Council of Official Visitors

Annual Report 2001 - 2002

Artwork produced through the
Creative Expression Unit at Graylands Hospital.
Front Cover paintings from left to right Craig Wood,
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Background paintings by Craig Wood.

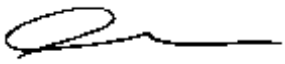
The Honourable Robert Charles Kucera
Minister for Health
10th Floor
Dumas House
2 Havelock Street
WEST PERTH WA 6005

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 2002.

As well as recording the operations of the Council for the 2001 - 2002 year the report once again reflects on some of the trends and issues affecting consumers of mental health services in Western Australia.

Yours sincerely



Stuart Flynn

HEAD
COUNCIL OF OFFICIAL VISITORS

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EXECUTIVE SUMMARY

The SANE Australia Mental Health Report for 2002 - 03 summarises Western Australia's performance on mental health issues as "… *moving in the right direction" but "… there is still a long way to go*".

The same comments could be made about the Council of Official Visitors after 4 years' operation and as it faces an examination of its effectiveness as part of a general review of the *Mental Health Act 1996*.

There are 3 major areas of concern in this report:

Lack of action and commitment to provide a better service

As in previous years this report offers stark evidence of the lethargy which characterises the performance of those charged with ensuring that consumers receive the services they need. In some instances, the areas requiring improvement have been known to those with the authority to change things for many years before the Council was established. For example:

- there are private psychiatric hostels which manifest all the worst features of total institutions; they still receive government funds but never have to raise their game;
- there are public hospitals which treat patients in ways which would make front page headlines if it occurred in acute general hospitals.

Much of what follows reinforces the view that mental health services are less important than other health services. Defensive rhetoric in response will deny this but actions speak louder than words.

Bureaucratic buck passing

The WA Government allocates large amounts of public funds to health and disability services. The public may feel that it has a right to expect that those charged with ensuring that this money gets to where it needs to go will be motivated primarily by concern for consumers.

In the Council's experience this is often not the case and slick jargon about a 'whole of government approach' rings very hollow when two departments fight strenuously to avoid responsibility for a vulnerable consumer. The sight of two branches of the same department proving equally skilled at buck passing is even less edifying.

Until government starts to arrange services from the perspective of the needs of the public rather than the needs of the bureaucracy the power of the silos will remain.

Reality in Rural Areas

It is to the credit of the WA Government that it has established inpatient mental health units in rural areas such as Albany, Bunbury and Kalgoorlie. This keeps political promises and reassures country voters that they will receive the same types and quality of services as those in the city. Unfortunately, they don't and won't.

As at 30th June 2002:

- the Albany unit was working well but its total operation is vulnerable to one individual resigning and the probability of no replacement;
- the Bunbury unit has not been accepting involuntary patients for the previous 10 months; and
- the Kalgoorlie unit has never opened.

The problem is not shortage of money but scarcity, often world wide, of certain types of health professionals. Whatever the reason country consumers generally receive an inferior, or no, service.

For as long as country services depend upon the presence of psychiatrists and, to a lesser extent mental health nurses, they will never be able to guarantee long-term continuity of service.

The current legislation and the current model of service delivery do not suit rural WA. Both need to be changed to take advantage of modern technology. If a surgeon in Sydney can 'operate' on a patient in Antarctica why cannot a psychiatrist in Perth 'treat' a patient in Kalgoorlie?

Maybe face to face care is better than care via a video internet link but wouldn't internet consultations be better than no care at all? The parent of the son or daughter who has to be transported from Kalgoorlie to Perth for treatment would probably say 'yes'.

PART ONE
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 least once every 2 months. The Council has maintained an active visiting programme to nine authorised hospitals and twenty licensed private psychiatric hostels, including four sets of group homes.

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

A visit from an Official Visitor can be requested by an '*affected person*' or another person on their behalf (section 189 the Act). 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. Official Visitors had contact with 521 consumers as a result of such requests during 2001 – 2002.

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 2001 – 2002

Appendix 3 lists the members of the Council during the 2001 - 2002 financial year.

COUNCIL MEETINGS

The Council continued to meet regularly as a full Council throughout 2001 – 2002. In June 2001 the Council established an Executive Group, including representatives from each of the sub groups of the Council, to act as the decision making body for the Council.

A summary of the meetings attended by Council members during 2001 - 2002 is contained in Appendix 4.

BUDGET

The Council was allocated a budget of $413,000 for 2001 – 2002. Taking into account CPI movements this was a significant reduction on the previous year's allocation. To accommodate this de facto reduction the Council undertook a major cost cutting exercise which culminated in expenditure for the financial year 2001 - 2002 of $401,294.

A summary of expenditure for 2001 - 2002 can be found at Appendix 5.

PART TWO
MAJOR ISSUES

The Council is frustrated that a number of the serious issues raised in its previous Annual Reports (1998 – 1999 through 2000 – 2001) have remained unresolved during 2001 - 2002. In some cases little or no action appears to have been taken by the appropriate authorities to address the issues.

Listed below are those matters previously reported on which there has been no action taken by the relevant authorities. For details concerning these issues please refer to the Council's previous annual reports, available through the Council's website or from the Council's office.

PERSISTENT FAILURE TO ACT

- DEVELOPMENT OF SYSTEM-WIDE POLICIES FOR ALL MENTAL HEALTH SERVICES - PUBLIC, PRIVATE, METROPOLITAN, RURAL AND REMOTE - REGARDING ISSUES IMPACTING ON CONSUMERS, INCLUDING "SEARCH THE PERSON", "USE OF CAMERA SURVEILLANCE" (Year First Raised 1998 – 1999)

  Recommendation: Office of the Chief Psychiatrist or Mental Health Division to develop system wide polices and / or guidelines regarding issues that impact on consumer care.

- CONSUMER ACCESS TO PERSONAL RECORDS - *Mental Health Act 1996*, sections 160 & 161 (Year First Raised 1998 - 1999)

  Recommendation: 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 person to psychiatrists only to be reviewed as a matter of urgency to allow the involvement of other professional groups.

- SUPPORT SERVICES TO RESIDENTS OF LICENSED PRIVATE PSYCHIATRIC HOSTELS (Year First Raised 1998 - 1999)

  Recommendation: An urgent review of the support services provided to residents of the licensed private psychiatric hostels be undertaken to ensure consistency of approach across the metropolitan area. If services are to be decreased or withdrawn then assistance to be provided to residents and/or licensees to identify appropriate, alternative sources of support.

- REVIEW OF THE *CRIMINAL LAW (MENTALLY IMPAIRED DEFENDANTS) ACT 1996*, IN PARTICULAR IN RELATION TO CONSUMERS' RIGHTS (Year First Raised 1998 - 1999)

  Recommendation: The provisions of the *Criminal Law (Mentally Impaired Defendants) Act 1996* be significantly reviewed in conjunction with the review of the *Mental Health Act 1996*.

- *CRIMINAL LAW (MENTALLY IMPAIRED DEFENDANTS) ACT 1996* – restricted access to outside areas (Year First Raised 1999 - 2000)

  Recommendation: Strategies be developed to ensure that access to outside areas is not unduly restricted for these consumers. Commitment from funding bodies is required to ensure adequate funding is available for adequate levels of staffing.

- MEDICAL TREATMENT MAY BE APPROVED BY THE CHIEF PSYCHIATRIST - *Mental Health Act 1996*, section 110 (Year First Raised 1999 - 2000)

  Recommendation: Guidelines be developed regarding the use of the delegated authority in relation to 'lifestyle issues' (e.g. prescribing of contraception to prevent pregnancy rather than treatment for a medical condition) to ensure an adequate degree of separation between the prescribing doctor and the authorising psychiatrist.

- IMPROVED ACCESS TO AGE APPROPRIATE SERVICES FOR ADOLESCENTS (Year First Raised 1999 - 2000)

  Recommendation: A contingency plan be developed to plan for those occasions when the inpatient beds at the WAY Centre, Bentley, the only authorised facility for adolescents, is at capacity. A review of adolescent inpatient beds and admission criteria should occur to ensure that appropriate types and levels of service are available.

- DESIGN OF NEW FACILITIES (Year First Raised 2000 - 2001)

  Recommendation: The designing of new facilities should reflect the requirements of the *Mental Health Act 1996*, particularly as they relate to patients' rights (e.g. access to telephone calls in reasonable privacy). The specific design requirements of secure units need to be considered separately to those of the facilities available in the overall building (e.g. designated visitors' room in each secure unit).

- HUMAN RELATIONSHIPS AND INTIMACY (Year First Raised 1999 - 2000)

  Recommendation: Policies be developed and implemented covering all mental health services and supported accommodation services for people with a mental illness to ensure that the human relationship and intimacy needs of consumers are identified and addressed in an appropriate manner. Staff to be provided with the necessary training and support.

In its 2000 – 2001 Annual Report the Council identified 10 quick and inexpensive ways to improve the quality of life for consumers of mental health services and / or the residents of psychiatric hostels. They are listed below with an update.

- Whenever any resident of any psychiatric hostel uses the bathroom in the hostel they can be confident that there will be soap and plugs and shower and toilet cubicle doors that lock. (Year First Raised 1998 - 1999)

  Update: Some hostels still fail to meet these basic standards.

- All bedrooms in licensed private psychiatric hostels will have doors and / or wardrobes that are lockable to ensure privacy and security for residents and their belongings. (Year First Raised 1998 - 1999)

  Update: Some hostels still fail to meet this basic standard.

- The outdoor area of Joondalup Mental Health Unit's secure ward to be extended to an appropriate size and / or its configuration changed to allow access to the garden area. (Year First Raised 1997 - 1998)

  Update: There has been no improvement to the outdoor area of the secure ward at Joondalup Mental Health Unit.

- Increased access to the gymnasium where there is one on site and / or basic exercise equipment in authorised hospitals with no gymnasium (e.g. bicycles, basketball or other court type games). (Year First Raised 1999 - 2000)

  Update: The frequency of access to gymnasiums or exercise equipment continues to vary between wards and hospitals and can be very restricted. Some units still have very limited basic exercise equipment.

- Make fresh milk available in all licensed private psychiatric hostels. (Year First Raised 1999 - 2000)

  Update: Some hostels still refuse to provide fresh milk and only powdered milk is available.

- Provision and use of BBQs in all hospitals to improve socialisation in a "normal setting" and to involve consumers (particularly long-stay) in cooking their own meals. (Year First Raised 2000 - 2001)

  Update: Many hospitals offer BBQs on site with the frequency varying between wards and hospitals. In Murchison Ward at Graylands Hospital no BBQ has occurred on site since September 2001. This is being addressed with the hospital.

- Use of the term "Acting Psychiatrist" or "Psychiatrist" to cease being used for medical practitioners who are not Psychiatrists. Staff to be clear in discussion with consumers and others of the correct title of medical staff responsible for their care. (Year First Raised 1999 - 2000)

  Update: There appears to have been a decrease in the use of the term "Acting Psychiatrist" or "Psychiatrist" for medical practitioners who are not Psychiatrists. This will continue to be monitored.

- Resident Agreements to be developed and implemented in all licensed private psychiatric hostels detailing the rights and responsibilities of residents and owners. (Year First Raised 1998 - 1999)

  Update: A limited number of hostels have such agreements. As an industry wide practice they are yet to be introduced. It is trusted that they will form part of the standards being developed for hostels by the Department of Health.

- "Search the Person" and Use of Video Monitoring policies to be developed, implemented and monitored across the whole mental health system. (Year First Raised 1998 – 1999)

  Update: Policies which apply across all WA mental health services still do not exist.

- Lighting to be installed in the car park adjacent to the Bunbury Acute Psychiatric Residential Unit to improve safety. (Year First Raised 2000 - 2001)

  Update: The lighting in the car park adjacent to the Bunbury Unit is yet to be installed.

ACTION

The Council is gratified to be able to report on the following issues which have been acted upon.

IMPROVED PROCEDURES FOR THE SECURITY OF CONSUMERS' BELONGINGS

The Council is pleased to report that the number of complaints it received in relation to lost or stolen property decreased, particularly at Graylands Hospital. Graylands Hospital instituted a review of its procedures associated with the handling of consumers' property which appears to have had a positive effect. Few complaints were received from other authorised hospitals relating to this matter.

PHYSICAL FACILITIES – MILLS STREET CENTRE

As of June 2002 the Lodge at the Mills Street Centre had started to receive new furnishings to replace the existing inappropriate furniture.

MENTAL HEALTH SERVICES – INPATIENT UNITS & COMMUNITY MENTAL HEALTH SERVICES

CONSUMERS' RIGHTS

On a number of occasions throughout 2001 – 2002 the Council encountered situations of non-compliance with the requirements of the *Mental Health Act 1996*. These occurrences were due to:

- a lack of knowledge of the Act; and / or
- policies and procedures that were not in keeping with the spirit of the Act.

Restriction of rights without appropriate authorisation

The Act contains a number of specific provisions related to the rights of patients (Part 7 sections 156 – 171). Section 169 of the Act provides for the restriction of some of these rights, in certain circumstances, and which must be authorised by a Psychiatrist.

Case Example

The Council became aware that consumers admitted to the secure unit of the (Adolescent) WAY Centre at Bentley Health Service had restricted access to making telephone calls. Specifically, there was a blanket restriction on all consumers within the unit to one telephone call per shift. There was no public telephone in the unit. The Council was of the view that the decision of the hospital not to provide a public telephone in the unit should not have an adverse effect on consumers, particularly in terms of their rights under the Act.

Further, any restriction or denial of the entitlement to make and receive telephone calls (section 167) can only be undertaken if the psychiatrist considers it to be in the interest of the patient to do so (the Act section 169). Any such order must be reviewed by the psychiatrist each day and the order lapses on the day on which it has not been reviewed. In addition, a record of the order and each review is to be made in the case notes of the consumer.

The Council was of the view that a blanket limit of one call per shift per consumer was a restriction that did not meet the requirements of the Act, section 169.

Limiting calls to one per shift was considered too restrictive particularly if consumers wished to contact a number of agencies, for example the Council, the Mental Health Law Centre, the Mental Health Review Board or who had parents in different locations. The Council is of the view that the number of phone calls allowed should be determined on a consumer by consumer basis.

This matter was raised with the management of Bentley Mental Health Service and the policy was immediately withdrawn.

Mechanical bodily restraint

Sections 121 – 124 of the Act and *Mental Health Act 1996* Regulations 1997 (regulations 14 – 17) provide for the use of mechanical bodily restraint. These provisions specify a number of requirements which must be satisfied (e.g. who can authorise the use and for what reasons) and special duties that must be performed if an individual is placed in mechanical bodily restraint.

Case Example

During two visits to a secure ward in Graylands Hospital an Official Visitor observed Ms C, an involuntary patient who had been placed in a mechanical bodily restraint (MBR) in both instances. On review of the documentation associated with these occurrences, it was identified that the requirements of the Act were not met including:

- there was no notation made of the name and the qualifications of the treating psychiatrist nor the date and time the treating psychiatrist was notified of the authorisations (regulation 15(c) and 15(d));
- there was no record within the restraint documentation of the date, time and results of any medical examinations conducted in the 24 hours after the restraints were applied (regulation 15(e)); and
- on the second occasion there was no documentation confirming that after the first 15 minutes a medical practitioner monitored the patient every 30 minutes (regulation 16(c)).

The Council's concerns related less to the actions of the individual clinicians involved but rather to the paucity and/or quality of the procedures and protocols in place within the hospital to ensure compliance with the Act.

This matter was raised with the management of Graylands Hospital and a review of the policies and procedures was initiated. A revised policy was adopted and the Council will monitor its implementation.

Failure to advise of Issuing Orders and / or Provision of Copy of Orders

The Act provides that whenever:

- a consumer is admitted to an authorised hospital (no matter his/her status); or
- when an order is made for a consumer to be detained as an involuntary patient; or
- when an order is made for a consumer to be subject to a community treatment order; or
- a consumer is given a leave of absence

he/she is to be advised of his/her rights and legal status, orally and in writing (section 156). Section 159 requires that he/she be given a copy of the order.

The examples below demonstrate how the Council works with service providers to improve service provision and compliance with the *Mental Health Act 1996*.

Case Example

An Official Visitor attended Ms G's Mental Health Review Board (MHRB) hearing with her at her request. Ms G was an involuntary patient in Joondalup Mental Health Unit and the MHRB hearing occurred at that facility. At approximately 3.00pm, during the hearing, the presiding member of the MHRB advised Ms G and those present that a Community Treatment Order (CTO) had been issued in relation to her at 10.30am on that day.

It was of grave concern to the Council that Ms G had not been advised that a CTO had been issued in relation to her. It was unclear whether this would have occurred if the MHRB hearing had not been scheduled. Further Ms G:

- was not provided with a copy of the order (section 159);
- was not advised of her legal status and rights under the Act at the time the CTO was issued (section 156); and
- remained under the misapprehension that she was a detained patient at Joondalup and therefore not free to leave the hospital.

This matter was raised with the psychiatrist in charge of her care. The response received from the hospital failed to adequately address the Council's concerns. There appeared to be a lack of understanding of the specific requirements of the Act. The Council continues to act in this case.

Case Example

During numerous visits to a secure ward of the Alma Street Centre it was noted that copies of orders issued under the Act (e.g. *Form 6 Involuntary Patient Order*) were not being provided to involuntary patients (the Act, section 159) at the time that their rights were explained to them. The consumers' copies were held in the staff office until it was determined that they were in an appropriate clinical state. In one case the consumer had been in the unit for 2 weeks and had yet to receive his/her copy of the Form 6.

In addition, consumers reported that they had not been informed of their rights, either verbally or in writing (section 156). On perusal of consumers' medical records the Official Visitors noted that often there was no notation that this had occurred (section 158 (2)).

Staff advised the Official Visitors that they preferred to wait until people were in a position to understand their rights and the forms prior to providing them.

It is acknowledged that on occasions consumers may forget that they have been advised of their rights. The lack of documentation that this occurred makes investigations of such complaints difficult and is in breach of the Act (section 158(2)).

The Council is of the view that the explanation of rights must occur at the time the order is made, not delayed until it is thought the consumer can understand this information. Further, the Council is of the view that good clinical practice would include staff ensuring that, subsequent to the initial explanation, consumers remember and understand their rights.

The Act (section 159) requires that copies of orders, with the possible exception of Form 1, must be given to the person concerned. The Council is gravely concerned that in some instances these orders were not being provided to people for up to fourteen days, on the basis that the person may not understand it. The Council is of the view that individuals should be provided with a copy of the order at the time it is made and that staff should offer subsequent explanations as required.

This matter was raised with Alma Street Centre Clinical Director and a response was received in May 2002 advising that the policy and procedures in place had been reviewed and a revised system introduced to ensure compliance with the Act.

Detention of Voluntary patients

In its 1999 – 2000 Annual Report the Council raised concerns regarding the detention of voluntary patients in authorised hospitals, in particular the psychogeriatric lodges. The Council referred the matter to the State Ombudsman during 2000 – 2001.

The Ombudsman recommended that the Department of Health obtain a formal legal opinion from the Crown Solicitor's Office concerning current practices with respect to the admission and management of voluntary patients:

- who were not capable of giving meaningful informed consent; and
- whose movements may need to be restricted to prevent them doing harm.

In November 2001 the Chief Psychiatrist provided the Council with a copy of the Crown Solicitor's opinion. In summary, the Deputy Crown Solicitor was of the opinion that:

- the existing assessment and management regime did not breach civil law,
- the "*position under the Criminal Code is one of some difficulty*", for which there is no easy solution, and
- the matter of extending the Council's jurisdiction ought to be seriously considered.

The Council's position has always been that the detaining of voluntary patients in an authorised hospital, other than as authorised by the *Mental Health Act 1996*, (the Act) is in breach of the Criminal Code. This effectively places the staff and their employer, the WA Government, at risk.

The opinion failed to address this matter.

In subsequent correspondence with the Deputy Crown Solicitor it was acknowledged that the matter of the criminal law was of ongoing concern and that it was unsatisfactory that matters remain as they are. However identifying and implementing the required changes was perceived as a matter of some difficulty.

The Ombudsman recommended that an administrative arrangement should be developed for detained voluntary patients to have access to the Council. The Council reversed its previously held position and agreed to this as it appeared to be the only option available at present to endeavour to ensure that the rights of the individuals concerned are observed.

The Council questions whether the Chief Psychiatrist or the Director General of Health has the power to make such an arrangement.

The proposed arrangement would allow the Council to deal with complaints made by voluntary detained patients, or their families, but it will not address the issue of this group of patients' rights being infringed. There are no legislative arrangements under the Act concerning their rights, other than the requirement to cease detaining an individual, nor avenues for recourse should these rights be infringed. In this way they are different to "referred persons" and involuntary patients under the Act.

The proposed arrangement for detained voluntary patients to have access to the Council does not address the lack of legislative provision nor the concern that these individuals are, in the Council's view, being detained illegally.

As at 30 June 2002 the Council had not been advised that such an administrative arrangement had been made.

PLANNING RATIOS & BED AVAILABILITY - ADULT AUTHORISED HOSPITALS

The pressure on inpatient beds in authorised hospitals continued during 2001 - 2002. As far as the Council is aware some of the unacceptable practices previously used at Graylands Hospital (e.g. use of seclusion rooms as bedrooms) were not employed there during 2001 - 2002.

The Council acknowledges the improved performance of Graylands Hospital in this regard.

An *Adult Metropolitan Inpatient Bed Management Policy* was developed and introduced by the Metropolitan Mental Health Service / Department of Health in relation to the mental health inpatient beds. Whilst this incorporates strategies to be enacted when one or more authorised hospitals do not have any vacant beds it does not address the issue of when all facilities are at capacity. The policy is reliant on co-operation between hospitals and health services which is often sadly lacking. This lack of co-operation between professionals can and does have a direct negative impact on consumers.

Mental Health Act 1996, section 47

The pressure on beds was further compounded in a number of instances by the use of section 47 of the Act which states that the person in charge of a hospital may "decline to accept" involuntary patients.

> "47. *(1) Where an order has been made that a person be received into, admitted to, or transferred to a specified hospital, the person in charge of the hospital may decline to accept the person if the facilities then available at the hospital are insufficient or inappropriate for accommodating or treating the person.*
>
> *(2) Where that happens, the person may be received into, admitted to, or transferred to another authorized hospital."*

Effective 31 August 2001 the South West Health Service ceased admitting involuntary patients to the Acute Psychiatric Residential Unit at Bunbury Hospital under section 47 of the Act. As a result, individuals from the South West requiring involuntary admission must be transferred to Perth for the treatment. Historically people from the South West had been admitted to Graylands Hospital for treatment but with opening of the Unit in Bunbury the beds allocated for South West patients at Graylands Hospital were closed as the service was to be provided locally. This means that even a small of number of consumers being transferred from the South West to Perth places an additional pressure on the beds available.

At 30 June 2002 the Bunbury unit continued to exclude involuntary patients.

This section has also been utilised within the Perth metropolitan area, generally for short periods of time. Whilst the Council does not advocate admitting people to clinically unsafe environments the flow on effect is that additional pressure is placed on the other metropolitan authorised hospitals and consumers may be discharged earlier than is clinically preferred.

Overcrowding

In February 2002 the Council received a number of complaints from consumers regarding the effects of overcrowding. The complaints related to the lack of bedrooms and space for consumers and the practice of moving consumers from one area to another in an attempt to 'juggle' the beds.

Specific examples of the complaints included:

- Ms M not having access to her bed until 11.30 PM as she required a secure environment and her allocated bedroom was in the open side, the external doors of which were not locked until that time;
- Ms M being woken and moved to an open ward at 2.15 AM as a secure bed was required for another consumer; and
- Mr I being woken at 11.30 PM to be transferred from the secure unit at one hospital to a secure ward at another hospital. He was not admitted to the other hospital until 2.20 AM.

The Council understands that when there is an inadequate number of beds in secure wards consumers who require a secure environment may spend the day in the secure ward and have a bed in the open section. This means that they are required to stay in that area until the external doors to the Unit are locked at which point they may be transferred into the open side. This results in the consumer not having their own space to rest during the day and it can be quite unsettling if the person is unable to retire at a time earlier than the time the doors are locked.

The Council has ongoing concerns regarding the transferring of consumers either between wards in the same facility or between authorised hospitals, particularly in the early hours of the morning. The Council is of the view that this is not conducive to the provision of quality care.

If such practices were utilised in acute general hospitals there would be a justifiable public outcry.

CONSUMERS WITH DUAL DISABILITIES

Individuals who have both a mental illness and an intellectual or other disability often encounter difficulties in accessing appropriate services. The Council's concerns regarding the potential for inappropriate admissions to acute psychiatric units continued during 2001 – 2002. In addition, there are current inpatients in authorised hospitals who have been deemed ready for discharge but for whom this has not been possible as there is no appropriate community accommodation available. This is often compounded when funding is required from both the Department of Health and the Disability Services Commission. This situation also means that scarce inpatient beds are being utilised by those who do not require them whilst those in need of such a resource are excluded.

Case Example

As reported in the Council's 2000 – 2001 Annual Report *Ms WN* has been an inpatient in an authorised hospital for at least five years. She is a registered client of the Disability Services Commission (DSC).

With her consent, *WN*'s situation was raised with the Minister for Health.

WN repeatedly expressed her great frustration in not being able to live independently to an Official Visitor. Although she may not be in a position to live independently (as assessed by DSC as well as her treating team at the hospital) she would be able to live in supported accommodation. Several unsuccessful attempts have been made to accommodate her in psychiatric hostels.

A number of applications for DSC-funded accommodation have been made by *WN*'s treating psychiatrist. These applications have all been unsuccessful.

It appears that the degree of priority given to *WN*'s applications for funding by DSC is decreased given her current accommodation in an authorised hospital. The Council is of the view that a bed in an acute psychiatric hospital is not appropriate accommodation and should not be considered as such. Further, her current admission to hospital should not be used to determine the degree of priority her application should receive.

WN's continued hospitalisation in an authorised hospital also reduces the availability of inpatient beds for those genuinely in need of hospital-based care.

After meeting *WN* the Minister wrote to his colleague, the Minister for Disability Services in support of *WN*'s applications for funding.

At 30 June 2002 *WN* remains in a scarce authorised bed because she has not been awarded DSC funding for accommodation.

Case Example

During the twelve month period prior to January 2002 *Mr BD* had lived in three licensed private psychiatric hostels and one boarding house. His tenure at these facilities was invariably terminated due to the facility staff being unable to manage his behaviour.

Both Mental Health Services and the Disability Services Commission declined to provide *BD* with any services. He had received services from both in the past.

Whilst living at one licensed private psychiatric hostel, *BD* received regular visits from a community mental health nurse and review by a psychiatrist from Bentley Mental Health Service. The nurse also served as a regular reference point for the licensee of the hostel, to provide support and advice on managing some of *BD*'s challenging behaviours.

When *BD*'s tenure at this hostel failed and he moved to a second and then a third private psychiatric hostel in a different catchment area, he was referred to Swan Mental Health Service. Initially his medication was supplied via the community mental health nurse from that service. However, when asked whether a service similar to that offered by Bentley would be provided the response was that even the delivery of medication was only a temporary measure until the service had decided whether to accept the referral of *BD*. Therefore, the nurse would not commence any other case management roles until that decision had been made. Swan Mental Health Service would not accept the referral.

Adding to the confusion was that the hostels received a subsidy from the Mental Health Division (MHD) of the Department of Health for providing care to *BD*. Thus, whilst the local mental health service declined to provide him with a service on the basis that he did not have a mental illness / did not meet their eligibility criteria at the same time the MHD was paying a subsidy because he did in fact have a mental illness and/or met their eligibility criteria for a mental health subsidy.

The Disability Services Commission also refused to accept *BD* for service as it was deemed he longer met their eligibility criteria. *BD* obviously was in need of specialist intervention but none was being made available to him and his carers.

The Council was gravely concerned that if the two departments continued to avoid responsibility for *BD* he was at serious risk of homelessness and, consequently, because of his behaviour, at risk of serious physical assault. Unless *BD* was provided with appropriate services he would be another individual who would "fall through the gaps".

The Council raised these concerns with the Ministers for Health and Disability Services recommending that at the very least *BD* required a thorough assessment by both mental health and disability services to ascertain what assistance he required to address his clinical needs.

The Council understands that as a result he was assessed by the Disability Services Commission who maintained that he did not meet their eligibility criteria. The Council was advised that *BD* did have access to public mental health services as of March 2002.

BD's tenure in the third psychiatric hostel failed and he was admitted to a boarding house. Given this he no longer met the criteria for service from the Council (section 175, "*affected person*") and the matter was referred to the Chief Psychiatrist for review. The Council was subsequently advised that a management strategy to "wrap services" around *BD* had been developed and it was trusted that this would be of benefit to him.

In February 2002 the Council received advice regarding the establishment of the *Community Options 100 Project* which aims to provide long term inpatients with supported community – based accommodation. This is a joint project between Graylands Hospital and the Mental Health Division of the Department of Health. It is primarily concerned with addressing the needs of the patients of the long stay ward at Graylands Hospital, Murchison Ward. A number of these consumers have multiple disabilities with a number being eligible for funding from the Disability Services Commission.

The Council trusts that this process will be truly collaborative and ensure that these individuals can be discharged to appropriate supported accommodation in the community. The issue of people who are living in the community who are experiencing difficulties accessing services continues to be of concern to the Council.

DUTY OF CARE v MEDICAL TREATMENT MAY BE APPROVED BY THE CHIEF PSYCHIATRIST

Mental Health Act 1996, section 110

The Act, section 110, provides the Chief Psychiatrist with the power to approve medical treatment for involuntary patients and mentally impaired defendants in authorised hospitals if they lack the capacity to make such a decision. This approval cannot be used to override the decision of an involuntary patient/mentally impaired defendant who has capacity to make decisions regarding medical treatment and refuses such treatment.

The Council is gravely concerned that a trend is developing and becoming accepted whereby people's rights are overridden in the name of "Duty of Care". This is of particular concern where there are specific provisions in the legislation concerning the issue, such as medical treatment. For example, an involuntary patient in an authorised hospital who is deemed to have the capacity to make a decision regarding medical treatment involving oral medication also has the right to decide not to take this medication. Unless the consumer is subsequently assessed as lacking capacity to make decisions regarding medical treatment and approval sought from the Chief Psychiatrist or delegate, the facility staff do not have the right to force or coerce the person into taking the medication. Not even in the name of "Duty of Care".

Case Example

The Council received a complaint from an involuntary detained patient, *Ms KN*, that her access to cigarettes had been denied. Initial inquiries confirmed that *KN*'s access to cigarettes had been denied and indicated that this decision was due to her having a chronic lung disorder. There was no notation of a section 110 approval for this on her file. Advice was sought from the hospital regarding the basis for the decision to deny her access and whether the Act's provisions had been satisfied.

The hospital's initial response indicated that no section 110 approval had been sought even though the stated reason for ceasing *KN*'s access to cigarettes "*was part of the treatment of her smoking related lung disorder*". Further, the treating psychiatrist stated in part:

"*The decision was taken as part of my duty of care to (name omitted) as many other similar decisions are made in relation to incapable patients. Such decisions include trying to ensure compliance with non-psychiatric medications, restricting patient's fluid intake because of risk of water intoxication, banning alcohol from the hospital and dietary restrictions of patients with morbid obesity. The vast majority of Ward's (name omitted) patients are incompetent to make decisions about their health. ….. Section 110 is in my experience primarily used for consent to surgical or medical procedures such as endoscopy.*"

The Council's view is that section 110 of the Act is not limited to the approval of surgical or medical procedures such as an endoscopy. The Council is concerned that actions such as "*trying to ensure compliance with non-psychiatric medication*" or restricting access to cigarettes as part of the treatment for a lung disorder are not considered medical treatment. Therefore the Council requested that a review be undertaken of such decisions to ensure that the intent and requirements of the Act were satisfied, in particular section 110.

The Council was of the view that a section 110 approval was required as the decision to deny *KN*'s access was "*part of the treatment of her smoking related lung disorder*". Further clarification was sought and a significant number of months later a section 110 approval was issued on the basis that the denial of cigarettes to *KN* was medical treatment and she was assessed as lacking the capacity to make such a decision.

LICENSED PRIVATE PSYCHIATRIC HOSTELS

DEVELOPMENT AND IMPLEMENTATION OF STANDARDS RELATED TO QUALITY OF LIFE / CARE ISSUES FOR THE LICENSED PRIVATE PSYCHIATRIC HOSTEL INDUSTRY

Licensing standards development

The Council has been an active participant in the P*rivate Psychiatric Hostels Standards Reference Committee* convened as part of the Licensing Reforms process instigated by the Department of Health. The focus of this committee is on the development of licensing standards relating to the arrangements for the management, staffing and equipment of the hostels.

The Council remains strongly committed to the aim of establishing effective standards for the sector however is concerned that unless an accreditation or similar system is developed and adequately resourced the implementation and monitoring of these standards will be at best ad hoc.

It is a matter of the gravest concern that, during 2001 – 2002, there were times when no visits were being made by departmental staff to ensure compliance with current requirements. The lack of such visits can result in practices developing which are in breach of the regulations. For example, during numerous inspection visits by Council members to the licensed hostels meals, in particular dinners, were being served at times other than as authorised by the regulations. These practices would have remained unnoticed by the Department as no visits were being undertaken by its staff, in particular in the late afternoon (5.00pm).

It is not the Council's role to act as the defacto monitoring agency of the Department of Health's standards and regulations.

Development and implementation of standards related to quality of life/care issues

The standards being developed by *Private Psychiatric Hostels Standards Reference Committee* do not relate to the quality of life / care issues for the residents of the hostels. This is an area of ongoing and grave concern to the Council.

The Council is of the view that hostel residents are the most vulnerable group of its clientele. This group is socially dependent and generally disempowered. Unlike the authorised hospitals there are not significant numbers of people visiting hostel residents to provide an informal check on the services offered.

In May 2002 the Head of Council wrote a letter to the Editor of *The West Australian* newspaper in response to a previous letter from the mother of a hostel resident. This mother raised concerns regarding the lack of standards in the licensed private psychiatric hostels and questioned why an accreditation system similar to that in aged care could not be instituted.

In part the Council's letter to the Editor stated:

> "… *The hostels cater for an extremely vulnerable and sometimes demanding group of people. They receive minimal subsidies from government and inconsistent support from local mental health services. Some hostels provide excellent, personalised care in well equipped buildings with trained staff. Others operate in totally unsuitable buildings catering for between 30 to 80 people with staff whose relevant training has been limited at best. They provide a custodial regime characterised by all the worst aspects of institutional living.*
>
> *The standards required of these hostels are minimal and relate in the main to the physical environment rather than to the care of the residents.* …

For over 4 years the Council has been asking for the introduction of a formal accreditation system for hostels. As Diana French says such a system has worked well in aged care so why not for psychiatric hostels?

No doubt some of the people who own, operate and presumably make profits from hostels will, as many did in aged care, claim that such a system is too expensive, will drive them out of business etc, etc. Well, if that is the price of providing quality care in a reasonable environment then so be it.

Similarly, government will probably say that it cannot afford to support the hostels to do the right thing. The Council would reply that when it comes to the most vulnerable in society the community has to ask government how can it afford not to."

The Council trusts that the Department of Health will pursue the development of standards related to residents' quality of care as a priority.

Personal Care Support Subsidies

In August 2001 the Council wrote to the Mental Health Division (MHD) requesting advice on the progress of the review of the funding framework for providing personal care support subsidies to the residents of the licensed private psychiatric hostels.

Council representatives attended a briefing on Monday, 27 August 2001, regarding this matter and on 7 September 2001 the then General Manager of the MHD provided further advice regarding the main features of the new framework. The Council understood from this information that the revised subsidy levels and framework would apply effective 1 October 2001.

As at 30 June 2002 no further advice has been received regarding the implementation of the new framework.

Financial Accountability - Residents of Licensed Private Psychiatric Hostels

In November 2000 the Council referred its concern to the Department of Health that there was no system in place for ensuring accountability for the management of residents' funds which would satisfy auditing industry benchmarks. The Department subsequently instituted an investigation of the account keeping of residents' finances in the psychiatric hostel industry.

In March 2002 the Council was advised that:

> '*The audit by Stanton Partners did not identify any instances of impropriety or irregularity, but confirmed the Council of Official Visitors' concerns regarding the lack of general accountability and financial management controls, including the lack of suitable audit trails. The Stanton Report states*
> "In our opinion, controls are not adequate to prevent, or detect in a timely manner, misappropriation of resident's funds. The major area of concern is the co-mingling of resident's trust funds with proprietor business funds." '

Further the Council was advised that the recommendations made as a result of this process would be incorporated into the standards being developed by the by *Private Psychiatric Hostels Standards Reference Committee*. The Council welcomes this and looks forward to the development of standards that safe guard both the residents and the proprietors.

For residents of the psychiatric hostels who were clients of the Public Trustee that office continued its practice of forwarding their clients' personal spending money, as well as the board and lodgings owed, directly to the licensee with no requirement to provide any evidence to the administrator that this money had been distributed to the residents and / or items purchased on their behalf.

The Council remains of the view that this practice places vulnerable people at risk of exploitation. Of equal concern is that the Public Trustee apparently believes that its procedures are acceptable.

The Council regularly has contact with residents of licensed private psychiatric hostels who are subject to Administration Orders, with the Public Trustee the nominated administrator. It is not uncommon for these residents to report being unaware of either the funds available to them and/or how to access them. As a result of one visit the Public Trustee's office was contacted and it was requested that an officer attend a number of their clients who were residents at a particular hostel.

In response an offer was made by the Trustee's staff to clarify the matter and visit to discuss in person with the residents their financial situations. The Council wrote to the Public Trustee commenting that the service offered in relation to Public Trustee clients at the hostel was a positive and welcome one. The Council recommended that a similar approach be undertaken with Public Trustee clients in other licensed psychiatric hostels. The Council was subsequently advised that due to high workloads at that office it was unlikely that similar visits could be made on a regular basis.

DUTY OF CARE – ALLEGATIONS OF ASSAULT

The Council of Official Visitors has had ongoing concerns regarding the response by some psychiatric hostel staff and/or proprietors to allegations of assault made by residents in those facilities. While the hostels are independently owned and operated businesses the Council is concerned that the responses to such allegations vary from a thorough examination of the alleged incident to an apparently dismissive attitude of "*with these people these things happen*".

During 2001 – 2002 residents raised with Council members allegations of assault on them by other residents. In one instance the resident reported being fearful of another assault occurring particularly when the Licensee was not present. In all instances the Official Visitors raised the allegations with the Licensee or Manager and requested advice regarding any action taken in response to the allegations. In at least one instance the Licensee did not appear to be overly concerned regarding the allegation, as it was seen as a not uncommon occurrence.

The Council views as inappropriate a lack of, or a dismissive response to, what is potentially a very serious allegation.

In February 2002 the Council raised concerns with the Office of the Chief Psychiatrist regarding the lack of consistent guidelines and procedures for licensed psychiatric hostels to deal with allegations of assault either by other residents or staff. Council is of the view that the provision of such guidelines to hostel Licensees would be beneficial for both the residents and the Licensees.

The guidelines could include procedures to ensure that:

- an investigation of the allegation is undertaken in a timely and thorough manner;
- consumers are assessed for the need for medical attention and receive this as soon as possible if required;
- consumers are aware of their rights and responsibilities (e.g. reporting the matter to Police);

- relevant clinical service providers (e.g. local mental health service, General Practitioner) are advised of the incident in relation to both the alleged victim and alleged assailant (if another resident);
- there is record of the alleged assault in the day book; and
- the Chief Psychiatrist is advised of the incident as per Regulation 15(2)(e) governing the licensing and conduct of psychiatric hostels.

The response from that Office in March 2002 acknowledged that guidelines would be beneficial for the residents and licensees but questioned whether the development and implementation of such guidelines fell within the mandate of the Chief Psychiatrist. Further it was noted that the Licensing Standards and Review Unit of the Department of Health would consider whether a standard should be imposed as part of the licensing framework but queried whether this would result in the best outcome. It was queried whether the Private Psychiatric Hostels Association should suggest the way in which they would like to see this matter addressed.

The Council concurs that the imposition of a standard may not produce the best outcome for residents and licensees. In June 2002 this matter was discussed with Private Psychiatric Hostels Association representatives who were supportive of the idea of being provided with such guidelines to assist them in dealing with allegations of assault, both resident upon resident and staff upon resident.

This matter will be referred back to the Chief Psychiatrist for his further consideration. The Council trusts that the response received will focus on addressing this issue rather than debating bureaucratic boundaries.

MANAGEMENT PLAN FOR PLANNED AND UNPLANNED CLOSURE OF PSYCHIATRIC HOSTELS

The Council endorsed the document, "*A Management Strategy for the Planned and Unplanned Closure of Private Psychiatric Hostels*" in August 2001 following acceptance by the Mental Health Division. As at 30 June 2002 this strategy has not had to be invoked.

POLICY ENVIRONMENT

LIMITATIONS ON THE ROLE OF THE COUNCIL

It has been the Council's consistently held view that the definition of "*affected person*" under the Act (section 175) should be amended to include all patients in an authorised hospital, no matter their status under that Act. This would be in addition to involuntary patients in the community (i.e. subject to a community treatment order) and residents of psychiatric hostels. The Council is of the view that the arbitrary decision to limit its contact to involuntary patients in authorised hospitals appears flawed given that the services that the individuals receive are the same no matter what their legal status.

In addition, as noted in the letter to the Editor in May 2002 (referred to above) the Council has no role with the numerous unlicensed hostels and boarding houses where many of the people the Council is concerned about are living. The Council is worried by what we know about some aspects of the licensed hostel sector. The community should be even more uneasy about what we don't know about those facilities beyond the Council's limited purview.

The Council trusts that this matter will be reviewed and rectified via the review of the *Mental Health Act 1996*, which was announced by the Minister for Health in November 2001. Any amendments to the Act are unlikely to occur until 2002 – 2003 at the earliest therefore serious consideration must be given to mechanisms to ensure that the rights of these individuals are respected and ensured in the meantime.

The Minister for Health does have power under section 186 (c) of the Act to require the Council to visit such facilities.

COUNCIL MEMBERS' ACCESS TO MEDICAL AND OTHER RECORDS

The *Mental Health Act 1996*, section 190 provide the members of the Council with the power to:

"*(4) In the course of the visit the Official Visitor or any person on the panel, as the case requires, may - …*

(d) subject to subsection (5), inspect -

(i) any medical record or other document or any thing relating to an affected person; or

(ii) any other record or document required by this Act to be kept at the place.

(5) An affected person has - …

(b) to deny an official visitor or any person on the panel access to the person's medical records."

The staff advising consumers of their rights (section 156 of the Act and regulation 18) should be advising consumers of this right as part of that process. The Council understands that this does not occur as a matter of course.

This provision does not require the obtaining of consent however provides the affected person with the right to deny access. The Council understands that the legislation was worded thus to ensure that it can undertake its role. There may be instances where individuals are incapable of providing or withholding consent. If Council members have concerns regarding these consumers' rights not being observed they would be unable to clarify this via the medical record if consent was required.

It should be noted that in the majority of situations Official Visitors do request consent even though this is not required. The denial of access relates only to the person's medical record. The Official Visitors retain their power to access documentation required to be kept by the Act, for example

seclusion and mechanical bodily restraint registers (*Mental Health Regulations 1997*, regulation 17).

A number of staff in mental health services have raised concerns regarding this provision. In part this appears to be based on a concern for consumers' right to confidentiality which the Council supports and in part a lack of understanding of the responsibilities of the Council members. The Council is separate to and independent of mental health services but by its establishment under the Act, is part of the mental health system.

There is also a view held by some that because Official Visitors may not be mental health professionals they can not be "trusted" with the information, in particular, that they may release the information to the affected person or other person.

Official Visitors are not empowered to "go through the record" or to release the information contained in the record to the consumer or any other person. The confidentiality provisions of the *Mental Health Act 1996* apply to Official Visitors, as they do to staff of mental health services:

"206. *(1) A person must not directly or indirectly divulge any personal information obtained by reason of any function that the person has, or at any time had, in the administration of this Act or the* Mental Health Act 1962.

Penalty: $2 000 or imprisonment for 6 months.

(2) subsection (1) does not apply to the divulging of information –

(a) in the course of duty;

(b) under this Act or another law;

(c) for the purposes of investigation of any suspected offence or the conduct of proceedings against any person for an offence; or

(d) with the consent of the person to whom the information relates, or each of them if there is more than one.

If those staff who are concerned understood the status of Official Visitors under the Act and, by implication, the constraints and penalties to which they are subject, lingering concerns about this issue would dissipate.

The Council will recommend that the wording of this section of the Act be clarified as part of the Act's review.

MENTAL HEALTH REVIEW BOARD

It was noted from the Mental Health Review Board's Annual Report 2000 that only a small percentage of involuntary patients were supported or represented at their Mental Health Review Board hearings by either a legal practitioner or member of the Council of Official Visitors (refer pages 12 and 15). This is an area of concern to the Council.

It is unclear whether this is due to a decision by the involuntary patient to not access the services of the Council, and if so the reason for this. Alternatively it may be that, despite being advised in the letter notifying of the review date, consumers remain unaware of their right to access the Council or legal representation, primarily via the Mental Health Law Centre.

The Mental Health Law Centre shared these concerns and discussions occurred regarding mechanisms for addressing this issue. This will be further explored during 2002 – 2003.

In 2001 - 2002 there was a 19% increase in the number of Mental Health Review Board hearings attended by Official Visitors compared to the previous year. As a matter of course Official Visitors requested access to the medical reports provided to the MHRB by the treating team. In some instances these reports were not available until just prior to the MHRB hearing allowing the consumer very limited time to prepare for the hearing.

The Council remains concerned that many consumers may not be aware that they can request a copy of these reports prior to their hearings. The fact that the reports are often not available until the day of the hearing compounds this.

This is matter of procedural fairness which must be rectified.

MEDIA TREATMENT OF MENTAL HEALTH ISSUES

During 2001 – 2002 *The West Australian* newspaper published very prominently an article which contained the full name of an individual who was currently receiving treatment and rehabilitation at Graylands Hospital.

The Council questioned the purpose of the article, which appeared to be merely sensationalist and likely to promote unfounded fear in the general public. In addition, parts of the article were factually incorrect.

The article contained information that was not a matter of public record, specifically relating to the individual's current treatment. This raises questions about the source of such information.

Whatever an individual's history, it does not remove the right to privacy relating to information that is not a matter of public record. Members of the general public would be outraged if information relating to their medical or psychiatric treatment were detailed in an article in the newspaper. The same principle should have applied in this instance.

The West Australian argued that the article raised issues of "*obvious or significant public interest*". However, informed debate on such issues, notably absent from the article in question, can be stimulated without naming particular individuals.

The Council lodged a formal complaint with the Press Council. In this complaint the Council specifically requested that if the Press Council' adjudication to the complaint was to be published that it not include the consumer's name.

The Press Council's adjudication found, in summary that it did not believe there was any basis to the Council's complaint. The adjudication, which had to be published by *The West Australian* newspaper, not only named the individual but contained wording which was subjective and emotive.

Whilst the Council must accept this adjudication (Number 1160) it expressed its concern to the Press Council that, in framing that adjudication in such a way that it included the individual's name only served to compound the Council's original concern. The Council is of the view that the adjudication lacked sensitivity given the issues it has raised and was disappointed that the Press Council saw fit to repeat the approach adopted in the original article.

PART THREE
ACTIVITIES OF THE COUNCIL

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

- respond to requests from consumers in a timely fashion; and
- undertake inspections of authorised hospitals and the licensed private psychiatric hostels.

INSPECTION VISITS

The Act specifies that an Official Visitor or panel must visit each authorised hospital at least once in each month. In addition the Minister, in accordance with the Act, has directed that an Official Visitor or panel should visit designated psychiatric hostels at least once every two months.

Inspection visits focus 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).

A summary of the inspection visits to authorised hospitals and licensed private psychiatric hostels by the time and day of the week is detailed in Appendices 6 and 7 respectively. All operational authorised hospitals were visited as planned with the exception of the October 2001 visit to the Lodge and Ward 8 of the Mills Street Centre. Similarly 118 of the planned 119 visits to the licensed private psychiatric hostels occurred, with Casson Group Homes being visited five out of the programmed six times.

The Council set itself the target of increasing the percentage of 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, with 40% of visits to secure wards

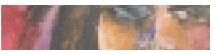
being at these times.

Individuals live and are cared for in these facilities 24 hours per day, seven days per week therefore it is essential that visits occur outside conventional 'business hours'. Numerous other visits, including responding to consumer requests, also occur outside these hours.

The Council's performance in conducting inspection visits outside normal working hours improved during 2001 - 2002 compared to previous years with a total of 51.4% of such visits to authorised hospitals and 53.3% of such visits to psychiatric hostels occurring outside these hours (Appendix 8).

The Act (section 190 (2)) empowers the Council members to visit facilities with or without notice. The Council continued with the majority of inspection visits occurring unannounced.

In July 2001 the Council received a letter expressing serious concern that a resident of a psychiatric hostel had been admitted to an authorised hospital in a deplorable physical state. The writer queried how this could occur when the Council and other agencies, including mental health services, were visiting the hostel. Official Visitors had recently visited the facility concerned however they had not seen the resident concerned. In an attempt to minimise the risk of this re-occurring the frequency of visits to the hostels was increased.



In September 2001 the Council adopted a process of informal visits to the licensed private psychiatric hostels, with the exception of the small group homes. These visits occurred during the alternate months to the formal inspection visits. The focus of these visits was to actively seek out the residents of the hostels and speak with them rather than have the distraction of having to complete inspection formalities at the same time.

CONSUMER CONTACTS

Appendices 9 and 10 summarise the number of consumers seen and actions taken by Official Visitors during 2001 – 2002 in response to a request and where a report was forwarded to the Council's office.

For the year 2001 - 2002 there was an increase of 23.4% in the total number of consumers having contact with the Council in response to requests, compared to 2000 - 2001 (refer to Appendices 9, 11A and 13).

Similar to previous years the majority of consumers with whom the Council had contact were from Graylands Hospital (50%) (refer to Appendix 12).

Since 1998 – 1999 there has been a 44% increase in the total number of consumers requesting contact with the Council (refer to Appendices 11A, 11B and 13). Limited requests from consumers from non-metropolitan areas, who were not inpatients, continued during 2001 – 2002. In part this is due to the small number of people subject to Community Treatment Orders in those areas. This is an area that requires further attention by the Council to ensure that these consumers are aware of the availability of the Council's service.

Similarly, over the same period the total number of contacts between Official Visitors and consumers following these requests has consistently increased (Appendix 13). It is interesting to note that for 2001 – 2002 there was a decrease in the letters written by Council in relation to consumer complaints compared to the previous year. This appears to be related to Official Visitors addressing issues at the lowest possible level, i.e. on the ward or in the hostel.

A summary of the issues raised by consumers is contained in Appendices 14A and 14B. The Council continued to utilise the same categorisation of complaints as that adopted by the Office of Health Review. Complaints are categorised based on the complainant's view of the issue.

OTHER ACTIVITIES

POLICY

Since its inception the Council has undertaken a role in policy development and advocacy at the local and systemic levels.

Position Statements

The Council has previously developed and adopted positions in relation to:

- Access to Telephones - Privacy Provisions; and
- Use of Video Monitoring.

These position statements are available from the Council. The Council has started to prepare position papers on issues that should be considered in the design and development of new inpatient units and on *Consumers' Right to Receive Visitors in Reasonable Privacy*.

These will be further developed in 2002 - 2003.

Submissions

The Council provided comment and submissions in relation to:

- Albany Mental Health Unit's Post Occupancy Evaluation
- Albany Mental Health Unit - Australian Council on Healthcare Standards - Indepth Review of Mental Health Services;
- Supported Community Living for People with a Psychiatric Disability Policy, November 2001 (Mental Health Division);
- National Practice Standards for the Mental Health Workforce, February 2002;
- Pamphlet for referred persons (Office of the Chief Psychiatrist); and
- Community Treatment Orders Practitioner's Guide (Office of the Chief Psychiatrist).

The Head of Council also participated in the review of the Development of the Role of the Chief Psychiatrist and the Office of the Chief Psychiatrist.

QUALITY ASSURANCE

The Council of Official Visitors continued in its commitment to continuous quality improvement in its service delivery during 2001 - 2002. A survey of service providers who had had contact with Official Visitors was conducted for the period 1 June 2001 – 31 August 2001. Feedback of an informal and formal nature regarding the operation of the Council and / or the conduct of individual Official Visitors or staff from customers of its service is essential to this process and welcomed.

Code of Conduct

The Council's Code of Ethics and Code of Conduct bind all members of the Council. A copy of the Code of Ethics and Code of Conduct is available from the Council's office.

Complaints Regarding Council Operations

During 2001 - 2002 two complaints were received regarding the operations of the Council. The complaints were received from service providers. The complaints related to the operation of the Council and the perceived actions of the Official Visitors including:

- failure to report concerns relating to physical health of residents to staff at the time of a visit; and
- timing of inspection visit and a staff member's feeling of "intimidation".

In relation to delays in failure to report concerns, statements were attributed to the Official Visitors, which were inaccurate, however it was acknowledged that the Official Visitors were remiss in not advising staff that they were leaving the premises.

The complaint regarding the timing of visits was lodged by a staff member who had not been present at the time of the visit and there were a number of points of alleged fact that the Council disputed. As this raised general issues relating to the procedure for visits it was agreed that the service provider and the Council would work together to address any concerns, including staff members' knowledge of the role of the Council.

In addition, a letter was received from a staff member at an authorised hospital posing the question of who advocates for residents of the licensed private psychiatric hostels? This was in response to a specific situation where a hostel resident was admitted to the authorised hospital in an "*extremely dishevelled state*" (see page 25 above). The individual staff member commented that Official Visitors appeared to attend authorised hospitals almost immediately in response to requests which could be perceived as trivial and "*pale into insignificance*" in comparison to this individual's apparently dire situation.

This was a valid concern.

As a result the Council reviewed its method of operation in an attempt to minimise the risk of a similar situation occurring and introduced informal visits to all hostels.

During an audit of the Council's records of contacts with consumers for 2001 – 2002, 9 occasions were identified where a member of the Council did not respond to requests from consumers. Whilst the Council did not receive complaints from the consumers concerned it treated these failures very seriously. The Official Visitor/s concerned were counselled regarding this matter and office procedures reviewed in an attempt to ensure that this did not re-occur.

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.

As part of the ongoing programme of providing training and development opportunities during 2001 - 2002 a two day orientation programme was provided to members of the Council. In addition a number of Official Visitors attended lectures, workshops and conferences external to the Council.

Presentations to Community Groups

To ensure that relevant individuals and service providers are aware of the Council it continued to provide presentations to community groups during the 2001 - 2002. Presentations were made to various groups including:

- Orientation of new staff at Armadale Mental Health Units and medical staff at Graylands Hospital;
- Mental Health Law Centre - Volunteer Training Program; and
- Mental Health Review Board conference - *Mental Health Law - Past, Present and Future* (November 2001).

PRIORITIES FOR THE COUNCIL

A number of areas of the Council's own operations were identified as requiring priority attention during 2001 – 2002. These areas are listed below with an accompanying comment regarding the progress to date:

- Provision of the 2001 - 2002 Annual Report to the Minister for Health by 30 September 2002.

  Outcome: This will be achieved.

- Development of a Position Statement related to "*Consumer's Right to Receive Visitors in Reasonable Privacy*" (*Mental Health Act 1996* section 168)

  Outcome: This Position Statement is under development.

- Development of a Position Statement relating to "*Translating Legal Rights into Building Design Guidelines*".

  Outcome: This Position Statement is under development.

- Development and implementation of strategies to ensure that consumers in non-metropolitan areas have access to and utilise the services of the Council.

  Outcome: This is an area requiring further consideration and targeting of mental health clinics in non-metropolitan areas.

- System-wide implementation of the formalised process adopted to audit whether the requirements of the *Mental Health Act 1996* associated with the issuing of Community Treatment Orders is occurring.

  Outcome: Initial discussions have occurred with staff from the Office of the Chief Psychiatrist regarding this matter. It has been agreed that the Audit form drafted by the Council can be incorporated into the *Community Treatment Orders – A Practitioner's Guide* being developed by that office.

- Increasing the percentage of inspection visits undertaken outside normal working hours for licensed private psychiatric hostels to 40% of visits and for authorised hospitals to 25% with 40% of visits to secure wards being at these times.

  Outcome: The Council has been successful in increasing the percentage of formal inspection visits at times other than Monday – Friday, 9.00 am to 5.00 pm (Appendices 6, 7 & 8). Over 50% of the total formal inspection visits have occurred outside these times.

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 (forensic)

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 [1]
Piccadilly Street
Kalgoorlie

Joondalup Health Campus
Joondalup Mental Health Unit
Shenton Ave
Joondalup

[1] Kalgoorlie Mental Health Unit authorised May 2002, however at time of report was not open to admit patients.

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

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 2001"*)

Casson Homes	
Aitken House	55 View Street, North Perth
Casson House	2-10 Woodville Street, North Perth
Violet Major House	47 View Street, North Perth
Woodville House	425 Clayton Road, Helena Valley
Richmond Fellowship	
	175 Anzac Tce, Bassendean
	56 Glyde Street, East Fremantle
	58 Glyde Street, East Fremantle
	2 Teague Street, Victoria Park
	13 Teague Street, Victoria Park
	4 - 6 Mann Way, Bassendean
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[1]	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	1 River Street, Guildford

[1] Inspections commenced October 2001

APPENDIX 3

COUNCIL OF OFFICIAL VISITORS 2001 - 2002 MEMBERSHIP

Head of Council	Expiry Date of Term
Mr Stuart FLYNN	01 February 2003
Official Visitors	
Mrs Di ANNEAR	07 April 2005 [1]
Ms Joyce ARCHIBALD	07 April 2005 [2]
Mrs Sherril BALL	07 April 2005 [2]
Mr Scott BARNDON	07 April 2005 [2]
Ms Sandra BROWN	07 April 2003
Mrs Rita BURGESS	07 April 2003
Mr Peter DAVIES	07 April 2002
Mrs Jean ELLIS	30 August 2001
Ms Jane ENSOR	07 April 2003
Mr Adrian GAVRANICH	07 April 2004
Ms Jane GIBSON	07 April 2003
Mr Kevin GUHL	30 August 2001
Ms Amara HOGEVEEN	07 April 2003
Mr Kevin HOGG	07 April 2003
Mrs Lynn HUDSON	07 April 2003 [3]
Dr Gary HULSE	06 April 2002
Mr Darren JONES	07 April 2005 [2]
Mrs Cushla LEECH	07 April 2003 [3]
Dr Helen LETTE	07 April 2003
Ms Barbara McDONALD	07 April 2004 [2 & 3]
Mrs Ann McFADYEN	07 April 2004 [2]
Ms Edana McGRATH	07 April 2004
Mr Sean O'CONNELL	07 April 2005 [1]
Ms June O'CONNOR	30 August 2001
Mrs Noreen PAUST	30 August 2001

Dr John ROONEY	30 August 2001
Ms Catherine SAWTELL	07 April 2002
Mrs Rosalind SAWYER	07 April 2003
Mrs Maxinne SCLANDERS	07 April 2003
Mrs Sheila STEPHENS	07 April 2004
Ms Margaret STOCKTON METCALF	07 April 2004 [2]
Mr Nepia TEIO	07 April 2002
Ms Hilary TUFFIN	07 April 2005 [1]
Ms Brenda VAN ZALM	07 April 2002
Ms Catriona WERE - SPICE	07 April 2005 [1]
Mr Michael WRIGHT	07 April 2003 [3]

Panel Appointments

The Council appointed 4 individuals as Panel Members, as prescribed in section 187 of the Act, during 2001 – 2002.

[1] Reappointment during 2001 - 2002

[2] New appointment during 2001 - 2002

[3] Resigned during 2001 - 2002

APPENDIX 4

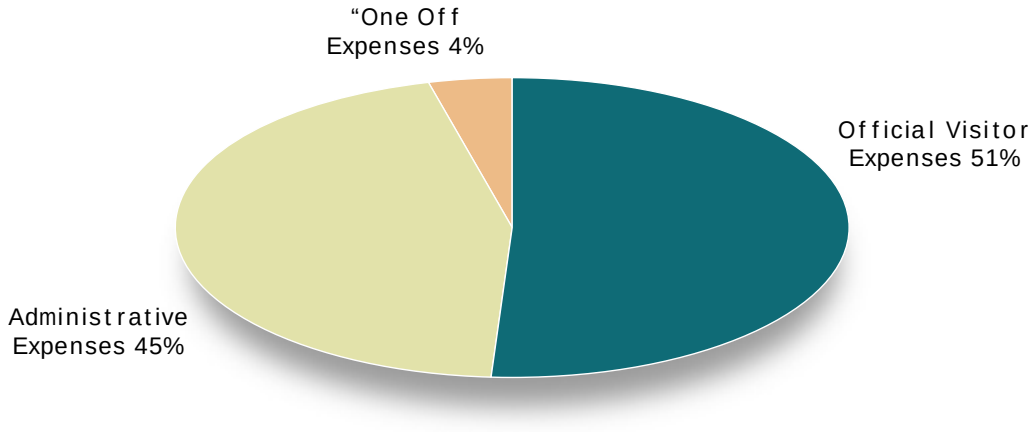
ATTENDANCE AT COUNCIL OF OFFICIAL VISITORS' MEETINGS 2001 - 2002

OFFICIAL VISITOR	FULL COUNCIL		EXECUTIVE GROUP	
	Present	Apologies	Present	Apologies
Mrs Di ANNEAR [1&2]	4	0	7	0
Ms Joyce ARCHIBALD [2]	1	–	–	–
Mrs Sherril BALL [2]	1	–	–	–
Mr Scott BARNDON [3]	–	–	–	–
Ms Sandra BROWN	3	1	–	–
Mrs Rita BURGESS	2	2	–	–
Mr Peter DAVIES [1]	3	–	–	–
Mrs Jean ELLIS [4]	–	–	–	–
Ms Jane ENSOR	1	2	–	–
Mr Stuart FLYNN (Head of Council)	3	1	7	0
Mr Adrian GAVRANICH	2	2	–	–
Ms Jane GIBSON	3	1	–	–
Mr Kevin GUHL [4]	–	–	–	–
Ms Amara HOGEVEEN	4	0	–	–
Mr Kevin HOGG	4	0	–	–
Mrs Lynn HUDSON [5]	2	1	5	0
Dr Gary HULSE [1]	1	0	–	–
Mr Darren JONES [2]	1	–	–	–
Mrs Cushla LEECH [7]	0	1	–	–
Dr Helen LETTE	3	1	–	–
Ms Barbara McDONALD [6]	–	–	–	–
Mrs Ann McFADYEN [2]	1	–	–	–
Ms Edana McGRATH	4	0	7	0
Mr Sean O'CONNELL [1&2]	4	0	–	–
Ms June O'CONNOR [4]	–	–	–	–
Mrs Noreen PAUST [4]	–	–	–	–
Dr John ROONEY [4]	–	–	–	–
Ms Catherine SAWTELL [1]	2	1	–	–
Mrs Rosalind SAWYER	4	0	7	0
Mrs Maxinne SCLANDERS	4	0	2	0
Mrs Sheila STEPHENS	3	1	–	–
Ms Margaret STOCKTON METCALF [2]	1	–	–	–
Mr Nepia TEIO [1]	3	–	–	–
Ms Hilary TUFFIN [1&3]	2	1	–	–
Ms Brenda VAN ZALM [1]	0	1	–	–
Ms Catriona WERE - SPICE [1&2]	4	0	–	–
Mr Michael WRIGHT [7]	–	–	–	–

[1] Term Expired April 2002
[2] Term commenced April 2002
[3] Term commenced May 2002
[4] Term Expired 30 August 2001 & no Full Council meetings prior to this date
[5] Resigned effective February 2002
[6] Resigned prior to commencing work
[7] Leave of Absence following appointment, resignation effective February 2002

APPENDIX 5

SUMMARY OF EXPENDITURE 2001 - 2002



One off expenses comprised $15,107 of a total expenditure of $401,294. This was for computer software development, asset purchases (computers), and consultant's and legal fees for lease renewal negotiations.

As required under the *Electoral Act 1907* Section 175ZE (1), during 2001 - 2002 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: nil.

APPENDIX 6

AUTHORISED HOSPITAL INSPECTIONS BY HOSPITAL & TIME & DAY OF INSPECTION 2001 - 2002

AUTHORISED HOSPITAL	TOTAL NUMBER OF INSPECTIONS	TIME OF INSPECTIONS			
		Mon–Fri 9am–5pm	Mon–Fri 5pm–9am	Sat/Sun/ Pub Hol 9am–5pm	Sat/Sun/ Pub Hol 5pm–9am
Albany Regional Hospital – Mental Health Unit	12	8	2	2	0
Alma Street Centre	24	8	8	8	0
Armadale Health Service – Adult and Elderly Units	24	1	6	16	1
Bunbury Acute Psychiatric Residential Unit [1]	11	9	1	1	0
Graylands & Special Care Health Services [2]	32	26	6	0	0
Joondalup Mental Health Unit	12	7	4	1	0
Kalgoorlie Mental Health Unit [3]	0	–	–	–	–
Mills St Centre [4]	28	7	10	10	1
Selby Lodge	12	10	1	1	0
Swan Health Service Boronia Unit & Swan Valley Centre	24	11	9	3	1
TOTAL	179	87	47	42	3

Notes:

[1] No visit in March 2002 as Unit closed
[2] Includes 2 visits to the Anglesey service.
[3] Unit authorised in May 2002 but did not open to admit patients
[4] No visit to Ward 8 and the Lodge in October 2001

APPENDIX 7

LICENSED PRIVATE PSYCHIATRIC HOSTEL INSPECTIONS BY HOSTEL & TIME & DAY OF INSPECTION 2001 - 2002

LICENSED PRIVATE PSYCHIATRIC HOSTEL	TOTAL NUMBER OF INSPECTIONS	TIME OF INSPECTIONS			
		Mon–Fri 9am–5pm	Mon–Fri 5pm–9am	Sat/Sun/ Pub Hol 9am–5pm	Sat/Sun/ Pub Hol 5pm–9am
Casson Homes [1]	5	0	1	2	2
Casson House	6	1	1	3	1
Devenish House	6	1	1	4	0
Dudley House	6	4	0	2	0
Franciscan House	6	4	0	2	0
Glyde Street Hostel	6	4	2	0	0
Honey Brook Lodge	6	3	2	1	0
John Wilson Lodge	6	4	1	1	0
Maude Armstrong	6	4	0	2	0
Richmond Fellowship - 175 Anzac Tce & 6 Mann Way, Bassendean	6	3	1	2	0
Richmond Fellowship – 56 & 58 Glyde Street, East Fremantle	6	3	2	1	0
Richmond Fellowship – 2 & 13 Teague Street, Victoria Park	6	3	2	1	0
Romily House	6	1	3	2	0
Rosedale Lodge	6	2	2	2	0
St Jude's Hostel [2]	5	4	1	0	0
Salisbury Home	6	2	4	0	0
Shannon House	6	6	0	0	0
Sherwood House	6	1	2	3	0
Success Hill Lodge	6	2	1	2	1
Woodville House	6	3	3	0	0
TOTAL	118	55	29	30	4

Notes:

[1] 'Casson Homes' includes Aitken House and Violet Major House. No inspection visit December 2001 & June 2002, additional inspection visit October 2001.

[2] Inspections commenced October 2001.

APPENDIX 8

FACILITY INSPECTIONS BY TIME & DAY OF INSPECTION 1998 - 1999 to 2001 - 2002

FINANCIAL YEAR	FACILITY TYPE	TIME OF INSPECTIONS (% OF TOTAL)			
		Mon–Fri 9am–5pm	Mon–Fri 5pm–9am	Sat/Sun/ PubHol	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%	25.2%	0%
	Licensed Private Psychiatric Hostels	46.6%	24.6%	28.8%	0%

APPENDIX 9

NUMBER OF CONSUMERS AND REQUESTS BY FACILITY 2001 - 2002

FACILITY	NUMBER OF CONSUMERS CONTACTED	NUMBER OF REQUESTS RECEIVED
Albany Mental Health Unit	8	13
Alma Street Centre Fremantle	45	66
Armadale Health Service – Adult & Elderly Units	17	25
Bunbury Acute Psychiatric Residential Unit [1]	4	6
Graylands & Special Care Health Services	266	435
Joondalup Mental Health Unit	15	26
Mills Street Centre Bentley	57	76
Selby Lodge	4	4
Swan Mental Health – Swan Valley Centre & Boronia	38	82
Metropolitan Clinics	29	29
Non - Metropolitan Clinics	2	2
Psychiatric Hostels	32	39
Other	4	4
TOTAL	521	807

Notes

[1] Suspended admissions of involuntary patients effective 31 August 2001 & Unit closed 22 February - 19 March 2002

Note: A total of 807 requests were received from 521 consumers. A number of consumers made multiple requests for contact from the Council. These consumers are recorded once.

APPENDIX 10

CONTACTS WITH CONSUMERS BY FACILITY 2001 - 2002

FACILITY	NUMBER OF CONSUMERS CONTACTED	CONTACT TYPE			
		VISIT	TELEPHONE CALL	LETTER	MHRB[1] ATTENDANCE
Albany Mental Health Unit	8	20	7	0	1
Alma Street Centre Fremantle	45	54	36	11	3
Armadale Health Service – Adult & Elderly Units	17	20	27	5	0
Bunbury Acute Psychiatric Residential Unit [2]	4	5	2	0	1
Graylands & Special Care Health Services	266	422	487	47	12
Joondalup Mental Health Unit	15	15	26	2	4
Mills Street Centre Bentley	57	55	87	12	2
Selby Lodge	4	14	11	0	0
Swan Mental Health – Swan Valley Centre & Boronia	38	60	101	2	9
Metropolitan Clinics	29	13	39	6	10
Non - Metropolitan Clinics	2	2	5	0	1
Psychiatric Hostels	32	42	93	13	0
Other	4	0	8	0	0
TOTAL	521	722	931	98	43

Notes

[1] MHRB Mental Health Review Board

[2] Suspended admissions of involuntary patients effective 31 August 2001 & Unit closed 22 February - 19 March 2002

APPENDIX 11A

TOTAL CONSUMERS CONTACTED BY FACILITY
1998 - 1999 to 2001 - 2002

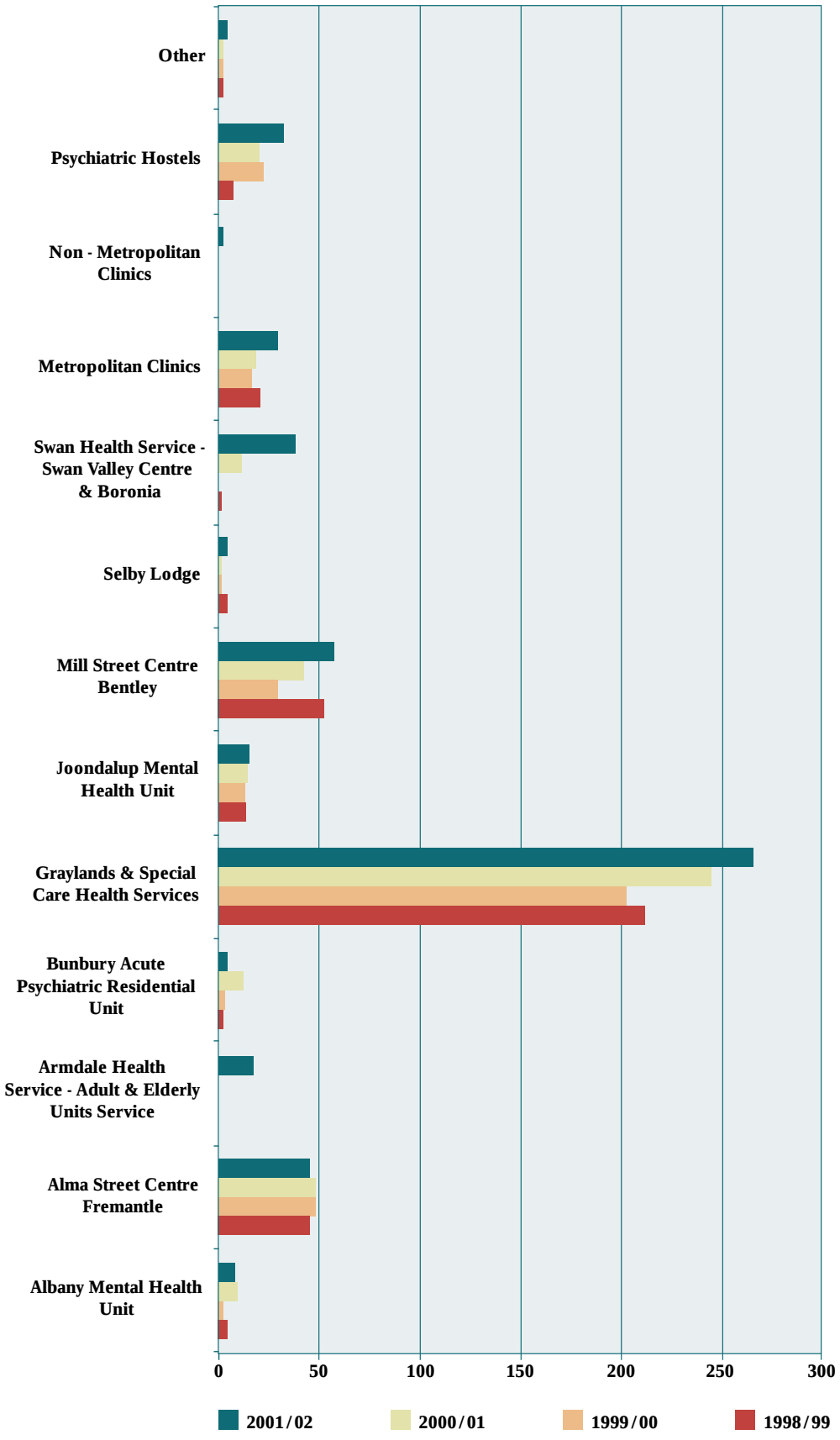
FACILITY	NUMBER OF CONSUMERS			
	1998 - 1999	1999 - 2000	2000 - 2001	2001 - 2002
Albany Mental Health Unit	4	2	9	8
Alma Street Centre Fremantle	45	48	48	45
Armadale Health Service - Adult & Elderly Units	–	–	–	17
Bunbury Acute Psychiatric Residential Unit [1]	2	3	12	4
Graylands & Special Care Health Services	212	203	245	266
Joondalup Mental Health Unit	13	13	14	15
Mills Street Centre Bentley	52	29	42	57
Selby Lodge	4 [2]	1	1	4
Swan Health Service – Swan Valley Centre & Boronia	1 [3]	0 [3]	11	38
Metropolitan Clinics	20	16	18	29
Non – Metropolitan Clinics	0	0	0	2
Psychiatric Hostels	7	22	20	32
Other	2	2	2	4
TOTAL	362	339	422	521

Notes:

[1] Suspended admissions of involuntary patients effective 31 August 2001
[2] Lemnos Hospital
[3] La Salle Hospital / Boronia Unit only

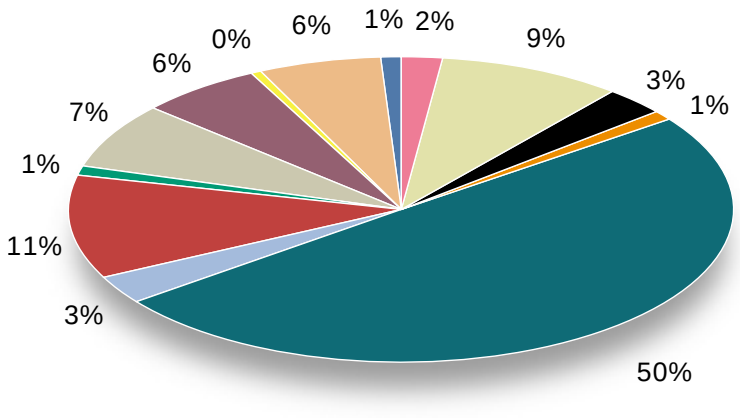
APPENDIX 11B

GRAPH - TOTAL CONSUMERS CONTACTED BY FACILITY
1998 - 1999 to 2001 - 2002



APPENDIX 12

PERCENTAGE OF TOTAL CONSUMERS BY FACILITY 2001 - 2002



- Albany Mental Health Unit - 2%
- Alma St - 9%
- Armadale Adult & Elderly - 3%
- Bunbury - 1%
- Graylands - 50%
- Joondalup - 3%
- Mills St - 11%
- Selby - 1%
- Swan Boronia & SVC - 7%
- Metro Clinics - 6%
- Non-Metro Clinics - 0%
- Psych Hostels - 6%
- Other - 1%

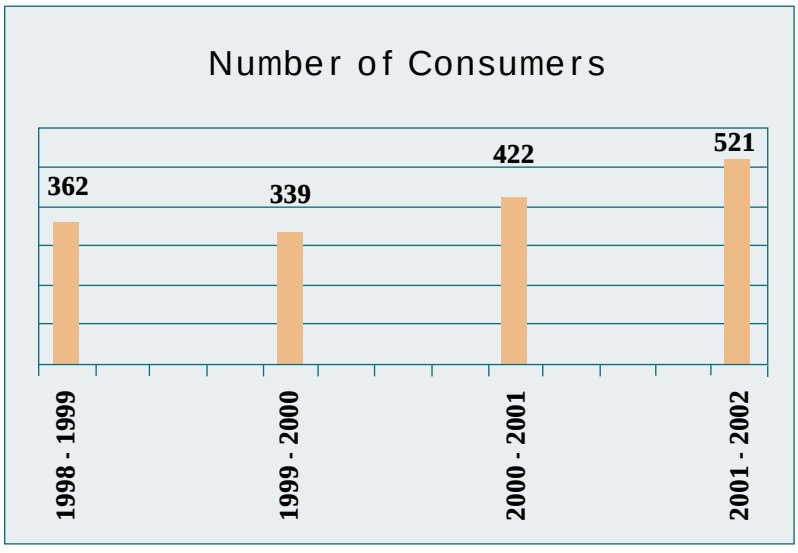
APPENDIX 13

TOTAL CONTACTS WITH CONSUMERS
1998 - 1999 to 2001 - 2002

FACILITY	NUMBER OF CONSUMERS	CONTACT TYPE			
		VISIT	TELEPHONE CALL	LETTER	MHRB[1] ATTENDANCE
1998 - 1999	362	519	189	48	Not Reported on
1999 - 2000	339	515	374	93	12
2000 - 2001	422	656	558	114	36
2001 - 2002	521	722	931	98	43
% increase – 2000 - 2001 to 2001 - 2002	23.4%	10.1%	66.8%	-14%	19.4%
% increase 1998 - 1999 to 2001 - 2002	43.9%	39.1%	392.6%	104.2%	258.3% [2]

Notes:

[1] MHRB Mental Health Review Board
[2] 1999 - 2000 to 2001 - 2002 only



APPENDIX 14A

TOTAL CONSUMER CONTACTS BY ISSUE CATEGORY - ALL FACILITIES 2001 - 2002

1.	ACCESS	NUMBER	PERCENTAGE (%) OF TOTAL
1.1	Delay in Admission or treatment	19	2.2
1.2	Waiting list delay	0	0
1.3	Non-attendance	0	0
1.4	Inadequate or no service	26	3
1.5	Refusal to admit or treat	1	0.1
1.6	Discharge or transfer arrangements	197	22.7
1.7	Access to transport	0	0
1.8	Physical access/entry	2	0.2
1.9	Parking	0	0
	TOTAL	245	28.2%

2.	COMMUNICATION	NUMBER	PERCENTAGE (%) OF TOTAL
2.1	Inadequate information about treatment options	4	0.5
2.2	Inadequate information on services available	7	0.8
2.3	Misinformation or failure in communication	15	1.7
2.4	Failure to fulfil statutory obligations	13	1.5
2.5	Access to records	7	0.8
2.6	Inadequate or inaccurate records	2	0.2
2.7	Failure to provide interpreter	1	0.1
2.8	Certificate or report problem	0	0
	TOTAL	49	5.6%

3.	DECISION MAKING	NUMBER	PERCENTAGE (%) OF TOTAL
3.1	Failure to consult consumer	3	0.4
3.2	Consent not informed	0	0
3.3	Consent not obtained	52	6
3.4	Private/public election	0	0
3.5	Refusal to refer or assist to obtain a second opinion	0	0
	TOTAL	55	6.4%

4.	QUALITY OF CARE	NUMBER	PERCENTAGE (%) OF TOTAL
4.1	Inadequate diagnosis	5	0.6
4.2	Inadequate treatment	61	7
4.3	Rough treatment	18	2.1
4.4	Incompetent treatment	1	0.1
4.5	Negligent treatment	1	0.1
4.6	Wrong treatment	4	0.5
	TOTAL	90	10.4%

5.	COSTS	NUMBER	PERCENTAGE (%) OF TOTAL
5.1	Inadequate information about costs	0	0
5.2	Unsatisfactory billing practice	1	0.1
5.3	Amount charged	3	0.4
5.4	Overservicing	0	0
5.5	Private health insurance	0	0
5.6	Lost property and/or reimbursement	1	0.1
	TOTAL	5	0.6%

6.	PRIVACY/CONSIDERATION/ DISCOURTESY	NUMBER	PERCENTAGE (%) OF TOTAL
6.1	Inconsiderate service/lack of courtesy	38	4.4
6.2	Absence of caring	11	1.3
6.3	Failure to ensure privacy	8	0.9
6.4	Breach of confidentiality	6	0.7
6.5	Discrimination	1	0.1
6.6	Discrimination of public consumer	0	0
6.7	Sexual impropriety	2	0.2
6.8	Sexual transgression or violation	0	0
6.9	Assault	15	1.7
6.10	Unprofessional conduct	1	0.1
	TOTAL	82	9.4%

7.	GRIEVANCES	NUMBER	PERCENTAGE (%) OF TOTAL
7.1	Inadequate response to a complaint	0	0
7.2	Reprisal following a complaint	1	0.1
	TOTAL	1	0.1%

8.	OTHER	NUMBER	PERCENTAGE (%) OF TOTAL
8.1	Administrative practice	6	0.7
8.2	Catering	21	2.4
8.3	Facilities	50	5.8
8.4	Security	14	1.6
8.5	Cleaning	9	1.0
8.6	Fraud/illegal practice	0	0
	TOTAL	100	11.5%

9.	*MENTAL HEALTH ACT 1996* (OTHER)	NUMBER	PERCENTAGE (%) OF TOTAL
9.1	Mental Health Review Board Application	72	8.3
9.2	Mental Health Review Board Attendance	62	7.2
9.3	Second Opinion Request (not 3.5)	15	1.7
9.4	*Mental Health Act 1996* Information	15	1.7
9.5	*Mental Health Act 1996* Non-Compliance (not 2.4)	16	1.9
	TOTAL	180	20.8%

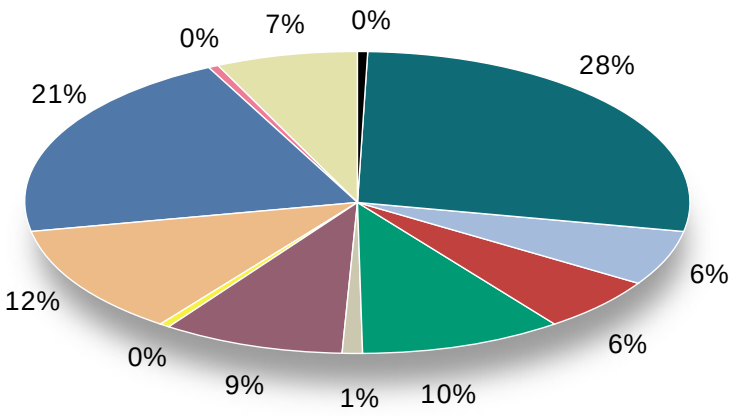
10.	*CRIMINAL LAW (MENTALLY IMPAIRED DEFENDANTS) ACT 1996*	NUMBER	PERCENTAGE (%) OF TOTAL
10.1	Mentally Impaired Defendants Review Board	2	0.2
	TOTAL	2	0.2%

11.	UNABLE TO BE DETERMINED	NUMBER	PERCENTAGE (%) OF TOTAL
11.1	Unknown/Undetermined	57	6.6
	TOTAL	57	6.6%

12.	COMPLIMENTS	NUMBER	PERCENTAGE (%) OF TOTAL
12.1	Compliments	2	0.2
	TOTAL	2	0.2%

APPENDIX 14B

PERCENTAGE ISSUE CATEGORY - ALL FACILITIES
2001 – 2002



- Access - 28%
- Communcation - 6%
- Decision making - 6%
- Quality care - 10%
- Costs - 1%
- Privacy/consideration/discovery - 9%
- Grievances - 0%
- Other - 12%
- Mental Health Act (other) - 21%
- Criminal Law (Mentally Impaired Defendants) Act 1996 - 0%
- Unable to be determined - 7%
- Compliments - 0%