 2011–2012 Annual Report with Ms Treasure’s kind permission.
## Contents

### INTRODUCTION

**YEAR IN REVIEW 2011-2012** ............................................................................................................................. 3

### PART ONE

**THE LEGISLATIVE AND OPERATIONAL FRAMEWORK** .................................................................................. 5

- FUNCTIONS AND POWERS OF COUNCIL AND OFFICIAL VISITORS ......................................................... 5
- RIGHTS PROTECTION ........................................................................................................................................... 6
- POWERS OF OFFICIAL VISITORS ...................................................................................................................... 7
- INDIVIDUAL ADVOCACY APPROACH OF OFFICIAL VISITORS ............................................................... 7
- OPERATIONAL FRAMEWORK - REPORTING LINES ...................................................................................... 7
- COUNCIL COMPOSITION 2011-2012 ............................................................................................................... 8
- PANEL APPOINTMENTS ................................................................................................................................. 8
- COUNCIL MEETINGS ...................................................................................................................................... 9

### PART TWO

**VISITS, INSPECTIONS, ISSUES AND ACTION IN 2011-2012** ..................................................................... 10

- ISSUE 1: RIGHTS ............................................................................................................................................. 10
- ISSUE 2: BED PRESSURES AND ACUITY ON THE WARDS ........................................................................... 18
- ISSUE 3: MENTAL HEALTH REVIEW BOARD HEARINGS ......................................................................... 26
- ISSUE 4: OTHER OPINION PROCESS .......................................................................................................... 28
- ISSUE 5: SUPPORTED ACCOMMODATION - LICENSED PSYCHIATRIC HOSTELS ..................................... 30
- ISSUE 6: FORENSIC ISSUES ......................................................................................................................... 39
- ISSUE 7: CHILDREN AND YOUNG PEOPLE ................................................................................................. 41
- ISSUE 8: ENVIRONMENTAL CONDITIONS .................................................................................................. 43
- ISSUE 9: SMOKING BAN ............................................................................................................................... 49
- ISSUE 10: OTHER ISSUES ............................................................................................................................. 50

### PART THREE

**ONGOING ISSUES RAISED IN PREVIOUS ANNUAL REPORTS THAT STILL REQUIRE REMEDY ......53**

### PART FOUR

**ACTIVITY MEASURES, BUDGET, STRATEGIC PLAN AND OTHER ACTIVITIES .................................56**

- CONSUMER NUMBERS ................................................................................................................................ 56
- ANALYSIS OF CONSUMER DATA .................................................................................................................. 58
- ANALYSIS OF ISSUES AND REQUESTS ......................................................................................................... 60
- BUDGET AND RESSOURCING ISSUES ............................................................................................................ 61
- STRATEGIC PLAN .......................................................................................................................................... 62
- OTHER ACTIVITIES ...................................................................................................................................... 63
- RECORDS MANAGEMENT ............................................................................................................................. 65
- QUALITY ASSURANCE ................................................................................................................................. 65
APPENDICES

Appendix 1: Authorised Hospitals ................................................................. 66
Appendix 2: Licensed Psychiatric Hostels ..................................................... 67
Appendix 4: Council of Official Visitors’ Attendance at Meetings in 2010–2011 ... 71
Appendix 5: State Records Commission Compliance Requirements .............. 72
Appendix 6: Authorised Hospital Inspections ............................................... 73
Appendix 7: Licensed Psychiatric Hostel Inspections .................................... 74
Appendix 8: Total Consumers Contacted By Facility - 2004–2005 to 2010–2011 .... 75
Appendix 9: Number and Percentage of Consumers and Authorised Hospital Beds and Number of Involuntary Orders by Facility .................................................. 76
Appendix 11: Total Consumer Requests by Complaint - All Facilities 2010–2011 .... 78
Appendix 12: Strategic Plan 2010–2011 .......................................................... 80

GLOSSARY OF TERMS ..................................................................................... 82
INTRODUCTION - YEAR IN REVIEW 2011-2012

For the third consecutive year, Council’s workload increased significantly. Consumer numbers have increased 50% in the last 2 years (increasing by 19.7% this year).

The issues dealt with by Official Visitors remain much as they have been for some years, but there is a sense of heightened acuity and stress on hospital wards. The impact of this on consumers (and staff) is immeasurable. While the reasons for this are complex, contributing factors are likely to include the increased population and resulting increased demand for beds, and that there still needs to be a lot more done in the community to help people before they become so unwell that they need admission to hospital. Some hospitals are coping by putting involuntary patients on open wards and locking the doors from time to time; others are increasing the amount of one on one and sometimes two on one nursing “specials”; and others have looked to innovative discharge programs. See Issue 2 in Part 2 of the report for more details.

There are also worrying issues in the oversight of the supported accommodation sector where so many vulnerable people live. Official Visitors are now assisting more than double the number of hostel residents than they were 2 years ago. Council is particularly concerned that this group of people are being forgotten about and that there is a lack of comprehensive oversight of the sector, yet there is a high potential for abuse. Issue 5 in Part 2 of the report provides more details.

Amidst this there are good news stories – of Graylands Hospital staff going out of their way to take an Indigenous patient shopping for kangaroo meat and cooking it for them; of staff at Fremantle Hospital who gently cared for a well-known mental health consumer who was dying by admitting the consumer to their ward and making the consumer’s last days as comfortable as possible. This consumer had nowhere else to go and saw the mental health ward almost as their home.

There are also stories which show the therapeutic power of advocacy where Official Visitors contributed to the consumer’s recovery because the consumer felt empowered and less vulnerable. A number of hospitals are embracing Official Visitors’ role in this regard, which Council works hard to encourage because it provides better outcomes for consumers.

While Council had an increase in consumer numbers, the number of involuntary inpatients decreased this year, although it is difficult to assess by how much or why from the data available to Council. There was an increase in the number of people made an involuntary inpatient in Western Australia for the first time: (14.9%) or 1,069 people. Part 4 of the Report attempts to analyse the data available to Council.

Council was also been busy this year preparing a 111 page submission on the draft Mental Health Bill. A copy of the submission is available on the websites of both Council and the Mental Health Commission (MHC). The draft Bill considerably broadens the scope of Council’s jurisdiction so that voluntary patients and others may also have access to an advocate. Council remains concerned, however, about losing legislated monthly visits to authorised hospitals and bimonthly visits to hostels as well as the role of ensuring that rights are observed and that facilities are “safe and suitable”. It is also very concerned to maintain the independence of the proposed new advocacy service which should be a primary mechanism to protect the rights of a very vulnerable group of people, namely those detained against their will in hospital and hostel residents. Keeping the body independent is in keeping with international human rights law.
As in previous years, I would like to take this opportunity on behalf of Official Visitors to thank all those people working in mental health who recognise and respect the rights of consumers and who assist Official Visitors in their advocacy and inspection work.

Official Visitors and Council office staff have also worked extremely hard in the past year. Many Official Visitors have other jobs or commitments or are semi-retired and did not expect to be working nearly fulltime. Due to the continued growth in consumer numbers and budget constraints, however, individual Official Visitors have to handle many more consumers now than they were 5 years ago. The issues also seem to be getting more complex and the nature of the work means that it can feel like working “24/7” because it is not a 9-5 job. I am also aware that many Official Visitors do not claim for all the time they spend working for Council. I thank them all for their compassion, professionalism and commitment.

I would like to thank Denise Bayliss who has been assisting me as Deputy Head of Council this year with a number of difficult policy papers, including a new complaints policy, and reviewing Council’s Code of Conduct. I would also like to thank Council’s Manager, Donna Haney, and her staff for the support they provide to me and Official Visitors. They continue to battle to keep up with the substantial increase in the number of consumer calls and reports coming into the office from Official Visitors.

Finally, Council has, since its inception, had its funding provided through the Department of Health. Next year this function will be taken over by the Mental Health Commission. I would therefore like to thank those staff in the Department who have been involved in this function. Official Visitors are independent Ministerial appointees and Council is often called a “watchdog” for mental health patients. This has necessarily involved criticism of the Department but I believe that there has always been mutual respect.

Debora Colvin
Head, Council of Official Visitors
October 2012
PART ONE
The legislative and operational framework

FUNCTIONS AND POWERS OF COUNCIL AND OFFICIAL VISITORS

The functions and powers of the Council of Official Visitors (the Council) and its members, called Official Visitors, are set out in ss 175 – 192 of the Mental Health Act 1996 (the Act).

It is the responsibility of the Council (s 186 of the Act) to ensure that an Official Visitor or panel visits:

- each hospital authorised under s21 of the Act at least once per month. In practice, visits take place more often. Official Visitors visit consumers on request, conduct formal and informal inspections and check Council mailboxes on the wards for correspondence from consumers. This is part of making themselves accessible and ensuring that the wards and hostels are “safe and otherwise suitable” as required by s 188 of the Act

- each licensed private psychiatric hostel at the direction of the Minister for Mental Health. Currently this is at least once every 2 months but sometimes more often based on the number of consumer requests for visits from particular facilities or where an ongoing issue has been identified which requires follow-up

- all consumers who request a visit as soon as practicable after the visit is requested. Council aims to respond within 24 hours to a new consumer and otherwise within 24 to 48 hours.

It is the responsibility of the Official Visitors (s 188 of the Act) to:

- ensure that “affected persons” (see definition below) are aware of their rights and that those rights are observed

- ensure that places where consumers are detained, cared for or treated under the Act are kept in a condition that is “safe and otherwise suitable”

- be accessible to hear and to enquire into and seek to resolve complaints concerning consumers made by the consumer, their guardians or their relatives

- refer matters on to other relevant bodies where appropriate

- assist with the making and presentation of applications and appeals under the Act, primarily Mental Health Review Board (MHRB) and Guardianship and Administration hearings and appeals.

The term “affected person” is defined by s175 of the Act to mean:

- an involuntary patient, including a person subject to a Community Treatment Order (CTO)

- a mentally impaired accused person who is in an authorised hospital

- a person who is socially dependent because of mental illness and who resides, and is cared for or treated at a private psychiatric hostel

- any other person in an institution prescribed for the purposes of the section by the regulations (no institutions have been prescribed to date).

Affected persons are referred to by Council and hereafter in this report as consumers when they have requested assistance from an Official Visitor or residents if they reside in a Licensed Psychiatric Hostel.
RIGHTS PROTECTION

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

- the United Nations “Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care” adopted in 1991 (the UN Principles) and in particular Principle 2 which reads:
  
  “all persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person”

- the Act, which accords a set of legal rights to consumers in Western Australia

- the Licensing Standards for the Arrangements for Management, Staffing and Equipment: Private Psychiatric Hostels prepared by the Licensing and Accreditation Review Unit (LARU) of the Department of Health (DOH) as regulated by the Hospitals and Health Services Act 1927; and various standards including Service Standards for Non-Government Providers of Community Mental Health Services

- the National Standards for Mental Health Services designed to guide policy development and service delivery in each of the States.

The UN Principles recognise that the role of community and culture is important, with each consumer having the right to be treated and cared for, as far as possible, in the community in which he or she lives. The objects of the Act (s5) reflect, but do not elaborate on, international principles. It does specify, however, (section 5(a)) that there must be:

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

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

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

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

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

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

INDIVIDUAL ADVOCACY APPROACH OF OFFICIAL VISITORS

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

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

OPERATIONAL FRAMEWORK - REPORTING LINES

Official Visitors

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

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

Similarly with hostels, Official Visitors first try to deal with issues by speaking to the hostel supervisor or licensee. Sometimes, however, Head of Council will also meet with the licensee or raise issues with other bodies such as the Office of the Chief Psychiatrist (OCP) or LARU.
In addition, the Head of Council meets regularly with the Minister for Mental Health, the Mental Health Commissioner, the management teams of each of the authorised hospitals, as well as the Chief Psychiatrist, the Executive Directors of North and South Metropolitan and Country Mental Health Services, and various others involved in the provision of mental health services in Western Australia, both from the government and non-government sector. At these meetings, various significant and ongoing issues identified by Official Visitors are raised and discussed with the aim of resolving them through effective and timely action.

**Administrative support - Executive Officer and other staff**

Council is provided with an Executive Officer and 3 other fulltime equivalent staff members, all of whom are public servants employed by the Department of Health (DOH) under Part 3 of the *Public Sector Management Act 1994*. Their role is to provide administrative support as required by s182 of the Act.

The Manager (as 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 (s189). The Manager also has the delegated responsibility for ensuring that the Official Visitors visit authorised hospitals, comply with Ministerial directions and visit affected persons as soon as practicable after a visit is requested in accordance with s186 of the Act.

**COUNCIL COMPOSITION 2011-2012**

A list of individuals who were members of the Council during 2011-2012 and their terms of appointment are contained in appendix 3. Ten Official Visitors were reappointed following the expiry of their terms during 2011-2012 and 7 new Official Visitors were appointed. This included 4 to Broome (one resigned shortly after appointment) for the newly opened Broome mental health unit which was expected, but is yet, to be authorised. These Official Visitors have therefore remained inactive. There were 6 resignations. As at 30 June 2011 therefore Council had 28 active Official Visitors, 3 on an extended leave of absence, 3 in Broome and Head of Council.

**PANEL APPOINTMENTS**

Section 187 of the Act allows the Council to appoint 2 or more persons, at least 1 of whom is an Official Visitor, to be a panel for the purposes of that part of the Act. The Act is silent on who may be empanelled or the purpose of panels but individuals appointed to be members of a panel have generally fallen into 4 categories:

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

There were 2 panel appointments in 2011-2012:

- Ms Dorothy Lavell for the purposes of providing training for Official Visitors
- Dr Mitsuru Suzuki, a visiting psychiatrist from Japan.
COUNCIL MEETINGS

Full Council Meetings (FCMs)
Council held FCMs in December 2011 and May 2012. These were combined with training days and metropolitan and regional group meetings. Further information about those meetings is contained in Part 4 of this Report.

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

The Executive Group held meetings in August, October, February and June.

A summary of the Full Council and Executive Group meetings attended by Council members during 2011-2012 is contained in appendix 4.

Country and metropolitan meetings of Council
Official Visitors were allocated to 2 groups in the metropolitan area, based roughly on the North and South Metropolitan Area Health Services. These were nominally called A and B group by the Council. In addition there were 4 groups in regional areas based on the location of authorised hospitals: South West, Lower Great Southern, Goldfields and Broome.

Each regional based group (except Broome) met on 8 occasions in the year to discuss issues of concern, share information and plan visits. The 3 regional groups also held combined meetings prior to each FCM to discuss and share issues of mutual concern and interest to regional areas. The newly appointed Broome Official Visitors attended the May 2012 FCM and took part in a joint regional group meeting on that day.

The 2 metropolitan groups also met on 9 occasions which included 2 meetings which coincided with Full Council meetings. The OVs meet both separately in their groups and in combined sessions. The joint meetings are used to discuss issues identified by Official Visitors across the metropolitan area and for occasional training. Most of the joint group meetings included video links with Official Visitors in regional areas to enable short training sessions to be available to all Official Visitors.

Focus Area Person
The Focus Area Person (FAP) nominates areas of concern to be considered by Official Visitors when conducting the formal monthly inspections of authorised hospitals, hostels and group homes (see Issue Part 2 Issue 10 of this report for further information). The FAP drafts the inspection question sheets which Official Visitors take with them on these visits. The FAP also sits on the Executive Group and consults with them in advance of inspection questions being published. A summary of the inspection reports is prepared which provides an understanding of the issues across all hospitals and hostels in that month.

1 Broome mental health unit was expected to be authorised during the year and so Official visitors were appointed in February and April 2012 but, as at 30 June 2012, Council was still waiting for confirmation of the authorisation of the unit.
PART TWO

Visits, inspections, issues and action in 2011-2012

In 2011-2012 Official Visitors:

- inspected 43 wards in 15 authorised hospitals and 41 licensed psychiatric hostels and group homes (which included 3 newly licensed facilities)
- visited and advocated for 1,438 consumers, dealing with 4,686 issues or complaints raised by those consumers.

The facilities visited by the Council are listed in appendices 1 and 2.

The number of consumers requesting visits increased by 19.7% from 1,201 last year to 1,438 this year. More detail about these figures is contained in Part 4 and appendices 8 to 10.

The issues and illustrations outlined below represent some of the issues and matters that Official Visitors have been involved with this year arising out of the visits and inspections, and the action taken. It includes some “good news stories”.

ISSUE 1: RIGHTS

Rights issues arise from breaches of the Act, other laws, standards, and human rights generally.

Illustration 1 – Search of patients’ rooms and belongings in breach of hospital policy and human rights

Patients in a secure ward had their rooms and belongings searched by ward staff for cigarette lighters. Contrary to hospital policy, nothing was recorded about the search in patients’ files and patients were told that the lighters would not be returned to them. Council queried the legal basis for the search and the confiscation of the items. Section 165 of the Act states that the treating psychiatrist is to ensure that patients are, so far as reasonably practicable, given facilities to store articles of personal use and allowed to use such articles, except where it is the psychiatrist’s opinion that it would not be appropriate to use or store such an item at the hospital. No such determination was made and the search included all patients on the ward.

Action and Outcome

Council wrote to the hospital concerned pointing out the above issues and that possession of a lighter was not prohibited. Even if smoking was prohibited on hospital grounds, the patient may be taken outside the grounds on leave where they could smoke, or they might have been brought into hospital with the lighter on their person and not had an opportunity to leave it at home – either way there were insufficient grounds to assume that everyone on the ward was at risk or had a lighter in their possession with the intention of breaching the smoking ban.

The hospital management replied explaining that patients were told on admission that lighters were restricted and that one patient had caused a fire two days previously. The hospital noted, however, that while ensuring safety of patients was paramount, this should not lose sight of the principle aims of the unit as a care setting.
Omissions in the management and documentation of the process was acknowledged, in particular the failure to record the lighters as being held in safe keeping of staff until discharge or being made available for when the patient was given ground access. The hospital said that directions had been issued to Clinical Nurse Specialists to ensure that all staff received updates and training in this area within 4 weeks. All lighters were subsequently returned to patients and there was to be a review of the policy.

**Illustration 2 – Visitor and phone restrictions not made in accordance with the Act**

The failure by some psychiatrists to observe the strict requirements of the Act in relation to imposing phone and visitor restrictions continued this year with Official Visitors dealing with 22 consumer complaints about restrictions2. Sections 167 and 168 of the Act require the treating psychiatrist to ensure that a consumer has the opportunity to make and receive telephone calls and to receive visitors of the consumer’s choosing in reasonable privacy. Pursuant to s169, the psychiatrist may order that these rights be restricted or denied if they consider it to be in the interest of the consumer to do so, but the order must be reviewed each day that it continues by the psychiatrist. A record of the order and each review of it must be kept in the medical file of the consumer. Pursuant to s169(3) of the Act, the order restricting rights lapses at the end of the next day on which it has not been reviewed.

The reasoning behind the daily review is to ensure that this further removal of human rights is not made without good reason and that the right is given back immediately that the need for the restriction no longer exists.

**Case 1: Restrictions made by junior doctor**

The consumer was put on phone restrictions by a registrar who told the Official Visitor she thought she could order such restrictions (when only a psychiatrist may make the order). In addition the restrictions were not being reviewed daily, the notes on the file recording why the restrictions were being imposed were ambiguous and staff were interpreting the extent of the restrictions differently. The hospital form for recording restrictions had not been used.

**Action and outcome**

The Official Visitor spoke to the registrar and informed her of the requirements of the Act. Council also wrote to the hospital concerned (without naming the registrar) suggesting that junior medical staff needed better training in this aspect of patient rights.

**Case 2: Restrictions not reviewed daily over Christmas period**

A consumer had restrictions imposed over the Christmas period without the restrictions being reviewed daily. The psychiatrist told the Official Visitor that it was not possible to comply with the Act at this time because too many doctors were on holiday. A further mini audit on the ward by the Official Visitor resulted in the discovery of three other cases of restrictions being authorised contrary to the Act over the late December-early January period.

**Action and outcome**

Council wrote to the head of the mental health service pointing out that the Act had been breached and, no matter what time of the year, patients had rights which had to be observed. It was also noted that there is flexibility in the Act to allow psychiatrists to confer with junior doctors over the phone and authorise the continuation of the restrictions. The Head of Service wrote back advising that he took this issue extremely seriously, would be sending Council’s letter to the medical staff with a view to discussing with them appropriate protocols and procedures to ensure that the Act was fully complied with.

---

1 See Appendix 11.
Illustration 3 – Invalid Community Treatment Orders (CTOs)

Official Visitors dealt with several cases during the year of CTOs which, it was argued, were not made validly in accordance with the Act. In one case the CTO was unsigned, the form used was for an extension of the CTO when there was no previous CTO in place, it did not sufficiently specify the treatment plan and the psychiatrist had not personally examined the consumer but relied on what he had overheard by telephone in a State Administrative Tribunal (SAT) hearing. The consumer was being asked to comply with the CTO and a MHRB hearing had been scheduled.

Action and outcome

Council wrote to the psychiatrist and the MHRB pointing out these flaws in the CTO referring to 2 Supreme Court decisions which held that:

1. the Act is to be strictly complied with and the natural meaning of words used are not to be extended because the Act deprives people of normal freedoms

2. sufficient detail must be stated in CTOs so that the consumer knows precisely what is required in terms of attending for treatment and is left in no doubt about the requirements because the CTO imposes obligations which, if not complied with, can lead to revocation of the order and subsequent incarceration of the consumer, thereby depriving them of that liberty which is so fundamental in our society.

The outcome was that the psychiatrist revoked the CTO and the MHRB hearing was cancelled. The psychiatrist also apologised to the consumer. However the consumer remained concerned that their medical file recorded that they had been on a CTO when the CTO had never been valid. Council therefore wrote to the psychiatrist asking that the consumer’s medical records be amended to reflect this fact relying on s45 of the Freedom of Information Act 1992. The psychiatrist agreed to do this. It should be noted that the psychiatrist also advised that he had taken legal advice regarding the validity of the CTO. He commented that the fact that he had followed multiple examples of CTO paperwork written by other local psychiatrists which meant that potentially dozens of regularly executed CTOs would also likely be invalid.

Council also received a reply from the then President of the MHRB noting that, while the CTO had been revoked, as a general observation Council’s reference to the comments of Justice Templeman were appropriate. In regards to the issue of what is meant by “examination” the position was less clear.

Council is aware that attempts are being made to deal with this legal issue in the proposed Mental Health Bill. Since this matter, SAT has handed down an appeal decision on a matter involving the interpretation of a CTO which may affect some of the issues raised by Official Visitors in this and other cases.

Illustration 4 – Unauthorised doctor making people involuntary

Council raised concerns about an overseas doctor working in a regional area who was listed as being a “supervised consultant psychiatrist”. The doctor was exercising powers under the Act, such as making people involuntary (and voluntary), which can legally only be exercised by a “psychiatrist” as defined in the Act: “a person whose name is contained in the register of specialist psychiatrists kept by the Medical Board of Australia under the Health Practitioner Regulation National Law (Western Australia) section 223”. It was difficult to see how a doctor who had to be supervised could be considered a specialist. There were also concerns about the level of supervision.
**Action and outcome**

Council wrote to the health service concerned, spoke and wrote to the Chief Psychiatrist and the Australian Health Practitioner Regulation Agency (AHPRA) and eventually wrote to the Director General of the DOH raising the concerns. No-one could answer Council’s question satisfactorily. AHPRA advised that the doctor concerned did not hold any specialist qualification and that, as a result of Council’s correspondence, they had removed the notation “registered to work in a specialist position in psychiatry” from their register and website.

Some months later, as Council was raising the concern again with the Clinical Director of the mental health service, we were informed that the doctor had been removed from exercising the powers of a psychiatrist under the Act. It is understood that the DOH took legal advice on the issue.

**Illustration 5 – Official Visitors denied access to secure ward in breach of s190 of the Act**

In breach of s190 of the Act, Joondalup Mental Health Unit denied 3 Official Visitors access to the secure ward over a 4 day period. The refusal of entry followed a weekend newspaper article about a well known person being detained on the ward. At the time journalists were camped outside the hospital and there had been attempts by unauthorised people to gain entry to the ward. Hospital executive had issued instructions that no-one was to enter the ward.

An Official Visitor first attended the hospital to visit a consumer. When she asked to go on to the secure ward, she was denied entry. Official Visitors do not have keys to secure wards. Two days later, on a scheduled monthly ward inspection, two more Official Visitors were denied entry.

It should be noted that this was the first time in Council’s 14 year history that an Official Visitor had been denied access to a ward. The Act makes it very clear that Official Visitors can visit a place where an affected person is detained, cared for or treated at any time and for as long as the Official Visitor sees fit. In the course of the visit the Official Visitor may inspect any part of the place or see any consumer who has not declined to be seen. These powers are crucial to the protection of human rights.

**Action and outcome**

Head of Council spoke to the Head of Psychiatry and the Official Visitors were quickly allowed access again. Other meetings were held with hospital executive and it was confirmed in writing that there was no valid basis for refusing entry to the Official Visitors. Council was reassured that the role, powers and importance of Official Visitors protecting patient rights under the Act would be made clear to medical and nursing staff and hospital executive to prevent denial of entry occurring again.

**Illustration 6 – Non-compliance with National Standards for Mental Health Services 2010 (NSMHS) - consumer involvement in care plans**

Official Visitors dealt with 26 complaints about care plans and 133 complaints about discharge plans in 2011-2012. The complaints included “lack of consultation, no plan, plan not reviewed and failure to follow the plan”. 6

It is a requirement of the NSMHS that there be a “current individual multidisciplinary treatment, care and recovery plan which is of the NSMHS developed in consultation with and regularly reviewed with the consumer and with the consumer’s informed consent, their carer(s), and the treatment, care and recovery plan is available to both of them” (NSMHS 10.4.8).

---

5 “Affected person” as defined under the Act which include involuntary patients, people on a CTO and psychiatric hostel residents.

6 Appendix 11.
The Chief Psychiatrist made a number of recommendations in relation to compliance with the NSMHS in his report on Admissions and Discharge on Presentations at Fremantle Hospital which followed on from the public reporting of three suicides.

As part of Council’s regular monthly hospital inspections Official Visitors also spoke to staff and consumers in October 2011 about the extent to which involuntary consumers were involved in, and knew about, their care plans.

**Action and outcome**

Official Visitors reported back that most hospitals were not including consumers in drafting the care plan, though some of those said consumers were involved in drafting a separate safety plan. Staff on a number of secure wards said the patient needed to be more involved in the plans for them to be effective. There were also different versions of the plans and what was included in them. Within one hospital, one ward referred to care, safety and management plans, while another ward referred to behavioural management, care and treatment plans. Staff spoken to at most hospitals said they did not give the consumers a copy of the care plan, with staff on two wards saying the patient could only get access if they applied using the *Freedom of Information Act 1992*. There was also significant variability in who was responsible for reviewing the plan and the timing of reviews. Other comments by staff included:

- “The quality of the plan varies according to the team involved. Quality takes time and this is a limited resource”.
- “Sometimes the weekly reviews appear to be a paper exercise to just get it done.”
- “The plan is not a “living” document, which would allow for more meaningful and current information to be included; it should involve the patient; and it should involve a multidisciplinary team approach. As it stands, in practice, this document is only a nursing document.”

Letters outlining the result of the Official Visitors’ inquiries were sent to all facilities and the Head of Council has raised this issue in meetings with senior management.

**Illustration 7 – Breach of s157 of the Act – not giving relatives and guardians an explanation of the consumer’s rights**

Official Visitors are required to ensure that patients are informed of their rights and that their rights are observed (s188 of the Act). This is done as a matter of practice for every consumer who requests Official Visitor assistance. In addition, as part of the monthly inspections in February 2012 Official Visitors conducted a random consumer file audit.

**Action and outcome**

Almost every hospital failed to record on the files whether consumers had been asked to specify relatives, guardians or friends to whom a copy of the explanation of patients’ rights could be given, as required by s157 of the Act. Consumers are usually given a package of information about their rights including pamphlets from the MHRB, OCP and the Council as well as information about the hospital, ward routine and so on.

Letters outlining the result of the Official Visitors’ inquiries were sent to all facilities and the Head of Council has raised this issue in meetings with senior management.
The benefit of s157 is that it facilitates a carer, friend or family advocating for a consumer’s rights. This was illustrated clearly for one family who were very concerned about the treatment their family member was receiving. They felt the medication was making the consumer worse and that a change of doctor was needed. The consumer was unable to speak up for themselves and the treating team were not listening to the family’s concerns. The family did not learn about Council for some weeks because s157 had not been complied with. When they telephoned Council, an Official Visitor quickly became involved asking for another opinion and the doctor and medical treatment changed shortly after.

The family wrote to Council later saying they wanted to show their “sincere gratitude to the Council for the role they play in the Mental Health System. We would like to let Council know we appreciate and value your organisation and especially those at Council who advocate for the involuntary mentally ill patients who cannot advocate for themselves”.

Illustration 8 – Breach of confidentiality and right to keep belongings safe
A ward staff member gave a consumer’s house keys to the consumer’s mother without authority. The consumer had previously told staff that they did not want the parent involved and that staff were not to take instructions from the parent. The mother had got copy keys cut so return of the keys was not sufficient.

Action and outcome
The hospital admitted the mistake and paid for new locks to be installed at the consumer’s home. It should be noted that dealing with consumers’ relatives is not always straightforward or easy for staff but this case was particularly clear.

Illustration 9 - Complaints handling by hospitals and hostels
Official Visitors are required under the Act to try to resolve consumers’ complaints. The type of complaints made to Official Visitors vary. Further analysis of the complaints is made in Part 4.
There were 10 complaints categorised by Official Visitors as serious issues invoking Council’s Serious Issue Policy which sets out a process to be followed. There were also 31 complaints by consumers categorised by Official Visitors as the consumer not feeling safe, and 31 complaints categorised by Official Visitors as “rough treatment”.
Some of the serious issues cases are referred to elsewhere in this report (both of which raised questions about the quality and transparency of the complaint investigation). A number of other comments can be made about complaints handling:

- In a number of the cases where consumers complained about rough handling it was usually in the process of the consumer being restrained and put into seclusion. In each case the hospital advised that it had investigated the matter but found that there was no mishandling of the consumer. Such cases are always difficult to deal with because the consumer does not have ready access to their file or witnesses to the incident. In some cases the patient is not spoken to as part of the investigation process and it seems the file notes are relied on.
- In other cases a meeting was held with the consumer. In one case dealt with by Council, the Clinical Director wrote back saying that, while the particular incident did not represent misconduct, it highlighted the importance of improved training and staff skill set in managing escalating situations.

---

7 Appendix 11.
8 See Issue 1, illustration 10 and issue 5, illustration 1.
There were some lengthy delays which were of concern which Council took up with the hospital service. One example was where a long term consumer complained about uncaring attitudes and being discriminated against by ward staff, which had also been observed by the Official Visitor. The response to the complaint took over 4 months. The result was a revision of the consumer’s management plan with a view to staff having clear guidelines with regard to the consumer’s behaviour and rights.

In another case Council complained to hospital management about the attitude of a nurse to the complaints process and the lack of respect for the consumer and Official Visitor. Amongst other things the nurse’s response to the raising of the consumer’s complaint by the Official Visitor was: “Bring it on, let her make a complaint, it won’t go anywhere anyway”.

The hospital investigated the complaint advising that they were satisfied that the events as reported by the Official Visitor were an accurate reflection of what happened. The hospital fully accepted that the standard of conduct of the staff member fell below that which was expected. Action was taken under the disciplinary process to address the staff’s member’s future performance and conduct.

Council is pleased that after more than 4 years of waiting, the DOH has finalised and released sexual assault guidelines: “Responding to an Allegation of Sexual Assault Disclosed Within a Public Mental Health Service” drafted in 2007. The guidelines provide a framework for a comprehensive and consistent response to an allegation made by patients on a mental health ward about sexual assault. The aim of the guidelines is to ensure support for the alleged victim, the alleged perpetrator, staff, family and friends including making sure that the parties involved feel safe and are treated with dignity and respect and that the allegation is taken seriously.

**Illustration 10 - Complaints about the Police**

Official Visitors have dealt with three complaints by consumers made about police this year.

**Case 1 – Consumer left handcuffed in the back of police van**

The complaint was that the consumer was left handcuffed in the back of the police van on a day when the temperature exceeded 30 degrees Celsius without being offered a drink or the doors being opened. The trip to the mental health hospital had taken about 45 minutes and there was an unexplained delay of 15 to 20 minutes in moving the consumer from the van to the ward upon arrival. Triage notes confirmed that the consumer was brought in from the police van “Dripping in sweat”. Records from the Bureau of Meteorology for that day noted that Perth temperatures at Perth Airport rose to 34 degrees and it was already 30.9 degrees at 9am.

**Action and Outcome**

The Western Australia Police has dismissed the complaint but Council has written to the Corruption and Crime Commission (CCC) asking them to look into the way the complaint was handled. The letter of complaint was sent in late December 2011 and an acknowledgement received shortly afterwards. On 2 April 2012 Council received a letter from the police which stated that the police investigation had relied upon “verbal accounts of the mental health staff who requested police transportation and staff” at the hospital and that such staff had declined to give police written statements. No other documents had been provided by the hospital which meant that the investigator had to rely on the “police officers’ hearsay account”. The letter went on to ask for Council’s assistance in finalising the police investigation by using its “authority and influence with the hospital and mental health workers involved” to provide statements, relevant documents and a list of witnesses.
When the Official Visitor spoke to the relevant hospital staff, all said they had never been approached by police, were agreeable to speak to the police, and one agreed to provide a written statement. The hospital’s Clinical Director also advised that they had no objection to the police contacting staff. This information was then provided to the police along with names of staff willing to talk to them on 27 April and 9 May. Council advised that the consumer had applied for a copy of their file to be given to the police through a freedom of information application. Prior to the file being provided to the police, Council received a letter dated 14 May 2012 enclosing a copy of a letter sent to the consumer advising them of the outcome of the investigation, dated 22 March 2012. That letter said that there was no wrong-doing by the police.

Council awaits a response from the CCC.

Case 2 – Police manhandling and leaving house unlocked

The consumer complained that they were dragged out of their house by a number of police officers resulting in injury to their wrist and leg. The consumer said the police were laughing as they manhandled the consumer and left the back door of the consumer’s house open.

Action and outcome

Council is waiting on the result of the police investigation but has been advised by the CCC that they are aware of the complaint and will be monitoring the handling of the complaint. Council wrote to the police on 27 April 2012; a response acknowledging the complaint and stating that the Official Visitor would be contacted “shortly” was received on 25 May. As at 30 June Council and the consumer were awaiting a further reply.

Case 3 – Police interviews

Criminal charges were laid against two consumers following police interviews held at the hospital with the consumers. Official Visitors were told that there was no effort to ensure that the consumers were advised, or had access to legal advice, prior to the interviews and it seems that no attempt was made to assess whether either consumer had legal capacity at the time of the interviews. Both consumers interviewed were long term involuntarily detained patients.

Action and outcome

Letters were sent in mid June 2012 to the Clinical Director of the hospital concerned, the Chief Psychiatrist and the Commissioner of Police. In the letter to the police, Council said it was concerned:

1. that the consumers had not been advised in advance of the police interviews so that they had an opportunity to take legal advice and/or organise an independent advocate
2. whether the consumers had been advised to take legal advice and/or told that someone else could attend the interview with them
3. whether they were properly cautioned prior to taking part in the interviews
4. as to who else was present in the interviews and
5. whether any consideration was given to the legal capacity of the patients to take part in such an interview or understand their rights.

As at 30 June 2012 Council was awaiting replies.
Case 4 - Police policies

In two of the above cases Council asked for a copy of the relevant Western Australia Police policies. In case 1 it was noted that Council often receives complaints from consumers about how they were brought to hospital by police. A request was made for a copy of the procedures that police are expected to follow when transporting a person to an authorised hospital. The initial response from an officer was that a freedom of information request would be required and then that the policies are available through the State Library, however the State Library conducted a search of their catalogue and could not locate the policy document. The Western Australia Police subsequently advised that an abridged version of operational policies, called the Western Australia Police Corporate Knowledge Database, is prepared annually primarily for libraries and can be released to the public at a cost of $10. A complimentary copy of the policies on CD was forwarded to the Council. As noted by the Official Visitor in the letter sent, consumers’ experiences of police, both positive and negative, impacts directly on their journey of recovery.

In case 3, Head of Council referred to other states having special provisions for cases involving people with a mental illness and asked if they had any such policies. The police sergeant advised Head of Council that he could not tell Council about their policies and the only way she could access them was by freedom of information legislation.

ISSUE 2: BED PRESSURES AND ACUITY ON THE WARDS

Increased acuity and stress on the wards and in hostels has been noticeable to Official Visitors this year. Hospital management confirm the increased acuity. It can be measured in part by the amount of increased staff time used to “special” patients by one-on-one nursing or through the provision of security guards. The increased acuity may partly explain the continuing significant increase in consumers requesting Council’s help despite the fact that the number of people made involuntary decreased this year from 2,142 to 2,093. These figures do not include long term consumers where an involuntary inpatient order was made prior to the start of the financial year and it is not known if there has been a change in the number of long term consumers.

There are many factors contributing to the increased acuity but a shortage of beds is one possible reason. Whenever Council inquires about vacant beds, it is told that there is a queue of patients waiting for a bed in Emergency Departments (EDs). Occupancy is often over 100% as beds of patients on leave from hospital are utilised.

Council is told that the impact of drugs and alcohol is another cause as it contributes to both the bed shortage and increased aggression on the ward. Such patients may stay on the mental health ward only for a few days but they are sent to the ward from the ED because a secure room or ward is needed.

Another contributing factor is the ongoing lack of alternative suitable accommodation for some of the State’s longest suffering mental health consumers. The Individualised Community Living Strategy initiated by the MHC (the 100 houses program), designed in part to free up some hospital beds, has only just started to roll out so consumers are still waiting to see the anticipated benefits. Council was told by the MHC that 30 people were either in a house or in “transition” to a house.

A selection of individual consumer cases and systemic issues which have emerged from the monthly inspections by Official Visitors is provided below. The illustrations demonstrate the complexity of the issues and show how mental health services are trying to adapt.

9 Source MHRB. See table 3 in Part 4.
**Illustration 1 – How one patient with complex needs can affect the whole mental health system**

The admission of a consumer with complex needs and issues resulted in a secure ward in a regional hospital being shut down for about 4 weeks. Patients on the secure ward at the time, and over the four weeks that the ward was shut down, were admitted or transferred to either the open ward (some were “specialled” with one-on-one nursing) or metropolitan hospitals. Numerous meetings were held. One argument was that the consumer could only be properly cared for in Perth, but Perth had no beds available and could not afford to close a ward down. A decision was then made to transfer the consumer to a secure 6 bed ward in Perth.

A significant number of consumers were directly and immediately affected by the transfer of the consumer to Perth and the need to close a whole ward. On the day the decision was made, Council was told that there were 6 patients waiting for a bed in EDs. In addition the 6 patients in the Perth secure ward had to be transferred to other wards/hospitals. One of those consumers also had complex needs and at least two patients were transferred to another hospital. It seems fair to assume that other people were either turned away or did not get a bed as soon as they needed one or were discharged earlier than they otherwise would have been.

Five beds on the Perth ward remained closed to patients for 22 days and 4 beds remained closed for a further 42 days – about 9 weeks.

**Action and outcome**

Apart from advocating for the consumer in the debate about the move to Perth and then assisting them in Perth in MHRB hearings, Official Visitors have been advocating and continue to advocate for the consumer to be transferred back nearer to their home and family with some form of “wrap around care”. It was proposed that this involve local Area Mental Health Services (AMHS) and support from both the MHC and Disability Services Commission (DSC).

Based on what Official Visitors have been told, however, there was considerable disagreement over what to do for the consumer. Depending on who Official Visitors talked to, there were different views as to what should be done. At one stage the Executive Directors of WA Country Mental Health Services and the Perth AMHS intervened advising Council that they were to be the sole decision makers about the discharge planning around this consumer.

Over 9 months later (as at 30 June 2012) the consumer was still in Perth and had been “living” on a hospital ward, a long way from home and family, for over a year. Council is very concerned that they will become another person “stuck” on a hospital ward.

Council also wrote to the Minister for Mental Health and the Mental Health Operational Review Committee (MHORC) within the DOH proposing that consideration be given to establishing a purpose built ward in the form of a “swing bed” that could be used as part of a bigger ward or locked off into a secure one bed ward for complex cases like this. Every year there is a case like this which results in a ward being closed. This would avoid whole wards having to be closed and provide the consumer with more timely and appropriate care as expertise would also develop around the ward.

It was noted that the majority of cases involved patients with some form of cognitive impairment and that skills held by DSC staff could be utilized in partnership. A major issue in these cases is a lack of relevant expertise.
The Mental Health Commissioner replied advising that the proposal had been canvassed with AMHS Executive Directors. There was little clinical support for a single bed or swing bed ward though merit was seen in an option of developing a specific unit.

The Mental Health Commissioner also wrote that it was generally recognised that there is a need to further develop clinical expertise and confidence in managing these complex presentations and that the development of a neuropsychiatric model with the appropriate training to treat and manage these patients would be a valuable initiative.

**Comment: Closure of authorised beds due to staffing issues**

Council is aware of two occasions where beds in the metropolitan area were closed due to “staffing” reasons. On the first occasion two open ward beds were closed for 6 weeks due to “medical” staffing reasons which is interpreted to mean a lack of doctors. On the second occasion between one and three beds were closed for a week due to “nursing” staff issues.

Another regional authorised hospital also closed a bed for nine days to “manage a difficult patient” on the ward. As was seen in the illustration above, the closure of a few beds can have a rippling effect, requiring patients to be transferred to other wards/hospitals, and creating further pressure for beds.

Other bed closures did occur during the year: for maintenance; or refurbishment for varying amounts of time up to a month.

**Illustration 2 – ED and hospital admission issues**

Although most metropolitan EDs have psychiatric liaison nurses and consultant psychiatrists, consumers often tell Official Visitors that they did not have a good experience in ED. Many have already been traumatised by being brought into the ED in a police van. While Official Visitors cannot assist people in EDs who are on a form 1, (that is, people who are awaiting psychiatric assessment, known as referred patients), it is not uncommon to have consumers complain about the way they were brought into hospital and/or treated in the ED.

Anecdotally senior management of one hospital told Council that pressures in the ED had become so acute that one patient had had to wait 6 days for a bed. Another hospital told Council that one patient had spent 5 hours in the back of a paddy wagon outside ED because ED was over-capacity. In the end, the patient was taken to another hospital. Official Visitors have been told by consumers of waiting in ED for 2 to 3 days.

The trauma of the admission process adds to the acuity and stress on the wards. Official Visitors spoke to consumers and hospital nursing staff about the admission process while on their monthly June visits. As one nurse told Official Visitors:\footnote{Feedback from those visits was sent to each hospital’s management.}

“They are subject to examination and likely to be in a distressed state. They seldom get access to showers, are only given sandwiches to eat and cannot smoke. This all contributes to their state of mind on arrival at the ward which can be a massive culture shock. Depending on the time of arrival which can be the middle of the night the patient may already be highly confused and unable to process the information we give them about their rights. If they are smokers they have often been told in the ED that they will be able to smoke when they get here but that is not true and they get more upset.”
A selection of consumer comments reported by Official Visitors is set out below

- From a young consumer who went to the ED voluntarily: “I would never go there again because the experience was too traumatic.” A nurse told the consumer that the “psych ward is a horrible place” but when the consumer tried to leave the ED the nurse threatened to call security guards. Requests for pain relief and the results of tests were refused.

- By a consumer who was picked up by police and taken to the ED: “At least they should let people pack a bag and be honest with them about what is likely to happen. Don’t treat people as if they don’t have a brain.”

- And another consumer taken to the ED in a police van said: “The community team thinks that to get you to hospital it is best to say as little as possible about what is likely to happen. They should understand that people do respond emotionally when confronted with leaving their house suddenly. Police escort is not pleasant and then you are left in a cold room by yourself for long periods of time. If they don’t give you time to pack a bag, then the hospital should have a small bag of toiletries in the rooms.” Not being given time to pack a bag is a common complaint by consumers.

- “They (ED staff) could have offered me the opportunity to take a shower. I was there over night. They could have provided me with more detailed information about my admission. I had absolutely nothing to do there.”

- “I would just like them to do it faster and don’t send consultants in to pacify us so that we will stay. The environment that I was detained in at the ED was very noisy with monitors beeping and nurses doing “obs” on patients. This made it very hard for me to relax and settle down and could lead to increasing my anxiety which is a negative effect.”

- From an older patient: “I didn’t have time to pack a bag so I arrived with nothing. I am locked up with elderly people who are clearly confused. I don’t like the ward routine where you have to do exactly what is expected or they think you are very unwell. I feel like I am in a fish tank. Suddenly my family think I can’t manage. I lost my job and now I have nowhere to go when they decide to discharge me.”

- “It took too long to get to the ward. By the time I got there, I was angry and ended up in seclusion. The ED did not treat my asthma. I am a smoker and they would not let me out of ED to smoke so I became desperate and then they sedated me.”

- “I don’t want to seek help again, now that I know what would happen if I do. I don’t want to come to (hospital) again. Staff at ED did not listen to me; I didn’t know what was going to happen to me. Now I’m in a locked ward with people who are very unwell which is not helping me. I’m more stressed than before. I just had a break up with my boyfriend but staff at ED did not listen to me.”

**Illustration 3 – Locked “open” wards**

Some hospitals have locked the doors of their open wards from time to time as a result of demand for beds in the secure ward and pressures from their ED. Patients who would normally be nursed on the secure ward were being nursed in the open ward to free up beds on the secure ward. Voluntary patients were allowed to leave the ward on request, but had to ask a nurse to open the door. In most cases the locking of the open ward door was temporary. Some regional hospitals also lock the doors of their wards even though it is not designated as a secure ward and this has been the case for some time.
In one case the locking of the open ward door is permanent and Council was told that it was not due to current bed pressures. The hospital was the subject of a petition given to the MHC complaining about the locked doors.

**Action and Outcome**

Council wrote to the Clinical Directors of the respective hospitals and, in the case of one hospital, the Chief Executive Officer. We were given reassurances as to the safety of the open ward and that there were no restrictions on the freedom of voluntary patients to enter and exit the ward.

In the case of the hospital which has chosen to permanently lock the doors of the open ward, Council was told that it was not a result of “the current shortage of beds” but a revised access control system. Under the previous system some patients had been leaving the ward without telling staff. The hospital said it was important that staff knew the whereabouts of patients in case of emergency or if the patient failed to return. There had also been people going into the unit “interfering with the care of patients”.

Official Visitors have been keeping a close watch on the issue to ensure that consumer rights are not infringed, but the locking of doors on open wards raises a number of issues. There is concern that locked open wards will become the norm without the implications of this being considered from the perspective of consumers.

On the one hand locking open wards on a regular or permanent basis:

1. avoids the need to have more secure beds and may get people out of the ED and into treatment sooner, but this may be at the cost of voluntary and other less unwell patients
2. has potential to make mental health wards feel like prisons rather than places of care and recovery
3. could perpetuate the stigma of mental health patients being dangerous
4. increases the patient’s sense of disempowerment in that, even while voluntary, the patient must still find a nurse and then ask permission to leave - and there is little doubt that some patients will have their request refused despite being voluntary.

On the other hand, locked open wards:

1. offer involuntary patients the potential of having a less restrictive environment than on the locked ward. However, there are always a number of involuntary patients being prepared for discharge on open wards with the doors open, so for them it will be more restrictive
2. may feel safer for some voluntary patients (and their families)
3. may mean that some patients, who would otherwise have been made involuntary so that they could be admitted to the secure ward, are admitted as voluntary patients instead, particularly where the patient is likely to self-harm
4. are not the least restrictive alternative (as required by the Act) because the involuntary patient could be “specialled” with 1 on 1 or 2 on 1 nursing on the open ward.

Head of Council therefore wrote (in late June) to the Minister for Mental Health and the Mental Health Commissioner raising the issues above and asking for their comments. It was noted that as the purchaser of mental health services, the MHC, was in a position to set standards in this regard. We await their response.
A letter was also sent to the Chief Psychiatrist who replied that he was aware of the petition but had not received any complaints. He said that: “Finding the balance of safety and inconvenience may require compromise, and this may not necessarily mean that a patient’s right to leave the premises are not complied with, with the procedure of leaving and entering the premises being a procedure, albeit with prescribed actions, rather than a restriction.”

**Illustration 4 - Discharge to general wards**

A metropolitan mental health service has established a procedure to “discharge” suitable patients to a general ward to facilitate acute admissions from the hospital’s ED and general wards to the mental health unit, when there are otherwise no mental health beds available metropolitan wide. The mental health consumer sleeps on the general ward but returns to the mental health ward by day.

**Action and outcome**

Council obtained a copy of the policy and discussed the issues with the AMHS Executive Director. Council was aware of another hospital which had done something similar but had run into issues when the ward had too many consumers by day. In this case however Council was told that a maximum of 2 consumers only could be discharged onto the general ward. They must be voluntary consumers. As with the previous illustration, there are a number of issues to be considered from the perspective of consumers. For example, it may help to reduce the stigma of being a mental health patient at least by other hospital staff. It does reflect, however, the way hospitals are adapting to the bed pressures. Council will maintain a watching brief.

**Illustration 5 – Rehabilitation beds taken up by acute ward patients disrupting recovery and patient shuffling between wards**

During the year Official Visitors continued to get complaints from consumers about the lack of relevant and appropriate rehabilitation and recovery activities on Graylands Hospital’s rehabilitation wards. Last year’s Annual Report featured a petition complaining about this.

The complaints continued this year. One Official Visitor also dealt with a consumer who had been shifted between an acute ward and what is supposed to be a rehabilitation ward 5 times in two and a half weeks. The patient was acutely unwell but was being shifted onto the rehabilitation ward every time a new patient was brought in to the acute ward.

**Action and outcome**

In following up this issue Official Visitors were told by ward staff that part of the difficulty was that up to 50% of the patients were acutely unwell and should not be on a rehabilitation ward. This made it difficult to effectively plan and conduct activities that should be run on a rehabilitation ward such as outings, BBQ’s, shopping, cooking etc.

Further inquiries with hospital management confirmed that, although there are meant to be 114 rehabilitation beds, as at 30 June 2012 about 10 -15 of those beds were being taken up with acute patients. Council continues to raise the issue and is aware of further changes since 30 June 2012 due to the opening of the Broome mental health ward.
Illustration 6 - People still stuck on wards and “100 Houses program”

Of the 6 long term consumers highlighted in the 2009-2010 Annual Report three years ago, all but one remain in hospital. Four of them have been in hospital for many years. Official Visitors also dealt with 130 complaints from consumers about being unable to be discharged due to lack of accommodation, and 133 complaints about discharge plans which includes “lack of consultation, no plan, plan not reviewed and failure to follow the plan”.

Some of the 6 long term consumers have had their names put forward to take part in the Individualised Community Living Strategy otherwise known as the “100 Houses program” by the MHC, and one has had a house allocated but the Official Visitor understands that their doctor is yet to approve the move. This consumer has been out to see their house and meetings have been held with the non-government organisation (NGO) contracted by the MHC to provide “wrap-around” care for the consumer.

Another consumer who Council has assisted told their Official Visitor how happy they were to have been put on the “100 Houses program” list. The consumer had telephoned and spoken to the Mental Health Commissioner to thank him. As the consumer told the Official Visitor:

“Things like this just don’t happen to people like me. I still can’t believe it.”

Illustration 7 – Hostel resident left in the Emergency Department

A hostel resident with a complex medical syndrome was taken by the hostel to the local hospital ED. The hostel did not want the consumer living at the hostel any longer because they could not handle the consumer’s illness. Later that afternoon the consumer was returned to the hostel, apparently by local police, but left on the front doorstep of the hostel. No-one realised the consumer was there for some time. The local mental health clinic said they could not help the consumer as the syndrome was not a mental illness. The consumer’s behaviour was affecting other residents and beyond the capacity of the hostel staff.

Action and outcome

The Official Visitors contacted the consumer’s guardian at the Office of the Public Advocate and, between them, various attempts were made to source alternative accommodation. The MHC was also contacted. Apart from the complex issues involved in this case, the Office of the Public Advocate makes decisions on behalf of the person based on information provided by the medical team. Because there was no AMHS involved, there was no easy access to a social worker or anyone with relevant expertise and knowledge taking responsibility for the consumer. The hostel agreed to keep the consumer in the meantime.

Two months later another issue arose and the hostel and Official Visitor were told that the only alternative was for someone to take the consumer to the local ED. Three months later the consumer was taken to an ED, Council has heard nothing further since then and is unable to continue to advocate for the person as they are no longer an “affected person”.

There are other cases like this where hostel residents have high care needs but the hostel is not funded, and does not have the appropriate staffing levels and competencies, to care for the person.
Illustration 8 – Dual diagnosis and interaction by mental health patients with the Disability Services Commission

For years Council has raised issues in its Annual Reports about long term patients on mental health wards and hostel residents who have obvious intellectual disabilities, yet do not receive DSC support or, who have been approved for funding but remain in a mental health facility.

Action and outcome

Noting that the Minister for Mental Health, Helen Morton, is now also the Minister for Disability Services, a series of meetings was organised, one with DSC and Ministerial staff, and another with the Minister and the Director General of the DSC. In preparation for that meeting Council wrote to the Minister outlining the range of cases in which Official Visitors were involved.

DSC staff explained that the DSC has strict criteria and people with a mild disability may not meet the criteria. Council explained that the consumers referred to by Official Visitors were very clearly cognitively impaired and were being required to live for years on a hospital ward where there was an undersupply of expertise to support people who have an intellectual disability. Alternatively they were living in hostels with little or no assistance provided to help them to improve their quality of life. The issue was about getting the right type of help so these consumers can recover to the best of their potential and not have to live on a hospital ward or remain dependent in a hostel for the rest of their life.

Council was advised in the meetings that the PECN project (People with Exceptionally Complex Needs) was to be expanded to another 10 people, 8 of whom had a mental illness. This makes 20 altogether. The Director General of the DSC also offered to review individual cases.

Subsequently Council received a letter from the Mental Health Commissioner, advising that he recognised a need to further develop clinical expertise and confidence in managing the range of complex cases that Council had highlighted in the letter to the Minister for Mental Health. He said he intended to discuss the shared responsibilities that exist in providing care with the Director General of the DSC.

The Minister for Mental Health also replied to Council’s letter noting that the meetings were the beginning of some problem solving around the issues.

Later in the year Council also raised with the MHC a report by the North Metropolitan Area Health Service – Mental Health Working Party titled: “Mental Illness and Intellectual Disability - a framework for working with consumers with a dual diagnosis”. The report contains a number of practical recommendations. Council was given a draft of the report to comment on prior to its finalisation. We are waiting to hear whether any of the recommendations are to be endorsed by either the DOH or MHC.
ISSUE 3: MENTAL HEALTH REVIEW BOARD HEARINGS

Apart from access to Official Visitors, there are 2 other major legislative safeguards designed to protect the human rights of involuntarily detained patients:

1. the right of review by the MHRB
2. the right to another opinion.

Potentially the most powerful protection is the right to regular reviews and/or to apply for a review by the MHRB. Apart from the psychiatrist, the MHRB is the only other body able to make a consumer voluntary or discharge them from hospital and allow them to go home on a CTO. Council has been raising issues about the MHRB process since its 2003-2004 Annual Report. The issues include psychiatrists failing to attend hearings or provide signed medical reports in time, or at all, and hearings being cancelled or postponed as a result.

Apart from failing to provide procedural fairness and natural justice, cancelled and postponed hearings create an enormous impost on the emotional wellbeing of consumers. Official Visitors frequently have to manage consumers’ expectations as well as prepare the submissions for the MHRB. Cancelling or adjourning hearings causes great disappointment and further anxiety in dealing with new hearing dates. Rescheduling hearings also add to Council’s costs.

According to the MHRB data, there were 779 cancellations and 1,135 reviews which were completed. Of the cancelled hearings, 526 hearings did not proceed because the consumer was no longer involuntary but 75 hearings were cancelled at the psychiatrist’s request in comparison with 58 hearings cancelled at the consumer’s request and 11 requests for a review withdrawn.

Cancellations by psychiatrists therefore continue to be of a concern to Council. While there will always be cases where the psychiatrist was suddenly taken ill, in some cases no apparent reason for the postponement was given other than psychiatrist unavailability.

Council is aware that the President of the MHRB has met with a number of hospitals and made new arrangements for the scheduling of hearings designed to facilitate better doctor attendance which is welcomed.

Illustration 1 – Non attendance by anyone from the treating team after hearing rescheduled at psychiatrist’s request

A scheduled 6 monthly review listing was cancelled the day before the hearing at the psychiatrist’s request because he was not available. The consumer was not consulted. The hearing was rescheduled to a day that the psychiatrist worked at the hospital 3 weeks later. Two weeks before the rescheduled hearing the psychiatrist was advised by the MHRB of the new date, asked to provide a medical report and asked to ensure that he, or one of the treating team familiar with the consumer’s case, was in attendance or available by telephone.

The Official Visitor received notice of the new date about 2 weeks prior to the hearing. Three days before the hearing the Official Visitor tried to get a copy of the medical report (the AMHS policy requiring that it should be available 3 days before a hearing). It was not available that day, nor the next, nor the morning of the hearing. In speaking to hospital staff about the missing medical report, the Official Visitor was told that neither the psychiatrist nor medical registrar was attending the hearing. The review therefore had to be rescheduled a second time for another 3 weeks later.
Action and outcome

The Official Visitor complained to the MHRB and asked that the MHRB compel the attendance of the psychiatrist in person at the next hearing. Letters were also sent to the Clinical Director of the hospital and the AMHS Executive Director. The psychiatrist and treating team members all attended the rescheduled hearing.

Illustration 2 - Quality and timeliness of psychiatrists’ medical reports

Council conducted a review of the timing and quality of medical reports provided for 12 MHRB hearings at 2 hospitals and 1 clinic within the South Metropolitan AMHS (having done the same in the North Metropolitan AMHS the previous year).

The medical reports are required by the MHRB and hospitals are notified 2 weeks in advance of hearing dates. It is important that the patient and any advocate assisting them are provided with a copy of the report at least 3 days in advance of the hearing so that the contents can be discussed and that any issues of contention can be raised in the hearing.

Official Visitors report typically having to chase up the medical report and receiving it either late the previous afternoon or on the morning of the hearing. In most other States, doctors are required to provide a copy of their report to the patient 3 to 7 days before the hearing.

Action and outcome

In each case the Official Visitors attempted to get a copy of the report 3 days before the hearing but none could be obtained at this time and only 1 report was provided the day before. Most were received just prior to the hearing. In 1 case the consumer was made voluntary the day before the hearing.

Some reports were dated a number of days prior to the hearing but despite this were still not made available to the consumer or Official Visitor until the day of the hearing. There were also some concerns about the quality of the reports:

• There appeared to be a number of inaccuracies and unsubstantiated allegations in 2 of the reports. When questioned in the MHRB hearing, the medical staff said the allegations had come from file notes made at another hospital and they conceded they were not sure if they were accurate.

• A report received the night before the consumer’s hearing was dated 6 weeks earlier. The psychiatrist advised that he had made only minor changes to the earlier report and gave the Official Visitor an amended report 1 hour prior to the hearing.

Council wrote to the Clinical Directors of all mental health units in the South Metropolitan AMHS and asked for a commitment by their medical staff to have medical reports available 72 hours before hearings and a monitoring and notification system whereby Official Visitors and Mental Health Law Centre (MHLC) lawyers would be provided directly with copies of the reports and would not have to chase them up. We also asked for hospital policies to state that it was best practice for the consultant psychiatrist to attend the hearing where possible and, if it were not possible, they should be available over the phone should the MHRB require any further clarification.

Two mental health units in the South Metropolitan AMHS have advised that they will create or amend their policies. Council continues to monitor this important issue.
Illustration 3 – Official Visitor representation and support in MHRB hearings

Since 2003 Council has had a strategic goal to increase the number of people represented in MHRB hearings by either an Official Visitor or a MHLC lawyer. This year the number of people represented in hearings jumped by 6.9% to 33.2% which is a significant “good news story”.

Of the 377 hearings in which consumers were represented by an Official visitor or MHLC lawyer, 271 were supported by an Official Visitor and MHLC lawyers represented consumers in 106 hearings.

<table>
<thead>
<tr>
<th>Year</th>
<th>Completed hearings</th>
<th>% represented by COV</th>
<th>% represented by MHLC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003-2004</td>
<td>1,250</td>
<td>8.48%</td>
<td>8.4%</td>
</tr>
<tr>
<td>2004-2005</td>
<td>1,203</td>
<td>6.73%</td>
<td>7.82%</td>
</tr>
<tr>
<td>2005-2006</td>
<td>1,089</td>
<td>7.25%</td>
<td>8.27%</td>
</tr>
<tr>
<td>2006-2007</td>
<td>1,174</td>
<td>13.88%</td>
<td>6.99%</td>
</tr>
<tr>
<td>2007-2008</td>
<td>1,103</td>
<td>14.87%</td>
<td>11.97%</td>
</tr>
<tr>
<td>2008-2009</td>
<td>1,141</td>
<td>13.4%</td>
<td>7.2%</td>
</tr>
<tr>
<td>2009-2010</td>
<td>1,131</td>
<td>16.9%</td>
<td>10.4%</td>
</tr>
<tr>
<td>2010-2011</td>
<td>1,242</td>
<td>19.5%</td>
<td>6.8%</td>
</tr>
<tr>
<td>2011-2012</td>
<td>1,135</td>
<td>23.9%</td>
<td>9.3%</td>
</tr>
</tbody>
</table>

Forty seven consumers were made voluntary by the MHRB at hearings (4.1%) during the year (20 people were involuntarily detained and 27 were on a CTO). Fifteen of those were assisted by Official Visitors (as compared to 24 the previous year) and 7 were represented by the MHLC (as compared to 3 the previous year), and 2 were assisted by both an Official Visitor and MHLC.

ISSUE 4: OTHER OPINION PROCESS

Council has been raising concerns in Annual Reports about other opinions not being independent, and related issues, since its inaugural Annual Report in 1998-1999. The vast majority of other opinions are provided by a colleague of the treating psychiatrist working at the same hospital. The opinion is carried out the next time the psychiatrist has some time available when attending the ward. The quality of the opinion varies as a result. Rarely are consumers given a copy of the other opinion. Council assisted 173 consumers with their requests for other opinions this year.\(^\text{15}\)

Council has a system in place to ensure that the treating psychiatrist is aware of the request for another opinion and to monitor the timeliness of the other opinions being given. Anecdotal feedback from psychiatrists indicates that many of them share Council’s frustration that other opinions are not truly independent.

There are complaints by some psychiatrists that consumers ask for the other opinion too readily and that rarely do other opinions result in change to the treatment. However for a person who has been put onto a locked ward and forced to take medication (often with serious side effects) against their will, another opinion can alleviate their concerns and held build trust in the treating team.

\(^{14}\) These figures have been updated from last year’s Annual Report.

\(^{15}\) Appendix 11.
Illustration 1 - The difficulty of finding an independent psychiatrist

A consumer requested an other opinion from a psychiatrist employed at another health service. The Clinical Director found a psychiatrist willing to provide the opinion but that psychiatrist was subsequently “too busy” to do it. This Clinical Director and several others have repeatedly told Council that resources do not enable psychiatrists to make arrangements for opinions to be provided by psychiatrists employed at other hospitals.

Action and outcome

Council wrote to the Chief Psychiatrist asking if he would put together and make available a list of psychiatrists, to be attached to his Operational Directive 0250/09, who would be willing to provide an other opinion. Council also asked whether the Chief Psychiatrist could arrange the opinion for this patient and if not, what advice or options he would suggest for psychiatrists so that opinions from psychiatrists employed at other hospitals could be arranged. We were referring primarily to private psychiatrists but also those in the system who might be prepared to go to other facilities. There are a number of psychiatrists who work part-time in the public system, for example, and who therefore might be prepared to go to another facility on one of the days they are not working for the DOH.

The Chief Psychiatrist replied:

“Any number of psychiatrists may nominate as willing to provide the other opinion but on a particular day they may be unavailable. It is my expectation that each Authorised Hospital would have their contact list of psychiatrists both within and external to the hospital that they would contact when a further opinion is required. The hospital would be in a better position than the Chief Psychiatrist to keep this list current. While I recognise that the Act assigns the role of facilitating or arranging for the opinion of another psychiatrist, I have no means of ensuring another psychiatrist’s opinion is readily available. Practically I have delegated this arrangement to the senior psychiatrist who is most likely to have awareness of the availability of psychiatrists who have not previously been involved with that issue (both within and external to that office). At this time I can offer no other suggestion to the practices that are already implemented in hospitals recognising that the process may not always be timely to the satisfaction of patients.”

Comment: Draft Mental Health Bill changes to the Other Opinion process

The draft Mental Health Bill put out for public comment offers some improvements to the other opinion process. In particular the other opinion must be provided in writing and a copy must be given to the consumer. However there is no reference to the psychiatrist being independent and the responsibility for finding another psychiatrist remains with the treating psychiatrist.

Council has called for, and continues to call for, a pool of other opinion psychiatrists to be administered by either the Chief Psychiatrist or the MHC. Consumers would contact the organiser of the pool (preferably by a free call number) who would arrange for an independent psychiatrist to attend by appointment. Psychiatrists from within the DOH and the private sector could be included as part of the pool roster. The Quality Care Commission in the United Kingdom and the Mental Welfare Commission in Scotland, for example, are responsible for arranging second opinions for involuntarily detained mental health patients. A panel of other opinion psychiatrists could be established (similar to the panel of psychiatrists organised by the MHRB) where they are paid a sessional rate for travelling between hospitals to conduct other opinions. Alternatively psychiatrists could be asked if they would donate time to the panel or perhaps it could be incorporated as part of their continuing professional development and/or registration.
Clearly, an added cost would be involved. However, involuntary patients are seriously ill, the diagnosis and treatment is usually complex, the medications often have serious side effects and, unlike any other serious illness, the process involves taking away fundamental human rights.

ISSUE 5: SUPPORTED ACCOMMODATION - LICENSED PSYCHIATRIC HOSTELS

The licensed psychiatric hostels visited every 2 months by Council comprise 41 facilities, some of which are run by NGOs and some by private “for profit” entities. The facilities range widely in style, size, standard of accommodation and care, and level of funding. In this Report they will all be referred to as hostels.

Council was advised of 38 new beds being licensed in the sector this year (and a reduction of 5 beds at one facility) resulting in a total of 868 beds licensed and funded by government for people with a severe and chronic mental illness. Appendix 2 contains a list of hostels, licensees and addresses. This figure does not include the “100 Houses program” by the MHC. Council’s jurisdiction does not cover these homes though consumers living under these arrangements may need advocacy, particularly in relation to any complaints they have with the NGO providing them with support and any issues relating to maintenance of the home.

There was a 43.3% increase in the number of hostel residents seeking visits from Official Visitors this year rising from 97 to 139, possibly supporting the concerns Council has about this sector. The concerns include the following:

1. The ongoing lack of comprehensive oversight and quality assurance because of gaps and overlaps. Until earlier this year 4 agencies were involved in the oversight of hostels – Council, the OCP, LARU and the MHC. In August 2011, Council was advised that the OCP was withdrawing from its monitoring role which was to be taken over by the MHC. (Council is waiting to hear how the MHC plans to conduct the monitoring).

2. The discrimination of “private hostel” residents who have little or no access to appropriate rehabilitation and recovery services which limits their potential for recovery and an improved quality of life. Council is concerned that these residents are being forgotten about and in many cases are also living in large institutional facilities, sharing bedrooms and facilities which are funded less than other newly built villa style hostels run by NGOs which are able to offer in-house services. The private hostels also tend to have the more chronic and severely impaired consumers because they do not fit the criteria of the NGO-run facilities.

3. Issues related to ageing of hostel residents and other disabilities (and see also Issue 2, illustration 7).

Illustration 1 – Complaints about inappropriate behaviour by hostel staff

Last year Council reported on complaints by hostel residents about a supervisor. The issues relating to that supervisor continued this year. Two other cases involving allegations about staff are also illustrated below to show:

1. the vulnerability of hostel residents – with many residents too scared to speak out because they are concerned they will be evicted or don’t know who to complain to particularly when a staff member is involved

2. the very different approaches taken by the 3 hostel licensees in dealing with allegations – while one licensee had no difficulty in being transparent about the way the investigation was conducted and the outcome, another refused to provide information requested saying it was confidential, and another left it up to LARU
3. the lack of clear oversight and regulation of this sector – the licensing body, LARU, can only deal with issues if an approved supervisor is involved; assumptions seem to be made that if an NGO is involved they can be allowed to handle the investigation themselves; and MHC, which provides funding to the hostels, currently appears to only maintain a “watching brief” when serious complaints or allegations are made. It is difficult for Official Visitors to know who to approach when there are concerns.

Case 1 – Supervisor drunk on duty

Last year Council reported on allegations made about a hostel supervisor which resulted in LARU sending in an investigator. The allegations included being drunk at work and bullying residents. A number of the allegations were substantiated. The supervisor was reappointed as a supervisor on multiple conditions that included that the person would be supervised by the license holder or another approved supervisor whilst on duty and monitored for a period of 6 months.

At the end of the 6 months the supervisor was allowed to work again unsupervised and was the sole staff member on night duty. Shortly after, hostel residents raised complaints again with Official Visitors. An anonymous call was also received about another staff member yelling at residents.

Action and outcome

Council notified LARU, the MHC and the licensee. The concerns were dismissed by the licensee but sometime later Council was advised that the supervisor had been dismissed after being found drunk during their work shift. The supervisor was then re-employed as a cleaner at the hostel under supervision and with conditions. Official Visitors are maintaining a watching brief.

Case 2 – Allegation that supervisor bullied residents

On a bimonthly visit a resident complained to an Official Visitor that a supervisor had “gone off at me” for going to hospital and not wearing shoes. The resident was clearly upset. The Official Visitor spoke to another resident asking if they were being treated well by staff. They said they were ‘too scared to say anything’. A third resident who was asked if they were being treated with respect by hostel staff replied “not all of them”. Further inquiries of staff supported the resident’s complaint with one staff member who was prepared to be named saying they had heard the supervisor yelling and swearing at residents and that residents tended to try to avoid the supervisor. Further inquiries were also made of the Community Mental Health Service (CMHS) nurse who visited the facility. He confirmed that he had heard the supervisor yelling at a resident for making coffee. Other concerns were raised by the CMHS nurse as well.

Action and outcome

In accordance with Council’s Serious Issues Policy, Head of Council telephoned the CEO of the licensee and letters were then sent to the licensee, LARU and MHC. A meeting was also held with the AMHS.

Council acknowledged that the supervisor deserved a full right of reply but in such cases Council usually asks that the staff member be moved from the facility and/or contact with residents pending the outcome of the inquiry. This is for the safety and protection of the residents and to avoid contamination of the inquiry. From experience in other cases, residents are often very concerned that by speaking out there will be unfavourable consequences and this is emphasised if the staff member remains on duty. Given the comments by staff and the CMHS nurse, Council also noted that it would expect the licensee to interview all staff, all residents, the Official Visitor and the CMHS nurse.
It was suggested that Official Visitors would like to be present at the facility when residents were interviewed in case residents wanted an Official Visitor to be with them during the interview.

Six days later the CEO of the licensee wrote to Council advising that the investigation had been concluded and that they were satisfied that the “resident care and the safety and suitability of the facility had not been compromised”. Some opportunities for improvement had been identified which would be addressed. They would not tell Council anything more, citing issues of confidentiality. The licensee also said they had concerns with the approach taken by Official Visitors during the initial and a subsequent visit to the facility.

Separately Council was told that the supervisor’s behaviour would be monitored more closely. Official Visitors also attended with a senior manager of the facility when she spoke to residents telling them that the supervisor had done the “wrong thing” but now knew the behaviour was wrong. Council took this to mean that the complaints had been substantiated. The Licensee later advised that this assumption was not correct and that the complaint was not substantiated but it did “identify further opportunities for improvement” with the staff member.

Council remained concerned about the quality of the investigation and the outcome and wrote again to the licensee asking for more details including the action taken to ensure the supervisor’s inappropriate behaviour would not happen again. The licensee was reminded that Official Visitors are required under the Act to ensure that residents’ rights are observed and that the facility is in a condition that is safe and suitable.

There were also some new concerns about another allegation raised by a resident about bullying by the supervisor (the second allegation) and instructions allegedly given to staff and residents about who they should, and shouldn’t speak to about complaints.

While Council is usually prepared to rely on LARU’s advice (as LARU is responsible for the approving hostel supervisors and will conduct its own investigations), in this case LARU had advised that they also wanted more information from the licensee.

A meeting was then held with the CEO of the licensee followed by further correspondence. The eventual outcome was that the licensee appointed an independent person to investigate the second allegation.

Four months after the initial letter of complaint was sent, Council was advised by the licensee that the second allegation was unable to be substantiated and the supervisor would remain a supervisor without any conditions. Recommendations made by the independent investigator would be implemented including ensuring that residents were provided with information regarding the avenues for complaints on a regular basis.

LARU also wrote to Council advising that they had now seen the final report. They required the licensee to implement all the recommendations from the report and advised that the licensee would be maintaining a “watching brief” on the supervisor.

Council accepts that LARU has seen the final report and is now apparently satisfied about the investigation of the complaints. Official Visitors will also maintain a watching brief.

16 These concerns were discussed later but agreement was not reached on the issues raised by the licensee. The “concerns” have been included in the statistics on complaints received by Council referred to in Part 4 of this report.
Case 3 – Anonymous complaint about hostel staff behaviour

Council received an anonymous letter alleging that:

1. a hostel staff member had been drunk and behaved inappropriately with 2 residents at a hotel by breaching expected boundaries of behaviour
2. a hostel supervisor who was present at the hotel had asked the residents not to say anything about the incident
3. another hostel staff member was “often intoxicated at work”.

Action and outcome

In accordance with Council’s Serious Issues Policy, Head of Council telephoned the CEO of the licensee and letters were then sent to the licensee, LARU and MHC. The licensee was asked to advise Council how they intended conducting the investigation, as well as the outcome in due course. It was suggested that Official Visitors could attend at interviews with residents if the residents wanted support.

The licensee quickly arranged for an investigation of the complaint. Staff were given a copy of the complaint and asked to provide written responses. One investigator was appointed to interview staff. A second investigator reviewed the written responses by staff and the report from the first investigator of the resident interviews and then interviewed each of the staff members and further written statements were taken. Council was invited to have an Official Visitor present at the facility for the residents’ interviews and advised of the approach which would be taken with the residents in the interview. Both residents asked for the Official Visitor to be present in the interviews when given the option.

Council was provided with a copy of the final investigation report 2 months later. The allegations were unsubstantiated although some mentoring and training about maintaining boundaries was recommended for one staff member. It should be noted that the residents interviewed did not send the anonymous complaint and said they were not upset by the staff member’s behaviour.

Illustration 2 - Review of hostel sector – oversight, regulation and licensing

Council has been calling for a review of the oversight and standards applied in the hostel sector for some years. This includes a review of the relevant legislation, standards, licensing, and quality assurance:

1. The combination of legislation, various standards and individual contractual arrangements with hostel licensees, coupled with different types of hostels, means that it is difficult to determine the rights of hostel residents and how to enforce those rights. Official Visitors have to refer to the following:
   1.1. the Hospitals and Health Services Act 1927
   1.2. the Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997
   1.3. the “Licensing Standards for the Arrangements for Management, Staffing and Equipment of Private Psychiatric Hostels” (last issued in 2006 and in need of a review)
   1.4. “Service Standards for Non-Government Providers of Community Mental Health Services” (Service Standards)
   1.5. the various policies of the licensees (which vary widely in content and detail)
   1.6. the agreements between the resident and licensees
   1.7. the terms of the licence granted by LARU
   1.8. the general/generic information we have been provided with about the contractual arrangements between the licensee and the MHC – Council does not know precisely what services the hostels are contracted to provide.
2. A number of the regulations are almost impossible to interpret and/or enforce. These include regulations to do with the standard of food to be provided to residents and clothing. There are also questions about regulation 14 regarding the amount that hostels are allowed to charge residents.

3. A number of the hostels do not fully comply with the Service Standards.

4. A number of the Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997 are being exempted on a regular basis as part of the licensing arrangements; further reflecting a need to review the Regulations.

5. There is limited quality assurance around the staffing of hostels yet there is a high potential for abuse. The approval and oversight of hostel staff is currently limited to LARU which can only approve (or remove approval for) staff who are employed as supervisors. There is also the question of who conducts investigations when serious allegations are made and the quality and transparency of those investigations (as illustrated in last year’s Annual Report and in Illustration 1 above).

6. There are concerns about the level of training and/or qualifications of both supervisors and other hostel staff.

7. This year LARU has had to issue a number of interim licenses. In the case of one hostel, conditions placed on the license were not complied with and several deadlines for compliance came and went. In another case LARU was given very little notice about significant changes at a hostel.

**Action and outcome:**

Council has written to the MHC and raised the issues in various meetings. In particular Council has asked:

1. whether and what plans there are for a review of the oversight and regulation of the hostel sector
2. whether there are plans to amend the Hospitals and Health Services Act and regulations
3. how serious issues and allegations are to be dealt with in future, including who Council is to go to when reporting such allegations, who conducts the investigation and what guidelines there are for such investigations
4. whether the MHC intends to get more involved in the approval and training of hostel supervisors either directly or by contractual/funding arrangements
5. what standards are currently applicable in hostels either by legislation or contractually
6. how the MHC is taking over the monitoring previously done by the OCP and whether any changes are anticipated in that regard?

Council is aware that the Henderson Report made a number of recommendations relevant to the oversight of hostels which included removing the current hospital and hostel inspection function from Council (which would become a new advocacy body). Henderson recommended that this inspection responsibility pass to the MHC which was to contract with an “independent evaluation and monitoring agency.” The MHC is also to develop an “integrated quality management framework built on existing Commonwealth processes using a Joint Collaborative Partnership approach between the MHC and DOH.”

---

18 ibid pp24-25.
19 ibid p 20.
While work is underway for the planning of the new advocacy body, we wait to hear further from the MHC about its plan for taking over and developing this quality assurance role.

Council also met with Sankey Associates who were retained by the MHC to conduct an evaluation of components of the supported accommodation program funded by the MHC. A sample of 18 sites was selected by the MHC for more in-depth evaluation. Council awaits the outcome of that report.

While work is underway for the planning of the new advocacy body, we wait to hear further from the MHC about its plan for taking over and developing this quality assurance role.

Council also met with Sankey Associates who were retained by the MHC to conduct an evaluation of components of the Supported Accommodation program funded by the MHC. A sample of 18 sites were selected by the MHC for more in-depth evaluation. Council awaits the outcome of that report.

**Illustration 3 – Lack of access by private hostel residents to programs which promote rehabilitation and recovery**

Official Visitors have been concerned for some time about the lack of rehabilitation, recovery and psychosocial community programs available for the 400+ private hostel residents. This concern was exacerbated when the North Metro Day Centre was closed.

The private hostels receive less funding than the NGO run hostels and most do not have the expertise to run inhouse programs so these residents, who tend to be the most chronically unwell, are particularly disadvantaged.

Inquiries revealed that most private hostel residents are not readily able to access DOH programs either, because they are not being case managed by the local CMHS. For example, only 25 of the 171 licensed hostel residents in 1 CMHS catchment area were case managed by the CMHS. Despite having a chronic and severe mental illness, the residents are usually cared for by GPs. There are some local NGO run activities, but the nature of the illness and resulting cognitive impairment suffered by many of these residents, means that most of these programs are not suitable.

The result is that many of the residents of the private hostels are being denied the prospect of recovery. Residents do not tend to improve and leave these hostels, they are not eligible for the MHC “100 Houses program“, attempts to get access to Commonwealth programs such as Home and Community Care (HACC) services are denied them because the hostel is State funded (by the MHC); and it has been Council’s experience that NGOs which are funded to run the Personal Helpers and Mentors programs are reluctant to provide services in such private hostels.

**Action and outcome**

Council made numerous inquiries through the year as outlined above and then wrote to the MHC and followed up the issue with them in 2 meetings. Council pointed out that it is the role of the MHC to organise the care co-ordination and future planning for the needs of private psychiatric hostel residents. The MHC funds the hostels and the DOH does not appear to consider hostel residents to be its responsibility unless they are case managed by the CMHS.

Council would like to see the MHC provide funding for in reach services to the hostels (many of which have over 50 residents); or for suitable services to be provided including transport for residents from the hostels; alternatively individualised care packages to be made available as a matter of priority.

Council was told by the MHC that “some discussions about the possibility of a trial with one or two hostels to move them towards psycho-social support” were being held. However we have not been made aware of any further plans and we understand that individualised care packages will not be given to hostel residents at least in the near future.
Council also requested that it be provided with a list of all community programs and activities funded by the MHC that would be suitable for psychiatric hostel residents to attend in Western Australia. This was with a view to Official Visitors promoting the programs to hostel residents and licensees whenever a complaint was received about the lack of programs and activities. A list of 12 providers was given but none were operating in the areas where the bulk of the private hostels are located, and most were unsuitable.

Council has also been liaising with the DSC (see Illustration 4 below) with a view to some hostel residents possibly accessing their programs.

Council also made inquiries of private hostel owners to establish what activities they offer residents. It was suggested that they consider inviting the author of a book published by former consumer, Jenny Middlemiss, titled “Secret Squirrel Business – A Guide to Mental Health Recovery” to present her story to residents. The MHC and others helped fund the publication of the book which is being distributed free. Copies of the book were sent to hostel licensees. One licensee of several private hostels replied that they were making inquiries about getting the author to speak to residents. Four private hostels provided a list of activities on offer to residents. The activities in the main included things like church visits, art activities, walking, board games, TV and similar.

Council will continue to advocate on behalf of this very disadvantaged group of people.

*Illustration 4 – Hostel residents with ABI, mental impairment and other disabilities*

Many private hostel residents have intellectual and physical disabilities as well as their mental illness. Some have DSC Local Area Co-ordinators (LACs) but many do not and, of those that do, the LACs may not have been overly involved in the resident’s life. This may be at the resident’s request or because they have fallen between the gap between DSC and MHC. For example Council was advised that some of the hostel residents who had been accessing the North Metro Day Centre before it was closed down had an acquired brain injury (ABI) or primary intellectual disabilities and so did not qualify for DOH programs in any event.

In one “good news story” the Official Visitor successfully assisted a hostel resident with an ABI with their application for “Accommodation Support and Alternative to Employment Funding”. In the short term, this hostel resident will be able to access DADAA (an alternative to work program) and, once an “Individual Needs Assessment” has been conducted to determine their level of funding, a service provider will be identified for their individual accommodation needs. As the Official Visitor put it: “Now there’s only another couple of hundred to go”.

Council’s interest in accessing DSC funding is aimed at finding more support for such residents, both financially and in terms of access to more relevant programs and housing (given the issues identified about lack of programs for hostel residents, many of whom have significant cognitive impairment). However the DSC has both strict criteria for acceptance as a DSC client and limited funding.

*Action and outcome*

Apart from dealing with individual cases as they arose, Council wrote to both the MHC and DSC about the issues. It was suggested to the MHC that they should find out how many hostel residents were already DSC clients or who might be eligible.
The MHC has said they would consider Council’s suggestion. Council continues to press the MHC to do more for hostel residents in this category.

The Director General of DSC and the Minister for Mental Health attended a meeting with Head of Council and there are ongoing discussions regarding Official Visitor access to LACs so that Official Visitors may advocate better for hostel residents.

**Illustration 5 - Elderly hostel residents**

Council has been raising concerns about the ageing population in hostels since the 2005-2006 Annual Report. It recommended then that Aged Care Assessment Team (ACAT) assessments be carried out for any hostel residents over 65 to ensure that they are getting the proper level of care and not being left languishing in psychiatric hostels which are not funded to be able to provide this level of care.

This year some hostel licensees obtained ACAT assessments for residents with the result that the resident was assessed as needing high level care. Getting an ACAT assessment done, however, does not necessarily mean improved care will follow. Most psychiatric hostels are not approved for elderly care funding and so the person either stays where they are, or has to move to an aged care facility. It is not always easy to find a suitable place in an aged care facility and there are difficulties trying to take advantage of the various Commonwealth funded programs which are designed to assist elderly people to stay in their homes – though Council argues that for many hostel residents, the hostel has been their home for 10 and sometimes 20 years.

**Case 1 – Resident moved from one hostel to another**

The resident was simply moved from one private psychiatric hostel to another. The resident told the Official Visitor they felt they were given no choice about the move and believed it was because they had suffered some falls. The Official Visitor sighted the resident’s ACAT assessment confirming that they were eligible for permanent residential care at a high level.

**Case 2 – Resident bounced back and forth between hostel and aged care facility**

The hostel resident was transferred to an aged care facility by the hostel licensee and then transferred back to the hostel almost immediately because there was no ACAT assessment. On arrival by ambulance at the hostel, staff refused to allow the former resident to be removed from the ambulance trolley so the resident was carted back to the aged care facility. There was a dispute between the licensee and the aged care facility as to whether an ACAT was requested.

**Action and outcome**

Council continues to raise the broader systemic issues with the MHC.

In relation to the second case noted above, Council wrote to the licensee of the hostel, MHC, LARU and the Chief Psychiatrist. The licensee and LARU responded. LARU noted that it investigates only complaints specifically related to their Standards (highlighting the gaps in oversight of the sector). However they had requested a statement about the case from the hostel licensee. LARU then reviewed the matter and noted that the hostel licensee would be contacting the aged care facility to “determine strategies to prevent reoccurrence” of the issue.

The licensee said it was an “oversight” by themselves, the CMHS, and the aged care facility. The licensee said this hostel like the other private hostels was “desperately in need of psychiatric and adequate case worker support” which would have alleviated this situation.
**Illustration 6 - Residents “stuck” in hostels**

Official Visitors are often told by residents that they do not like living at a particular hostel but have nowhere else to go. Such residents are likely to have some cognitive impairment, are being treated by a GP rather than the local CMHS and so cannot access any social worker assistance. They may not have any family members or a guardian who is interested enough to assist them. Trying to access and negotiate the various hostel referral pathways can be very difficult in such cases where most referrals are made through the CMHS and require a lot of medical background information.

The case below illustrates the difficulties (and the value of an advocate).

**Case 1 – Good news story - success helping a resident move hostels**

An application for a regional consumer to move into an NGO-run hostel in the metropolitan area had been started by a regional CMHS some months earlier. Before it was completed, the consumer was admitted to a metropolitan hospital. The consumer was then discharged into a large hostel in the metropolitan area (not the hostel which was the subject of the original application). They were very unhappy at the hostel and asked the Official Visitor to help them reactivate the original application to the hostel of their choice. The Official Visitor contacted the regional CMHS but was told that they could not help because the consumer was not in their area any more. As the consumer was not being case managed by the local CMHS in the metropolitan area either, they would have to make their own application.

The Official Visitor helped the consumer draft up the application. Eventually the Official Visitor also managed to persuade the local CMHS to track down some of the necessary medical information. This process took many weeks and many phone calls.

The Official Visitor also assisted the consumer in making a Centrelink application for work (which involved more assessments and supply of medical information which had to be tracked down). When the consumer told a staff member at the hostel that they were hoping to get a job, the staff member said that this was good because it meant they could charge the consumer more and that the cheap cigarettes and pharmaceuticals they provided the consumer would also cost more.

The consumer became very frustrated at this point in the process as there seemed to be hurdle after hurdle to overcome, both in getting a job and finding alternative accommodation. The consumer expressed that there was no point in working if the hostel was going to take all the money anyway. They commented that they would be better off making an attempt on their life and going to hospital as a means to save money. The consumer also expressed frustration that they had not been able to do a reading course and complained of being bored and uninvolved and needing interaction with other people.

Eventually the application was able to be submitted but by this time the vacancy at the hostel where the consumer had hoped to live had been taken. There was a vacancy at another hostel but it had a 1 year maximum stay time limit and required the consumer to be more independent. More information had to be collected and the consumer had to decide if the new hostel would suit them but they did move into the hostel and have been happy with the move.

Council has also written to the MHC asking if they can provide any assistance or support for these cases or whether it has any other suggestions on how Official Visitors might assist hostel residents who want to move. No suggestions have been made in meetings with the MHC about this issue as at 30 June 2012.
ISSUE 6: FORENSIC ISSUES

Forensic mental health issues relate to people who are put on a Custody Order or prisoners made involuntary and treated in the Frankland Centre.

Illustration 1 - Lack of procedural fairness or natural justice for Custody Order patients and lack of a declared place

People who have been found not guilty of a crime by reason of unsound mind or because they were not fit to stand trial because of their mental illness are usually put on a Custody Order by the Court. There is no expiry date or set term of the Custody Order and it may last many more years than the sentence for the crime and even for “life”. The Mentally Impaired Accused Review Board (MIARB) reviews the terms of the Custody Order at least annually and makes recommendations to the Governor on where the person must reside. The only options are prison, the Frankland Centre which is a maximum secured forensic hospital, a ward at Graylands Hospital, or in the community, but usually on strict conditions. Official Visitors may respond to requests for help from those people on a Custody Order who are admitted to the Frankland Centre or Graylands Hospital.

The number of people on Custody Orders who Official Visitors can help is small but there are two major concerns:

1. the lack of transparency, natural justice and procedural fairness in the review process
2. the lack of a declared place (as provided for in the legislation) where people on a Custody Order with a mental illness can be sent as an alternative to prison or a hospital ward.

In relation to the first issue, Official Visitors have prepared written submissions to, and liaised with, MIARB for consumers on a Custody Order at the time of their review by MIARB. However MIARB’s review deliberations are closed and there is no right of personal appearance or legal representation (other than by written submission). MIARB does not have to give written reasons for their decisions unlike other tribunal bodies.

Even when MIARB recommends release into the community, its decision can be rejected by the Governor and no reasons are required to be given. It has been Council’s experience that the Attorney General’s office sometimes goes back to MIARB asking for further information before eventually agreeing to pass the recommendation on to the Governor for decision. The difficulty for the Custody Order patient is that this can take many months and even years in the process and they are given little or no information in the meantime. They usually know that MIARB has recommended conditional release but do not know why there are delays or about the process back and forth between the Attorney General’s office and the MIARB, nor why a year or more later they are still awaiting release.

Apart from the immense frustration for the Custody Order person who has been declared mentally well but who has to stay living in a hospital, it means they are taking up scarce forensic hospital beds. Leaving the decision at the Governor’s discretion is also arguably inconsistent with Principle 17(1) of the “Principles for the Protection of Persons with Mental Illness & the Improvement of Mental Health Care” adopted by the UN General Assembly in 1991. The Criminal Law (Mentally Impaired Accused) Act 1996 (the CLMIA Act) needs to be amended.

20 It provides: “The review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. It shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account.”
**Action and outcome**

Council continues to raise these issues with relevant parties including the Minister for Mental Health and the MIARB President. A review of the Criminal Law (Mentally Impaired Accused) Act 1996 (CLMIA Act) was carried out in 2003 resulting in a number of recommendations but as at 30 June 2012 there appeared to be no impetus for implementing the recommendations. The recommendations included removing the role of the Governor.

In relation to a declared place, the DSC has announced that it intends to establish 2 facilities as declared places under the CLMIA Act. It is intended that Council or its successor under the draft Mental Health Bill will be involved in an inspection and advocacy role at the facilities. The facilities will be designed and funded, however, for people who were put on the Custody Order as a result of their intellectual impairment rather than a mental illness. There are currently only 2 options for these people – prison or the community.

**Illustration 2 – Lack of forensic beds and a step-down or community facility**

Council is aware that the State’s only secure forensic hospital, the Frankland Centre, usually has a long waiting list of people in prison who need a bed in the hospital. At times there have been up to 12 prisoners on the waiting lists. There are clearly risks in leaving seriously mentally unwell patients in prison for too long and it means the acuity on the wards is raised substantially when they eventually get a bed.

Council has been contacted by parents of prisoners and prison staff asking if we can help the many prisoners suffering from a mental illness but Council has no jurisdiction in prisons. They are referred to the Office of the Inspector of Custodial Services (OICS).

Official Visitors are also aware how difficult it is for consumers with a criminal history to find appropriate accommodation in the community or even at a less secure hospital than Frankland. It can hold up their discharge thereby using up scarce forensic hospital beds. A significant number of patients would benefit from the provision of transitional step-down arrangements that provide intermediate levels of care on consumers’ journeys towards recovery and independent living in the community.

**Action and outcome**

Again Council continues to raise the issues at various levels along with other DOH staff and interested parties. We are aware that the MHC has provided funding for a Forensic Community Accommodation Feasibility Study led by the Director of the State Forensic Mental Health Service. The Deputy Head of Council is a member of the Project Working Party at the invitation of the Director.

Council has also met with the Aboriginal Visitors Scheme with a view to sharing information and expertise and maintains contact with the Inspector of Custodial Services. The OICS is an independent body responsible for the inspection of prisons. They have repeatedly raised the issue of the need for priority attention to be afforded to mental health service provision for prisoners and detainees.

**Illustration 3 – Lack of forensic mental health beds for young people**

Two young people under the age of 18 were admitted to the Frankland Centre this year because there was nowhere else for them to go. See also Issue 7, Illustrations 1 and 2 about children on adult wards and young people on supervised bail orders.
ISSUE 7: CHILDREN AND YOUNG PEOPLE

Council’s involvement with children and young people is limited to those young people (aged up to 18) who are involuntarily detained at the Bentley Adolescent Unit (BAU) or on an adult ward. This year Official Visitors assisted 36 young people (compared with 34 last year and 26 the year before). This remains a low percentage of the overall number of patients who were involuntary in the BAU (127).

Table 2: No. of patients discharged from the BAU in 2010–2011 and 2011–2012

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Involuntary</td>
<td>Voluntary</td>
</tr>
<tr>
<td>9</td>
<td>&lt;5</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>13</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>14</td>
<td>12</td>
<td>&lt;5</td>
</tr>
<tr>
<td>15</td>
<td>24</td>
<td>17</td>
</tr>
<tr>
<td>16</td>
<td>36</td>
<td>73</td>
</tr>
<tr>
<td>17</td>
<td>46</td>
<td>83</td>
</tr>
</tbody>
</table>

As reported last year, the BAU is being upgraded which is a significant “good news story”. While it has meant some inconvenience for patients (and staff), Official Visitors have reported positive comments from both about the changes. Council has also been kept up to date with a regular “BAU Redevelopment” newsletter. It is hoped the redevelopment will be completed by the end of this year.

Council was told that throughout the renovations staff managed to keep all beds open which is also a “good news story”. Council has been advised that “occupancy” also “improved” since November 2011 because there is now central bed co-ordination between Princess Margaret Hospital (PMH) and the BAU. Procedures have also been put into place which allow for options other than hospitalisation to be explored, particularly in relation to young people in EDs.

Illustration 1 – Children on adult wards

Council is aware that young people living in rural and regional areas are sometimes treated on adult wards (both general and mental health wards) as the only alternative is to wait for a bed and transport to the BAU. Across the State there were 32 young people (under the age of 18) discharged from adult mental health wards in 2011-2012. There were also 921 young people discharged from general adult wards who had a primary diagnosis of a mental illness or intentional self-harm in 2011-2012. These figures do not include young people discharged from a child and adolescent facility (BAU accepts young people under the age of 18 and PMH accepts young people under the age of 16) who may have spent time on an adult ward or those assessed in EDs.

21 Source: Hospital Morbidity Data System, DOH. Number of separations from the BAU by age on admission and legal status for the inpatient episode. This is preliminary data. Involuntary inpatient status is understood to mean a patient was involuntary at any time during the “episode” however at time of publication this was being confirmed by DOH. Where the cell count is less than 5 patients the data are considered to be too identifiable therefore the actual number is not provided.

22 Source: Hospital Morbidity Data System, DOH. The number of mental health patients under 18 years old on admission who separated from an adult ward in 2011-2012. This excludes separations from PMH and BAU wards. Individuals may have been ‘separated’ on multiple occasions from adult wards during the year but will only be counted once. The main reason these young people were being treated in hospital was due to a diagnosis of mental illness or intentional self-harm (ie their primary diagnosis).
The “good news” is that “Guidelines for the Management of under 18 year olds in non CAMHS emergency and inpatient settings” have been endorsed at a statewide level. Last year Council questioned the number of young people under 18 years being treated on adult mental health wards and whether there was a DOH policy which resulted in a working party being established to determine the actual numbers being admitted to adult mental health units and to identify best practice where a young person under 18 has to be cared for on an adult ward. An Official Visitor from a regional area took part on the working party.

Illustration 2 – “Supervised bail orders” and forensic mental health issues for children and young people

As has been reported by Council since 2008-2009, there are concerns about the lack of a suitable facility for unwell young people on supervised bail orders on remand from Rangeview and those in prison at Banksia Hill. Young people on bail orders are being sent to the BAU which raises a number of safety and risk issues for other consumers on the ward. Those in Banksia Hill have nowhere to go as the BAU will not accept sentenced prisoners even if they are under 18 years of age.

Two young people (from Rangeview and Banksia Hill) under the age of 18 were also admitted this year to the Frankland Centre which is a maximum secured adult forensic mental health facility. Official Visitors offered support to the consumers.

CAMHS has advised Council that there are fewer young people being admitted from Rangeview on supervised bail orders with only 2 admitted in the period 1 January to 30 June 2012. In the previous six months there were 9 young people admitted to the BAU on supervised bail orders making a total of 11 for the year. This is possibly because there is an increased presence of mental health staff at Rangeview. CAMHS also now conducts a risk assessment prior to any new patient coming onto the ward. Previous year’s figures from 2008 to 2011 (January to December) were, respectively, 7, 8, 14 and 12 placements23.

The issue of the bail order creating conditions which are basically unenforceable by nurses remains. Bail order children are also unable to access an Official Visitor unless and until they are made involuntary under the Act.

Action and outcome

Council continues to maintain a watching brief on this issue.

Illustration 3 – Good news story – agencies working together

An Official Visitor and staff from the BAU, CAMHS, King Edward Memorial Hospital (KEMH) Social Work Department and Mother and Baby Unit, the MHC’s “100 Houses program”, the Hill’s Community Support group and the Department of Child Protection (DCP) worked closely together to assist and support a young pregnant consumer at the BAU. After being discharged the consumer went to a facility run by the Hill’s Community Support group then to the KEMH to have the baby. Following the birth she was transferred from the maternity ward to the specialist mental health “Mother and Baby” Unit at KEMH before returning to the Hill’s facility for more parenting support and finally moving into one of the MHC’s 100 Houses with a support package through Perth Home Care Services. As a result the consumer and her child were able to stay together in a safe and supported environment.

23 Placement is different to the number of children. For example, one child had 3 placements in the BAU in 2010.
ISSUE 8: ENVIRONMENTAL CONDITIONS

Official Visitors are required under the Act to ensure that places where consumers are detained, cared for, or treated under the Act are “kept in a condition that is safe and otherwise suitable”. To this end an environmental audit of all authorised hospitals and licensed psychiatric hostels is conducted annually in May and June 2012 as part of the monthly visits.

The audit is conducted by Official Visitors making observations using a checklist and speaking to consumers. They approach the audit by considering what a reasonable person would consider to be acceptable conditions in terms of “safety and suitability”. Official Visitors are not qualified as building inspectors and the reports are not aimed at determining, for example, whether a facility is structurally safe and sound, although obvious safety hazards will be raised.

As to “suitability”, the role and impact of the environment on the recovery of a person with a mental illness is taken into account, along with the fact that people are being detained against their will for weeks, months and even years on the hospital wards, and that the hostels are people’s homes.

A letter and copy of the checklist, which notes any issues of concern, is forwarded to each facility. Council has received very positive feedback on the way the audit is conducted from some hospitals. As one senior manager said:

“We are allies in creating better places, standards and conditions for mental health consumers”.

Bentley Hospital management also advised that they had decided to launch their own patient safety and environment audit. This takes the form of a weekly executive team “walk around” focussing on one patient area weekly. Conducted from the patient safety aspects, managers engage staff in discussion based on their opinions and experience as a means to improving ward environment. They said this had led to some immediate changes and, where issues required external funding or attention, they would be compiling risk assessments and business cases.

HOSTELS

Last year the Annual Report listed a summary of the condition of each hostel, although the hostels were de-identified. Concerns were raised about the living conditions of residents in 15 of the 36 hostels inspected. This year the number is about the same with 16 of the 41 hostels inspected raising issues of concern. Often the issue is about cleanliness, but lack of routine maintenance is also evident in some facilities. Some of the newer facilities are also starting to show wear and tear requiring maintenance.

Many of the hostels raising concerns for Council are the same hostels as last year but some have improved. In one case there has been a vast improvement because of Official Visitors working with the licensee throughout the year. In some cases the licensee has responded to this year’s audit advising that the issues have been rectified or are scheduled to be rectified. In other cases Official Visitors will continue to discuss the issues with the licensees.

Copies of the detailed report for every hostel have also been sent to the MHC which funds the hostels, and LARU as the licensing body.
The sorts of concerns raised in some of the worst hostels include the following:

- All carpets require cleaning as they are dirty and heavily stained. One carpet in particular has more staining than the original carpet colour. All walls are stained and marked and require immediate cleaning and painting. Many light fittings throughout the facility did not have light globes in them. Some fire alarms appear broken and require immediate repair or replacement for safety reasons. The lounge suite in one unit has two missing legs and is balanced on phone books, while a sofa in another unit has tears and also needs replacing. In the bedrooms sheets do not appear to fit the beds properly, pillows need replacing and lockable storage is needed, particularly in shared bedrooms.

- Garden areas require attention due to safety concerns. These include an old unstable bench surrounded by concrete, rubble, an old tree that needs to be removed, and concrete work which is in poor repair with metal reinforcing poking through. Bathroom exhaust fans are dirty. In the hallway of one unit, there is rising damp on the walls and ceiling. There is a strong smell of urine/decay and evidence of rodent faeces in the roof cavity of one unit.

- In all units the shower/toilet tap fittings are leaking and require repair or replacement. Water run-off from the showers is not contained within the shower area: the fitting of hobs or beading is required to ensure bathroom floors remain free of excess water. The vinyl flooring in two units is lifting in some areas.

- A number of walls and ceilings throughout the facility require painting due to cracks and peeling paintwork. All linoleum floor coverings are stained and/or cracked and lifting in some rooms. The ceiling is sagging in the main living area. Some residents do not have lockable storage cupboards. The lighting and power socket to the outdoor gazebo do not appear to be weather proof. Outdoor furniture is old and weathered.

- In the bedrooms, there are no shades over ceiling lights; paintwork is shabby and dirty; most rooms smell musty or foul due to an accumulation of odours and poor ventilation; and many wardrobes and bedside tables are broken and dilapidated. Bathrooms require thorough cleaning as toilet pedestals are grimy and unclean; taps are grubby and dirty; and exhaust fans and light fittings are dusty. The lounge room has an inadequate number of armchairs. In the patio area there is an unpleasant dirty flycatcher; furniture consists of concrete blocks; and a BBQ for residents is placed and used adjacent to rubbish bins.

- Several bedrooms need cleaning and floors were scuffed and dirty. Some bed frames require attention and some mattresses need to be replaced. Two bathrooms do not have windows and the extractor fans do not appear to be performing well resulting in poor ventilation. There is water damage on a wall adjacent to one of the bathrooms.

- Floors throughout the home required mopping and/or vacuuming. In the kitchen the oven, microwave and windows are all in need of cleaning. In the bathroom the grout and exhaust fan also require cleaning. There is water damage to the hallway ceiling adjacent to the laundry.

HOSPITALS

Below is a summary of the environmental audits carried out in every authorised hospital ward in Western Australia. Copies of the audit checklist and a letter which reflects the summary were sent to the management of each facility as well as the MHC.
Below is a summary of the environmental audits carried out in every authorised hospital ward in Western Australia. Copies of the audit checklist and a letter which reflects the summary were sent to the management of each facility as well as the MHC.

Some wards have clearly improved since last year while others have remained about the same or slightly improved and a couple of wards have deteriorated. In June 2010 the MHC announced that it had allocated an extra $1.37m to the DOH to undertake minor works on mental health facilities in Western Australia that had been identified in Council’s 2009-2010 Annual Report as requiring repair or improvement. The repairs and refurbishments were linked to issues identified in the Annual Report. As a result there has been a refurbishment of the bathrooms at Fremantle Hospital, minor works at Bentley Hospital and a major renovation to the BAU, which at 30 June 2012 was still underway.

There continue to be issues with either lack of access to outdoor areas and/or poor garden maintenance. Gardens are an under-utilised therapeutic tool which can allow a person who has been “locked up” for weeks with a dozen or so strangers who are also unwell, to sit in the sun and get away from the noise and stress of the ward. A number of the older locked wards have 12 to 16 patients plus staff with very little space for patients to get away from each other.

Official Visitors will continue to raise the issues with hospital staff. The wear and tear on authorised wards is very high so regular maintenance and upgrading of furniture is required in order to keep the wards in a habitable condition which is conducive to recovery. A number of hospitals have replied advising that matters have been or will be rectified or that they will be applying for funding to carry out the work.

**Albany Hospital, G Ward**

Floor coverings are in a poor state, most furnishings look tired, incongruous and aesthetically bland and almost all windows require cleaning. Outside, the garden area has declined compared to last year’s environmental audit. There is a pervasive smell and visual pollution from cigarette butts. Improvements to the ward include clothes storage and the popular addition of white boards to patients’ rooms which are often used as a means of self-expression. General cleanliness, tidiness and safety of patient’s rooms and common interior recreation areas was excellent.

**Armadale Hospital, Leschen Unit**

HDU – Two bathrooms do not have toilet roll holders or towel hooks, one shower head is calcified and a label is missing on 1 hot water tap. Furniture in the lounge, dining and visitor rooms requires cleaning. A water fountain in the lounge area requires cleaning. A number of seats in the dining area are missing cushions. In the visitors’ room the pathology chair arm rest is ripped and there are marks and cracks in the paintwork. Mould was observed under the eaves in the courtyard.

Open ward – The paintwork in a number of bedrooms and ensuites is chipped or cracked, 2 toilet roll holders are missing and curtains in 2 bedrooms require rehanging. In the lounge a cupboard door requires repair and the water cooler needs cleaning. Some of the chairs in both the lounge and interview rooms are stained. Some paving in the courtyard is uneven in places and may present a trip hazard.

Karri ward – The ward appeared clean, neat and welcoming. However the quality of window treatments was inadequate allowing a lot of light into the rooms. There were no bedside tables or lamps in the bedrooms. The absence of shower curtains in bathrooms results in both a lack of privacy and excess water on the bathroom floor, which presents a slip hazard. There are no shelves or storage in the bathrooms to place toiletry items and clothes.

---

24 Council understands the G ward at Albany Hospital is to be replaced as part of the new hospital development.
Banksia ward – With the exception of some chipping and marks on the walls from beds and paint peeling on door frames the bedrooms and bathrooms were considered to be of a good standard. The use of heavy fireproof bedcovers is not considered practical for frail patients who cannot move under the covers. Seating in the lounge room needs to be upgraded as the individual disability chairs are uncomfortable and institutional.

**Bentley Adolescent Unit**

The BAU was undergoing major refurbishment at the time of the audit so the issues raised in the audit were temporary (see Issue 7). Patients complained about the hardness of the mattresses.

**Bentley Hospital - Mills Street Centre**

Ward 6 – Air vents throughout the ward need cleaning. None of the bedrooms have lockable storage and privacy from the doorway is limited. Patients complain that the beds are uncomfortable and some place the mattresses on the floor for sleeping. The showers require curtains for privacy. Although some furniture on the ward has been replaced, furniture in the lounge areas, visitors’ room and foyer is worn and grubby.

Ward 7 – Bathrooms are in a state of disrepair with many broken fittings. Shower curtains are required for privacy. There is no lockable storage in bedrooms. The furniture in the family area is old and grubby and board games and magazines need to be replaced. Vents throughout the ward require urgent cleaning.

Ward 8 – All air vents, window treatments and light fittings need cleaning. Repairs are required to some bathrooms, for example, a toilet seat is missing; there is a broken tile in 1 shower; 1 door lock does not work properly and there is mould on the ceiling. All chairs in communal areas need to be thoroughly cleaned or replaced. In the outdoor areas a wooden bench seat needs repairing and there is a tree stump in the lawn area which may constitute a trip hazard.

Ward 10 - Recent painting, refurbishment of bathrooms and new lounge furniture have made the ward more welcoming and pleasant. Bedside drawers in 2 rooms have missing draws.

**Bunbury Hospital, Acute Psychiatric Unit and Psychiatric Intensive Care Unit**

PICU - The overall standard of the unit has declined since the 2011 environmental audit. Paintwork throughout the ward is dull and marked. Damage to walls has either not been attended to or has been inadequately repaired. Dining room furniture is badly marked, spartan, and barely functional and does not facilitate a pleasant eating experience.

APU – Climate control remains problematic: some areas overheat while others are cold. Tiles in wet areas are showing wear and are difficult to keep clean. Vinyl furniture in the patient lounge is cracked and requires replacement.

**Frankland Centre**

Paintwork on various walls is peeling. A number of bedrooms show signs of water damage that has leaked through from ensuites. Ceiling vents in many of the ensuites are rusty and there are no toilet paper holders. Bedroom windows are stained from either bore water or some other agent which prevents patients seeing the outside grounds through the windows.

---

25 Council’s position is that all consumers should have access to a lockable storage cupboard for their personal possessions as they may be in hospital for a month and often much longer and, unlike many other hospital patients, are not confined to bed.

26 Council’s position is that all consumers should have access to a lockable storage cupboard for their personal possessions as they may be in hospital for a month and often much longer and, unlike many other hospital patients, are not confined to bed.
Fremantle Hospital, Alma Street Centre

Ward 4.1 – The dining room, corridors and lounge areas require a thorough clean and furniture in these areas is in a poor condition. The water cooler is also in need of a clean. Shared toilets and showers including vents and light fittings require a thorough clean. Furniture in the northern end courtyard consists of old indoor furniture which needs to be replaced with appropriate outdoor furniture.

Ward 4.2 – The overall standard of bedrooms and bathrooms was good, paintwork was fresh and floors were clean. Carpet near the door to the courtyard is filthy and needs to be removed or replaced. The ward lacks a comfortable lounge area. Relaxing lounge chairs, clean floors and better accessibility to the book shelves would improve the larger TV room. New outdoor furniture for the courtyard is required as it currently consists of old waiting room and dining room chairs and a couple of wooden benches.

Ward 4.3 – Paintwork in some bedrooms is chipped or damaged due to raising and lowering of bed frames. Curtains clips are either missing or incorrectly fitted resulting in difficulty opening and closing the curtains.

Ward 5.1 – A number of bedrooms had dirty air vents and hooks missing from curtains. Ventilation and air-conditioning on the ward is a concern. The temperature in bedrooms varied greatly between warm and cold with some bedrooms totally lacking ventilation. In the program area the chairs appear stained and worn and carpet tiles are lifting.

Graylands Hospital

Casson ward – One bedroom did not have any window treatments and in another the night light was faulty. One ensuite bathroom has tiles missing from the floor of the shower and in another the exhaust fan is faulty. The carpet in the recovery room requires cleaning.

Dorrington ward – Five bedrooms had missing window blinds creating a privacy issue. This is an ongoing issue on this female-only ward. The water pressure in the drink fountain was low. Courtyard access for patients is severely restricted by a gated enclosure under the patio area of the building.

Ellis ward – One ensuite bathroom has mould on the wall above basin and a rusty ceiling vent. The dining room has marks on the walls and the entry door needs painting. In the laundry there are signs of slight water damage from leaks on the ceiling and around the flue. In the courtyard several columns are dirty and require either cleaning or painting.

Hutchinson ward – In the bedrooms a number of window treatments need repairing; bedside cabinets require upgrading; the amount of personal storage space is considered inadequate; and the plastic chairs in some rooms have cigarette burns. Bathrooms require maintenance as walls need painting; some soap dispensers and fittings are missing; some doors are water damaged; and taps need to be replaced as current ones are potential ligature points. The stair wells need painting and graffiti needs to be removed. In the downstairs lounge 2 curtains need replacing and 1 is missing. In the upstairs lounge 1 wall needs patching and the curtains are old and dirty.

Montgomery ward – Many of the bedroom floors are damaged by cigarette burns. Not all consumers have keys to the lockers in their bedrooms. Walls throughout the ward, particularly in the bedrooms, need patching and painting. Soap dispensers were missing or damaged in a number of bathrooms. In the activity room furniture needs replacing. Furniture in the courtyard needs updating.

Murchison ward – Window treatments in some bedrooms need to be repaired or replaced. Both shared and ensuite bathrooms require attention as taps can be used as ligature points; some taps were leaking; 1 toilet does not flush; some shower heads need replacing; and some have signs of damage and mould.
On the “good news” front, Murchison has at last got an automatic door enabling disabled consumers easier access. Council has been arguing for this for some years as there are a number of people with physical disabilities on this ward.

Pinch ward – In 1 ensuite bathroom the hot water tap could not be turned on; the thermostatic mixing box appears to be rusted and may be leaking. Lounge chairs in 1 of the visitors’ rooms appear worn.

Plaistowe ward – Bedrooms, doors, door frames and other areas throughout the ward require painting. Wardrobes and bedside cabinets are generally in a poor condition. There is insufficient storage space; half of a wardrobe is not enough for long term consumers.

Smith ward – Storage cabinets in most rooms were either damaged, had missing shelves or were unlockable27. Light fittings in 2 bedrooms required cleaning as they contained dead insects. In 1 shared bathroom 2 shower heads are placed low and close to the wall making them ineffective and there is no privacy curtains for the showers. The other shared bathroom is generally in poor condition and has a strong offensive odour. The night lounge only has 11 chairs which is inadequate and the ventilation outlets are worn and in need of replacement. A water fountain in this room has a strong jet and there are signs of water spills between the fountain and the window behind it. The seclusion room also has a strong odour.

Joondalup Hospital, Mental Health Unit

Secure ward – Storage cabinets in some rooms lacked shelving and were not lockable, while other rooms had new 2 compartment cupboards with shelves. Showers in ensuite bathrooms have a continuing problem of inadequate hot water. The water in 1 bathroom does not drain away. In the lounge room, chair coverings are ripped and carpet needs replacing.

Open ward – Paintwork in most bedrooms is in a poor condition with numerous chips and peeling. There is water damage to 2 bedroom/ensuite walls. There is only 1 towel hanger in most shared en-suite bathrooms. Shower heads in 2 bathrooms were clogged and need replacing. Lounge and dining areas appear in a good condition.

Kalgoorlie Hospital, A Ward

Carpets throughout the ward appear worn and stained. Ensuite bathrooms require maintenance and repair: a number of toilet seats are missing; shower heads are corroded; and shower curtains cause water to pool on the tiles in front of toilets causing a slip hazard.

King Edward Memorial Hospital, Mother and Baby Unit

This facility is specific in design and operation and is of a high standard.

Mercy Hospital, Ursula Frayne Unit (older adult)

Overall the ward appeared clean and inviting, however, walls throughout the ward required patching or painting. It was noted that red light switches in ensuite bathrooms were more suggestive of a panic button than a light switch. Water damage was noted in a number of bathrooms.

Rockingham Hospital Mental Health Inpatient Unit, Mimidi Park

Open ward – Furniture in the activity and dining rooms is stained and requires cleaning. The viewing windows within bedroom doors can swing open and injure patients when the door is being used.

Secure ward – The viewing windows within bedroom doors can swing open and injure patients when the door is being used. In the dining room the walls are chipped; paint is peeling; and a sealing strip between floor panels is missing.

27 Council’s position is that all consumers should have access to a lockable storage cupboard for their personal possessions as they may be in hospital for a month and often much longer and, unlike many other hospital patients, are not confined to bed.
Elderly ward – This ward has recently opened and as such there are no current major environmental issues. However it was noted during the visit that elderly patients were unable to bathe as the bath hoist was not functional. The battery pack that powers the hoist was missing and a replacement was pending.

**Selby Older Adult Mental Health Service**

Many bedrooms, doors and door frames throughout the building require painting. In all wards except for Red Wing, wardrobes and desks are in a poor condition. Two bathroom heaters are not working. In the courtyards fascias and pergolas require painting as bare timber is showing.

**Swan District Hospital**

Swan Valley Centre open and secure wards – The paintwork in most rooms appeared to be in a good condition. A number of bathroom vents are rusted. Chairs in the open ward lounge are showing signs of wear and tear.

Boronia unit (elderly) – A number of bedroom walls have chips to the paintwork. Large lights in both Wattle and Eucalypt lounge areas were not working. Two wall heaters in the shared bathrooms are not working and in need of repair. Some shower curtains are missing.

**ISSUE 9: SMOKING BAN**

The issue of seriously unwell people detained against their will on wards not being able to smoke continues as a major source of complaints made to Official Visitors by consumers, their families and staff working in mental health hospitals.28 There were 58 specific complaints made to Official Visitors but Official Visitors say that the issue is raised with them by many more consumers and almost every time they visit a locked mental health ward. They do not record it as a complaint because there is no action that can be taken in most cases. Council’s office staff also receive calls from consumers, their families and staff complaining about the situation. See also the comments above in Issue 2 about the stress it puts unwell patients under when they arrive after already spending some time in the ED.

**Case 1 – Family hid cigarettes in a tree**

The family of a consumer contacted Council and described how their family member had begged them for cigarettes. In the end the family agreed to hide the cigarettes in a tree so the consumer could find them when on ground access from the locked ward. As the family member said: “Cigarettes are not illegal... how ludicrous is this ... how demeaning for patients and their families”.

**Case 2 – Plants removed because patients hiding in them to smoke**

Official Visitors were told that the plants in the courtyard of a ward were removed and replaced with grassed areas because patients were hiding in the bushes and smoking. Apart from the added expense, the courtyard was out of bounds for consumers for 3 days.

**Case 3 – Letter from a locked ward consumer**

A letter from a locked ward patient: “....the patients here are already mentally unstable and find it hard to cope with everyday life especially when locked up like animals without stress relief such as cigarettes. The cigarettes help with calming the brain from overloading. As well as no cigarettes there are no sugar drinks sold in the cold drink machine....”. It is the case that consumers’ food intake is also regulated on many wards to enforce healthy eating. This can add to the discomfort and despair felt by consumers being detained in locked wards and not allowed to smoke.

---

28 See Appendix 11.
**Cases 4 and 5 – Letters from consumers to the Minister for Mental Health**

Two consumers sent letters to the Minister for Mental Health via Council which were passed on to the Minister. In 1 of the letters the consumer proposed a strict quota of cigarettes each day to at least provide some relief.

The other consumer wrote: “…I would like to know if we would be allowed to smoke again in the hospital because I get even sicker if I don’t smoke and a lot of other people would be happy if you let it back in ……Could you please, please let us smoke back in here again…”.  

The Minister replied separately to both consumers noting that she was exploring options that could “respond to the unique circumstances of involuntary mental health patients by providing a practical and balanced approach regarding the smoking of tobacco products”. The options included a partial exemption to allow for involuntary mental health inpatients to access designated smoking areas. The Minister said that whilst she anticipated that it might take some time to work though the necessary issues, she remained committed to pursuing this initiative.

Council was also involved in a working group for the purpose of developing a submission for Cabinet to establish designated smoking areas and, as at 30 June 2012 was awaiting the outcome of Cabinet’s deliberations.

**ISSUE 10: OTHER ISSUES**

**Illustration 1 – Monthly and bimonthly inspection visits**

Official Visitors are required to inspect authorised hospital wards monthly and hostels bimonthly. Inspections usually include questions for relevant staff and any consumers who are happy to talk to Official Visitors based on particular “focus areas” – not a survey as such, but part of the process of ensuring rights are observed and that the facilities are “safe and suitable”. Benefits of the focus area process include:

- helping Official Visitors to identify issues (individual and systemic) that may otherwise have been missed - any issues identified are followed up in subsequent visits through an Action List system, alternatively in meetings between Head of Council and management. Serious issues may result in letters to relevant parties
- helping Official Visitors to understand facilities better and to build relationships with staff so that they can be more effective advocates for consumers. For example, the question process can give rise to discussions with staff to sometimes inspire them to make suggestions to management and/or change their thinking
- opening up opportunities for engagement with consumers – this often leads to consumers raising issues about other things but it starts the conversation
- ensuring that Official Visitors have a good understanding of all aspects of the issues so that they can better advocate for consumers
- allowing feedback (negative and positive) to the services so they can improve
- allowing comparison across hospitals and health services and from year to year particularly in areas which Council knows are an issue.
Issues arising out of some of the focus areas have been highlighted earlier in this Report. The focus areas for 2011-2012 were:

- July – Quality of life issues – food and beverages
- August – Allied health care / services
- September – Administering medication
- October – Management / Care plans (see Issue 1)
- November – Night Visits
- December – Community mental health issues (including visits to some CMHS)
- January – Psychiatric and psychological services
- February – Consumer Rights – random audit of files (see Issue 1)
- March – Culture, gender and age bias
- April – Quality of life issues – rehabilitation and recovery activities (see illustration 3 below)
- May/June – Environmental audit (see Issue 8)
- June – Admission processes.

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

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

**Illustration 2 - Food issues**

Food is always an issue on hospital wards and in hostels. Lack of fresh fruit and access to coffee, and meals not complying with advertised menus is a common complaint by hostel residents.

In hospitals the main issues are the lack of variety and/or not getting as much food as they would like to eat or the type of food they want to eat, because they are being obliged to follow healthy eating guidelines.

Although all hospital patients are presumably on similar healthy diet choices, mental health consumers can be locked up for long periods of time on a ward. Some don’t have access to family or friends to bring in food or regular ground access which might allow them to visit a kiosk. Sometimes nursing staff will ask for more sandwiches, for example, but other times they won’t – it seems to be variable.

In the case of one hospital, Council received a petition from consumers for more condiments. A copy of the hospital guide to breakfast serve sizes accompanying the petition indicated that just 1 portion of margarine and 1 portion of spread should be served with 2 pieces of toast. The consumers complained that this was too little for 2 pieces of toast. They felt that their rights to make dietary choices were being
limited. The hospital took swift action to rectify the situation.

In one “good news story” the hospital arranged special serves of kangaroo meat for a long term indigenous patient after it was raised with them by the Official Visitor. In this case the consumer’s Case Manager took the consumer shopping to buy the ingredients and they cooked it together.

Illustration 3: Boredom on the wards

Consumer complaints about being bored have been reported by Council every year since the 1999-2000 Annual Report. Apart from the issues which emerged from the monthly visit, Official Visitors reported 30 complaints by consumers relating to occupational therapy (OT) including issues about activities, lack of exercise, no outings and boredom. It was interesting to note that when painting of an acute ward meant patients had to spend a few days in the gym or the garden, nursing staff reported that they halved the use of PRN (sedation) medication. Management of patients was easier than usual because staff ensured that every patient was kept active during the renovations.

The issues raised by consumers in this focus month included that:

1. the OT is too “juvenile” and not recovery focussed
2. the OT is too female oriented (Council passed on a petition by consumers at Graylands Hospital for a Men’s Shed and a consumer commented at another hospital: “OT is for girls – making cards and things like that”)
3. there are not enough OT or activities in general, particularly the sort of activities which will help consumers to re-engage with society and/or regain basic living skills
4. there is not enough to do on the weekend when the gym is closed and OT activities are not scheduled
5. broken facilities – e.g. table tennis tables with no balls or bats or broken pool tables
6. gardens which are locked off from consumers for much of the day or which are in poor condition with weeds and dry lawns and broken down outdoor furnishings.

Suggestions made to Official Visitors by staff and consumers to improve boredom on the ward included things like having more modern music (hip hop was one example given), mobile libraries, up to date magazines and magazines for men.

Staff from every hospital complained that lack of funding and staff for activities was a major issue and were strongly of the view that lack of activities affected the mood of consumers and the ward as a whole. Combined with the pressures of not being able to smoke and sometimes being on a ward with up to 15 other very unwell consumers, staff told Official Visitors that it meant there was more aggression on the ward and hence more PRN and seclusion being used.

Action and outcome

Council passed on consumer and staff comments about the issues in April 2012 to hospital management and continues to raise the issues and deal with individual complaints.
PART THREE
Ongoing issues raised in previous annual reports that still require remedy

Below is a year by year summarised list of issues which have been raised in previous Annual Reports and which remained unresolved in 2011-2012.

1998-1999 ANNUAL REPORT
1. Need to expand the definition of “affected person” in s175 of the Act so that Official Visitors can also advocate for voluntary consumers, referred persons and Hospital Order patients. It remains the case that Official Visitors cannot assist voluntary patients. The draft Mental Health Bill as released for public comment in December 2011 would address this issue (although there are likely to be financial restrictions on how many people in these categories will be able to be assisted).

2. Overcrowding in authorised hospitals with pressures on beds in all hospitals. See Issue 2 in this Annual Report.

3. Lack of system wide policies that have a direct impact on consumers. This continues. Terminology is also often different. Examples include different policies relating to mobile phone use, care/management and other “plans” and policies on MHRB reports. Council is also waiting for the implementation of standardised clinical documentation trialled in 2010-2011.

4. Other opinions process not providing truly independent opinions and related issues. See Issue 4 in this Annual Report.

5. Hostel issues including minimal health care and support services, need for review of the standards, lack of proper facilities and lack of privacy and security in bedrooms. See Issue 5 in this Annual Report.

1999-2000 ANNUAL REPORT
6. More respect and facilities needed for human relations and intimacy. This continues to be an issue. Official Visitors dealt with 101 complaints and requests for assistance relating to dignity and privacy issues. See appendix 11 in this Annual Report.

7. Boredom on the wards and lack of access to on site gyms, or to exercise equipment etc. See Issue 10 in this Annual Report and appendix 11 which notes 30 consumer complaints relating to this issue.
2002-2003 ANNUAL REPORT


9. Need to improve opportunities for socialisation for people with a long term illness. See Issue 5 in this Annual Report in relation to hostel residents and Issue 10 in relation to consumers’ boredom in hospital. Appendix 11 also records 30 complaints raised dealing with OT activities which would include issues like this.

2003-2004 ANNUAL REPORT

10. Ward environment and lack of maintenance. This has been raised in every report since then. See Issue 8 in this Annual Report.

11. Need for new initiatives in services for Aboriginal and Torres Strait Islander peoples. Council is aware of extra funding and some initiatives in the community. It remains the case however that many of the children assisted by Official Visitors in the BAU are Indigenous. Council is also aware of difficulties for Indigenous people accessing treatment in rural and regional areas as well as the trauma of being flown to and from Perth and remaining isolated from family while being treated in Perth. The opening of the new mental health unit in Broome in May 2012 is welcomed but as at 30 June 2012 it remained unauthorised and so unable to issue involuntary orders and some patients still have to be flown to Perth.

12. Issues with the MHRB process, in particular doctor non attendance and failure to provide medical reports in a timely manner or at all. See Issue 3 in this Annual Report.


14. Treatment of people with a mental illness in hospital EDs including delays and not being treated with dignity and respect. See Issue 2 in this Annual Report.

2004-2005 ANNUAL REPORT

15. Low levels of representation in MHRB hearings. The representation and support levels increased 6.9% this year to 33.2% which is welcome but 66.8% of consumers went into MHRB hearings in 2011-2012 without the support of an Official Visitor or MHLC lawyer. See Issue 3 in this Annual Report.

2005-2006 ANNUAL REPORT
17. Failure to comply with s157 of the Act requiring that a relative, guardian, friend or other person also be given an explanation of the consumer’s rights. See Issue 1, in this Annual Report.

18. Neglect of dental health, hygiene and physical care treatment. Although no illustrations are provided in this year’s Annual Report, Official Visitors dealt with 86 complaints about physical health issues. See appendix 11 in this Annual report.


20. Seclusion practices. There has been considerable improvement in seclusion practices, however, Official Visitors dealt with 14 complaints from consumers arising out of seclusion. See appendix 11 in this Annual Report.

2006-2007 ANNUAL REPORT
21. Inconsistent and inappropriate complaints processes in hospitals. See Issue 1 in this Annual Report. See also Issue 5 for similar issues in the hostel sector raised this year.

2007-2008 ANNUAL REPORT

2008-2009 ANNUAL REPORT

2009-2010 ANNUAL REPORT
24. Doctor and other staff shortages. While there are no specific illustrations in this year’s Annual Report, Council is aware of issues during the year, exacerbated by the acuity on the wards. Official Visitors dealt with 52 complaints related to access to consultant or medical team. See Issue 2 and appendix 11 in this Annual Report.

25. Mandatory sentencing law and need for amendment to exclude people who were mentally unwell at the time. This law remains and Council continues to hear about people with a mental illness being charged under this law (although the charge may later be withdrawn or amended) and from carers saying that they are concerned about calling for police or ambulance assistance because of the law.

2010-2011 ANNUAL REPORT
PART FOUR
Activity measures, budget, strategic plan and other activities

CONSUMER NUMBERS
Annual data collected by Council and set out in appendix 10 show increases in all measures in 2011-2012 (with the previous year’s figures in brackets):

- number of consumers assisted by Council: 1,438 (1,201): 19.7% increase
- number of issues dealt with by Council (formally called requests): 4,686 (3,518): 33.2% increase
- number of new consumers (i.e. consumers making their first contact with Council): 580 (532): 9.0% increase.

Data obtained by Council from the DOH and the MHRB (see Table 3 below) on the other hand shows decreases in a number of key measures:

- number of involuntary inpatient orders to detain a person under the Act (as reported by the MHRB): 2,626 (2,690): 2.4% decrease
- number of people put on a form 6 involuntary inpatient order (as reported by the MHRB): 2,093 (2,142): 2.3% decrease
- CTOs issued (as reported by the MHRB): 844 (923): 8.6% decrease
- first time on a form 6 i.e. first time made an involuntary inpatient in Western Australia (as reported by the MHRB): 1,069 (930): 14.9% increase
- involuntary inpatients (as reported by the DOH): 2,583 (2,722): 5.1% decrease
- mental health inpatients (voluntary and involuntary as reported by the DOH): 16,142 (14,721): 6.9% increase
- people who contacted public mental health services (as reported by the DOH): 49,233 (48,145): 2.3% increase.
30 Source: Hospital Morbidity Data System, DOH. Data represents the number of people who were involuntary at some point during their admission to public mental health facilities and were discharged during the financial year. These data do not reflect multiple admissions as people who have been discharged more than once during the financial year are counted once. This figure cannot be compared directly with the MHRB data due to different data parameters. Data reported by Council in previous years has been updated by DOH.

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

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

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

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

35 Source: Hospital Morbidity Data System, DOH. Represents people whose primary diagnosis was mental health, and who received treatment during their admission on a mental health ward, but were discharged from a general ward (non-psychiatric ward) during 2011-2012. People may have been voluntarily or involuntarily treated as a mental health patient.

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

Increases in Council’s consumer numbers

As can be seen in appendix 10, Council’s consumer numbers have increased by 50% in the past 2 years and almost doubled since 2003-2004. Approximately 60% of the people assisted by Council were “repeat customers” and 40% were new to Council. Most of the growth in consumer numbers was also from consumers already known to Council (the numbers increasing by 28.3% on last year while the increase in new consumers was 9.0%).

The significant increase in Council’s consumer numbers in the past few years, while involuntary patient numbers have remained relatively stable, could reflect increasing acuity and stress in the system (leading to more consumer complaints) and/or high levels of satisfaction by consumers with the service provided by Official Visitors. The number of “repeat” consumers seeking help from Council also indicates high levels of satisfaction by consumers for the support provided to them by Official Visitors.

MHRB data and numbers of involuntary patients

The MHRB data in Table 3 shows small decreases in the number of involuntary orders issued, the number of people put on a form 6 (as distinct from the number of orders made) and the number of CTOs issued. There was however a significant increase (14.9%) in the number of orders making people an involuntary inpatient for the first time. The figures show that 1,069 orders in 2011-2012 were made to people who had not previously been an involuntary inpatient in Western Australia. That is 51.1% of the people made an involuntary inpatient during the year were on a form 6 for the first time. This is a significant increase from 930 (or 43.4%) the previous year. There are a number of possible interpretations of this figure including the increasing population. This statistic has only been gathered by the MHRB for the past 3 years (at Council’s request) so there is minimal history with which to compare but the increase in the number of people made an involuntary inpatient for the first time last year was only 0.9%. It raises issues for the management of the mental health system.

It should be noted that Council had previously understood that MHRB data on involuntary inpatient orders included long term consumers, where a form 9 continued their involuntary detention beyond the initial 28 days of a form 6, and people detained when their CTO had been revoked (form 11). This was recently found not to be the case. The MHRB data does not include long term consumers and therefore under-represents the number of people detained in hospitals as an involuntary patient. Information on the number of form 9’s to continue the involuntary order cannot be provided by the MHRB due to system limitations.

The number of people put on a form 6 (as distinct from the number of orders issued) highlights the number of people who are made involuntary inpatients, some of whom were made involuntary on more than one occasion during the year. Council had not asked for this data in previous years. The comparison in the number of orders issued versus the number of people to whom the orders were issued, shows that in the 2011-2012 there were 533 orders that were made for people who had already been subject to an involuntary inpatient order in the year. In the previous year the figure was 548 and in 2009-2010 there were 560 orders made for people who had already been involuntary during the year so the figure appears to be steadily decreasing. Again these figures have implications for the future management and planning of mental health services.
**DOH data and mental health patient numbers**

As can be seen from Table 3, the DOH figures also show a decrease in the number of involuntary inpatients in 2011-2012 (5.1% compared with the MHRB data decrease of 2.3%). The DOH involuntary inpatient data represents the number of mental health patients discharged during the financial year who were involuntary at some point during their admission. This in part explains the difference in the figures supplied by the DOH and MHRB. It should be noted, however, that consumers who are still in hospital at the end of the financial year, or indeed in hospital for many years, are not counted in the DOH data either. It appears that there is no readily accessible data on the total number of people detained against their will and being forced to take treatment in Western Australia. The data which Council has been able to obtain, for example, do not include long term consumers who Council have reported are “stuck on wards”.

In contrast to the slight decrease in involuntary patient numbers, the DOH data reported in Table 3 show that of the 16,142 mental health inpatients, 2,583 were involuntary, leaving 13,559 voluntary patients. This is a 13.0% increase in the number of voluntary inpatients from the previous year. This may also explain the acuity and bed stresses being felt on authorised wards.

Perhaps not surprisingly given the population growth, the number of mental health inpatients has been steadily increasing over the past 9 years and the figures show a 41.1% increase in mental health inpatients (voluntary and involuntary) since 2003-2004. Similarly the number of people who contacted public mental health services has been steadily increasing over the past 9 years, with a 2.3% increase in 2011-2012. This is the number of people who have “had an occasion of service” from either the inpatient or outpatient services.

Council also received data for the first time on the number of mental health patients discharged from general wards. There was a 12.0% increase in 2011-2012 compared to the previous year in the number of mental health patients discharged from general wards. This follows increases of 9.0%, 6.7%, and 7.1% in each of the previous three years. There may be various reasons why a mental health patient was on a general ward and further analysis would be required to provide more information but patient overflow could be one explanation.

It is curious that less involuntary inpatients seem to be entering the system (2,093) as compared to people being discharged (2,583). Comparison of the rate of change in the last two years for each of these figures suggests that in 2010-2011 there was a greater increase in the number of involuntary inpatients being discharged as compared to the number of people made involuntary inpatients. While in 2011-2012 both the number of people being made involuntary inpatients and the number discharged both decreased, there was a greater decrease in discharges. This may support the sense of increased acuity as length of stay would increase if people are not being discharged at the same rate.

**Source of consumer requests for Council assistance**

Areas where Council has experienced an increase in requests for visits (see appendix 8) included:

- Community clinics – 94.7% increase
- Hostels – 43.3% increase
- Regional authorised hospitals – 33.3% increase
- Selby Lodge - 85.7% increase (but the numbers are small, up from 7 consumers to 13)
- Swan Valley Centre – 69.8% increase.

37 As at the time of publication the DOH were confirming that their data represents patients who were involuntary inpatients at some point during their admission (as opposed to involuntary on discharge) and were “uncovering a number of issues with how legal status is being recorded by the hospitals…”. 
There was a greater increase in requests, and therefore in the number of complaints, from people being treated on a CTO from community clinics in regional areas as compared to the metropolitan area. The overall increase in requests from people on a CTO increased from 38 consumers last year to 74 this year.

There was a significant increase in the number of requests made by residents of psychiatric hostels (139 residents up from 97 last year and 60 the year before - or a 43% increase this year). This is in line with Council’s ongoing strategic goal to improve residents’ access to Official Visitors but also supports Council’s concerns about the lack of proper oversight of, and standards of care in, supported hostels.

The increase in requests from consumers in regional authorised hospitals was greatest in Bunbury where there was a 21.9% increase on the previous year.

There were marked decreases in the number of consumers raising complaints with Council at Alma St Centre Fremantle (10.3%) and Leschen Unit Armadale (15.4%).

Appendix 9 shows the percentage of consumers who sought Official Visitor assistance in relation to the percentage of authorised bed numbers in the state. Facilities with relatively higher proportion of consumers who have made a complaint to Council compared to the proportion of bed numbers were Graylands Hospital, the Frankland Centre, and Bunbury APU and PICU. The facilities with a relatively lower proportion were Selby Lodge, Mills St Centre Bentley and Joondalup Hospital’s mental health unit. Appendix 9 also shows the number of involuntary orders for each facility which brings further perspective to the data in this table.

**ANALYSIS OF ISSUES AND REQUESTS**

The data provided in appendix 11 is derived from individual consumer reports prepared by Official Visitors. It categorises the nature of consumer complaints. The categories used this year are new so there is no data from previous years with which to compare. The 33.2% increase in issues seen in appendix 10 may reflect in part the categorisation changes (although it is to be expected that there would be an increase in the number of issues where there has been an increase in the number of consumers seeking help).

The complaint codes used by Council were not designed specifically for mental health patient complaints nor use by Council but it has been adapted manually in an attempt to better reflect the nature of the complaints usually received by Official Visitors. As a result, there are a number of limitations on the information which can be derived from the complaint categories. For example when comparing the number of issues to the number of consumers there may be duplication where a consumer makes the same complaint more than once which could happen if they have several admissions or the issue reoccurs. Council is hoping to get a new software system in the coming financial year which will be easier to use, significantly reduce duplication, and provide more useful information.

The majority of requests received by Council were as follows:

- Disagreement with involuntary status or diagnosis – raised on 409 occasions or by 28.4% of consumers
- Medication and treatment – raised on 286 occasions or by 20.0% of consumers
• Issues with the forms or explanation of rights – raised on 237 occasions or by 16.5% of consumers
• Transfer to another ward, hospital or hostel – raised on 177 occasions or by 12.3% of consumers
• Requests or delays in providing an other opinion – raised on 173 occasions or by 12.0% of consumers
• Ground access or leave – raised on 167 occasions or by 11.6% of consumers
• Discharge plans – raised on 133 occasions or by 9.2% of consumers
• Accommodation – raised on 130 occasions or by 9.0% of consumers
• Personal possessions – raised on 102 occasions or by 7.1% of consumers
• Dignity, privacy and staff attitude – raised on 101 occasions or by 7.0% of consumers.

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

There is a discrepancy between the number of MHRB hearings attended by an Official Visitor as recorded by Council (223) and by the MHRB (271). As Council’s codes were introduced in July 2011, further training is being provided for Official Visitors on coding requests.

BUDGET AND RESOURCING ISSUES

Council was allocated a budget of $1,505,033 for the 2011-2012 year. Council’s actual expenditure was $1,656,440, which was 10% over budget ($151,407). The additional expenditure was anticipated during the course of the year with the continued significant increase in consumer numbers (19.7%) and the authorisation of a new hospital mental health unit at Rockingham Hospital, the licensing of 3 new hostels (requiring extra inspections) and the recruitment, appointment and training of Official Visitors for the new Broome Hospital mental health unit. Payments to Official Visitors accounted for 63.6% of expenditure and 36.4% was spent on administration costs, reduced from 39% the previous year.

Budget pressures on Council result in significant restrictions in improving the quality of Council’s operations. For example, Council’s website is long overdue for an overhaul as are its pamphlets and brochures and a number of Council’s policies need review. Official Visitor training is mainly restricted to inhouse events provided by speakers freely providing their time; alternatively Official Visitors attend seminars and conferences in their own time. Quality assurance practices have been minimised as office staff workload has significantly increased.

Various efficiencies have been identified during the year to reduce Council’s expenditure. Administrative practices continue to be reviewed with non essential practices eliminated and cost saving initiatives implemented. Council is endeavouring to ensure that accessibility to Official Visitors is not compromised by any such initiatives.
Remuneration of Official Visitors

Official Visitors are entitled to remuneration as determined by the Minister for Mental Health (section 180 of the Act). Remuneration rates were increased from 13 February 2011 for the first time in 4 years having been last reviewed and increased as of 17 October 2006.

Official Visitors are paid on a sessional (half day/full day) basis. The method of payment does not reflect the way Official Visitors work nor the hours worked and Executive Group members cannot be paid for additional work they undertake to fulfil the role or a higher rate, despite taking on increased responsibility. There is an increasing amount of report writing, phone calls following up on consumer complaints and requests, reading, research and record keeping, all of which is done from their own home, using their own computers and telephones.

They are not paid for travel time (except when travelling between facilities), and many do not claim the costs of phone calls, parking tickets or for things like printing off documents from their home computers.

Administrative support

As a result of raising concerns for several years about the inadequate level of administrative support given to Council, an external review was commissioned by the DOH in 2010. The report recommended 2 additional staff members be provided to the Council based on 2009-2010 figures. Council received approval for, and recruited, 1 additional member of staff in 2010-2011.

Since 2009-2010, however, the number of consumers has increased by 50.3%. There have also been additional facilities opened requiring inspections. The volume of work has therefore increased exponentially including increases in phone calls to the Council requesting a visit, coordination of Official Visitor responses, reports submitted by Official Visitors and the number of complex issues identified. This is impacting on Council’s ability to properly manage its operations and ensure a quality service is provided.

In addition Council has for many years raised the inadequacy of the MS Access database (which produces the data in appendix 11) that was developed specifically for Council in 1999. The database significantly impedes Council’s ability to monitor and report on trends, a lot of which is managed by ad hoc spreadsheets, causes significant duplication and inefficiencies, and hampers internal management of workload and budget. The database is also preventing Council’s software from being upgraded from Microsoft Office 2003. Internal improvements in recent years mean Official Visitors provide reports by email, however, the full benefits of electronic reporting cannot be realised until this database is replaced. Similarly substantial productivity gains and efficiency dividends cannot be realised until this antiquated system is modernised.

Electoral Act requirements

As required under the Electoral Act 1907 s175ZE(1), during 2011-2012 the Council expended the following in relation to the designated organisation types:

(a) advertising agencies: nil
(b) market research organisations: nil
(c) polling organisations: nil
(d) direct mail organisations: nil
(e) media advertising organisations: $1,308.
STRATEGIC PLAN

Council’s strategic plan aims to focus Council’s attention on issues of concern to Official Visitors within the parameters of their legislative functions. Last year Council decided on a 2 year strategic plan for 2011-2013. A copy of the strategic plan is provided in appendix 12. The goals reflected the 6 issues of greatest concern to Official Visitors:

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

It is complemented by a 1 year operational plan. The goals are aimed at ensuring Council is well placed for any change in the legislation which expands its jurisdiction to voluntary patients.

OTHER ACTIVITIES

Liaison with services and other agencies

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

The Head of Council also confers with these parties and a number of other agencies as and when relevant issues arise. Some meetings were requested by the other party; some meetings were requested by Council. Head of Council uses the meetings to share information or to raise issues of concern and/or advocate for specific change both on behalf of individual consumers and at a systemic level.

Consultation processes / requests

Council was heavily involved in a number of consultation processes this financial year:

- Council presented a 111 page submission on the draft Mental Health Bill which is available on the websites of both Council (under Other Publications) and the MHC
- “Review of the Admission or Referral to and the Discharge and Transfer Practices of Public Mental Health Facilities/Services in WA” led by Professor Bryant Stokes, AM
- Sankey Associates’ evaluation of the MHC’s supported accommodation program (see Issue 5 above)
- various meetings with Gregor Henderson, the consultant retained to advise the Minister for Mental Health on the quality assurance framework for mental health in Western Australia
- advocacy forum organised by the MHC titled “Developing a Vision for Mental Health Advocacy in WA”.
Presentations

Presentations on the role of Council and consumer rights under the Act were given to the following:

- South Metropolitan Mental Health Advisory Group
- Graylands Hospital medical staff’s Academic Hour
- Peel and Rockingham/Kwinana (PaRK) Guidance Group for consumer and carer representatives
- Mimidi Park, Rockingham – eight presentations for staff of the adult ward, then a further session for staff of the older adult ward when it commenced operations
- Mills St Centre, Bentley Hospital – five presentations for nursing and support staff and one for medical staff
- Social Work Department of King Edward Memorial Hospital
- Advocare Inc
- licensed psychiatric hostels – Richmond Fellowship Mann Way, Ngulla Mia and Glyde St, Ngurra Nganhungu Bardiyigu and St Bartholomew’s House Sunflower Villas.

Official Visitor training

Training is provided to Official Visitors twice a year on the day before the 2 FCMs so that regional Official Visitors can also attend. In addition Council has begun inviting occasional monthly speakers with regional Official Visitors taking part by videolink.

The December 2011 FCM training included:

- a presentation by a pharmacist on psychiatric medication and their side effects
- a presentation by Yorgum Aboriginal Corporation on cultural awareness
- a presentation on the work of the June O’Connor Centres
- a presentation by the Mental Illness Fellowship of WA (MIFWA) on their Early Intervention Recovery Program
- in house training on consumers’ rights
- presentations by Official Visitors from forums they have attended.

The May 2012 FCM training included:

- a presentation on the use of interpreters by Official Visitors who are accredited NAATI interpreters
- accountable and ethical decision making training
- a presentation by the President of the MHRB
- a presentation on Official Visitor safety.

The format of group meetings changed during 2011-2012 with more preparation for the coming month’s focus for the inspection. Group meetings included discussion of the focus topics and specific questions to be asked of consumers and facility staff. A presentation was given by MHC staff on the draft Mental Health Bill endorsed by Cabinet for release for public comment.

Newly appointed Official Visitors spend 3 and a half days in the office receiving intensive training in the Act and Council’s position statements and procedures with invited guest speakers including people with the lived experience of mental illness and a psychiatrist. They are also allocated mentors and spend some time visiting facilities with their mentors before visiting alone.
RECORDS MANAGEMENT

In accordance with the State Records Act 2000, section 19, the Council has a record keeping plan governing the management of all its records. Refer to appendix 5 for the statement of compliance with section 19 of the Act and State Records Commission, Standard 2, Principle 6.

QUALITY ASSURANCE

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

**Code of Conduct and Conflict of Interest Policy**

The Council has a Code of Conduct and Conflict of Interest Policy that bind all its members. Copies of the Code and Policy are available from the Council’s office or on the website (under Other Publications). Both were reviewed and updated by Council this year.

Official Visitors were also required to declare any disqualifying interests (see s178 and Schedule 3 of the Act) for 2011–2012. No disqualifying interests were identified.

**Complaints regarding Official Visitors and Council operations**

The Council has a Code of Conduct and Conflict of Interest Policy that bind all its members. Copies of the Code and Policy are available from the Council’s office or on the website (under Other Publications). Both were reviewed and updated by Council this year.

Official Visitors were also required to declare any disqualifying interests (see s178 and Schedule 3 of the Act) for 2011-2012. No disqualifying interests were identified.

There were 11 complaints received this year, 8 from hospital management or staff, 1 from a hostel licensee, 1 from a parent/Guardian and 1 from a consumer. In each case the complaint was investigated by Head of Council in consultation with the Deputy Head of Council and Manager. One complaint was considered by Council’s Executive Group. Of the 11 complaints, two were not put in writing and the others were received by letter or email.

Most of the staff complaints related to a misunderstanding of the pure advocacy role of Official Visitors which was explained or clarified, and accepted by the complainant. In some cases Official Visitors followed up by giving staff presentations on the role of Official Visitors and patient rights.
### APPENDIX 1: Authorised Hospitals

<table>
<thead>
<tr>
<th>Hospital name, mental health ward and address</th>
<th>No of beds authorised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany Regional Hospital, Albany Mental Health Unit</td>
<td>9</td>
</tr>
<tr>
<td>Hardie Road, Albany</td>
<td></td>
</tr>
<tr>
<td><strong>Child and Adolescent Health Service, Bentley Adolescent Unit</strong></td>
<td>12</td>
</tr>
<tr>
<td>Mills Street, Bentley</td>
<td></td>
</tr>
<tr>
<td><strong>Bunbury Regional Hospital</strong></td>
<td>27</td>
</tr>
<tr>
<td>Acute Psychiatric Unit (APU) and Psychiatric Intensive Care Unit (PICU)</td>
<td></td>
</tr>
<tr>
<td>Bussell Highway, Bunbury</td>
<td></td>
</tr>
<tr>
<td><strong>Bentley Hospital and Health Service, Mills Street Centre</strong></td>
<td>76</td>
</tr>
<tr>
<td>Mills Street, Bentley</td>
<td></td>
</tr>
<tr>
<td><strong>Fremantle Hospital and Health Service, Alma Street Centre</strong></td>
<td>64</td>
</tr>
<tr>
<td>Alma St, Fremantle</td>
<td></td>
</tr>
<tr>
<td><strong>Frankland Centre, State Forensic Mental Health Services</strong></td>
<td>30</td>
</tr>
<tr>
<td>Brockway Road, Mount Claremont</td>
<td></td>
</tr>
<tr>
<td><strong>Graylands Hospital, Adult Mental Health Services</strong></td>
<td>168</td>
</tr>
<tr>
<td>Brockway Road, Mount Claremont</td>
<td></td>
</tr>
<tr>
<td><strong>Joondalup Health Campus, Joondalup Mental Health Unit</strong></td>
<td>42</td>
</tr>
<tr>
<td>Shenton Ave, Joondalup</td>
<td></td>
</tr>
<tr>
<td><strong>Kalgoorlie Regional Hospital, Mental Health Inpatient Service</strong></td>
<td>7</td>
</tr>
<tr>
<td>Piccadilly Street, Kalgoorlie</td>
<td></td>
</tr>
<tr>
<td><strong>King Edward Memorial Hospital, Mother and Baby Unit</strong></td>
<td>8</td>
</tr>
<tr>
<td>Loretto Street, Subiaco</td>
<td></td>
</tr>
<tr>
<td><strong>Leschen Unit, Armadale Health Service</strong></td>
<td>41</td>
</tr>
<tr>
<td>Albany Highway, Armadale</td>
<td></td>
</tr>
<tr>
<td><strong>Mercy Hospital, Ursula Frayne Unit</strong></td>
<td>12</td>
</tr>
<tr>
<td>Thirlmere Road, Mount Lawley</td>
<td></td>
</tr>
<tr>
<td><strong>Rockingham Hospital, Mimidi Park</strong></td>
<td>30^39</td>
</tr>
<tr>
<td>Elanora Drive, Rockingham</td>
<td></td>
</tr>
<tr>
<td><strong>Selby Older Adult Mental Health Service</strong></td>
<td>40</td>
</tr>
<tr>
<td>Lemnos Street, Shenton Park</td>
<td></td>
</tr>
<tr>
<td><strong>Swan Health Service, Swan Valley Centre and Boronia Inpatient Unit</strong></td>
<td>41</td>
</tr>
<tr>
<td>Eveline Road, Middle Swan</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL BED NUMBERS</strong></td>
<td>607</td>
</tr>
</tbody>
</table>

^38 Not all beds were necessarily open.

^39 As at 30 June 2012, Mimidi Park had not opened an elderly ward with 4 beds.
### APPENDIX 2: Licensed Psychiatric Hostels

<table>
<thead>
<tr>
<th>Licensee, hostel name, and address</th>
<th>Bed Nos</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Albany CSRU</strong></td>
<td>11</td>
</tr>
<tr>
<td>Albany Halfway House Association Inc. (licensee)</td>
<td></td>
</tr>
<tr>
<td>Ballard Heights, Spencer Park, Albany</td>
<td></td>
</tr>
<tr>
<td><strong>Burswood Care Pty Ltd atf Roshana Family Trust (licensee)</strong></td>
<td>31(^{43})</td>
</tr>
<tr>
<td>Burswood Care (^{41}) 42</td>
<td></td>
</tr>
<tr>
<td>16 Duncan Street, Burswood</td>
<td></td>
</tr>
<tr>
<td><strong>Casson Homes Inc. (licensee)</strong></td>
<td></td>
</tr>
<tr>
<td>Aitken House</td>
<td>4</td>
</tr>
<tr>
<td>55 View St, North Perth</td>
<td></td>
</tr>
<tr>
<td>Casson House</td>
<td>92(^{44})</td>
</tr>
<tr>
<td>2-10 Woodville Street, North Perth</td>
<td></td>
</tr>
<tr>
<td><strong>Woodville House</strong></td>
<td>25</td>
</tr>
<tr>
<td>425 Clayton Road, Helena Valley</td>
<td></td>
</tr>
<tr>
<td><strong>Devenish Lodge</strong></td>
<td>41</td>
</tr>
<tr>
<td>AJH Nominees Pty Ltd (licensee)</td>
<td></td>
</tr>
<tr>
<td>54 Devenish St, East Victoria Park</td>
<td></td>
</tr>
<tr>
<td><strong>Franciscan House</strong></td>
<td>75</td>
</tr>
<tr>
<td>Meski International Pty Ltd (licensee)</td>
<td></td>
</tr>
<tr>
<td>16 Hampton Road, Victoria Park</td>
<td></td>
</tr>
<tr>
<td><strong>Ngatti, Fremantle Supported Accommodation for Homeless Youth</strong></td>
<td>16</td>
</tr>
<tr>
<td>Life Without Barriers (licensee)</td>
<td></td>
</tr>
<tr>
<td>5-9 Alma St, Fremantle</td>
<td></td>
</tr>
<tr>
<td><strong>Ngurra Nganhungu Barndiyigu</strong></td>
<td>14</td>
</tr>
<tr>
<td>Fusion Australia Ltd (licensee)</td>
<td></td>
</tr>
<tr>
<td>Onslow St, Geraldton</td>
<td></td>
</tr>
<tr>
<td><strong>Pu-Fam Pty Ltd (licensee)</strong></td>
<td>52</td>
</tr>
<tr>
<td>St. Jude’s Hostel</td>
<td></td>
</tr>
<tr>
<td>30-34 Swan St, Guildford</td>
<td></td>
</tr>
<tr>
<td>East St Lodge</td>
<td>10(^{45})</td>
</tr>
<tr>
<td>53A and 53B East St, Guildford</td>
<td></td>
</tr>
<tr>
<td><strong>Romily House</strong></td>
<td>70</td>
</tr>
<tr>
<td>Judith Balfe (licensee)</td>
<td></td>
</tr>
<tr>
<td>19 Shenton Road, Claremont</td>
<td></td>
</tr>
</tbody>
</table>

---

\(^{40}\) Licensed psychiatric hostels include group homes, CSRUs, and community options homes.

\(^{41}\) The license for Burswood Psychiatric Hotel was transferred from Ms Teresa Nowicki to Burswood Care Pty Ltd atf Roshana Family Trust under the name of Burswood Nursing Care on 15 March 2012.

\(^{42}\) Change of trading name from Burswood Nursing Care to Burswood Care on 16 August 2012.

\(^{43}\) The license for the number of beds at Burswood Care increased from 22 to 31 on 15 March 2012.

\(^{44}\) The license for the number of beds at Casson House increased from 84 to 92 on 1 August 2011.

\(^{45}\) The license for the number of beds at East St Lodge increased from 3 to 10 on 21 September 2011.
APPENDIX 2: Licensed Psychiatric Hostels

Rosedale Lodge
David Wortley (licensee)
22 East St, Guildford

Richmond Fellowship (licensee)
  Anzac Tce Service\(^{47}\)
    175 Anzac Tce, Bassendean
  East Fremantle Service
    56 Glyde Street and 58 Glyde Street
  Bunbury CSRU
    12 Jury Bend, Carey Park
  Busselton CSRU
    Powell Court, Busselton
  Hilton Service\(^{48}\)
    Units 1 and 2, 35 Oldham Crescent, Hilton
  Kelmscott Community Options
    25 Hicks Road, Kelmscott
  Mann Way
    4-6 Mann Way, Bassendean
  Ngulla Mia
    96 Moore St, East Perth
  Queens Park Service
    21-23 Walton Street, Queens Park
  Westminster Service\(^{49}\)
    32A and 32B Ullswater Place, Westminster

Roshanna Pty Ltd (licensee)
  BP Luxury Care
    22 The Crescent, Maddington
  Honey Brook Lodge
    42 John St, Midland

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

\(^{46}\) The number of beds was reduced from 32 to 27 as of 31 March 2012.
\(^{47}\) Richmond Fellowship Anzac Terrace Service first was licensed for 3 residents on 19 December 2011. The Ministerial directive requiring Council to inspect was made under s186 on 1 May 2012.
\(^{48}\) Richmond Fellowship Hilton Service was first licensed for 5 residents on 19 December 2011. The Ministerial directive requiring Council to inspect was made under s186 on 1 May 2012.
\(^{49}\) Richmond Fellowship Westminster Service was first licensed for 5 residents on 19 December 2011. The Ministerial directive requiring Council to inspect was made under s186 on 1 May 2012.
### Southern Cross Care (WA) Inc. (licensee)
- **Bentley House**
  - 1182 Albany Highway, Bentley  
  - 8 beds
- **Mount Claremont House**
  - 60 Mooro Drive, Claremont  
  - 7 beds
- **Stirling House**
  - 4 and 6 Limosa Close, Stirling  
  - 8 beds

### St Bartholomew’s House Inc. (licensee)
- **Arnott Villas**
  - 20 Arnott Court, Kelmscott  
  - 22 beds
- **Bentley Villas**
  - 1 Channon St, Bentley  
  - 25 beds
- **Sunflower Villas**
  - 15 Limosa Close, Stirling  
  - 25 beds
- **Swan Villas**
  - 91 Patterson Drive, Middle Swan  
  - 25 beds

### St Vincent de Paul Society (WA) Inc. (licensee)
- **Vincentcare Bayswater House**
  - 65 Whatley Crescent, Bayswater  
  - 6 beds
- **Vincentcare Coolbellup House**
  - 66 Waverly Road, Coolbellup  
  - 4 beds
- **Vincentcare Duncraig House**
  - 270 Warwick Road, Duncraig  
  - 4 beds
- **Vincentcare South Lakes House**
  - 9 Plumridge Way, South Lake  
  - 3 beds
- **Vincentcare Swan View House**
  - 8 Wilgee Gardens, Wan View  
  - 4 beds
- **Vincentcare Vincentian Village**
  - 2 Bayley St, Woodbridge  
  - 28 beds
- **Vincentcare Warwick House**
  - 39 Glenmere Road, Warwick  
  - 4 beds

**TOTAL BED NUMBERS**: 868
### APPENDIX 3: Council of Official Visitors Membership

<table>
<thead>
<tr>
<th>Head of Council</th>
<th>Commencement</th>
<th>Expiry of Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debora Colvin</td>
<td>1 February 2007</td>
<td>31 March 2014 (HOC from 1 April 2008)</td>
</tr>
</tbody>
</table>

#### Official Visitors

<table>
<thead>
<tr>
<th>Name</th>
<th>Commencement</th>
<th>Expiry of Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sherril Ball</td>
<td>2002</td>
<td>1 February 2013</td>
</tr>
<tr>
<td>Denise Bayliss</td>
<td>7 March 2006</td>
<td>7 April 2015</td>
</tr>
<tr>
<td>Helen Bresloff-Barry</td>
<td>2 February 2010</td>
<td>1 February 2013</td>
</tr>
<tr>
<td>Donald Cook</td>
<td>2 February 2010</td>
<td>1 February 2013</td>
</tr>
<tr>
<td>Alessandra D’Amico</td>
<td>1 February 2007</td>
<td>1 February 2013</td>
</tr>
<tr>
<td>Richard Desouza</td>
<td>2 February 2010</td>
<td>1 February 2013</td>
</tr>
<tr>
<td>Sharon Dimer</td>
<td>2 May 2011</td>
<td>6 April 2014 (resigned effective 9 November 2011)</td>
</tr>
<tr>
<td>Michael Dixon</td>
<td>18 January 2008</td>
<td>8 April 2013</td>
</tr>
<tr>
<td>Gerard Doyle</td>
<td>18 January 2008</td>
<td>8 April 2013</td>
</tr>
<tr>
<td>Mardi Edwards</td>
<td>16 April 2012</td>
<td>6 April 2014</td>
</tr>
<tr>
<td>Brian Evans</td>
<td>5 December 2011</td>
<td>6 April 2014</td>
</tr>
<tr>
<td>Margaret Fleay</td>
<td>2 May 2011</td>
<td>6 April 2014</td>
</tr>
<tr>
<td>Christina Giannaros</td>
<td>2 May 2011</td>
<td>6 April 2014 (resigned effective 19 June 2012)</td>
</tr>
<tr>
<td>Rodney Hay</td>
<td>1 February 2007</td>
<td>1 February 2013</td>
</tr>
<tr>
<td>Barbara Hewitt</td>
<td>5 December 2011</td>
<td>6 April 2013</td>
</tr>
<tr>
<td>Naka Ikeda</td>
<td>7 March 2006</td>
<td>7 April 2015</td>
</tr>
<tr>
<td>Norma Josephs</td>
<td>2 May 2011</td>
<td>6 April 2014</td>
</tr>
<tr>
<td>Kelly-Ann Letchford</td>
<td>2 February 2010</td>
<td>1 January 2013 (extended leave from February 2011)</td>
</tr>
<tr>
<td>Kerry Long</td>
<td>23 March 2005</td>
<td>8 April 2013</td>
</tr>
<tr>
<td>Ann McFadyen</td>
<td>7 April 2002</td>
<td>7 April 2015</td>
</tr>
<tr>
<td>Edana McGrath</td>
<td>22 July 1999</td>
<td>8 April 2013</td>
</tr>
<tr>
<td>Melinda Manners</td>
<td>1 April 2007</td>
<td>1 February 2013 (extended leave from August 2011)</td>
</tr>
<tr>
<td>Gary Marsh</td>
<td>23 February 2010</td>
<td>7 April 2015</td>
</tr>
<tr>
<td>Bruce Morrison</td>
<td>2 February 2010</td>
<td>1 February 2013</td>
</tr>
<tr>
<td>Mary O’Reeri</td>
<td>27 February 2012</td>
<td>8 April 2013</td>
</tr>
<tr>
<td>Val O’Toole</td>
<td>21 January 2003</td>
<td>7 April 2012 (resigned effective 31 October 2011)</td>
</tr>
<tr>
<td>Graham Pyke</td>
<td>3 December 2009</td>
<td>7 April 2015</td>
</tr>
<tr>
<td>Sheila Rajan</td>
<td>7 April 2009</td>
<td>7 April 2015</td>
</tr>
<tr>
<td>Patricia Ryans-Taylor</td>
<td>3 December 2009</td>
<td>7 April 2015</td>
</tr>
<tr>
<td>Margaret Robinson</td>
<td>2 May 2011</td>
<td>6 April 2014</td>
</tr>
<tr>
<td>Kathleen Simpson</td>
<td>27 February 2012</td>
<td>6 April 2014</td>
</tr>
<tr>
<td>Jeff Soliss</td>
<td>7 April 2009</td>
<td>7 April 2015</td>
</tr>
<tr>
<td>Allison Solomon</td>
<td>27 February 2012</td>
<td>6 April 2014 (resigned effective 15 March 2012)</td>
</tr>
<tr>
<td>Kelly Spouse</td>
<td>1 August 2009</td>
<td>7 April 2015</td>
</tr>
<tr>
<td>Helen Taplin</td>
<td>7 March 2006</td>
<td>7 April 2015</td>
</tr>
<tr>
<td>Judith Taylor</td>
<td>23 March 2005</td>
<td>1 February 2013 (resigned effective 1 February 2012)</td>
</tr>
<tr>
<td>Catriona Were-Spice</td>
<td>14 August 2000</td>
<td>8 April 2013 (extended leave from August 2011)</td>
</tr>
<tr>
<td>Suzanne Williams</td>
<td>5 December 2011</td>
<td>6 April 2014</td>
</tr>
<tr>
<td>Ian Wilson</td>
<td>2 May 2011</td>
<td>6 April 2014</td>
</tr>
<tr>
<td>(Angela) Leonie Wilson</td>
<td>1 February 2004</td>
<td>8 April 2013 (resigned effective 27 December 2011)</td>
</tr>
</tbody>
</table>
## APPENDIX 4: Council of Official Visitors’ Attendance at Meetings

<table>
<thead>
<tr>
<th>Official Visitor</th>
<th>Full Council Meetings</th>
<th>Executive Group Meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debora Colvin (Head of Council)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Sherril Ball</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Denise Bayliss</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Helen Bresloff-Barry</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Don Cook</td>
<td>✓</td>
<td>Leave</td>
</tr>
<tr>
<td>Alessandra D’Amico</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Richard Desouza</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Sharon Dimer</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Mike Dixon</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Gerry Doyle</td>
<td>✓</td>
<td>Apology</td>
</tr>
<tr>
<td>Mardi Edwards</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Brian Evans</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Margaret Fleay</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Christina Giannaros</td>
<td>✓</td>
<td>Leave</td>
</tr>
<tr>
<td>Rodney Hay</td>
<td>✓</td>
<td>Apology</td>
</tr>
<tr>
<td>Barbara Hewitt</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Naka Ikeda</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Norma Josephs</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Kelly-Ann Letchford</td>
<td>Leave</td>
<td>Leave</td>
</tr>
<tr>
<td>Kerry Long</td>
<td>✓</td>
<td>Apology</td>
</tr>
<tr>
<td>Ann McFadyen</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Edana McGrath</td>
<td>✓</td>
<td>Apology</td>
</tr>
<tr>
<td>Melinda Manners</td>
<td>Leave</td>
<td>Leave</td>
</tr>
<tr>
<td>Gary Marsh</td>
<td>✓</td>
<td>Apology</td>
</tr>
<tr>
<td>Bruce Morrison</td>
<td>Apology</td>
<td>✓</td>
</tr>
<tr>
<td>Mary O’Reeri</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Val O’Toole</td>
<td>✓</td>
<td>n/a</td>
</tr>
<tr>
<td>Theresa Piper</td>
<td>✓</td>
<td>n/a</td>
</tr>
<tr>
<td>Graham Pyke</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Sheila Rajan</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Margaret Robinson</td>
<td>Leave</td>
<td></td>
</tr>
<tr>
<td>Patricia Ryans-Taylor</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Kathleen Simpson</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Jeff Soliss</td>
<td>Leave</td>
<td>Leave</td>
</tr>
<tr>
<td>Kelly Spouse</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Helen Taplin</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Judith Taylor</td>
<td>✓</td>
<td>n/a</td>
</tr>
<tr>
<td>Catriona Were-Spice</td>
<td>✓</td>
<td>Leave</td>
</tr>
<tr>
<td>(Angela) Leonie Wilson</td>
<td>✓</td>
<td>n/a</td>
</tr>
<tr>
<td>Ian Wilson</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Donna Haney (Manager)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Michelle Galvez (Minute Taker)</td>
<td>✓</td>
<td>Leave</td>
</tr>
</tbody>
</table>

- ✓ attended
- n/a not appointed
- - not required to attend
- Leave (extended leave)
- p proxy
APPENDIX 5: State Records Commission Compliance Requirements

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

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

1. The efficiency and effectiveness of the organisation’s recordkeeping systems is evaluated not less than once every 5 years.

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

2. The organisation conducts a recordkeeping training program.

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

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

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

   The training program is reviewed annually to ensure its adequacy.

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

   The Code of Conduct includes the roles and responsibilities of employees and official Visitors regarding laws and policies. Official Visitors’ induction training includes their record keeping responsibilities.
## APPENDIX 6: Authorised Hospital Inspections

<table>
<thead>
<tr>
<th>AUTHORISED HOSPITAL</th>
<th>TOTAL NUMBER INSPECTIONS (INFORMAL INSPECTIONS)</th>
<th>TIME OF INSPECTION</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Weekdays 9am – 5pm</td>
<td>Weekdays 5pm – 9am</td>
<td>Weekends and Public Holidays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albany Mental Health Unit</td>
<td>12 (17)</td>
<td>10 (11)</td>
<td>1 (1)</td>
<td>1 (5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alma Street Centre, Fremantle</td>
<td>47</td>
<td>39</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bentley Adolescent Unit</td>
<td>12</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bunbury APU and PICU</td>
<td>24(18)</td>
<td>17(18)</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frankland Centre</td>
<td>12</td>
<td>8</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Graylands Hospital</td>
<td>108</td>
<td>90</td>
<td>10</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joondalup Mental Health Unit</td>
<td>12</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kalgoorlie Mental Health Inpatient Service</td>
<td>12(11)</td>
<td>11(11)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leschen Unit, Armadale</td>
<td>36</td>
<td>28</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mills Street Centre, Bentley</td>
<td>48(11)</td>
<td>41(9)</td>
<td>4(1)</td>
<td>3(1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mimidi Park, Rockingham</td>
<td>2150</td>
<td>16</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother and Baby Unit, KEMH</td>
<td>12</td>
<td>9</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selby Lodge</td>
<td>12</td>
<td>11</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swan Valley Centre and Boronia Unit, Swan District Hospital</td>
<td>24</td>
<td>20</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ursula Frayne Unit, Mercy Hospital</td>
<td>12</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>403 (57)</strong></td>
<td><strong>329 (49)</strong></td>
<td><strong>37(2)</strong></td>
<td><strong>37(6)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

50 Mimidi Park, Rockingham Hospital, was authorised on 23 September 2011.
### APPENDIX 7: Licensed Psychiatric Hostel Inspections

<table>
<thead>
<tr>
<th>Licensed Hostel, Group Home, CSRU and Community Options Homes</th>
<th>Total Number of Inspections</th>
<th>TIME OF INSPECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Weekdays 9am to 5pm</td>
</tr>
<tr>
<td>Albany CSRU</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Burswood Care</td>
<td>12(3)</td>
<td>9(1)</td>
</tr>
<tr>
<td>Casson Homes - Casson House</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Casson Homes - Woodville House</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Devenish Lodge</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>East St Lodge</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Franciscan House</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Nguurra Nganhungu Barndiyigu</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Ngatti Fremantle Supported Accommodation for Youth Homeless</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Richmond Fellowship – East Fremantle Service</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Richmond Fellowship – Anzac Terrace52</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Richmond Fellowship – Bunbury CSRU</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Richmond Fellowship – Busselton CSRU</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Richmond Fellowship – Hilton52</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Richmond Fellowship – Kelmscott CSRU</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Richmond Fellowship – Mann Way</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Richmond Fellowship – Ngulla Mia</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Richmond Fellowship – Queens Park</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Richmond Fellowship – Westminster52</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Romilly House</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Rosedale Lodge</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Roshanna – Honey Brook Lodge</td>
<td>12(2)</td>
<td>8(2)</td>
</tr>
<tr>
<td>Roshanna – BP Luxury Care</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Salisbury Home</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Southern Cross – Bentley House</td>
<td>10(2)</td>
<td>10(1)</td>
</tr>
<tr>
<td>Southern Cross – Mt. Claremont</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Southern Cross – Stirling House</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>St Bartholomew’s – Arnott Villas CSRU</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>St Bartholomew’s – Bentley Villas CSRU</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>St Bartholomew’s – Sunflower Villas</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>St Bartholomew’s – Swan Villas</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>St Jude’s Hostel</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Vincentcare – Bayswater House</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Vincentcare – Coolbellup House</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Vincentcare – Duncraig House</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Vincentcare – South Lakes House</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Vincentcare – Swan View House</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Vincentcare – Vincentian Village</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Vincentcare – Warwick House</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>279 (7)</strong></td>
<td><strong>229 (4)</strong></td>
</tr>
</tbody>
</table>

Note – Informal inspections are provided in brackets.

---

51 Licensed psychiatric hostels includes group homes, CSRUs, and community options homes.

52 A license to conduct a private psychiatric hostel was granted on 19 December 2011 under the Hospitals and Health Services Act 1927. A Direction under section 186 of the Mental Health Act 1996 was granted on 1 May 2012.
### APPENDIX 8: Total Consumers Contacted By Facility - 2004-2005 to 2011-2012

<table>
<thead>
<tr>
<th>Facility</th>
<th>Number of Consumers</th>
<th>No of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany Mental Health Unit</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>Alma Street Centre, Fremantle</td>
<td>88</td>
<td>107</td>
</tr>
<tr>
<td>Bentley Adolescent Unit</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Bunbury APU and PICU</td>
<td>19</td>
<td>26</td>
</tr>
<tr>
<td>Frankland Centre</td>
<td>43</td>
<td>53</td>
</tr>
<tr>
<td>Graylands Hospital</td>
<td>330</td>
<td>299</td>
</tr>
<tr>
<td>Joondalup Mental Health Unit</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Kalgoorlie Mental Health Inpatient Service</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Leschen Unit, Armadale</td>
<td>36</td>
<td>45</td>
</tr>
<tr>
<td>Mimidi Park, Rockingham</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mills Street Centre, Bentley</td>
<td>58</td>
<td>117</td>
</tr>
<tr>
<td>Mother and Baby Unit, KEMH</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Selby Lodge</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Swan Valley Centre and Boronia, Swan</td>
<td>40</td>
<td>45</td>
</tr>
<tr>
<td>Ursula Frayne Unit, Mercy Hospital</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Metropolitan clinics</td>
<td>54</td>
<td>58</td>
</tr>
<tr>
<td>Regional clinics</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Psychiatric hostels</td>
<td>59</td>
<td>58</td>
</tr>
<tr>
<td>Other57</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>800</strong></td>
<td><strong>891</strong></td>
</tr>
</tbody>
</table>

Note – Informal inspections are provided in brackets.

53 Source: Council's Visitor Tracking System database.
54 Prior to 2010-2011 the BAU was part of the Mills St Centre. For comparison purposes the numbers of consumers have been reported separately for the BAU and Mills St Centre in previous years.
55 Mimidi Park, Rockingham Hospital, was authorised on 23 September 2011.
56 As at 30 June Mimidi Park had not opened an elderly ward of 4 beds.
57 Includes consumers who are no longer involuntary but whose complaint arose while they were involuntary, involuntary patients being treated at non authorised mental health wards, by private psychiatrists, or on leave to general hospitals wards.
## APPENDIX 9: Number and Percentage of Consumers and Authorised Beds and Number of Involuntary Orders by Facility

<table>
<thead>
<tr>
<th>AUTHORISED HOSPITAL</th>
<th>NUMBER OF BEDS</th>
<th>% OF TOTAL AUTHORISED BEDS</th>
<th>NUMBER OF INVOLUNTARY ORDERS&lt;sup&gt;58&lt;/sup&gt;</th>
<th>NUMBER OF COV CONSUMERS&lt;sup&gt;59&lt;/sup&gt;</th>
<th>% OF TOTAL COV CONSUMERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany Mental Health Unit</td>
<td>9</td>
<td>1.5%</td>
<td>59</td>
<td>26</td>
<td>2.2%</td>
</tr>
<tr>
<td>Alma Street Centre, Fremantle</td>
<td>64</td>
<td>10.5%</td>
<td>312</td>
<td>113</td>
<td>9.4%</td>
</tr>
<tr>
<td>Bentley Adolescent Unit</td>
<td>12</td>
<td>2.0%</td>
<td>62</td>
<td>36</td>
<td>3.0%</td>
</tr>
<tr>
<td>Bunbury APU and PICU</td>
<td>27</td>
<td>4.4%</td>
<td>135</td>
<td>89</td>
<td>7.4%</td>
</tr>
<tr>
<td>Frankland Centre</td>
<td>30</td>
<td>4.9%</td>
<td>Included in Graylands</td>
<td>89</td>
<td>7.4%</td>
</tr>
<tr>
<td>Graylands Hospital</td>
<td>168</td>
<td>27.7%</td>
<td>935</td>
<td>424</td>
<td>35.1%</td>
</tr>
<tr>
<td>Joondalup Mental Health Unit</td>
<td>42</td>
<td>6.9%</td>
<td>218</td>
<td>52</td>
<td>4.3%</td>
</tr>
<tr>
<td>Kalgoorlie Mental Health Inpatient Unit</td>
<td>7</td>
<td>1.2%</td>
<td>70</td>
<td>21</td>
<td>1.7%</td>
</tr>
<tr>
<td>Leschen Unit, Armadale</td>
<td>41</td>
<td>6.8%</td>
<td>179</td>
<td>88</td>
<td>7.3%</td>
</tr>
<tr>
<td>Mimidi Park, Rockingham</td>
<td>30&lt;sup&gt;60&lt;/sup&gt;</td>
<td>4.9%</td>
<td>97</td>
<td>39</td>
<td>3.2%</td>
</tr>
<tr>
<td>Mills Street Centre</td>
<td>76</td>
<td>12.5%</td>
<td>251</td>
<td>111</td>
<td>9.2%</td>
</tr>
<tr>
<td>Mother and Baby Unit, KEMH</td>
<td>8</td>
<td>1.3%</td>
<td>9</td>
<td>3</td>
<td>0.2%</td>
</tr>
<tr>
<td>Selby Lodge</td>
<td>40</td>
<td>6.6%</td>
<td>42</td>
<td>13</td>
<td>1.1%</td>
</tr>
<tr>
<td>Swan Valley Centre and Boronia Unit, Swan District Hospital</td>
<td>41</td>
<td>6.8%</td>
<td>237</td>
<td>90</td>
<td>7.5%</td>
</tr>
<tr>
<td>Ursula Frayne Unit, Mercy Hospital</td>
<td>12</td>
<td>2.0%</td>
<td>17</td>
<td>13</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>607</strong></td>
<td><strong>100%</strong></td>
<td><strong>2,622</strong></td>
<td><strong>1,207</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

---

<sup>58</sup> Source: MHRB. Data represents the number of involuntary inpatient orders made during the financial year and does not include people who are an involuntary inpatient following their CTO being revoked, an involuntary inpatient where the order (form 6) was made prior to 1 July 2011, long term patients on a form 9 or mentally impaired accused persons. A person may be counted more than once if multiple involuntary orders are made in the same financial year.

<sup>59</sup> Source: Council’s Visitor Tracking System database. Does not include residents of hostels and or those attending clinics on CTOs.

<sup>60</sup> Mimidi Park became an authorised hospital on 23 September 2011. As at 30 June 2012, 4 beds in an elderly ward had not been opened.

<table>
<thead>
<tr>
<th>FINANCIAL YEAR</th>
<th>NUMBER OF CONSUMERS</th>
<th>NUMBER OF NEW CONSUMERS</th>
<th>NUMBER OF COMPLAINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003-2004</td>
<td>744</td>
<td>412</td>
<td>1,415</td>
</tr>
<tr>
<td>2004-2005</td>
<td>800</td>
<td>391</td>
<td>1,600</td>
</tr>
<tr>
<td>2005-2006</td>
<td>891</td>
<td>386</td>
<td>1,891</td>
</tr>
<tr>
<td>2006-2007</td>
<td>979</td>
<td>440</td>
<td>2,257</td>
</tr>
<tr>
<td>2007-2008</td>
<td>1,052</td>
<td>479</td>
<td>2,676</td>
</tr>
<tr>
<td>2008-2009</td>
<td>850</td>
<td>365</td>
<td>2,775</td>
</tr>
<tr>
<td>2009-2010</td>
<td>957</td>
<td>446</td>
<td>2,864</td>
</tr>
<tr>
<td>2010-2011</td>
<td>1,201</td>
<td>532</td>
<td>3,518</td>
</tr>
<tr>
<td>2011-2012</td>
<td>1,438</td>
<td>580</td>
<td>4,686</td>
</tr>
</tbody>
</table>

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

Source: Council’s Visitor Tracking System database.
# APPENDIX 11: Total Consumer Requests by Complaint

<table>
<thead>
<tr>
<th>1. Issues requiring consultant or medical team input</th>
<th>NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Forms and explanation of rights. Includes forms not completed properly, time period expired, form not provided to consumer, rights not explained (oral and written – ss.156 to 159). For example “how long do I have to stay here”, “they haven’t told me why I’m here” and “they didn’t explain my CTO”.</td>
<td>237</td>
</tr>
<tr>
<td>1.2 Disagreement with involuntary status or diagnosis. Includes CTO. For example “I want to go home”, “there’s nothing wrong with me”, “I want to change my doctor”.</td>
<td>409</td>
</tr>
<tr>
<td>1.3 Medication and treatment. Includes ECT.</td>
<td>286</td>
</tr>
<tr>
<td>1.4 Ground access and leave. For smoking related issues use code 2.1.</td>
<td>167</td>
</tr>
<tr>
<td>1.5 Transfer to another ward, hospital or clinic. Includes moving to an open ward and wanting/not wanting to transfer to another facility.</td>
<td>177</td>
</tr>
<tr>
<td>1.6 Access to consultant or medical team. Includes delays, insufficient staff, staff not available, monthly CTO review not done (ss. 164 and 75).</td>
<td>52</td>
</tr>
<tr>
<td>1.7 Other opinions. Includes requests for opinions, delays, or opinion not provided (ss.76, 111 and 112).</td>
<td>173</td>
</tr>
<tr>
<td>1.8 Phone, post or visitor rights and restrictions. Includes public phone not working, mobile/laptop taken by staff, daily review of restrictions not done (inc. ss.166 to 169).</td>
<td>22</td>
</tr>
<tr>
<td>1.9 Seclusions and restraints. Includes not being given food, drink, or access to toilet, 15 min observations or 2 hourly authorisation by psychiatrist not documented, de-escalation techniques not used and post seclusion interview not completed (inc. ss.116 to 124). For rough treatment use code 9.2.</td>
<td>14</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. General issues</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Smoking.</td>
<td>58</td>
</tr>
<tr>
<td>2.2 Meetings. Includes facilitating a meeting of family and treating team (with or without Official Visitor attendance).</td>
<td>45</td>
</tr>
<tr>
<td>2.3 Personal possessions. Includes access to or loss of property and completion of property sheet (inc. s.165).</td>
<td>102</td>
</tr>
<tr>
<td>2.4 Physical environment. Includes temperature, access to courtyards and internet connection.</td>
<td>55</td>
</tr>
<tr>
<td>2.5 Food and beverages.</td>
<td>50</td>
</tr>
<tr>
<td>2.6 Financial matters. Includes costs, access to money and hostel boarding fees. For access to welfare officers use code 31 and liaison with the Public Trustee use code 8.1</td>
<td>91</td>
</tr>
<tr>
<td>2.7 Referral to another agency. Includes MHLC, Health Consumers’ Council and Legal Aid.</td>
<td>99</td>
</tr>
<tr>
<td>2.8 Other hospital or supported accommodation issues.</td>
<td>327</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Allied services - access and quality</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Social workers, welfare officers, or case managers. Includes access, disagreement with decisions, wanting to go shopping and “who’s feeding my dog?” For staff attitude issues use 9.4.</td>
<td>101</td>
</tr>
<tr>
<td>3.2 Occupational Therapy. Includes activities, lack of exercise, no outings and boredom.</td>
<td>30</td>
</tr>
<tr>
<td>3.3 Psychologist and other counseling services. Includes drug and alcohol support.</td>
<td>14</td>
</tr>
<tr>
<td>3.4 Other allied services. Includes non-health services such as Centrelink, Tenancy Advice and Silver Chain.</td>
<td>34</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Physical health – access, delays or failure to diagnose</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Dental.</td>
<td>12</td>
</tr>
<tr>
<td>4.2 Podiatry.</td>
<td>3</td>
</tr>
<tr>
<td>4.3 Physiotherapy.</td>
<td>4</td>
</tr>
<tr>
<td>4.4 Dietician.</td>
<td>2</td>
</tr>
<tr>
<td>4.5 General Practitioner.</td>
<td>12</td>
</tr>
<tr>
<td>4.6 Other physical health issues. Includes x-rays, operations and tests.</td>
<td>53</td>
</tr>
</tbody>
</table>
## APPENDIX 11: Total Consumer Requests by Complaint

**Council of Official Visitors Annual Report 2011-12**

### 5. Plans (care and discharge) and accommodation

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Care plans. Includes lack of consultation, no plan, plan not reviewed and failure to follow plan.</td>
<td>26</td>
</tr>
<tr>
<td>5.2</td>
<td>Discharge plans. Includes lack of consultation, no plan, plan not reviewed and failure to follow plan.</td>
<td>133</td>
</tr>
<tr>
<td>5.3</td>
<td>Accommodation. Includes unable to discharge due to lack of accommodation and wanting to move.</td>
<td>130</td>
</tr>
</tbody>
</table>

### 6. MHRB Hearing

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Request for a hearing. Includes requests without COV attendance.</td>
<td>503</td>
</tr>
<tr>
<td>6.2</td>
<td>Preparation for hearing.</td>
<td>334</td>
</tr>
<tr>
<td>6.3</td>
<td>Attendance at hearing.</td>
<td>223</td>
</tr>
<tr>
<td>6.4</td>
<td>Cancellation of hearing. If the hearing starts and is adjourned use code 6.6.</td>
<td>128</td>
</tr>
<tr>
<td>6.5</td>
<td>Medical report. Report not provided 3 days prior to the hearing.</td>
<td>9</td>
</tr>
<tr>
<td>6.6</td>
<td>Attendance at adjourned hearing.</td>
<td>9</td>
</tr>
<tr>
<td>6.7</td>
<td>Other MHRB. Any thing else related to the MHRB including 8 week and 6 monthly reviews (ss.138 and 139).</td>
<td>78</td>
</tr>
</tbody>
</table>

### 7. Regional issues – not covered elsewhere

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1</td>
<td>Transport. Includes PATS and RFDS.</td>
<td>0</td>
</tr>
<tr>
<td>7.2</td>
<td>Regional issue. Issue is unique to regional areas. Only use when issue is not identified elsewhere.</td>
<td>4</td>
</tr>
</tbody>
</table>

### 8. Mental Health Act and other legal issues

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>Guardianship and administration. Includes liaison with Public Trustee or Public Advocate.</td>
<td>86</td>
</tr>
<tr>
<td>8.2</td>
<td>State Administrative Tribunal. Attendance at Guardianship and Administration hearings and MHRB appeals.</td>
<td>30</td>
</tr>
<tr>
<td>8.3</td>
<td>FOI and s.160 applications.</td>
<td>34</td>
</tr>
<tr>
<td>8.4</td>
<td>Criminal law and MIAR Board. Includes liaison and submissions and “when is my next court date?”.</td>
<td>38</td>
</tr>
<tr>
<td>8.5</td>
<td>Voting. (ss.201 and 202)</td>
<td>0</td>
</tr>
</tbody>
</table>

### 9. Safety, dignity, privacy, and staff attitudes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1</td>
<td>Safety. Includes feeling unsafe. Use for matters not included in code 10.</td>
<td>31</td>
</tr>
<tr>
<td>9.2</td>
<td>Rough treatment. Includes rough treatment by patients, residents, staff, police or guards. See also code 10.</td>
<td>31</td>
</tr>
<tr>
<td>9.3</td>
<td>Conflicts. Includes issues with other residents or patients, family member, and staff.</td>
<td>61</td>
</tr>
<tr>
<td>9.4</td>
<td>Dignity, privacy, and staff attitude. Includes ignoring consumers, entering rooms without knocking, confidentiality (s.206) and “staff treat me like I’m a child”.</td>
<td>101</td>
</tr>
<tr>
<td>9.5</td>
<td>Cultural awareness. Includes lack of sensitivity, no interpreter and attending church.</td>
<td>9</td>
</tr>
<tr>
<td>9.6</td>
<td>Inappropriate location. Includes lack of sensitivity, no interpreter and attending church.</td>
<td>7</td>
</tr>
</tbody>
</table>

### 10. Serious issues

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1</td>
<td>Serious issues. Follow COV guidelines in the manual.</td>
<td>10</td>
</tr>
</tbody>
</table>

### 11. Office Use

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1</td>
<td>Request for a Visit. Office use only.</td>
<td>n/a</td>
</tr>
</tbody>
</table>

### 12. Compliments

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1</td>
<td>Compliments to staff and COV</td>
<td>42</td>
</tr>
</tbody>
</table>

**TOTAL** | **4,686** |
APPENDIX 12: Two Year Strategic Plan
1 July 2011 - 30 June 2013

Vision/Statement of Purpose:

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

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

Strategies to Achieve Goal

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

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

1.3 Improve the standard of representation at MHRB hearings.

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

1.5 Promote the right of consumers to natural justice and procedural fairness in hearings and endeavour to improve the observance of that right and in particular their right to:
   • be provided with a copy of the medical report a reasonable amount of time in advance of the hearing (Council’s position is a minimum of 3 days before)
   • be given access to their medical file and any other documents made available to the MHRB as part of its deliberations.

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

Strategies to Achieve Goal

2.1 Continue to lobby for a review of the sector.

2.2 Improve standards and the quality of care in facilities.

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

2.4 Encourage engagement with industry, Department of Housing and other stakeholders to explore housing options and opportunities.
TWO YEAR GOAL 3 - LIFE AND CARE ON THE WARDS
To improve the quality of life and care on authorised hospital wards in accordance with consumers having the best care and treatment with the least restriction of their freedom and least interference with their rights and dignity (as per s5 Objects of the Act).

Strategies to Achieve Goal

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

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

3.3 Improve Official Visitor accessibility to, and advocacy for, the most vulnerable consumers on wards:
   - people “stuck on wards”
   - the elderly
   - children
   - regional and remote patients being transferred and treated away from their home and family.
   - indigenous and CALD consumers
   - women and sexually abused and particularly vulnerable consumers on mixed gender wards
   - consumers with an intellectual disability or an ABI.

3.4 Continue to lobby for consumers’ rights to a truly independent “other opinion”.

TWO YEAR GOAL 4 – COUNCIL OPERATIONS
To improve Council’s processes and procedures.

Strategies to Achieve Goal

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

4.2 Improve the quality and satisfaction of Official Visitor work.

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

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

TWO YEAR GOAL 5 – NEW LEGISLATION
To advocate for, and on behalf of, consumers in order to preserve, protect and improve their human rights in any relevant proposed legislative or other change.

Strategies to Achieve Goal

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

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

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACAT</td>
<td>Aged Care Assessment Team</td>
</tr>
<tr>
<td>Act</td>
<td>Mental Health Act 1996</td>
</tr>
<tr>
<td>AEC</td>
<td>Australian Electoral Commission</td>
</tr>
<tr>
<td>ABI</td>
<td>Acquired Brain Injury</td>
</tr>
<tr>
<td>AMHS</td>
<td>Area Mental Health Service</td>
</tr>
<tr>
<td>BAU</td>
<td>Bentley Adolescent Unit</td>
</tr>
<tr>
<td>CAHMS</td>
<td>Child and Adolescent Mental Health Service</td>
</tr>
<tr>
<td>CMHS</td>
<td>Community Mental Health Service</td>
</tr>
<tr>
<td>CLMIA Act</td>
<td>Criminal Law (Mentally Impaired Accused) Act 1996</td>
</tr>
<tr>
<td>Consumer</td>
<td>An “affected person” as defined by s175 of the Act who can be assisted by an Official Visitor; individuals who do not come within this definition are referred to by various titles including patient, referred patient, voluntary patient or resident.</td>
</tr>
<tr>
<td>COV</td>
<td>Council of Official Visitors</td>
</tr>
<tr>
<td>CTO</td>
<td>Community Treatment Order</td>
</tr>
<tr>
<td>DCP</td>
<td>Department of Child Protection</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>ECT</td>
<td>Electroconvulsive therapy</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EO</td>
<td>Executive Officer of Council, now Manager</td>
</tr>
<tr>
<td>FAP</td>
<td>Focus Area Person</td>
</tr>
<tr>
<td>FCM</td>
<td>Full Council Meeting</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>KEMH</td>
<td>King Edward Memorial Hospital</td>
</tr>
<tr>
<td>LAC</td>
<td>Local Area Co-ordinator</td>
</tr>
<tr>
<td>LARU</td>
<td>Licensing and Accreditation Review Unit</td>
</tr>
<tr>
<td>MHC</td>
<td>Mental Health Commission</td>
</tr>
<tr>
<td>MHLC</td>
<td>Mental Health Law Centre</td>
</tr>
<tr>
<td>MHRB</td>
<td>Mental Health Review Board</td>
</tr>
<tr>
<td>MIARB</td>
<td>Mentally Impaired Accused Review Board</td>
</tr>
<tr>
<td>NCH</td>
<td>New children’s hospital</td>
</tr>
<tr>
<td>NGO</td>
<td>Non government organisation</td>
</tr>
<tr>
<td>OCP</td>
<td>Office of the Chief Psychiatrist</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational therapy</td>
</tr>
<tr>
<td>PMH</td>
<td>Princess Margaret Hospital</td>
</tr>
</tbody>
</table>