Council of Official Visitors

Annual Report 2003 - 2004

Artwork produced through the
Creative Expression Unit at Graylands Hospital.
Front Cover painting by Roch Dziewaltowski-Gintowt,
Background painting by Craig Wood

The Honourable J A McGinty MLA
Minister for Health
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PERTH WA 6000

Dear Minister

In accordance with section 192(3) of the *Mental Health Act 1996* I submit for your information and presentation to Parliament the Annual Report of the Council of Official Visitors for the financial year ending 30th June 2004.

As well as recording the operations of the Council for the 2003 - 2004 year the report once again reflects on a number and range of issues that continue to affect consumers of mental health services in Western Australia.

Yours sincerely

Dr Judyth Watson
HEAD
COUNCIL OF OFFICIAL VISITORS

27 October 2004

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Although there have been many changes for the better in mental health and illness that must be acknowledged and celebrated, many matters remain of great concern.

Western Australia's mental health services do not reflect vibrant and modern ideas that meet the ambitions and ideals of this community in 2004. There are pockets, especially those related to long term living conditions, that resemble those of another age.

The enduring stigma surrounding mental illness is contributed to by inadequate resources allocated to this field for services and programmes, including for accommodation. This means that the impact is felt very strongly by these most vulnerable of health care consumers and their families.

The voices of individuals who have been diagnosed with a mental illness and their worn out carers are seldom heard and this can reinforce the low status they hold in the illness hierarchy. The vulnerability of people who have an acute or enduring mental illness, and those who are at risk, is exacerbated because they have not had the priority in the broader health care system that they need and deserve.

Decision-makers send a very powerful message about the priority that mental illness has when budgets are allocated. Mental health budgets have been reduced in real terms. They are not quarantined and for some years have been vulnerable to redistribution by and within the Department of Health.

Although the dedication of committed clinicians is acknowledged, substantial concerns remain about persistently negative attitudes towards rights by some service providers. Such views can only compound fiscal problems and the stigma and distress attached to these illnesses in a very direct way.

Overcrowding in acute psychiatric wards is common as are long waits in Emergency Departments while beds are found. This common situation is compounded by a stark lack of so-called 'step down' beds and slow stream rehabilitation facilities. As well there is scant provision of appropriate community based services. Because of this, acute hospital care is often the only option available for individuals in crisis. This means that hospital patients are discharged early so as to admit another person from circumstances that are likely to reflect those that the discharged person goes to. The metaphor of revolving door becomes literal.

People who live in rural Western Australia have extra burdens imposed on them and their families. Services are thinly spread and either discontinuous or at risk of being so. For instance the situation for the South West region based on Bunbury is, in our view indefensible, and requires an urgent commitment to ensure that high quality services are provided.

Inpatient services for children and adolescents remain terribly inadequate, both in terms of bed numbers and in addressing the complex nature of their acute and ongoing needs in a timely way.

There is still no modern dedicated family-based service for mothers and babies.

Psychiatric disability represents more than 25% of all disability. Accommodation presently provided for people with a long-term mental illness, in licensed psychiatric hostels or long term in hospital wards, must compound their vulnerability. There is a dearth of appropriate and supported accommodation services. Some licensed private psychiatric hostel residents were the subjects of previous de-institutionalisation programmes, yet they live in institution-like conditions, as do residents at Murchison Ward, Graylands Hospital. One challenge lies in the ageing of this population and their access to aged care services, including nursing home care. No matter what the will of individual staff may be, any kind of serious rehabilitation or socialisation measures for people with chronic illnesses have either been abandoned by service providers or, at best, rationed.

The situation for people treated by Community Treatment Order (CTO) and involuntary patients whose cases are to be reviewed by the Mental Health Review Board, continues to present challenges for Council in ensuring that their rights are observed.

Some concerns are again recorded about the capacity for family, friends and colleagues to visit individuals in hospitals and hostels. The absence of provisions to facilitate ongoing contact, let alone to satisfy any intimacy needs are, in this writer's view, a direct reflection of, and contribution to, the stigma surrounding mental illness.

Despite information campaigns to reduce stigma, it is easy to conclude that mental illnesses are so different that even family and friends are discouraged and dissuaded from maintaining their connections as visitors. There are few dedicated spaces set aside anywhere for visitors and often a blanket ban on them going to the bedside or to the common room/lounge in acute units. Not infrequently visitors need to wait until a room that can be monitored by staff becomes vacant. If maintenance of contact becomes difficult, visits become infrequent. These issues affect almost every consumer irrespective of age.

Licensed hostels, which are the person's home, also have similar problems with no spaces for visitors. In the 15 months of my appointment I have never seen one visitor in any of the hostels I have visited, [apart from a Christmas party at one hostel]. Council has welcomed the introduction of new licensing standards that this industry sector must comply with. We are committed to working with the sector although our brief is to ensure that the rights of people with a mental illness who reside in a licensed hostel are observed. This includes their recognition as individuals with the right to privacy and dignity in a place that is their home.

The Council has had a series of discussions with the Public Trustee about individual as well as systemic concerns related to hostel residents, and has embarked on joint meetings with their staff at two hostels to date. People with enduring mental illness constitute the fastest growing population of new clients of the Public Trustee.

The consequences of a terrible and unexpected assault on a nurse and social worker by a very ill new patient have reverberated throughout the whole sector. Health care providers have remained anxious about the potential for a recurrence. The Council understands this. It cannot comment with any authority on the details of the events nor the investigations. However we do note a disturbing trend in proposals that suggest the way to prevent further such attacks lies in the erection of more barriers, installation of more Closed Circuit Television, recruitment of male nurses etc. Among other impacts on consumers, they will be forced to reflect on how safe they might be from co-patients in a ward or waiting room, if staff need such protection.

We do not know whether a range of options for the protection of staff has been canvassed or whether choices have been made through a consultative process. We also do not know whether there may be models of non-barrier provisions for safety elsewhere that the sector should explore to implement or adapt. One of our concerns is that current proposals will reinforce the stigma associated with mental illness, they certainly will not reduce it. The Council argues that proposed caged car seats and dense perspex screens in front of receptionists will also contribute to diminished dignity and privacy for patients.

As a priority for the coming year the Council will continue to consult with stakeholders about provisions for the safety of consumers and staff that meet legal and practical standards and are appropriate to a therapeutic environment.

These and other issues affecting acutely ill as well as disabled consumers, consumers of all ages and backgrounds, present ongoing challenges for the brief of Council to protect the rights of '*affected persons*'.

I acknowledge the day to day work of each Official Visitor and the administrative staff; each of them is tenacious in ensuring that the rights of people protected by the *Mental Health Act 1996* are observed. This work is often quite difficult and may be prolonged, it can be in adverse circumstances and the same challenges and issues recur, however, the results can make a positive difference to the experience and life of those individuals whose concerns are taken up.

The focus of Council is on rights and this report addresses how statutory rights are too often breached, and expectations of the right to privacy and dignity for instance are not met. The report also addresses related issues including the past year's progress and deficits.

As a final point the Council urges the Government to give new mental health legislation the highest of priorities, in order to better protect the rights of all individuals with a mental illness as well as recognise their carers.

PART ONE

THE LEGISLATIVE AND OPERATIONAL FRAMEWORK

LEGISLATIVE FRAMEWORK

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

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

OPERATIONAL FRAMEWORK

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

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

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

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

The Council is required to ensure that an Official Visitor or panel visits each hospital authorised under section 21 of the Act at least once per month and each licensed private psychiatric hostel at the direction of the Minister for Health (currently at least once every 2 months). In practice each hostel is visited every month, alternating formal with informal visits. The Council has maintained an active visiting programme, visiting eleven authorised hospitals and nineteen licensed private psychiatric hostels including four sets of group homes, during 2003 – 2004.

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

The Council has also made a commitment to offering its services to more individuals who are treated by Community Treatment Order, a hard population to reach, and with some success (refer to *Part Three Activities of the Council*).

An '*affected person*' or another person on their behalf (section 189) can also request a visit from an Official Visitor. A visit is then arranged as soon as is practicable (section 186 (c)). Requests can be made in writing or via telephone or personal contact. 744 consumers had contact with Official Visitors during 2003 – 2004, an increase of almost 24.2% over the previous year.

Reporting Lines

Official Visitors

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

Executive Officer & Other Staff

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

Council Composition 2003 – 2004

A list of the members of the Council during the 2003 – 2004 financial year and their terms of appointment is contained at Appendix 3.

Panel Appointments

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

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

2 Interested community members: - Where members of the community wish to obtain a greater understanding of the role of the Council.

Three individuals were appointed as Panel Members of the Council, as prescribed in section 187 of the Act, during 2003 – 2004. Panel members were not paid a fee for work undertaken as a result of that appointment.

Council Meetings

The Council had Full Council meetings four times throughout 2003 – 2004, with one of these having a specific professional development focus. The Executive Group, comprising representatives from each of the sub-groups of the Council, met four times to act as the decision making body for the Council between meetings of the Full Council.

The strategic planning exercise undertaken by the Council in May 2003 identified the need for a programme of meetings for regionally based Official Visitors. This programme has been established, with regional Official Visitors meeting as a group prior to each Full Council meeting.

A summary of the meetings attended by Council members during 2003 - 2004 is contained at Appendix 4.

Budget

The Council was allocated a budget of $496,708 for 2003 – 2004. Expenditure for the financial year 2003 – 2004 totalled $529,570 at 30 June 2004 (Appendix 5).

Members of the Council are entitled to remuneration (section 180 of the Act). During 2003 – 2004 the remuneration rate for members of the Council was reviewed and increased thus impacting on the Council's expenditure for the year. This was the first review of the remuneration rates since the Council was established in 1997. The Department of Health provided additional funding to meet this expense.

PART TWO

THE RIGHTS OF PEOPLE WITH A MENTAL ILLNESS

A FRAMEWORK OF PRINCIPLES TO PROTECT RIGHTS

Council's functions include the observance of the rights of people defined under the *Mental Health Act 1996* as "*affected persons*". It has the power, among others, to inspect consumers' records in order to ensure that those rights are observed, including that explanations have been given verbally and in writing to the individual.

In the Council's Annual Report for 2002 – 2003 we elaborated on the derivation of rights for people who have a mental illness from sources including:

- The "*Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*" (UN Principles), a resolution adopted in 1991 by the General Assembly of the United Nations.
- Building on this resolution twelve Guiding Principles were adopted in Australia in December 1996 to underline the *National Standards for Mental Health Services*. Each set of guidelines for policy development and service delivery in the states was to be developed against this framework of national and international principles. Mental Health Services continue to be assessed for accreditation against the National Standards for Mental Health Services.
- The *Mental Health Act 1996* (the Act) accords a set of legal rights to consumers that protect them and mental health professionals.
- A pamphlet published by the Office of the Chief Psychiatrist sets out, in an abbreviated form, some of the rights accorded to consumers treated under the Act, viz:

  "Written and verbal information about your legal status, rights and entitlements.

  Copies of most of the orders made about you.

  An interview by a psychiatrist.

  Access your medical records (this right may be restricted).

  Make a complaint to the hospital authorities, the Council of Official Visitors, the Chief Psychiatrist or the Mental Health Review Board.

  A second opinion from another psychiatrist.

  Ask questions and be fully informed about any treatment you are offered.

  Contact people by letter or phone and be visited, use of personal possessions at the hospital, and vote at elections (these rights may be restricted).

  Obtain legal advice (The Mental Health Law Centre can provide free legal advice about your rights under the Mental Health Act 1996).

  Ask the Mental Health Review Board to review your case.

  Request a visit from an Official Visitor".

These documents address issues of human rights including those, for example, of the inherent dignity of the individual and the rights to respect and privacy.

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

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

A strategic planning exercise undertaken by the Council in May 2003 established a number of targets for the next three years that continue the focus on increasing the protection of consumer rights. The Council's achievements associated with these targets are reported on in *Part Three Activities of the Council* below.

This year the Council has also developed practical guides for Official Visitors. These are derived from the legislation and human rights principles and include position statements on the statutory rights to Second Opinions and a guide for preparation for hearings at the Mental Health Review Board. The Council also reviewed and confirmed its previous position paper related to Closed Circuit TV monitoring.

The Council urges the Minister to ensure that the protection of rights based on both UN Principles and the National Standards is explicit in forthcoming amended legislation.

EXAMPLES OF BREACHES

Adherence to the above statements of rights and principles remains critical to best mental health practices and to a high quality of care.

The statutory functions of the Council of Official Visitors are rights focused. In the course of their work Official Visitors have identified numerous issues that demonstrate that the rights of consumers in a variety of settings are not always observed. Readers are invited to ask themselves whether these breaches would occur and/or be tolerated by and for individuals with acute or chronic physical illnesses.

The Council recognises that there is pressure on inpatient beds throughout the whole system and that more than the accepted number of people are commonly admitted to units. The Council also recognises that services and providers charged with delivering services often face a range of problems, many related to resources.

However, the Council will raise any practices identified as not being conducive to patient care and likely to impact adversely on treatment and recovery, especially those which breach rights accorded either in principle or law. Case examples that outline these concerns, and on which Council has intervened, follow.

Intervention on behalf of an individual consumer by an Official Visitor can make an enormous positive difference to that person's stay and/or experience.

The examples demonstrate that patient rights as prescribed by the Mental Health Act [e.g. rights to information, to second opinions and to privacy, dignity and respect] and the underlying principles are frequently breached by those charged with the care of people with acute or enduring mental illnesses.

MENTAL HEALTH SERVICES

Respect of Individual Dignity

A number of issues are provided to illustrate how a not unreasonable expectation that dignity will be valued in a hospital is too often not respected.

1 Residents of the Murchison Ward, Graylands Hospital had been provided with and dressed in open backed night gowns, a situation that had apparently prevailed for some time. Men and women walked around the ward wearing nothing else but these, in our view demonstrating little respect for individual dignity.

Although the hospital has reassured the Council that they have now reached an agreement with the providers of clean clothing, it should not be up to the Council to draw this to notice.

2 At the Swan Valley Centre a woman who is a practicing Muslim was nursed in the secondary seclusion room because ward beds were not available. It was difficult for Council to understand why nursing staff were reluctant to ensure that she had privacy by placing a temporary cover over the window. Among other things she was anxious not to be seen by men when sleeping without hijab.

In this community, health care providers need to be sensitive to the implications of the cultural beliefs held by men and women as to head coverings, preference for women carers etc. In any case the Council cannot support the use of seclusion rooms as bedrooms. There is a community expectation that when a person is ill enough to be admitted to hospital they will be provided with a bed.

3 Seclusion practices: lack of facilities

The Act section 120 requires that [in seclusion area/s] appropriate provision is made for the basic needs of the patient, including *"bedding, clothing, food, drink and toilet facilities"*. The following examples, affecting three consumers, demonstrate that the Act has not been complied with, and it is clear that little attention was paid to the protection of dignity for these patients.

a) The Council has received complaints from 2 individuals who had been subject to seclusion but who were left without toilet facilities and said they had no option other than to urinate on the floor.

b) Another woman who was menstruating while in seclusion was unable to get a pad or tampon.

The Council acknowledges that staff must judge what inherent risks there may be when responding to patient requests in these circumstances, but observes that these incidents were highly distressing to the individual patients. In anyone's view their individual dignity was diminished.

Services for Indigenous Australians

Over the summer a number of requests were made of Official Visitors by Indigenous Australians to see or speak with another person they thought would better understand their circumstances. The service at Derbarl Yerrigan had been defunded, the Aboriginal Psychiatric Service based at Graylands is not a state or sector wide service and the mental health units do not employ Aboriginal liaison staff, as do general hospitals.

The Council was unable to access any services that could help to meet these simple [our view] requests. As a consequence the Council plans to develop a panel of Indigenous people and has asked the Minister for Health to authorise their payment.

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

Bunbury Unit: Multiple Matters – A Selection

In the last Annual Report the Council expressed its concern at the number of South West Region consumers transferred to Perth hospitals and while this practice has decreased [but still continues] other issues endure, we argue, to the detriment of people needing treatment.

1 Overnight Seclusion and failure to inform of rights

A man admitted to the Acute Psychiatric Unit (APU) was placed in seclusion at just before 8pm and subsequently spent the whole night in the seclusion room. The Medical Record revealed that "seclusion was unable to be ceased due to staff shortage 1:1 security/nurse special ordered overnight however there being no cover between midnight and 07:00 hours" (sic).

In the view of Council as the man slept for most of the night this measure was not appropriate. It remains unclear as to whether the situation continued to meet the requirements for seclusion under the *Mental Health Act 1996*.

As was noted in the medical record a request for a security guard as a 'Security Guard Special' was made. Nursing personnel have, several times, informed the Official Visitors that a "security guard special" is used when male nursing staff are not rostered for a shift.

The Council does not support in any way the use of a security guard to substitute for the nursing care clearly needed for people in an acute phase of their illness. A security guard is not able to provide care, make and record observations, and carry out treatment regimes. If the intent is solely to guard the person the Council suggests that using the term "special" can and does lead to confusion, often unfortunately by staff.

This is a matter of grave concern and one that Council continues to raise with the Office of Mental Health, the service and the Chief Psychiatrist.

In relation to this man there was no record that, as required [S156, 157], his rights had been explained to either himself or a relative on admission. In April 2004 the Council asked for clarification of the circumstances surrounding this man's admission. At the time of writing we have yet to receive this advice.

2 Diminished personal dignity

The woman referred to above as being unable to access sanitary supplies while in seclusion was at Bunbury APU.

An Official Visitor was at the ward within an hour of the woman's release. She was by then distressed and humiliated. The Official Visitor questioned the staff who said they did not know whether they had the power under the Act to break seclusion in order to provide the woman with sanitary supplies.

Despite the staff being quite senior, their lack of knowledge as to how the Act applies and as to their capacity to make decisions to provide needed care and services had a direct impact on diminishing this woman's dignity. The Council claims that this treatment also breaches S120 of the Act. It should be noted that despite the Council requesting information as to the reasons for this woman's complaint in April 2004, at the time of writing no response has been received.

3 Right to second opinion

The *Mental Health Act 1996*, section 111 provides involuntary patients with the right to access an opinion from a psychiatrist, who has not previously considered the matter, as to whether the treatment they are receiving should be given.

A patient at the Bunbury Unit who requested a second opinion was advised that as she had already been seen by two psychiatrists there was no need; further she was told that should she want to pursue this opinion she would need to pay for a private psychiatrist.

The consumer's "Involuntary Patient Order" had been completed by one of the Unit's psychiatrists. She was then admitted under the care of the other psychiatrist within the unit. At no point had the consumer requested that either of these psychiatrists provide an opinion for the purposes of giving a second opinion. Due to the erroneous view held by staff no arrangements were made for the opinion to be provided.

Only after the intervention of the Official Visitor was a second opinion arranged.

The delay and attitude of the staff coupled with lack of information about second opinions is of grave concern and constitutes a breach of the legislation. Involuntary patients are reliant on staff to receive information in relation to these and related rights. The Council is concerned about the level of preparation that staff receive to ensure they understand their statutory responsibilities in regard to the patient's right [among others] to seek a second opinion.

4 Observance of statutory rights

This instance concerns a complaint brought to an Official Visitor by a man admitted to the APU. He was concerned about the rationale for his admission as an involuntary patient and thought that he was being detained because of his religious beliefs.

He had been taken to the Emergency Department by the Police and when he asked the nurses and doctor at the hospital what his rights were was told that he would have to wait to be assessed by a psychiatrist.

He said that he was not told that he been placed on a Form 1 [and was required to remain at the hospital until he was seen by a psychiatrist] so he left the hospital, going back to the police station from where he was returned to the hospital.

He was sedated and woke up in the medical ward with a security guard by the bed. Nurses on the medical ward told him that he had to remain in the hospital until a psychiatrist saw him and that a videoconference had been set up for a day or so hence. He was agreeable to remaining in the hospital until he was assessed but was not told that he may be made an involuntary patient after he was assessed.

The Official Visitor provided strong advocacy for this person both within the hospital and the APU as well as by providing referral to the Mental Health Law Centre.

Some of the issues encountered for this one man:

- A copy of the Form 6 had not been placed as required on the record;
- Despite an intention for him to be transferred from the ED to the APU he was sent to a medical ward.
- A Mental Health Review Board hearing originally scheduled for three days after admission was booked for another 8 days after that, then another three weeks after that.
- The man left the ward without leave for a few days and when he was persuaded to return could not be accommodated as his bed was occupied by another patient. He was transferred to a metropolitan hospital.

5 *Security guards substitute for nurses*

Following a meeting between local Official Visitors and three professional staff to try to clarify hospital policy on the use of security guards to "special" patients an Official Visitor was told next day by nursing staff that a security guard had been used to "special" a patient since admission the previous day. Two psychiatrists had requested nurse specials for patients only to have security guards deployed.

The Council remains absolutely opposed to any policy or practice where a security guard could be substituted for a nurse and compromise patient care. The matter has been taken up with the hospital management as well as with the Chief Psychiatrist.

6 *Accident and Emergency Unit*

The Council received a complaint from an involuntary consumer who had been the subject of a "Form 1" or a Referral for Examination by a Psychiatrist at the Bunbury Emergency Department (ED). An ED doctor told him that he would be transferred to the APU for assessment. However he was then sedated and sent to a Medical Ward guarded by a security guard. He was told that he could not leave.

From the medical record it appeared that besides a psychiatrist, no staff in the APU knew that there was a patient in these circumstances in the ED awaiting a bed.

The Council asked a series of questions of the ED Director and also pointed out that referral of any person to a hospital other than an authorised hospital does not allow for their detention under the Mental Health Act [i.e. this person was in reality free to leave the medical ward].

A long and considered response was received that essentially pointed to the difficulties inherent in providing mental health services at Bunbury: "Admissions to the APU …… can only occur after a doctor has accepted the patient, this creates some difficulty when a person is present who requires admission to the APU and no accepting doctor can be obtained"; and "The ED medical staff are aware that the general wards and ICU are not part of the authorized hospital. Unfortunately incomplete access to the APU creates the situation where the safest choice for the patient is to admit to those areas whilst attempting to obtain mental health review".

Despite our concern about experiences in Accident and Emergency units [where this case could alternatively be recorded], this issue is placed here, to emphasise the Council's unresolved concerns about the Bunbury Acute Psychiatric Unit.

The Council acknowledges the difficulties for medical, nursing and administrative staff at the Bunbury Regional Hospital but as a consumer advocate our charge is to ensure that patients who fall within the ambit of the Mental Health Act are dealt with according to the processes established by that statute. Too often, and for a range of reasons, these procedures are not followed.

Overcrowding in Acute Units

More patients than there are available beds has resulted in a number of complaints by patients, Official Visitors and ward staff.

1 Swan Valley Centre

The woman referred to in the notes about respect for dignity was placed in the secondary seclusion room because of bed pressures.

Late in 2003 on three consecutive days this Unit was 'over the count' by 4, then 3, then 2 patients, remaining so for the next six days. Then a brief respite again saw a consistent 2 over the count for several more days. The consequences include the more obvious such as staff pressures when ideal nurse patient ratios are unable to be adhered to; however it also means for patients that there is nowhere to secure their belongings, nowhere to rest during the day, nowhere to be alone, and nowhere to see visitors. Nurses report that more medication is needed and that the level of frustration/aggression increases among all patients as a result of overcrowding.

2 Alma Street Centre

People have been received at the hospital and accommodated in a side room, with only a mattress on the floor. This is inappropriate and distresses patients especially when a mattress rather than a bed is provided. The lack of an available bed does not excuse the hospital from providing appropriate and convenient facilities for any patient no matter what their

diagnosis. There is a community expectation that when an individual is ill enough to be admitted to a hospital s/he will be provided with a bed, not a mattress on a floor.

3 Graylands Hospital

In just less than six weeks one woman admitted to Graylands Hospital as an involuntary patient was moved 13 times, sometimes within less than 24 hours, and on one occasion at 11.00 pm. The concern of the Official Visitor who advocated for her and managed her complaint centred on her illness and her highly aroused state. We understood the pressure on beds, but so many transfers for a patient in this condition is not conducive to quality care nor does it assist in establishing routines. The multiple transfers were not all related to changes in the woman's mental state, but rather reflected the need to find a bed for someone else.

The Council appreciates the demands put on staff to find solutions and beds, but by no measure could this woman's treatment be deemed to be showing consideration to her.

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

The Council knows that there is pressure on inpatient beds throughout the whole system and that it is not uncommon for more than the accepted number of people to be admitted to units. Placement into seclusion rooms or side rooms cannot be conducive to good patient care and in the long term is likely to impact adversely on treatment and recovery.

Correspondence with Coroner

A number of newspaper and anecdotal reports have suggested that from time to time patients admitted to psychiatric units or those recently discharged from a mental health unit have died suddenly, in all likelihood as a result of suicide. Some hearsay estimates put this at between 10 and 14 cases a year. We wondered whether there may be a pattern of deaths linked to early discharge.

The Council wrote to the Coroner to inquire as to whether any more exact information about these claims could be obtained. In particular one of our concerns was about the lack of appropriate community support services.

The Coroner responded with several suggestions and an offer to Council to review certain files, once cleared by the Coronial Ethics Committee. It is not possible for the Council to follow this through but there is clearly interest from Service Directors, the Office of Mental Health and the Chief Psychiatrist.

As a consequence the Office of Mental Health has initiated a process to establish a Sentinel Events Review Committee chaired by the Chief Medical Officer. The process will make 'a detailed examination of circumstances surrounding any serious adverse event involving mentally ill people and make appropriate recommendations'. The Council welcomes this initiative.

Hospital Emergency Department: Management of People with Mental Illness

Increasingly the management of people in Emergency Departments of general hospitals has come under scrutiny in the sector. It is acknowledged that these departments are focussed on providing care to individuals with life threatening conditions that in some circumstances may detract from the ideal care of individuals with an acute psychiatric illness.

This particular group of patients, in an acute phase of an illness, is likely to be aroused and provide many challenges. But people with a psychiatric illness may wait for many hours in an Emergency Department for a suitable bed: some will require admission to an authorised hospital and others will agree to treatment.

Experienced psychiatric nurses are usually unavailable in Emergency Departments.

The Council has had instances drawn to our notice when individuals have been restrained either physically or by medication in order to manage them while waiting a bed.

One man for instance, reportedly became violent and was held by a four point restraint for 22 hours in a metropolitan hospital. A psychiatrist (or registrar) had assessed the consumer and completed both a Form One "Referral for Psychiatric Examination" and a Form Three "Transport Order". There was no bed available at any authorised hospital so the orders were cancelled and the consumer was transferred to a non-authorised hospital ward with a nurse special. After two days he was transferred to an authorised hospital via new Forms One and Three.

Another person referred to above was sedated and transferred to a medical ward where a security guard was placed with him.

These practices are invoked in order to manage access to beds, not the clinical condition of each individual.

It is of concern to the Council that due to the pressure on authorised beds the first consumer was restrained and treated within the Emergency Department for an extended period and in particular the report that he was physically restrained for 22 hours. It is unclear on what basis his treatment in the ward occurred and if, in effect, he was being detained and treated involuntarily, but not subject to the provisions and safeguards of the Act.

It is again acknowledged that the pressure on acute beds is a system-wide issue compounded by the lack of intermediate care (step down beds), however it has a direct impact on individual consumers and their care.

People with Acquired Brain Injury

The Council is aware of a number of individuals with an Acquired Brain Injury (ABI) whose behaviour has been unable to be effectively managed in general/rehabilitation hospitals. Despite their not having a psychiatric illness each has been transferred to an authorised hospital effectively as involuntary patients, though not subject to the requirements and protections of the Mental Health Act.

The Council's concerns about the accommodation of people with an ABI at the authorised hospital site/s and the consequential deprivation of their liberty include:

- secure mental health units are being used as the solution to concerns about safety in general medical wards;
- individuals with an ABI are neither defined as, nor dealt with as, involuntary patients as prescribed by the *Mental Health Act 1996* (eg to receive scheduled assessments by a psychiatrist and reviews before the Mental Health Review Board);
- their care detracts from the care of 'affected persons', one example being that three staff are required to walk one person into the garden leaving fewer staff available for the care of other patients;
- individualised and specialised programmes of physical rehabilitation and re-socialisation should be in place but the secure mental health units do not have the staff or funding to provide this;
- issues related to consent to detention and to treatment, including if provided by a guardian appointed under the *Guardianship and Administration Act 1990*; and
- scarce mental health resources are used for non-mental health clients.

It is the Council's view that this particular sub-population of individuals with aggressive and challenging behaviours should be treated in a specialised service. They need skilled and trained staff and appropriate long term accommodation.

The Council believes that the issue of people who have an ABI will be addressed in the forthcoming Strategic Plan for Mental Health, however the need for an appropriate service for those with challenging behaviours is most urgent. There must be a better response from the health care system to such needs than that made currently.

Second Opinion (*Mental Health Act 1996*, sections 111 & 164(2))

Despite the legislation being quite clear, Official Visitors encounter differing practice on the process for second opinion requests even within the same hospital. In some wards nursing staff accept a consumer's request for a second opinion (verbal or written) and in other wards the consumer is expected to ask the treating doctor directly. The doctor may advise that the consumer put the request in writing.

The Council has taken up these inconsistencies with Graylands and other hospitals, in particular the practice requiring that the request be placed in writing. In December 2002 a Nursing Notice was issued at Graylands reminding nursing staff that requests made by patients for second opinions were not required to be in writing.

Less than one year later a consumer in that hospital advised an Official Visitor that staff had told her that any request for a second opinion must be placed in writing. When the Council raised this matter with the Clinical Nurse Specialist it was said that there was no current written policy in relation to second opinions requests. Further, on asking nursing staff what they advised consumers, most were of the belief that a written request was required.

Confusion for staff in Graylands and other hospitals regarding the procedures for second opinions remain and are widespread.

The Council has published its own statements, derived from the Act, for the information and reference of its Official Visitors and sent it to all services for their information as to our position. We have taken our concerns to the Chief Psychiatrist to urge him that there should be a sector wide policy developed for clinicians.

Charges for Board and Lodging: Graylands Hospital

The Council received the complaint that a man at Graylands Hospital was admitted as an involuntary patient and as part of a management plan was to be charged $22.05 a day for board. A note in the medical record confirmed that this would be part of a disincentive to discourage him from seeking readmission.

Staff confirmed with the Official Visitor that board is charged to those who "treat Graylands Hospital as a rest home or the like", and has been the practice with a number of other consumers.

The Council is of the view that should a person meet the criteria to be admitted under the Mental Health Act then s/he meets the criteria for acute care and there can be no justification for charging board. If that person does not need inpatient care then it seems to us that s/he should be discharged, if necessary with a Community Treatment Order.

This matter remains unresolved and the questions we asked at the time remain unanswered. It continues to affect several individuals and it requires a sector wide determination based on a number of principles. One of those principles is that under no circumstances should a charge be levied on anyone who is an involuntary patient detained in an authorised hospital.

Further comment is added:

- *It could be argued that there is a disciplinary component to a practice said to be a disincentive, but imposed at a time when an individual has no choice about their detention.*
- *If an individual does not really need acute care then the bed occupied is unavailable for a person who does.*
- *This issue may accentuate the lack of appropriate accommodation for people with enduring illness.*

Community Treatment Order Issues

1 In this case the treating psychiatrist directed that the conditions of a Community Treatment Order include that the consumer "accept treatment as advised under direction of Doctor X…". The treating psychiatrist required the person to remain as an in-patient at a private and non-authorised psychiatric hospital.

The woman told an Official Visitor that the treating psychiatrist had advised her that unless she complied with the CTO conditions he would revoke the CTO and readmit her as an involuntary patient to an authorised hospital.

This is a clear breach of the Act that specifies that a Community Treatment Order is for treatment in the community which is defined in the legislation as "other than as an in-patient of a hospital".

This is an example of a disturbing misuse of the authority of a psychiatrist and a breach of the Mental Health Act.

The Council continues to hear anecdotes of similar circumstances.

2 In another instance the conditions of a Community Treatment Order were varied in as much as a different treating psychiatrist was named to replace the original one, now on leave. The woman did not receive a copy of the notification. An Official Visitor contacted a community mental health nurse who found that, after two weeks, the variation on the CTO form was still held in the records office.

Whilst there is no time frame specified in section 159 of the Act related to the giving of a copy of such orders to the affected person, two weeks is an unacceptable delay. This would have been particularly significant had the variation contained any changes to her treatment plan, as she would not be in a position to comply with such treatment. This would potentially place her in breach of her CTO with the possibility that it would be revoked and she be made an involuntary detained patient.

Mental Health Review Board Hearings: Medical Staff Attendance and/or Reports

Two instances of several are described where hearings at the Mental Health Review Board were not attended by medical staff who had been involved in the consumers' treatment.

One man, a patient at the Swan Valley Centre had a medical report provided, but neither the consultant nor the registrar attended the hearing. As the man wanted to challenge some of the report content the hearing had to be postponed for three weeks.

Another man with a CTO from the Mills Street Centre appeared but with no medical staff, no report and no discharge summary. His hearing continued as scheduled.

The Council claims that because the health care providers, for whatever reason, were unable to either attend a hearing or to present a report, there will be a perception by their patients that fairness and justice are compromised.

LICENSED PRIVATE PSYCHIATRIC HOSTELS

Level of Supervision

The standards that licensees are expected to meet include that the approved supervisor should "have adequate communication skills in the English language both written and verbal".

Official Visitors have met supervisors, particularly on evening shifts, at hostels who are not able to converse meaningfully in English and could be assumed not to be able to read or write in English. The Council regards this very seriously, its concerns extending to the workers involved as well as to the residents.

Provisions for Individual Possessions and Security

The facilities provided for consumers to store their clothing and belongings and to keep them secure vary greatly between hostels and constitutes an ongoing source of complaint from individual residents at most of the hostels.

Some hostels provide individual wardrobes, most do not. In some the number of beds in bedrooms means that there is no space for wardrobes or even for small personal pieces of furniture.

Some hostels refuse to provide lockable bedroom doors so that people have both a degree of privacy and a safe place for them and their belongings, claiming that consumers will lose the key and that locked doors in this population pose a fire risk.

This claim is flawed as some hostels, with similar resident populations, do provide locks on bedroom doors for residents. If the person loses his/her key, or the staff needs to enter for any reason, including fire, a master key system would be utilised.

There is a community expectation that individuals should exercise control over personal belongings. There is also a community expectation that individuals should control who enters one's home, in particular the bedroom. Denial of this control diminishes the right to privacy and reinforces the residents' institutionalisation.

The Council does not accept that residents of licensed hostels are unable to be provided with some modicum of personal control.

Public Trustee

A matter of ongoing concern for the Council in relation to some hostel residents regards the management of their income and expenditures. Regulation 14 Hospitals [Licensing and Conduct of Private Psychiatric Hostels] states that the hostel license holder is to ensure that a resident who receives a Commonwealth pension must be "paid or remitted" at least 12.5% of this pension.

Standard 4 of the Licensing Standards is directed to ensuring a "clear and transparent process for the management of the finances of those residents whose finances they manage".

There is currently no uniformity within or between hostels and it is unclear how some of the arrangements are made. Certainly as noted below, resident agreements are few and far between. The Council is concerned that there are hostels that do not have clear and transparent arrangements for dealing with residents' monies.

Many individuals are clients of the Public Trustee. The Trustee and the Council have developed a schedule of visiting in order for them to review the records kept by licensees, one aim being to ensure that all income and outgoings are accounted for as set in the standards that licensees are expected to meet. The visits started recently and are planned to continue at 2 or 3 per annum.

ACCOMMODATION

Authorised Hospitals: Design and Furnishing

Much of the accommodation in acute hospital settings, old and more recent, is open to criticism because the ward environments reflect decision-making processes that did not engage with providers or consumers in the planning stages.

For example few have separate visiting rooms. It is often impossible to make a private telephone call because of the location of telephones. Few have adequate outside areas, especially those where secure facilities are imperative.

It is noted below that the outdoor area at Joondalup is, and always has been, inadequate and similar concerns remain to be addressed at Armadale. Further the outdoor area at Armadale has had no outdoor furniture for well over a year because it was deemed that extra robust tables and seats are needed – however the point can be made that Bentley has long used domestic quality plastic outdoor furniture.

Similarly the outdoor areas at Frankland Unit have been inappropriate since renovations started in February this year. These are yet to be completed. The consequences of this disruption have been that unless staff are available to accompany individuals, there is no access to the limited outdoor areas.

These environs impact adversely on consumers. In other hospitals, repairs take an inordinate time to be effected, leading to impressions of drabness and inertia. Areas surrounding units often add to negative impressions with gardens not tended and cleaning neglected.

The Council trusts that the design and furnishing of new Units and renovations to existing ones will address these and related issues. The Council has welcomed the opportunity to comment this year along with service providers, at the planning stage of renovations for Mills Street Centre.

The Council continues to make representations about the concerns which impact on the quality of life in hospital, as well as on the rights of individuals. Factors such as furniture and access to outdoor spaces can have a major impact on consumers, and on their experience of acute illness.

In closing this section we make the point that it should not be necessary for Council to correspond – as we have needed to do - with senior management or even with the Minister to rectify some relatively minor matters that should be dealt with as a matter of quality management.

Accommodation Needs for People with an Enduring Illness

There is no doubt that in this state as in others, there is a complex and daily struggle to provide necessary accommodation services. Plans to meet a predictable increased need for services for individuals with a mental illness including family support, slow stream rehabilitation, accommodation (including supported community based housing) and staff recruitment are underdeveloped.

About 20% of the population in WA will be diagnosed with a mental illness during their lifetime. The nature of these illnesses is that many are recurrent, becoming chronic and enduring. Modern pharmacotherapies are increasingly available to control and/or manage exacerbations. Of the new illnesses diagnosed in WA each year a good proportion are bound to progress to disability and, of the people diagnosed, many, if not most, will eventually require supported accommodation. It is estimated that psychiatric disability constitutes over 25% of all disability.

People with long-term psychiatric illnesses and disability too often live on the margins of, and in the shadow of, the community, mostly neither accepted nor challenged by it, few can stay connected to it.

Official Visitors regularly meet individuals admitted to hospital with acute illness essentially because of accommodation issues. As reported last year we continue to learn of people whose behaviour has led to a prison sentence, and yet others who sleep rough. In 2004, it is difficult to accept that individuals with long-term psychiatric illness continue to be at risk of homelessness, or forced by circumstance to live in sub-standard conditions because there are neither sufficient nor appropriate housing options. It is unthinkable that people diagnosed with physical illnesses characterised either by remission and exacerbation, or by a gradual deterioration and disability, would be left with inadequate services, excluded from others, or be made vulnerable to exploitation in housing options.

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

The current state government committed to an expenditure of $4 million over 4 years (project Community Options 100) to provide supported accommodation options for people with chronic illness. The individuals concerned include 30 of the 42 residents of Murchison Ward at Graylands Hospital. Most of these individuals are involuntary patients, some for 30 years. A lengthy consultative and planning process was started but as it became clear that no progress was being made Council reluctantly withdrew from the project reference group.

Preparation of these most vulnerable individuals for any transition, including socialisation and slow stream rehabilitation should be part of every Murchison resident's daily activity, but unfortunately it is not and has not been.

Besides a responsibility for the consumers at Murchison, the Council also holds a brief for those residents of licensed psychiatric hostels who are socially dependent because of mental illness.

To the end of June 2004 there were 584 beds in 15 licensed psychiatric hostels with a further 41 beds in 5 sets of group homes, (Richmond Fellowship and Casson Homes), all in the Perth metropolitan area. Two hostels are run by non-profit, non-government agencies. However most of them are privately owned and operate as business concerns.

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

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

It is also noticeable that many hostel residents have additional degenerative and lifestyle health problems associated with ageing and these problems compound their disability.

A meagre 'care package' [max. $12 daily] is provided by the State to hostel owners for those individuals who are most severely disabled. Disability and aged care services provide models that could, and should be, examined and modified for the mental health field.

The Council welcomes the implementation of the Department of Health's Licensing Standards and Care Standards for licensed private psychiatric hostels. The Care Standards have been developed through the Office of the Chief Psychiatrist. A forum to which Council contributes has been established in order to identify how best to improve standards of housing and care for residents of the licensed hostels.

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

The need for a variety of suitable supported accommodation for people with an enduring illness is emphasised as requiring urgent attention. This is the right of all very vulnerable men and women, elderly and young and for people from diverse backgrounds, including Indigenous Australians.

ONGOING ISSUES THAT REQUIRE REMEDY

A number of issues raised in the Council's Annual Reports from 1997 remain unresolved and have continued to give concern during 2003 - 2004. They are again outlined and although a few require amendment to legislation for progress to be made, most are matters to be resolved by committed management decisions. If these were addressed not only the Official Visitors, but importantly the consumers themselves, believe that the quality of life for people with acute, as well as enduring illnesses will be improved.

FOR PEOPLE ADMITTED TO AUTHORISED HOSPITALS

1997 - 1998

1 *The outside area at Joondalup Mental Health Unit secure ward has always been inadequate.*

2004 update: The outdoor area should be extended to an appropriate size and configured to enable access to the garden.

1998 - 1999

1 The impact of overcrowding in authorised hospitals

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

2004 update: Many examples outlined above reflect this long standing observation.

2 Definition of "affected person"

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

2004 update: Although this recommendation has been provided to the Minister for his consideration in forthcoming legislation, the need is set out here as a reminder that Council is frequently requested to intervene on behalf of these groups of consumers. We emphasise that the rights of the above groups of hospital consumers can be breached.

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

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

2004 update: Issues continue to be monitored by Council and reported as they are brought to our attention [n.b. consumers report the differences between hospitals to which they have been admitted].

4 Consumer access to personal records Mental Health Act 1996, s 160 & 161

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

2004 update: Council recommends that amendment to the legislation is required.

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

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

2004 update: There must be a separation between the psychiatrist who is prescribing the medical (non-psychiatric) treatment and the psychiatrist who is approving the giving of this medical treatment.

6 Second opinions

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

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

2004 update: The Council has developed a position statement, derived from the Act, for its use and for the information of Official Visitors, including one for individuals treated by Community Treatment Order.

1999 - 2000

1 Shortage of age appropriate facilities for children and adolescents

A contingency plan is urgently required for occasions when all beds are full at the WAY Centre.

2004 update: Almost two years ago the Office of Mental Health (OMH) circulated a discussion paper to seek responses to policy proposals, but to June 2004 there has been no decision.

The Council thinks that a small number of age appropriate forensic beds are required.

2 Mentally impaired defendants restricted access to outside areas at Frankland Centre

This is an issue related to staffing levels. Appropriate levels need to be resourced and a budgetary allocation made.

2004 update: The situation has been compounded by additional restrictions due to a security upgrade, including security for outside areas. This was started in February 2004 and is incomplete at June 30th. The consequence is that consumers have had even more restricted time in the fresh air.

3 Human relations and need for intimacy

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

2004 update: Little progress has been made, even on a very practical level where visits and telephone calls often cannot be enjoyed in private.

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

Increase access to on-site gyms and to equipment (bikes, balls etc).

2004 update: Access to physical exercise opportunities continues to vary between hospitals and wards.

2000 - 2001

1 Design of facilities

The Council noted that they, consumers, and providers should be invited to participate in planning renovations and new units to ensure a consumer perspective is considered in design. Over the past two years the Council has been asked to comment on proposed renovations for a small number of facilities.

2004 update: Unfortunately with few exceptions, this input still may not be incorporated. Among other matters, the standard and provision of facilities for visitors, outdoor areas, and telephone access continues to differ between acute units.

2002 - 2003

1 Access to Allied Health Professionals / Multi-disciplinary team

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

2004 update: There has been no marked change.

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

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

2004 update: There has been no marked change.

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

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

2004 update: There has been no marked change.

FOR PEOPLE RESIDENT IN LICENSED PRIVATE PSYCHIATRIC HOSTELS

1998 – 1999

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

Services have continued to be reduced through inadequately funded Government programmes, reinforcing the isolation of hostel residents from main stream health services. Some services are rationed by the providers, others, including transport to appointments, are reliant on the licensee making arrangements as required.

Although Official Visitors take up these matters case by case, it is clear that more global management is required, including by processes initiated by the Office of Mental Health and the Office of the Chief Psychiatrist.

From Council experience, individuals need to be assessed, and their needs identified for access to a range of services including:

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

2004 update: A concerted campaign is needed to inform and remind providers about the physical health needs of hostel residents and to ensure that General Practitioners and other health professionals provide services under newly introduced Medicare arrangements.

2 Licensing standards in licensed private psychiatric hostels required

2004 update: The Council welcomes the introduction of standards and the process of implementation from 01 January 2004. Despite representation on the working parties, and despite having three years to implement the standards, several hostel owners claim that they are not feasible.

The Council has a good working relationship with the Licensing Standards and Review Unit of the Department of Health and Official Visitors frequently observe issues of concern that are then reported to the Unit. We also have a positive relationship with most individual licensees throughout the sector.

However, the Council argues that the reports of standards that are monitored and audited by the LSRU should be subject to publicly accessible reporting.

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

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

2004 update: These are ongoing issues of concern for residents in a number of hostels and can contribute to a demeaning of dignity and privacy.

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

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

2004 update: See item above.

5 *Residents of most licensed psychiatric hostels do not have a resident agreement with the licensee.*

A resident agreement should, among other requirements, detail the rights and responsibilities of the resident and the owner/licensee.

2004 update: These are a crucial component of the licensing arrangements and Council argues that all hostels should provide this kind of undertaking to residents.

1999 - 2000

1 *Powdered, not fresh, milk provided at some psychiatric hostels*

Fresh milk should be available for residents of private psychiatric hostels. Some hostels refuse to provide fresh milk, providing a sharp reminder that cost containment lies in this decision.

2004 update: There has been no marked change.

While it disturbs the Council to report on the number of unresolved matters, the Council is pleased to acknowledge the improvements made to the WAY Centre in terms of refurbishment for its young consumers. Last year it was reported that the Centre had a drab, custodial, institutional environment, was poorly maintained and had a number of inbuilt design faults. The hospital is commended on its positive approach to re-dressing these matters. Council will continue to monitor this area.

POLICY AND LEGISLATIVE ENVIRONMENT

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

A large number of individuals, the Council and other organisations participated in the review of the *Mental Health Act 1996* and the *Criminal Law (Mentally Impaired Defendants) Act 1996*.

We attended the presentation of the report of a very comprehensive process to the Minister for Health. We take this opportunity to welcome the general consensus that an increased and explicit emphasis on rights should be incorporated into new legislation.

It is hoped that the Government will write new legislation rather than amend the old, one reason being that this statute is a working document for health care providers and should be presented in as easy and accessible a form as possible. Council trusts that a new Mental Health Act will be a priority for Government and that a bipartisan approach will be taken to its passage in the Parliament.

In the meantime the Council remains concerned that the rights of voluntary patients can also be trespassed on without the individual having the capacity to access mainstream services either due to their health state and/or the treatment they are receiving. We receive numerous inquiries from individuals and family members concerning voluntary patients but because we have no mandate to act on their behalf can only refer the individual to another agency.

MENTAL HEALTH REVIEW BOARD

It is the statutory right of involuntary patients to have their status reviewed by the Mental Health Review Board (Part 6 of the Act) and to appear with a legal representative and/or an Official Visitor. Individuals also have a right to request a review of their status.

As raised in previous Annual Reports, the low levels of legal representation and/or non-legal advocacy accessed by consumers at their Mental Health Review Board (MHRB) hearings remain of concern (see below). In relation to the process, questions of justice and fairness must be raised about such minimal representation and advocacy.

These concerns are shared by the Office of Mental Health that provided funding to Council in order to identify reasons for this low representation. This research, to be undertaken by Ms Barbara Gatter, is to be completed before the end of the calendar year 2004. A reference group comprising representatives from the Mental Health Law Centre, Health Consumers' Council, Mental Health Review Board and convened by the Council has been established to guide the research method and process.

It is unclear what impact the proposed inclusion of the functions of the Mental Health Review Board into the State Administrative Tribunal (SAT) will have. In acknowledging the potential advantages of a SAT in general, Council needs to be reassured that a beneficial outcome in terms of consumer contact and representation will occur. In its submission to an Inquiry of the Legislative Council, the Council of Official Visitors proposed that the Board continue to sit as prescribed by the *Mental Health Act 1996* until new mental health legislation is enacted.

When the SAT does assume the powers of the MHRB, individual consumers must have access to appropriate specialist panels for their review/s and the Tribunal must sit as does the current Board, in hospitals and clinics as required by the consumer's condition. Certainly consumers' rights to access legal representation or the assistance of an Official Visitor must remain, with adherence to those international and nationally accepted principles outlined above.

The Council's previously reported concerns regarding consumers' timely access to medical and other reports provided to the Mental Health Review Board continued during 2003 – 2004 with several examples of cases where reports were not provided in time, sometimes compounded by the psychiatrist being unavailable for the hearing.

ACTIVITIES OF THE COUNCIL

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

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

Mental Health Act 1996, section 186

INSPECTION VISITS

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

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

Appendices 6 and 7 contain summaries of the inspection visits to authorised hospitals and licensed private psychiatric hostels by the time and day of the week. All authorised hospitals were visited each month, with an additional visit to G ward at Albany Regional Hospital. In addition to the formal monthly visits, the regional hospitals (Albany, Bunbury and Kalgoorlie) were visited at least one other time each month on an informal basis. All licensed private psychiatric hostels were visited as planned with 114 formal inspection visits.

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

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

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

being at these times.

The Council's performance in conducting formal inspection visits outside normal working hours was lower during 2003 - 2004 compared to the previous year with a total of 31.7% of such visits to authorised hospitals and 35.1% of such visits to psychiatric hostels occurring outside these hours (Appendix 8).

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

STRATEGIC PLAN

In May 2003 a strategic planning exercise for the Council was undertaken and priorities developed for the next three years.

One of the key activity areas identified was to address the rights and quality of life of '*affected persons*' i.e.:

1.1 The rights and quality of life of involuntary patients in hospitals
1.2 The rights and quality of life of hostel residents
1.3 The rights and quality of life of people with a Community Treatment Order

The following priorities were then set for the year to 30 June 2004:

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

A summary of the Council's achievements in relation to these targets is as follows, with more detail below:

2003 – 2004 TARGET	2003 – 2004 OUTCOME compared to 2002 – 2003
25% increase - Mental Health Review Boards hearings attended	41.5% increase
50% increase - number of consumers on Community Treatment Orders assisted	50% increase – overall 125% increase – non-metropolitan 39.1% increase – metropolitan
10% increase - total number of '*affected persons*' having contact	24.2% increase

To assist in increasing the Council's profile with consumers the Council produced double-sided "business" cards that provide a brief overview of the role of the Council for Official Visitors to give to consumers. The Council also had the information on these cards translated into five languages; Polish, Serbian, Croatian, Italian and Vietnamese.

CONSUMER CONTACTS

Contacts Overall

During 2003 – 2004 a total of 1415 requests for contact with the Council were received from 744 consumers (Appendix 9).

These requests resulted in 1234 visits by Official Visitors to consumers and a further 2149 telephone calls either to or on behalf of the consumers as reported by the Official Visitors (Appendix 11).

The Council exceeded its strategic plan target of a 10% increase in the number of consumers contacting the Council. Compared to 2002 – 2003 there was a 24.2% increase in the total number of consumers having contact with the Council for the year 2003 – 2004. Similarly there was a 25.7% increase in the number of requests received (Appendices 9, 12A and 13A).

With the exception of 1999 – 2000, there has been an increase in the number of consumers having contact with the Council each year since it commenced operation.

Overall there has been a 105.5% increase in the total number of consumers requesting contact with the Council since 1998 – 1999 (Appendices 12A, 12B).

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

Authorised Hospitals and Licensed Private Psychiatric Hostels

Similar to previous years the most significant number of consumers with whom the Council had contact were receiving treatment in Graylands Hospital: 298 individuals (Appendices 9 and 10).

The overall number of consumers contacting the Council from non-metropolitan authorised hospitals continued to be low however there was a significant increase in these figures during 2003 – 2004. This was due to the Bunbury Unit recommencing admission of involuntary patients; the Kalgoorlie Unit being operational for the full year and a doubling of the number of individuals in the Albany Inpatient Unit requesting contact from the Council (Appendices 9, 10, 12A and 12B).

The Council has mailboxes located in the wards of some authorised hospitals. During 2003 – 2004, in addition to correspondence collected from the boxes that resulted in action by Official Visitors, the Council received 36 pieces of correspondence that was either anonymous or the author was unable to be identified, primarily via the mailboxes at Graylands Hospital.

There was a continuing increase (by 38% for 2003 – 2004) in the number of licensed private psychiatric hostel residents requesting assistance from the Council compared to previous years (Appendices, 12A and 12B).

Community Mental Health Services

There are a significant number of individuals subject to a Community Treatment Orders (CTOs) who may never have contact with the Council and it is difficult (and usually impossible) for the Council to fulfil its role of ensuring that their rights are respected.

The Council identified the need to increase contact with people on CTOs as part of its strategic plan, in particular setting a target increase of 50% for the number of consumers on Community Treatment Orders who receive assistance from the Council. This was to allow the Council to ensure that these consumers' rights are being observed and they are aware of the availability of the Council's service.

The Head of Council met with the Psychiatrist and/or Managers at the metropolitan community mental health services who had a significant number of people subject to CTOs, in an endeavour to identify ways of increasing the Council's contact with this group. The services visited, and the regional based services in Kalgoorlie, the South West and Lower Great Southern agreed to provide letters of introduction from the Council to all consumers on CTOs.

The Council has been able to meet its strategic plan target in the non-metropolitan areas with a 125% increase in the number of consumers contacting the Council. It must be noted that the actual number of consumers contacted remains low, only nine individuals, with a number of these individuals already known to the Official Visitors due to a recent admission to an authorised hospital.

In the metropolitan area there was increase of 39.1% in the number of consumers on CTOs having contact with the Council. A number of these consumers had not had any previous contact with the Council.

Council is acutely aware that most consumers treated by CTO throughout the State have no contact with us: our concern is to ensure that their rights are observed.

Mental Health Review Board

Providing assistance to consumers attending Mental Health Review Board hearings was also identified as a priority area as part of the Council's strategic plan. A target increase of 25% in the number of Mental Health Review Board hearings attended by Official Visitors at the request of consumers was set.

During 2003 - 2004 there was a 41.5% increase in the number of Mental Health Review Board hearings attended by Official Visitors in a support/advocacy role compared to the previous year (77 in 2002 – 2003 compared to 109 in 2003 - 2004). These figures only represent a very small percentage of the total hearings conducted.

Analysis

A summary of the issues raised by consumers is contained at Appendices 14A & 14B. Issues are categorised based on the consumer's view of the matter. The major issue raised is the one categorised and recorded. The Council continued to utilise the same categorisation of complaints and issues as in previous years.

Approximately 37% of contacts with consumers during 2003 – 2004 related to issues associated the *Mental Health Act 1996*, including Mental Health Review Board applications (18.5%) and attendance (12.8%).

Eighteen percent (18%) of issues related to discharge or transfer arrangements, with the majority of these based on the consumer's complaint that they did not require inpatient treatment. A small proportion of these related to delays in transfer to open wards or multiple transfers between wards.

Six percent of complaints related to the individual being given medication against their will, i.e. without their consent. This directly related to the consumer's involuntary status. Complaints related to inadequate treatment accounted for 8%.

OTHER ACTIVITIES

Policy Review and Development

Since its inception the Council has increasingly participated in policy development and advocacy at local and systemic levels throughout the mental health sector.

Position Statements

As part of the strategic planning process the need for position statements related to consumers' access to second opinions, derived from the Act, was identified as a priority for the Council. In response to this the Council developed two position statements during 2003 – 2004. These were adopted on 11 December 2003:

"*Access To Second Opinions In Authorised Hospitals, Mental Health Act 1996* section 111"; and
"*Access To Second Opinions – Community Treatment Orders, Mental Health Act 1996* section 76".

The Council reviewed and confirmed its position related to "*Closed Circuit Television [CCTV] Monitoring in Inpatient Units*".

A copy of these position statements is available from the Council's office.

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

Submissions

The Council provided comment and submissions in relation to:

- Recommendations of the Review of the *Mental Health Act 1996* and *Criminal Law (Mentally Impaired Defendants) Act 1996*;
- The Legislative Council Committee considering the State Administrative Tribunal Bill 2003 & State Administrative Tribunal (Conferral of Jurisdiction) Amendment and Repeal Bill 2003, in particular as it related to the incorporation of the Mental Health Review Board into the proposed State Administrative Tribunal;
- The Report of the *State Mental Health Strategic Plan Child and Adolescent Mental Health Services (CAMHS) Working Party - Planning for Infancy to Young Adulthood* (The Office of Mental Health);
- Health Reform Committee - the Reid Review;
- Draft Service Standards for Non-Government Providers of Community Mental Health Services;
- The State Mental Health Plan; and
- Proposed renovations to Ward 6, Mills Street Centre, Bentley.

Committee Participation

- *Private Psychiatric Hostels Standards Reference Committee*

  The Council continued as a participant in and contributor to the Private Psychiatric Hostels Standards Reference Committee. Its final meeting occurred in February 2004 following the release of the standards.

- *Community Options 100 Project Reference Group*

  Until April 2004 the Council continued to have a representative as a member of the Community Options 100 Project Reference Group for the community housing of people with serious and persistent mental illness. They have been long stay patients in public mental health inpatient facilities, primarily at Graylands Hospital. The Council withdrew its representative but remains committed to the intent of the project (refer above).

- *Human Rights and Social Justice Committee*

  The Council continued to have membership of the Human Rights and Social Justice Committee convened by the WA Association for Mental Health. The last meeting of this group occurred in November 2003.

- *Open Forum, Licensed Private Psychiatric Hostels*

  During 2003 – 2004 the Council was invited to be a member of the above forum convened by the Office of Mental Health. The Head of Council represents the Council at these forums.

- *Chief Psychiatrist Advisory Group on Electroconvulsive Therapy (CPAG on ECT)*

  The Council accepted an invitation to be involved in the CPAG on ECT. The purpose of this group is to provide advice and recommendations to the Chief Psychiatrist on the future developments of best practice and monitoring of ECT in Western Australia.

Additionally, Council representatives participated in the Australian Council on Health Care Standards – In depth Review of Mental Health Services Surveys for Bentley Health Service.

LIAISON WITH SERVICES

The Head of Council continued and expanded the process of meeting regularly with the Chief Psychiatrist, Director of the Office of Mental Health, Clinical Directors, management at the authorised hospitals in the metropolitan area and representatives from the Licensed Private Psychiatric Hostel Association. The opportunity was also taken to meet with managers and/or psychiatrists in regional areas when visiting them.

The Head of Council also met with psychiatrists and/or managers at various community mental health services to request their assistance in directing people on CTOs to the Council and also to raise its profile.

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

QUALITY ASSURANCE

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

Codes of Conduct and Ethics

The Council's Codes of Ethics and Conduct bind all members of the Council. Copies of these Codes are available from the Council's office.

Complaints Regarding Council Operations

During 2003 – 2004 five formal complaints were received regarding the operation of the Council. The complaints were investigated in line with the Council's complaint management policy, a copy of which is available from the Council's office.

In brief the content of these complaints and the associated outcomes were:

1. A staff member from a community mental health service raised concerns regarding issues of confidentiality and the need to ensure that Official Visitors were who they said they were.

Outcome: A process for community mental health service staff to confirm Official Visitors' bona fides was established.

2. Comments attributed to Official Visitors during Mental Health Review Board Hearings were raised as concerns from the President of the Mental Health Review Board.

   Outcome: Head of Council spoke directly with the President to clarify the claims. No further comment has been made.

3. Complaint from an authorised hospital regarding the process utilised by the Council in its inspection visits, in particular the asking of questions related to policy.

   Outcome: Head of Council met with Director to clarify Council's role in inspection visits and Council's autonomy. There has been no further complaint.

4. Complaint from a licensed private psychiatric hostel manager regarding interaction with two Official Visitors. It was asserted that the Official Visitors lacked rudimentary knowledge about the governance of the hostel, were expressing personal opinions with no recourse to hostel standards and had inadequate knowledge of fire safety regulations and standards. It was alleged that an Official Visitor also made an unprofessional, offensive and defamatory remark.

   Outcome: The Head of Council responded to the complaint by mail, describing the roles of Official Visitors to support our view that most of the questions raised by the complainant did not relate to the Council's functions, rather to other agencies with different but specific briefs; no further correspondence has been received.

5. Letter of complaint from a psychiatrist regarding a section of a presentation given entitled "Rights for Rural Patients: Reality or Rhetoric" at the Rural and Remote Mental Health Conference in 2003. The particular section which caused concern, and related to services at the Bunbury Acute Psychiatric Unit, noted that: "*There was no overt local professional or managerial commitment to ensure that this crucial regional service was provided*".

   Outcome: The information presented at the conference was extracted from the Council's previous Annual Reports and was directly based on the Council's experience of the system concerned. Some correspondence was exchanged between the complainant and the Head of Council, but she declined to meet with him in his public clinic time.

Professional Development Activities

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

A two day orientation programme was provided to members of the Council during 2003 - 2004. In addition a number of Official Visitors attended lectures, workshops and conferences external to the Council. Whilst in Sydney for personal reasons one of the Council's Official Visitors had the opportunity to attend the NSW Official Visitors' conference which was found to be beneficial.

CONFERENCE PRESENTATION

The Council made a presentation to the Rural and Remote Mental Health Conference 2003, entitled "Rights for Rural Patients: Reality or Rhetoric?". This was presented by Ms Dana McGrath, Official Visitor, on behalf of Dr Judyth Watson, Head of Council of Official Visitors.

PRESENTATIONS TO COMMUNITY GROUPS

The Council provided presentations to a number of community groups during 2003 - 2004. The major aim of these presentations was to increase people's awareness and understanding of the Council's role under the Act. Presentations were made to various groups including:

- Mental Health Law Centre - Volunteer Training Programme;
- Pathways Mental Health Support Group;
- Mental Health Law Centre - *Advocacy matters in mental health* - a seminar;
- Sir Charles Gairdner Hospital - CME Presentations - Department of Psychiatry; and
- Jarrah Road Centre.

PRIORITIES FOR 2004 - 2005

The Council's functions are prescribed in the Act with its value base, as well as its statutory obligations, being embedded in the protection of the rights of individual consumers. In day to day activities, and in longer term planning, consumer rights underline the Council's priorities.

The Council will continue to address its strategic plan targets during 2004 – 2005 with particular emphasis on the Mental Health Review Board hearing attendances and contact with individuals subject to Community Treatment Orders.

The need for ongoing professional development for Official Visitors and raising the profile of Council will be pursued and the Council will continue developing position statements covering the following areas:

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

Other priority activities for the Council will include:

- Monitoring of the emerging sector wide policies and practices regarding safety;
- Conducting visits to authorised hospitals and licensed private psychiatric hostels at night;
- Review of seclusion practices in a selection of authorised hospitals;
- Establishment of a panel of Indigenous Australians to assist the Council with its responsibilities; and
- Conduct spot audits during two calendar months to quantify the number of requests for assistance made of the Council that must be referred elsewhere.

Official Visitors will continue to participate in meetings convened to plan improvements in services and/or conditions for consumers.

APPENDIX 1: Authorised Hospitals

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

Albany Regional Hospital
Albany Mental Health Unit
Hardie Road
Albany

Fremantle Hospital and Health Service
Alma Street Centre
Alma Street
Fremantle

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

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

Graylands Selby-Lemnos and Special Care Hospital
Graylands Hospital
Brockway Road
Mount Claremont
Including: Frankland Centre (State Forensic Mental Health Service)

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

Kalgoorlie Regional Hospital
Mental Health Inpatient Service
Piccadilly Street
Kalgoorlie

Joondalup Health Campus
Joondalup Mental Health Unit
Shenton Ave
Joondalup

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

Mercy Hospital
Ursula Frayne Unit
Thirlmere Road
Mount Lawley

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

APPENDIX 2: Licensed Private Psychiatric Hostels

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

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

[1] Vacant as of March 2004
[2] Ceased operation effective 5 May 2003

APPENDIX 3: COUNCIL OF OFFICIAL VISITORS 2003 - 2004 MEMBERSHIP

Head of Council	Expiry Date of Term
Dr Judyth WATSON	01 April 2006
Official Visitors	
Mr Bruce AMBROSIUS	07 April 2005
Ms Joyce ARCHIBALD	07 April 2005
Mrs Sherril BALL	07 April 2005
Mr Scott BARNDON	07 April 2005
Mrs Toni DACEY	07 April 2007 [3]
Mr Clive DEVERALL	07 April 2005
Mr Adrian GAVRANICH	07 April 2006 [3]
Ms Jane GIBSON	07 April 2006
Mr Kevin HOGG	07 April 2006
Mr Darren JONES	07 April 2005
Dr Helen LETTE	07 April 2006
Mrs Ann McFADYEN	07 April 2007 [3]
Ms Edana McGRATH	07 April 2007 [3]
Mr Stewart McMULLIN	07 April 2007 [3]
Mr Sean O'CONNELL	07 April 2005
Ms Val O'TOOLE	07 April 2005
Ms Leanne PARNHAM	07 April 2006 [3]
Ms Leanne PECH	07 April 2005
Mr Ian ROBERTSON	07 April 2006 [3 & 4]
Mrs Rosalind SAWYER	07 April 2006
Mrs Maxinne SCLANDERS	07 April 2006
Mrs Sheila STEPHENS	07 April 2005 [3]
Ms Margaret STOCKTON METCALF	07 April 2007 [3]
Ms Catriona WERE - SPICE	07 April 2005
Ms Rachael WILSHER – SAA	07 April 2005
Mrs (Angela) Leonie WILSON	07 April 2007 [3]

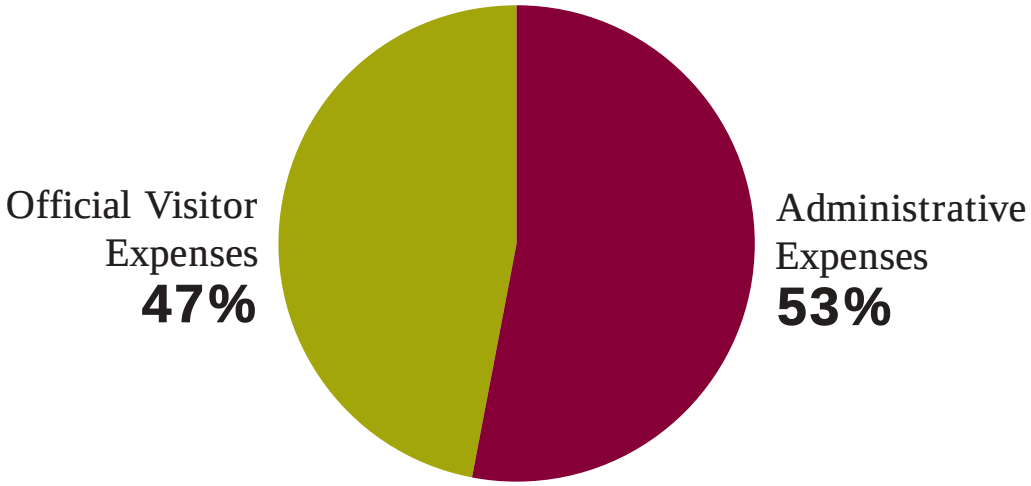
[3] Appointments effective February 2004
[4] Resigned effective May 2004

APPENDIX 4: COUNCIL OF OFFICIAL VISITORS' MEETINGS ATTENDANCE 2003 - 2004

OFFICIAL VISITOR	FULL COUNCIL		EXECUTIVE GROUP	
	Present	Apologies	Present	Apologies
Dr Judyth WATSON (Head of Council)	4	-	4	-
Mr Bruce AMBROSIUS	4	-		
Ms Joyce ARCHIBALD	4	-		
Mrs Sherril BALL	4	-	4	-
Mr Scott BARNDON	2	2		
Mrs Toni DACEY [5]	1	-		
Mr Clive DEVERALL	3	1		
Mr Adrian GAVRANICH	2	2		
Ms Jane GIBSON	2	2		
Mr Kevin HOGG	4	-		
Mr Darren JONES	3	1		
Dr Helen LETTE	2	2		
Mrs Ann McFADYEN	4	-		
Ms Edana McGRATH	4	-	3	1
Mr Stewart McMULLIN [5]	1	-		
Mr Sean O'CONNELL	3	1		
Ms Leanne PARNHAM [5]	1	-		
Ms Leanne PECH	4	-	2 (Proxy)	-
Ms Val O'TOOLE	3	1		
Mr Ian ROBERTSON [5 & 6]	-	-		
Mrs Rosalind SAWYER	3	1	2	1
Mrs Maxinne SCLANDERS	3	1	2	1
Mrs Sheila STEPHENS	1	3		
Ms Margaret STOCKTON	4	-	2	2
Ms Catriona WERE - SPICE	4	-	2 (1 as Proxy)	-
Ms Rachael WILSHER - SAA	2	2	2 (1 as Proxy)	-
Mrs Leonie WILSON [5]	1	-		

[5] Appointments effective February 2004
[6] Resigned effective May 2004

APPENDIX 5: SUMMARY OF EXPENDITURE 2003 - 2004



As required under the *Electoral Act 1907* section 175ZE (1), during 2003 - 2004 the Council expended the following in relation to the designated organisation types:

(a) advertising agencies: nil;

(b) market research organisations: nil;

(c) polling organisations: nil;

(d) direct mail organisations: nil; and

(e) media advertising organisations: $ 135.77.

APPENDIX 6: LICENSED PRIVATE PSYCHIATRIC HOSTEL INSPECTIONS BY HOSTEL & TIME & DAY OF INSPECTION 2003 - 2004

LICENSED PRIVATE PSYCHIATRIC HOSTEL	TOTAL NUMBER OF INSPECTIONS*	TIME OF INSPECTIONS		
		Mon – Fri 9 am – 5 pm	Mon –Fri 5 pm – 9 am	Sat / Sun / Pub Hol
Casson Homes [7]	6	3	3	0
Casson House	6	2	3	1
Devenish House	6	5	0	1
Dudley House	6	3	2	1
Franciscan House	6	5	0	1
Glyde Street Hostel	6	5	1	0
Honey Brook Lodge	6	2	3	1
John Wilson Lodge	6	4	0	2
Maude Armstrong	6	6	0	0
Richmond Fellowship – 6 Mann Way, Bassendean	6	4	1	1
Richmond Fellowship – 56 & 58 Glyde Street, East Fremantle	6	5	0	1
Richmond Fellowship – 23 Walton Street, Queens Park	6	6	0	0
Romily House	6	0	6	0
Rosedale Lodge	6	4	0	2
St Jude's Hostel	6	5	0	1
Salisbury Home	6	4	0	2
Shannon House	6	4	1	1
Sherwood House	6	5	1	0
Woodville House	6	2	1	3
TOTAL	114	74	22	18

* Note: The 114 recorded inspections represent the minimum requirement as decreed by the Minister for Health (viz at least every 2 months). However informal inspections in alternate months are also undertaken to seek out residents who may be particularly vulnerable. The actual number of visits is approximately double that recorded above.

[7] 'Casson Homes' includes Aitken House and Violet Major House

APPENDIX 7: AUTHORISED HOSPITAL INSPECTIONS BY HOSPITAL & TIME & DAY OF INSPECTION 2003 - 2004

AUTHORISED HOSPITAL	TOTAL NUMBER OF INSPECTIONS	TIME OF INSPECTIONS		
		Mon – Fri 9 am – 5 pm	Mon –Fri 5 pm – 9 am	Sat / Sun / Pub Hol
Albany Regional Hospital – Mental Health Unit	13 [8]	12	0	1
Alma Street Centre	24	14	4	6
Armadale Health Service – Adult and Elderly Units	24	22	2	0
Bunbury Acute Psychiatric Residential Unit	12	6	4	2
Graylands & Special Care Health Service	26	19	3	4
Joondalup Mental Health Unit	12	6	3	3
Kalgoorlie Mental Health Unit	12	8	4	0
Mercy Hospital, Ursula Frayne Unit	12	7	1	4
Mills St Centre	34	26	1	7
Selby Lodge	12	4	5	3
Swan Health Service Boronia Unit & Swan Valley Centre	24	16	4	4
TOTAL	205	140	31	34

[8] Two formal inspection visits conducted in January 2004

APPENDIX 8: PERCENTAGE OF FACILITY INSPECTIONS BY TIME & DAY OF INSPECTION 1998 - 1999 to 2003 - 2004

FINANCIAL YEAR	FACILITY TYPE	TIME OF INSPECTIONS (% OF TOTAL)			
		Mon – Fri 9 am – 5 pm	Mon –Fri 5 pm – 9 am	Sat / Sun / Pub Hol	Mon –Fri Time not recorded
1998 – 1999	Authorised Hospitals	77.8%	13.8%	0.6%	7.8%
	Licensed Private Psychiatric Hostels	75.2%	16.5%	0%	8.3%
1999 – 2000	Authorised Hospitals	69.7%	12.9%	17.4%	0%
	Licensed Private Psychiatric Hostels	77.6%	14.6%	5.2%	2.6%
2000 – 2001	Authorised Hospitals	71.1%	17.6%	11.3%	0%
	Licensed Private Psychiatric Hostels	63.3%	27.5%	9.2%	0%
2001 – 2002	Authorised Hospitals	48.6%	26.2%	23.5%	1.7%
	Licensed Private Psychiatric Hostels	46.6%	24.6%	25.4%	3.4%
2002 – 2003	Authorised Hospitals	54.6%	31.9%	13.5%	0%
	Licensed Private Psychiatric Hostels	44.9%	27.1%	28%	0%
2003 – 2004	Authorised Hospitals	68.3%	15.1%	16.6%	0%
	Licensed Private Psychiatric Hostels	64.9%	19.3%	15.8%	0%

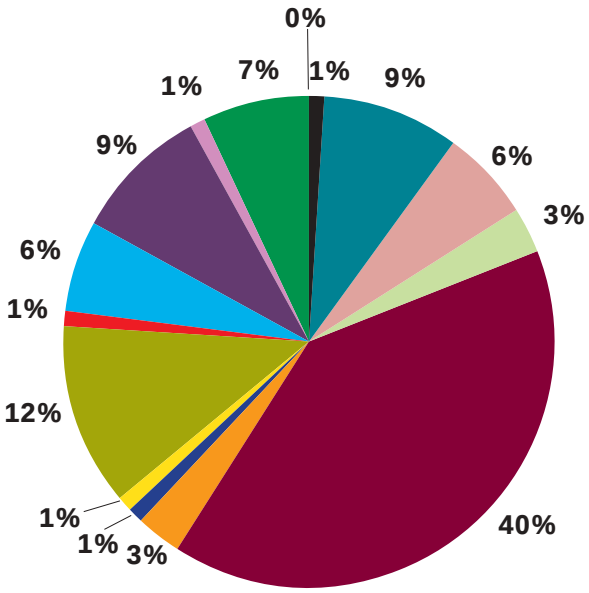
APPENDIX 9: NUMBER OF CONSUMERS AND REQUESTS BY FACILITY 2003 - 2004

FACILITY	NUMBER OF CONSUMERS CONTACTED	NUMBER OF REQUESTS RECEIVED
Albany Mental Health Unit	10	14
Alma Street Centre, Fremantle	69	105
Armadale Health Service – Adult & Elderly Units	43	71
Bunbury Acute Psychiatric Residential Unit [9]	22	39
Graylands & Special Care Health Services	298	614
Joondalup Mental Health Unit	22	41
Kalgoorlie Mental Health Unit	11	20
Ursula Frayne Unit	4	7
Mills Street Centre, Bentley	90	151
Selby Lodge	7	14
Swan Mental Health – Swan Valley Centre & Boronia	45	117
Metropolitan Clinics	64	162 (combined)
Non – Metropolitan Clinics	9	
Psychiatric Hostels	50	60
Other	0	0
TOTAL	744	1415

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

[9] Suspended admission of involuntary patients effective 31 August 2001 recommenced admitting involuntary patients during August 2003

APPENDIX 10: PERCENTAGE[10] OF TOTAL CONSUMERS BY FACILITY 2003 - 2004



- Albany Unit - **1%**
- Alma Street Centre - **9%**
- Armadale Adult & Elderly Units - **6%**
- Bunbury Unit - **3%**
- Graylands Hospital - **40%**
- Joondalup Unit - **3%**
- Kalgoorlie Unit - **1%**
- Ursula Frayne Unit - **1%**
- Mill Street Centre **12%**
- Selby Lodge - **1%**
- Swan Valley Centre & Boronia - **6%**
- Metropolitan Clinics - **9%**
- Non-Metropolitan Clinics - **1%**
- Psychiatric Hostels - **7%**
- Other - **0%**

[10] Percentages rounded to the nearest whole value

APPENDIX 11: CONTACTS WITH CONSUMERS BY FACILITY 2003 - 2004

FACILITY	NUMBER OF CONSUMERS CONTACTED	CONTACT TYPE			
		Visit	Telephone Call	Letter	MHRB[11] Attendance
Albany Mental Health Unit	10	20	12	0	0
Alma Street Centre, Fremantle	69	91	194	7	7
Armadale Health Service – Adult & Elderly Units	43	70	142	3	3
Bunbury Acute Psychiatric Residential Unit [12]	22	71	62	5	1
Graylands & Special Care Health Services	298	601	783	40	47
Joondalup Mental Health Unit	22	20	75	0	2
Kalgoorlie Mental Health Unit	11	16	14	0	1
Ursula Frayne Unit	4	6	6	0	1
Mills Street Centre Bentley	90	153	288	5	9
Selby Lodge	7	18	16	1	2
Swan Mental Health - Swan Valley Centre & Boronia	45	65	168	2	8
Metropolitan Clinics	64	37	234	9	23
Non - Metropolitan Clinics	9	4	37	4	5
Psychiatric Hostels	50	62	118	8	0
Other	0	0	0	0	
TOTAL	744	1234	2149	84	109

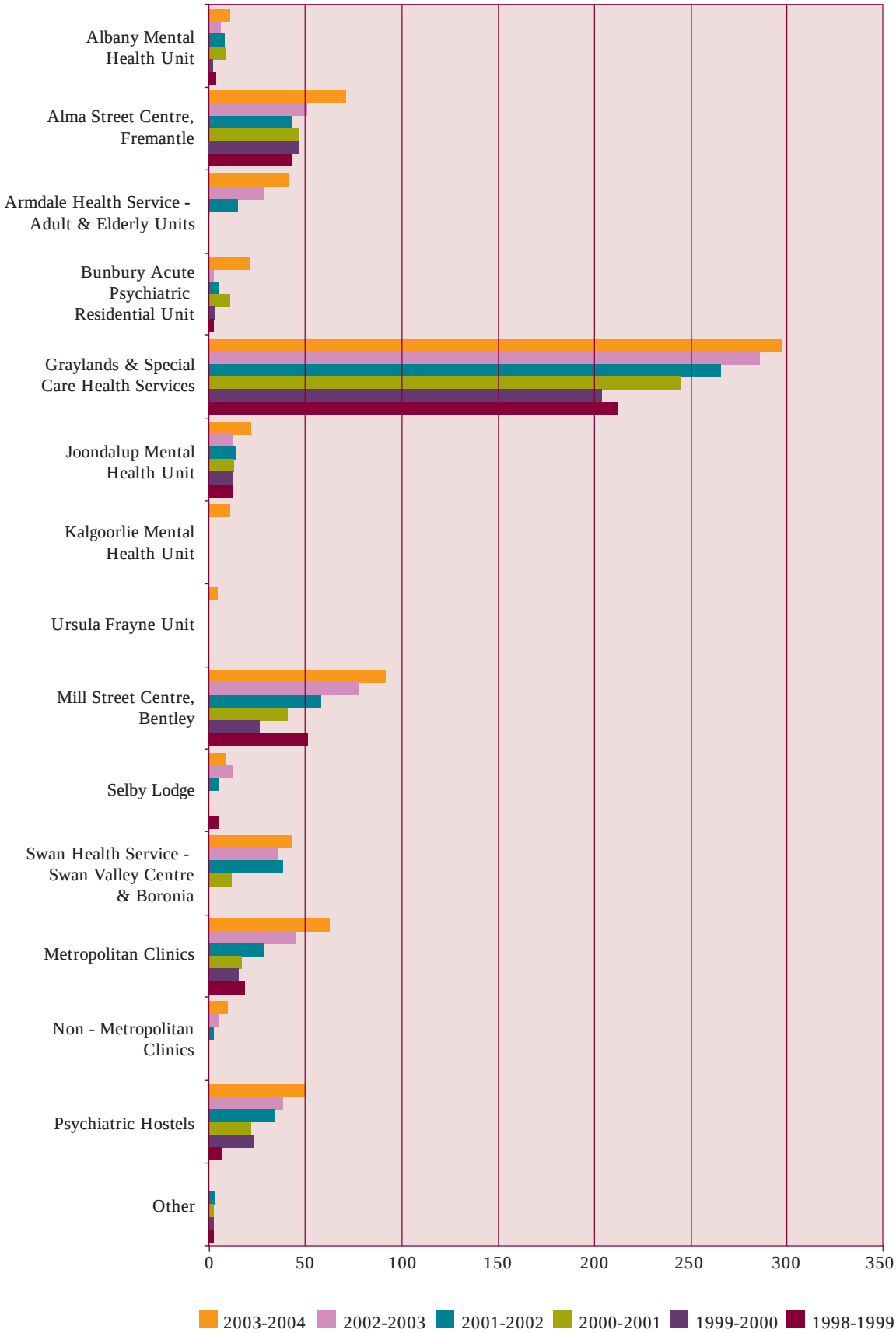
[11] MHRB – Mental Health Review Board
[12] Suspended admission of involuntary patients effective 31 August 2001 recommenced admitting involuntary patients during August 2003

APPENDIX 12A: TOTAL CONSUMERS CONTACTED BY FACILITY 1998 - 1999 to 2003 - 2004

FACILITY	NUMBER OF CONSUMERS					
	1998 - 1999	1999 - 2000	2000 - 2001	2001 - 2002	2002 - 2003	2003 - 2004
Albany Mental Health Unit	4	2	9	8	5	10
Alma Street Centre, Fremantle	45	48	48	45	51	69
Armadale Health Service - Adult & Elderly Units	-	-	-	17	29	43
Bunbury Acute Psychiatric Residential Unit [13]	2	3	12	4	2	22
Graylands & Special Care Health Services	212	203	245	266	289	298
Joondalup Mental Health Unit	13	13	14	15	13	22
Kalgoorlie Mental Health Unit [14]	-	-	-	-	1	11
Ursula Frayne Unit [15]	-	-	-	-	0	4
Mills Street Centre, Bentley	52	29	42	57	77	90
Selby Lodge	4[16]	1	1	4	10	7
Swan Health Service- Swan Valley Centre & Boronia	1[17]	0 [17]	11	38	35	45
Metropolitan Clinics	20	16	18	29	46	64
Non – Metropolitan Clinics	0	0	0	2	4	9
Psychiatric Hostels	7	22	20	32	36	50
Other	2	2	2	4	1	0
TOTAL	362	339	422	521	599	744

[13] Suspended admission of involuntary patients effective 31 August 2001 recommenced admitting involuntary patients during August 2003
[14] Commenced admitting patients 26 March 2003
[15] Commenced admitting patients March 2003
[16] Lemnos Hospital
[17] La Salle Hospital / Boronia Unit only

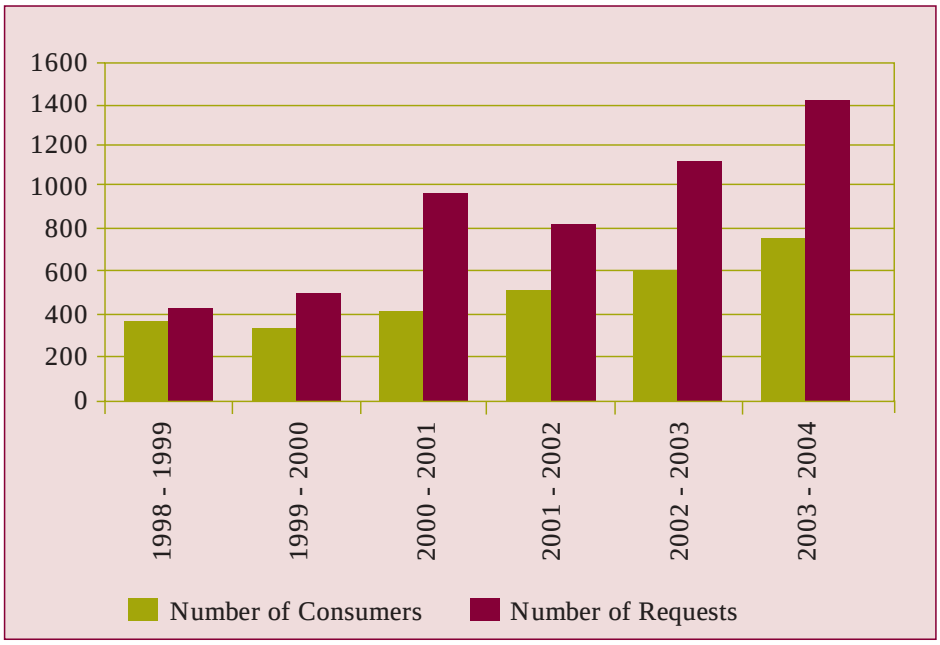
APPENDIX 12B: GRAPH - TOTAL CONSUMERS CONTACTED BY FACILITY 1998 - 1999 to 2003 – 2004



APPENDIX 13A: TOTAL CONTACTS WITH CONSUMERS 1998 - 1999 to 2003 – 2004

FINANCIAL YEAR	NUMBER OF CONSUMERS (# REQUESTS)	CONTACT TYPE			
		Visit	Telephone Call	Letter	MHRB[18] Attendance
1998 - 1999	362 (439)	519	189	48	Not Reported on
1999 - 2000	339 (511)	515	374	93	12
2000 - 2001	422 (963)	656	558	114	36
2001 - 2002	521 (807)	722	931	98	43
2002 - 2003	599 (1126)	974	1474	67	77
2003 - 2004	744 (1415)	1234	2149	84	109
% increase 2002 - 2003 to 2003 - 2004	24.2% (25.7%)	26.7%	45.8%	25.4%	41.5%
% increase 1998 - 1999 to 2003 - 2004	105.5% (222.3%)	137.7%	1037%	75%	808.3% [19]

APPENDIX 13B: GRAPH - TOTAL CONSUMERS CONTACTED AND REQUESTS RECEIVED 1998 - 1999 to 2003 – 2004



[18] MHRB – Mental Health Review Board
[19] 1999 - 2000 to 2003 - 2004 only

APPENDIX 14A: TOTAL CONSUMER CONTACTS BY ISSUE CATEGORY - ALL FACILITIES 2003 - 2004

1.	ACCESS	NUMBER	PERCENTAGE (%) OF TOTAL
1.1	Delay in Admission or treatment	21	1.48
1.2	Waiting list delay	1	0.07
1.3	Non-attendance	2	0.14
1.4	Inadequate or no service	19	1.34
1.5	Refusal to admit or treat	2	0.14
1.6	Discharge or transfer arrangements	261	18.44
1.7	Access to transport	0	0
1.8	Physical access/entry	0	0
1.9	Parking	0	0
	TOTAL	306	21.6%

2.	COMMUNICATION	NUMBER	PERCENTAGE (%) OF TOTAL
2.1	Inadequate information about treatment options	8	0.57
2.2	Inadequate information on services available	7	0.49
2.3	Misinformation or failure in communication	22	1.55
2.4	Failure to fulfil statutory obligations	2	0.14
2.5	Access to records	3	0.21
2.6	Inadequate or inaccurate records	2	0.14
2.7	Failure to provide interpreter	0	0
2.8	Certificate or report problem	0	0
	TOTAL	44	3.1%

3.	DECISION MAKING	NUMBER	PERCENTAGE (%) OF TOTAL
3.1	Failure to consult consumer	5	0.35
3.2	Consent not informed	0	0
3.3	Consent not obtained	92	6.5
3.4	Private/public election	0	0
3.5	Refusal to refer or assist to obtain a second opinion	2	0.14
	TOTAL	99	6.99%

4.	QUALITY OF CARE	NUMBER	PERCENTAGE (%) OF TOTAL
4.1	Inadequate diagnosis	1	0.07
4.2	Inadequate treatment	124	8.76
4.3	Rough treatment	11	0.78
4.4	Incompetent treatment	0	0
4.5	Negligent treatment	0	0
4.6	Wrong treatment	1	0.07
	TOTAL	137	9.68%

5.	COSTS	NUMBER	PERCENTAGE (%) OF TOTAL
5.1	Inadequate information about costs	0	0
5.2	Unsatisfactory billing practice	0	0
5.3	Amount charged	1	0.07
5.4	Overservicing	0	0
5.5	Private health insurance	0	0
5.6	Lost property and/or reimbursement	1	0.07
	TOTAL	2	0.14%

6.	PRIVACY / CONSIDERATION / DISCOURTESY	NUMBER	PERCENTAGE (%) OF TOTAL
6.1	Inconsiderate service/lack of courtesy	25	1.77
6.2	Absence of caring	26	1.84
6.3	Failure to ensure privacy	6	0.42
6.4	Breach of confidentiality	3	0.21
6.5	Discrimination	0	0
6.6	Discrimination of public consumer	0	0
6.7	Sexual impropriety	3	0.21
6.8	Sexual transgression or violation	3	0.21
6.9	Assault	13	0.92
6.10	Unprofessional conduct	0	0
	TOTAL	79	5.58%

7.	GRIEVANCES	NUMBER	PERCENTAGE (%) OF TOTAL
7.1	Inadequate response to a complaint	2	0.14
7.2	Reprisal following a complaint	1	0.07
	TOTAL	3	0.21%

8.	OTHER	NUMBER	PERCENTAGE (%) OF TOTAL
8.1	Administrative practice	4	0.28
8.2	Catering	20	1.41
8.3	Facilities	48	3.4
8.4	Security	21	1.48
8.5	Cleaning	9	0.64
8.6	Fraud/illegal practice	1	0.07
	TOTAL	103	7.28%

9.	*MENTAL HEALTH ACT 1996* (OTHER)	NUMBER	PERCENTAGE (%) OF TOTAL
9.1	Mental Health Review Board Application	262	18.52
9.2	Mental Health Review Board Attendance	182	12.86
9.3	Second Opinion Request (not 3.5)	32	2.26
9.4	*Mental Health Act 1996* Information	28	1.98
9.5	*Mental Health Act 1996* Non- Compliance (not 2.4)	17	1.2
	TOTAL	521	36.82%

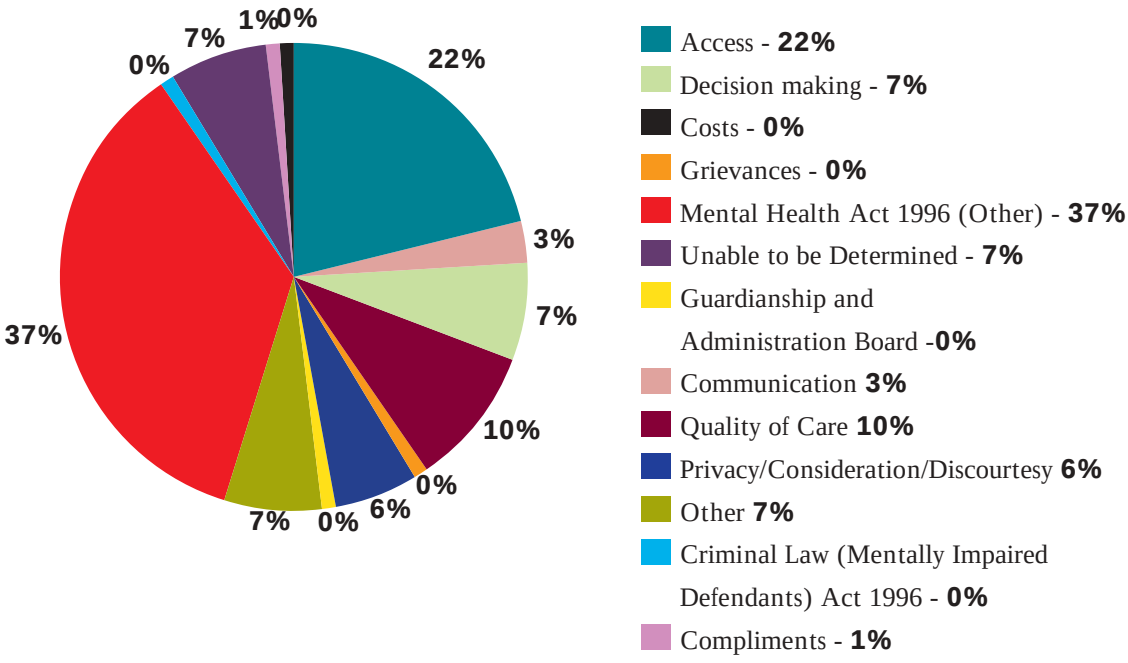
10.	*CRIMINAL LAW (MENTALLY IMPAIRED DEFENDANTS) ACT 1996*	NUMBER	PERCENTAGE (%) OF TOTAL
10.1	Mentally Impaired Defendants Review Board	2	0.14
	TOTAL	2	0.14%

11.	UNABLE TO BE DETERMINED	NUMBER	PERCENTAGE (%) OF TOTAL
11.1	Unknown / Undetermined	97	6.86
	TOTAL	97	6.86%

12.	COMPLIMENTS	NUMBER	PERCENTAGE (%) OF TOTAL
12.1	Compliments	16	1.13
	TOTAL	16	1.13%

13.	GUARDIANSHIP AND ADMINISTRATION (G & A) BOARD	NUMBER	PERCENTAGE (%) OF TOTAL
13.1	Information on processes	6	0.42
13.2	G & A Board attendance	0	0
	TOTAL	6	0.42%

APPENDIX 14B: PERCENTAGE[20] ISSUE CATEGORY – ALL FACILITIES 2003 – 2004



[20] Percentages rounded to the nearest whole value