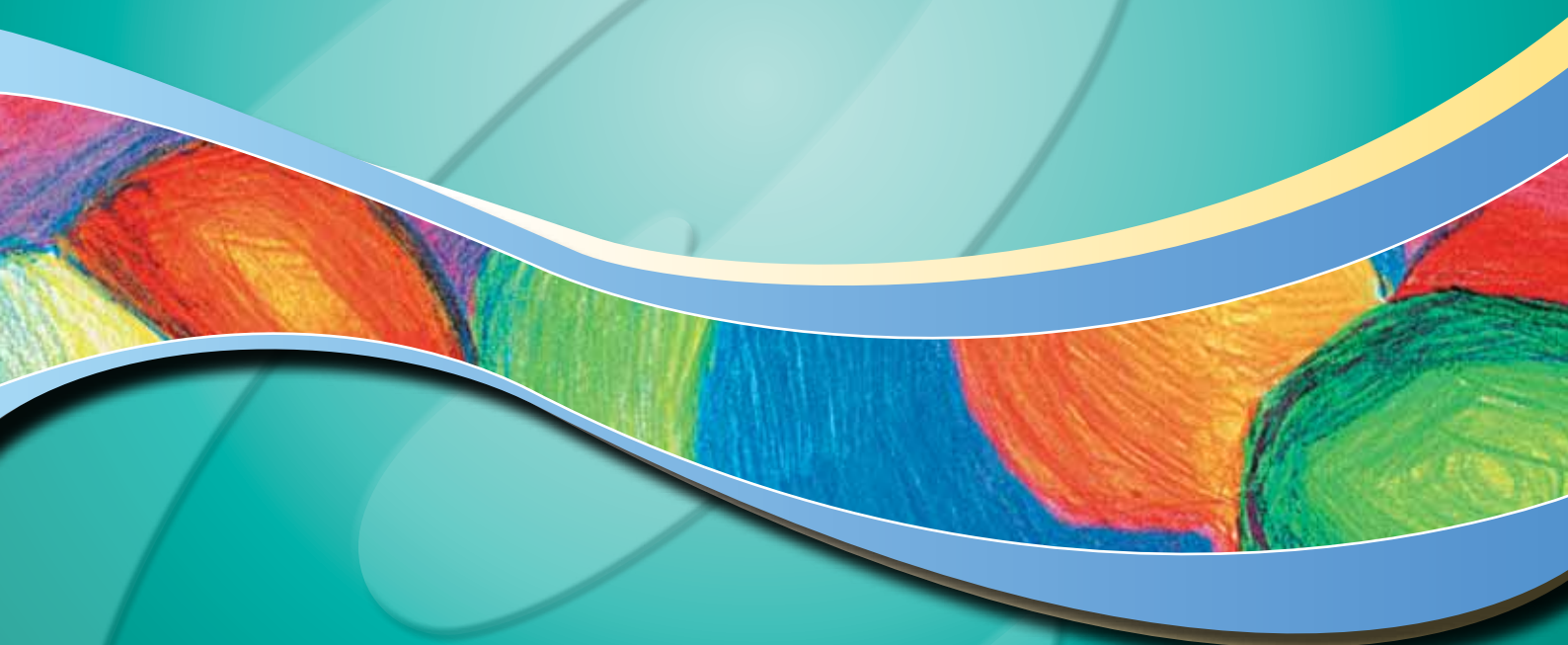


COUNCIL *of* OFFICIAL VISITORS



Annual Report
2009-2010

Hon Dr G Jacobs MLA
MINISTER FOR MENTAL HEALTH

In accordance with section 192(3) of the *Mental Health Act 1996* I hereby submit for your information and presentation to Parliament the Annual Report of the Council of Official Visitors for the financial year ending 30 June 2010.

As well as recording the operations of the Council for the 2009–2010 year the report reflects on a number and range of issues that continue to affect consumers of mental health services in Western Australia.

A handwritten signature in black ink, appearing to read 'D. Colvin', with a long horizontal flourish extending to the right.

Debora Colvin
HEAD, COUNCIL OF OFFICIAL VISITORS

November 2010



ACKNOWLEDGEMENTS

Front cover artwork produced by Craig Wood
through the Creative Expressions Unit at
Graylands Hospital.

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INTRODUCTION

YEAR IN REVIEW 2009-2010

This year saw a 12.5% increase in the number of consumers requesting visits by Official Visitors. Many of the consumers were new to Council and experiencing for the first time the personal trauma of being an involuntary person on the State's locked wards. While the figures have only been collected by Council for the past 18 months, the indications are that there has been a steady increase in the number of people being made involuntary for the first time. Indeed there were increases across all measures. Further analysis is contained in Part 4 of this report.

A sample of the issues dealt with by Official Visitors is provided in Part 2 of the report. They largely repeat issues highlighted in previous years' Annual Reports. Part 3 provides a list of 27 issues which have been reported by Council since its inception in 1998 and which remain ongoing. There are many more stories than those listed. Council visited 957 consumers and dealt with 2,864 issues this year.

The aim in raising the issues in the Annual Report is to advocate for change by highlighting the problems which Council witnesses on a daily basis. As a "watchdog" for consumers' rights, Council is in the unique position of being able to see and respond to the problems encountered by a very vulnerable group, their carers and their loved ones. The Annual Report, which must be laid before each House of Parliament, allows Council the opportunity to represent the voices of consumers. The independent nature of Council permits a frank and honest reporting of individual and systemic issues.

The importance of the Council for many consumers, though, lies in knowing that there is someone "on their side" who is always contactable, who knows their rights and who can and does speak up for them: someone who listens and who is independent from the hospital and the people who detained them; someone who has the power to visit at any time, to demand answers to their inquiries and who can argue on their behalf; someone who sees first hand and can appreciate that the standards of care and conditions in which they are being forced to live are frequently not good enough. Visitors, in one form or another, have been available to assist mental health consumers since 1871, shortly after the first asylum was open in the then colony.

It is difficult to articulate the feeling of disempowerment felt by many consumers. Being an involuntary patient can mean:-

- being locked up on a noisy ward, which is often shabby and run-down, with limited access to the outdoors which frequently amounts to little more than a garden full of dead plants;
- not being allowed to make your own decisions about what, when and how much to eat;
- not being able to access your bedroom during the day;
- having people force you to take drugs especially if this involves being injected in your buttocks against your will;
- possibly being banned from using the phone or having people visit;
- not being able to smoke;
- being treated by a doctor who you didn't choose but who made the decision to lock you up against your will;
- knowing implicitly that what you say can mean the difference between staying in or going home, getting ground access or not;
- feeling misunderstood, unprepared or perhaps ignored when present at team meetings and Mental Health Review Board hearings;
- feeling so bored, with almost nothing to do day-in, day-out, that you lose hope; and
- witnessing the very physical restraint of a fellow patient knowing that this could happen to you and that you could be secluded in a locked, windowless room with only a mattress on the floor.

Vulnerability is not confined to hospital wards. Finding and keeping accommodation is the single biggest issue for people with a mental illness. The standards of accommodation and care available range widely. The type and availability of accommodation and care, however, is very limited. It is not unusual to hear from consumers that when they complain about conditions, they are told they can leave – but they think there is nowhere else for them to go and usually there is nowhere else for them to go.

Council welcomes the new Mental Health Commission and is hopeful that the Commission and promised legislative reform will lead to some real improvements in the future.

There are some "good news" stories scattered throughout Part 2 of the report and, on behalf of Council I would like to thank all those dedicated and compassionate mental health staff who, more often than not, work in difficult conditions while respecting the rights of patients and welcoming Official Visitors.

I would also like to thank the very hard working Official Visitors. This year Council had to struggle with budget cuts and ongoing administration staff shortages. Despite this, Official Visitors supported and represented an extra 39 consumers in Mental Health Review Board hearings, visited an extra 107 consumers and conducted 51 extra visits to facilities.

Official Visitors have not had a pay rise for 4 years and have had to fit in more and more work into their sessional payments, including increased complexity of issues, paperwork and training. Their job is difficult and often emotionally exhausting, yet many of them do not charge the full amount for their time and expenses.

Thanks must also go to those people who have given their time to come and speak to Official Visitors at various educational sessions throughout the year.

Finally, I would like to thank the hard-working office staff including my Executive Officer, Donna Haney who has had a “baptism of fire” since starting last year. She and I look forward to the independent review of Council which is being conducted in the second half of 2010. More administrative support is long overdue and necessary if Council is to keep working for consumers at the same level as it has done this year.

Debora Colvin

Head, Council of Official Visitors

November 2010

PART ONE

THE LEGISLATIVE AND OPERATIONAL FRAMEWORK

FUNCTIONS AND POWERS OF COUNCIL AND OFFICIAL VISITORS

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

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

- each hospital authorised under section 21 of the Act at least once per month. In practice, visits take place more regularly. Official Visitors visit consumers on request, conduct formal and informal inspections and check Council mailboxes on the wards for correspondence from consumers. This is part of making themselves accessible and ensuring that the wards and hostels are “safe and otherwise suitable” as required by section 188 of the Act;
- each licensed private psychiatric hostel at the direction of the Minister for Mental Health. Currently this is at least once every 2 months but sometimes more often based on the number of consumer requests for visits from particular facilities or where an ongoing issue has been identified which requires follow-up; and
- all consumers who request a visit as soon as practicable after the visit is requested. Council aims to respond within 24 hours to a new consumer and otherwise within 24 to 48 hours.

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

- ensure that “affected persons” (see definition below) are aware of their rights and that those rights are observed;
- ensure that places where consumers are detained, cared for or treated under the Act are kept in a condition that is “safe and otherwise suitable”;
- be accessible to hear and to enquire into and seek to resolve complaints concerning consumers made by the consumer, their guardians or their relatives;
- refer matters on to other relevant bodies where appropriate; and
- assist with the making and presentation of applications and appeals under the Act, primarily Mental Health Review Board and Guardianship and Administration hearings and appeals.

The term “affected person” is defined by section 175 of the Act to mean:

- an involuntary patient, including a person subject to a Community Treatment Order;
- a mentally impaired accused person who is in an authorised hospital;
- a person who is socially dependent because of mental illness and who resides, and is cared for or treated at a private psychiatric hostel; and
- any other person in an institution prescribed for the purposes of the section by the regulations (no institutions have been prescribed to date).

Affected persons are referred to by Council and hereafter in this report as consumers.

CONSUMER RIGHTS

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

- the United Nations “*Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*” adopted in 1991 (the UN Principles) and in particular Principle 2 which reads:
“all persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person”;
- the Act which accords a set of legal rights to consumers in WA;
- the *Licensing Standards for the Arrangements for Management, Staffing and Equipment: Private Psychiatric Hostels* prepared by the Licensing Standards and Review Unit of the Department of Health as regulated by the *Hospitals and Health Services Act 1927*;
- various standards set by the Chief Psychiatrist including *Standard in Care Outcomes in Licensed Psychiatric Hostels*; and
- the *National Standards for Mental Health Services* designed to guide policy development and service delivery in each of the States.

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

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

The statutory rights provided to consumers by the Act include the right to:

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

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

- have information about them maintained in a confidential manner (section 206);
- be detained, treated, cared for in a safe and otherwise suitable environment (section 188(c)); and
- have access to proper standards of care and treatment (section 13).

POWERS OF OFFICIAL VISITORS

In order to ensure that the consumers' rights are observed and that they have been informed of their rights, Official Visitors have the power pursuant to section 190 of the Act to:

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

OPERATIONAL FRAMEWORK - REPORTING LINES

Official Visitors

The Council and its individual members are directly responsible to the Minister for Mental Health who appoints people from the general community in accordance with section 177 of the Act. Any Official Visitor, or person on a panel, who considers that the Minister for Mental Health or the Chief Psychiatrist should consider a matter, may make a report to that person (section 192 of the Act). The Head of Council is required to make a report to the Minister for Mental Health as soon as practicable after the end of each financial year on the activities of the Official Visitors and the Minister is to table this report in Parliament (sections 192(3) & 192(4) of the Act).

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

Similarly with hostels, Official Visitors first try to deal with issues by speaking to the hostel supervisor or licensee. Sometimes Head of Council will also meet with the licensee or raise issues with other bodies such as the Office of the Chief Psychiatrist or Licensing Standards Review Unit.

In addition, the Head of Council meets regularly with the Minister for Mental Health, the management teams of each of the authorised hospitals, as well as the Chief Psychiatrist, the Director of the Mental Health Division and now the Commissioner for Mental Health, the Executive Directors of North and South Metropolitan and Country Mental Health Services, the Clinical Director of Infant, Child, Adolescent and Youth Mental Health Services and various others involved in the provision of mental health services in WA, both from the government and non-government sector. At these meetings various ongoing issues identified by Official Visitors are raised and discussed with the aim of resolving them through appropriate action.

Administrative Support - Executive Officer & Other Staff

Council is provided with an Executive Officer and 2 other full-time staff members, all of whom are public servants employed by the Department of Health under Part 3 of the *Public Sector Management Act 1994*. Their role is to provide administration support as required by section 182 of the Act though these positions have not all been filled substantively in 2009/2010.

The Executive Officer is legislatively responsible for the Council records (sections 183 and 184) and taking requests from affected persons for visits by Official Visitors (section 189). The Executive Officer also has the delegated responsibility for ensuring that the Official Visitors visit authorised hospitals, comply with Ministerial directions and visit affected persons as soon as practicable after a visit is requested in accordance with section 186 of the Act.

COUNCIL COMPOSITION 2009 - 2010

A list of individuals who were members of the Council during 2009/2010 and their terms of appointment are contained at appendix 3. Eight Official Visitors were reappointed following the expiry of their terms during 2009/2010 and 6 new Official Visitors were appointed. There were 3 resignations, 1 death and 2 Official Visitors did not reapply on expiry of their term. As at 30 June 2010 Council had 30 active Official Visitors and 3 on an extended leave of absence.

PANEL APPOINTMENTS

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

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

There were 12 panel appointments in 2009/2010:

- Eight people were empanelled as an interim measure pending Cabinet approval of their appointment as Official Visitors.
- An ex-Official Visitor was empanelled to assist in a country region following the resignation of an Official Visitor.

- The Commissioner for Children and Young People was empanelled to allow her to visit a facility.
- The Executive Officer and Acting Enquiries Officer were empanelled to allow them to visit various facilities.

COUNCIL MEETINGS

Full Council Meetings

Full Council Meetings (FCMs) were held in June and December for 2009/10. These were combined with training days and regional group meetings. Further information about those meetings is contained in Part 4.

In between FCMs the Executive Group (see below) met including 2 full day meetings in Perth (the other meetings were held by teleconference with rural and regional Executive Group members). At those two full day meetings Council's strategic plan and major policy and position statements were developed. Due to budget cutbacks, the number of meetings was reduced this year with meetings being held in the months of July, August, September, October, November, February, April and May,

Executive Group

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

A summary of the Full Council and Executive Group meetings attended by Council members during 2009-2010 is contained at appendix 4.

Country and Metropolitan Meetings of Council

Official Visitors are allocated to two groups in the metropolitan area, based roughly on the North and South Metropolitan Mental Health Area Health Services. These are nominally called A and B group by the Council. In addition there are three groups in the country based on the location of authorised hospitals: South West, Lower Great Southern and Goldfields.

Each regional-based group met monthly except when there were FCMs and in January and July. This was due to budget cut backs. The 3 regional groups also held combined meetings prior to each FCM, to discuss and share issues of mutual concern and interest to regional areas.

The metropolitan groups also met, both separately and in a combined session, on the third Thursday of every month except when there were FCMs and in January and July. Again this was for budgetary reasons. The joint meetings are used to discuss issues identified by Official Visitors. Occasional training sessions were also held which were specific to those groups.

Focus Area Person

The Focus Area Person drafts the formal inspection report forms which are used by Official Visitors when carrying out inspections of authorised hospitals, hostels and group homes. The Focus Area Person sits on the Executive Group and consults with them in advance of inspection report forms being published. During the second half of this year the Focus Area Person also began compiling a summary of all the inspection reports. This initiative has been useful for gaining an understanding of the issues across all hospitals and hostels in that month.

PART TWO

VISITS, INSPECTIONS, ISSUES AND ACTION IN 2009-2010

IN 2009-2010 OFFICIAL VISITORS:

- inspected 36 wards in twelve authorised hospitals and 33 licensed psychiatric hostels and group homes (which included 5 new accommodation facilities); and
- visited 957 consumers, dealing with 2,864 issues raised by those consumers.

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

The number of consumers requesting visits increased by 12.6% from 850 to 957 and the number of issues dealt with increased 3.2% from 2,775 to 2,864. A more detailed analysis of these figures is contained in Part 4 and appendices 8 to 12.

The issues outlined below represent a selection of the concerns and matters that Official Visitors have been involved with in 2009-2010 and the action taken. It includes some “good news stories”.

ISSUE 1: PEOPLE STUCK ON WARDS

General observations and comment: Last year’s Annual Report outlined a sample of 7 consumers, old and young, who had been “stuck on wards”. Some had been there for many months but in most cases, for years. One of those cases, a consumer with an acquired brain injury, had turned into a “good news” story and moved off the ward. The rest, however, remained on locked wards. A year later, 4 of the original 7 consumers remain on locked wards. An update on their situation is provided below along with further examples of consumers “stuck” on psychiatric wards because there is no appropriate alternative for them.

Council reiterates its concerns that:

1. despite more alternative accommodation being opened up in the past 2 years, a significant number of consumers, often with very complex needs, are never going to qualify for this type of accommodation - there needs to be a wider variety of “step-down” and other accommodation and care than that which is currently available;
2. many of the long-term consumers have an intellectual disability yet are denied Disability Services Commission (DSC) funding or accommodation because they have been diagnosed with a mental illness;
3. acute locked wards do not encourage recovery or rehabilitation and sometimes they actively delay recovery because the consumer finds living on a closed ward so distressing - in some cases the ward is not safe for the consumer;
4. there are a number of young people under 35, who have been “stuck” on wards for years; and
5. keeping the consumer on a hospital ward is not giving them “*the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity*” as required by section 5 of the Act.

There is some “good news” as a result of changes at Graylands that commenced in March 2010. Wards were separated into acute care and rehabilitation. As at 30 June 2010, Council was waiting to see substantial changes in rehabilitation practices. We are aware that bed pressures have impeded implementation on some wards. Also outlined below is a “good news” story about a person who was this year discharged from Graylands to one of the new Community Options facilities after “living” at Graylands for over 10 years.

Illustration 1: Three years from one locked ward to another

This consumer, in their early 30s, was referred to in last year’s Annual Report as living very unhappily on an acute secure ward in a metropolitan hospital for nearly 2 years with a strict behavioural management plan, and no prospect of leaving the ward. The consumer remains an involuntary patient on a locked ward but is now living at Graylands following a precedent-setting application to the Mental Health Review Board in which the Board ordered that the consumer must be moved to Graylands within a set period of time. While this might appear to be simply swapping one locked hospital ward for another, the consumer:

- is now living on a ward which is said to be aimed at rehabilitation and getting people back into the community;
- has a new, more relaxed management plan;
- is happy with the new treating team; and
- gets more regular ground access.

Official Visitors continue to work closely with this consumer with a view to ensuring the consumer's rights are observed. This includes receiving the best care and treatment with the least restriction of their freedom and the least interference with their rights and dignity.

Illustration 2: Seven years on a locked ward

This consumer in their late 30s, referred to in last year's report remains on a locked ward without Disability Services Commission (DSC) funding or any prospect of alternative accommodation. This takes their time on locked wards to seven years.

The consumer, however, has been moved to a newer ward at Graylands, with other long term patients, which is more physically attractive and comfortable but ground access remains a major issue. The consumer continues to be supported by an Official Visitor who regularly deals with complaints raised by the consumer on issues such as seclusion, restriction of telephone rights and ground access.

Illustration 3: Five years on a locked ward since the age of 15 but some good news

This young consumer referred to in last year's Annual Report, now aged 20, also remains on a locked ward at Graylands. Official Visitors have been working closely with the consumer and their social worker and there is some good news to report.

Apart from being diagnosed with a mental illness, the consumer has very low literacy and numeracy skills. The consumer's institutionalisation from such a young age also meant that the consumer had no skills to deal with ordinary life outside the hospital. The Official Visitor suggested the Ethnic Disability Advocacy Centre be approached regarding funding for personal support/mentoring. This was not possible because of the consumer's detention on a locked ward. The social worker, however, found another organisation to provide a carer to take the consumer out of the hospital once a week for shopping, movies, walks etc.

Soon after the move to a new ward, one of nurses mentioned to the Official Visitor that the consumer was interested in reading books. The nurse spent time with the consumer on weekend duty, reading children's books. When the Official Visitor next spoke to the consumer she asked the consumer if they were interested in going back to school. The response was enthusiastic. After some research, the Official Visitor put the social worker in touch with a program which provides volunteer tutors for one on one teaching of literacy skills. The program was unable to find any volunteers at that time so the social worker and another staff member took on the tutoring roles themselves.

According to the Official Visitor, the consumer is a changed person – the consumer now gets unescorted ground access, which was out of the question 6 months ago, continues on weekly outings with a carer, has been going to a library to borrow books, and is soon to begin on the tutoring scheme with a volunteer from the program.

Illustration 4: Nine months of constant distress and agitation on a locked ward

A consumer in their early 50s diagnosed with "treatment resistant Chronic Paranoid Schizophrenia" has remained on a locked ward since early November 2009, apart from a 5 week attempt to settle the consumer into a hostel which resulted in expulsion. The consumer's doctor wrote to Council asking for assistance to "*find a solution to an intractable problem*" that the doctor said was causing the consumer to be "*constantly distressed and agitated*". When not in a locked ward, the consumer chooses to leave the hospital and ends up on the streets. In these circumstances the consumer is physically abused and financially exploited. The consumer is described as "*a person of the streets but who cannot survive on the streets*". In the past street living has caused their physical condition to deteriorate to dangerous levels.

According to the consumer's doctor, the consumer needs housing and care with a very high level of support while also allowing freedom for the consumer to come and go. Currently none is available. As described by the doctor, the "*absence of adequate alternative care constitutes systemised discrimination against people with a mental illness*". Meanwhile the consumer remains in a locked ward, supported by an Official Visitor on request, but is unable to smoke or be given regular ground access. The ward is neither a safe nor appropriate place for this consumer.

Illustration 5: Under 30 and spent the last 17 years on hospital wards

This consumer tells Official Visitors they have spent every birthday and Christmas in hospital since the age of 10. Council has been involved with the consumer since early 2006. The consumer started on the Bentley Adolescent Unit (BAU) and, apart from a few short spells off the wards, has been in hospital ever since. In the past few years, the absences from hospital have been measured in mere days. The consumer is now so institutionalised, every attempt to find accommodation fails as the consumer no longer knows how to socialise or cope with day to day living in the community. The Official Visitor is continuing to work with the consumer and their treating team to ensure their rights under the Act are observed.

Illustration 6: 25+ years at Graylands

A consumer aged in their 50s with severe autism has been living at Graylands Hospital for nearly 25 years. The consumer came to an Official Visitor's attention because of an injury which resulted in the consumer being nursed, including sponge bathed and toileted, on the floor of the ward lounge. Staff were waiting for a special bed to arrive and other assistance such as a sheep skin to assist with reducing skin wounds. Prior to this the patient had been sent from Graylands to a general hospital for treatment but, according to staff, was discharged too early. The consumer's injury severely limited their ability to move. It was considered that the patient was at risk of physical harm if they remained on the ward. This had resulted in the consumer being moved to another, smaller ward. The transfer was initially extremely distressing for the patient and the consumer's anguish was difficult for both staff and other patients on the ward. Attempts are now being made to find alternative accommodation for the consumer, who has DSC funding. In the meantime the Official Visitor is maintaining close contact with ward staff and hospital social workers.

Illustration 7: Over 10 years waiting for appropriate accommodation

In September 2001 the then Head of Council, Stuart Flynn, wrote to the "Combined Application Panel" seeking funding for this consumer who has a physical disability. The aim was to allow them to live in an appropriate residential facility funded by the DSC. As Mr Flynn wrote: "*Taking a 'whole of government approach' it is also clearly unsatisfactory for a bed in an acute facility to be occupied by someone who could be catered for elsewhere more appropriately and at significantly less cost*".

At that time the consumer had already been an inpatient for 3 years. The application was unsuccessful despite the then Minister for Health also writing to the Minister for Disability Services and the consumer being a registered DSC client.

This year, after 9 years, the consumer moved out of Graylands Hospital to one of the new Community Options housing developments and, as at 30 June 2010, was working part-time.

The Official Visitor who has advocated for this consumer for many years says this case was a "Catch 22" situation. The relevant disability accommodation provider organisation refused to assist because the patient was involuntary, but the medical team and Mental Health Review Board refused to make the consumer voluntary until the consumer had somewhere to go.

ISSUE 2: AUTISM AND HUNTINGTON'S DISEASE PATIENTS

General observations and comment: Each year patients with autism and Huntington's disease are admitted as involuntary patients to mental health wards because there is nowhere else for them to go. As already noted under Issue 1 Illustration 6, a consumer with autism has lived at Graylands for over 25 years. The main issues common to these consumers are that:

1. acute mental health wards are not appropriate places for their care and treatment from either the individual's perspective nor that of the other patients on the ward;
2. they require doctors and care staff with specialist expertise but such expertise is not available at every hospital so there have been delays in commencement of treatment and consumers have sometimes had to be moved to other hospitals to get treatment, which is stressful for the consumer and their family; and
3. suitable accommodation after discharge is very hard to find and, for the Huntington's patients, elderly nursing homes (if they will accept them) is often the only option although these patients are generally aged in their thirties or early forties.

Illustration 1: The Armadale secure ward partially closed for 2 weeks

In April 2010 patients on the secure ward at Armadale Hospital had to be moved onto the open ward, some patients on the open ward had to be discharged and new admissions were diverted to other hospitals due to the admission of an autistic consumer. The consumer was a danger to other patients and to themselves. The ward remained partially closed for 14 days and only patients who were considered suitable to share a ward with the autistic consumer were being admitted. Official Visitors were immediately advised and made themselves available to consumers to ensure that their rights, and those of the autistic consumer, were observed. Apart from the impact of this ward closure on other patients, there were delays in treating the consumer with autism because of issues identifying a suitable specialist in the field to provide an opinion.

Illustration 2: Autistic adolescent consumer

An adolescent non-verbal consumer with autism was admitted to the Bentley Adolescent Unit (BAU) in early December 2009 as an involuntary patient because Princess Margaret Hospital had refused to accept the child. It was believed that the consumer's aggressive behaviour, which had led to the admission, was being caused by a physical problem causing ongoing pain which required surgery. The consumer was being nursed in the BAU in the Focal Care Area in order to be kept separate from the other children on the ward.

Council became aware of the child in early January and was told that Princess Margaret Hospital had refused to do the operation because the child was too big. Instead a referral was made to Royal Perth Hospital. The operation was said to be scheduled for 18 January but a few days before this, Official Visitors were told that the operation had been deferred and would be performed "sometime in February".

Head of Council immediately wrote to the Minister for Mental Health, Dr Jacobs, and Princess Margaret and Royal Perth hospitals complaining that this child had waited far too long for relief, which was distressing for the consumer and other children on the BAU. As a result the consumer was admitted to RPH for surgery on 28 January 2010. By this stage the child had been on a locked ward for nearly 2 months.

Illustration 3: Huntington's disease consumer

Council was contacted by the office of the Minister for Mental Health to see if we could assist a consumer with Huntington's Disease who had been moved from their accommodation and placed on a locked ward. The consumer's guardian had called their local member of parliament due to delays in the consumer receiving treatment at Bentley Hospital and because of concerns about the loss of the accommodation. Council was told that Bentley Mental Health Service did not have the appropriate expertise and the consumer needed to be transferred to Graylands but there were no beds available. Council also understood that the accommodation provider had said they could no longer look after the consumer because they could not resource the necessary support.

The consumer remained at Bentley Hospital for 8 weeks before eventually moving to Graylands. The Official Visitor supported and advocated for the consumer and their Guardian in various meetings during this time and thereafter relating to the consumer's treatment and proposed accommodation after discharge. The consumer is now in an aged care facility that is close to family and receives ongoing support from rural mental health services.

Illustration 4: Accommodation issues for patient with Huntington's disease

A patient in their late 30s with Huntington's disease, who had spent 3 years intermittently on an acute ward, and the previous 5 months on a locked ward, was eventually housed in an aged care facility because it was considered this would be quicker than waiting for other accommodation. The family was anxious for the consumer to be in a homelike environment where the consumer could more easily spend time with their teenage child.

Council was told that the DSC had rejected the consumer's application on the basis that the consumer had dementia rather than Huntington's Disease. As the consumer lived in the south-west of WA, it was considered that an aged care facility would be found more quickly than appealing the DSC decision and finding appropriate DSC accommodation. Official Visitors and Head of Council made various inquiries and the issues were discussed with the hospital social

worker and consumer's family, with a view to providing support and ensuring the consumer's rights were observed.

Following a process lasting from January 2010 to May 2010, accommodation was eventually found and both DSC and the Aged Care Assessment Team were involved.

ISSUE 3: "VOLUNTARY" PATIENTS

General observations and comment: The Act limits Council's "jurisdiction" by defining "affected persons" as patients on wards who are involuntary. It is common, however, for Official Visitors to:

1. be approached by patients on the wards who are voluntary but have been told, by their doctor, that if they leave the ward they will be made involuntary;
2. be assisting a consumer who is involuntary one day, voluntary the next, and shortly thereafter made involuntary again;
3. receive calls from exhausted carers, friends and family members who need advocacy assistance but their loved one is a voluntary patient;
4. receive complaints from voluntary patients about the failure to treat them with dignity and respect;
5. be approached by consumers whose rights were breached during the referral process prior to them being made involuntary;
6. receive requests for assistance from patients on a Hospital Order in the Frankland Centre – (patients on a Hospital Order are not included in the definition of "affected person" under the Act);
7. meet patients on wards where the guardian has agreed to their voluntary admission; and
8. see elderly patients who are voluntary but unable to leave the ward.

In each case the Official Visitor is not able to assist the person unless the complaint can be connected to involuntary status. Council has been raising this issue and calling for the legislation to be changed since the 1998-99 Annual Report. The Holman Review¹ recommended such changes be made to the new Mental Health Act. These recommendations were accepted by the then Government in August 2004.

In the meantime this issue continues to cause difficulties as illustrated in the examples below.

Illustration 1: Voluntary patient not allowed to leave or instruct lawyers

This voluntary patient contacted Council about the hospital not allowing them to go home until a State Administrative Tribunal (SAT) hearing to appoint the Public Advocate as guardian had been held. The patient was also told they could not leave the grounds unless supervised by a hospital staff member. This was confirmed by an Official Visitor. The patient was very concerned about the consequences of leaving, even for a coffee at a local café. Initially the patient was also without appropriate clothes or money.

As the Official Visitor was unable to act on behalf of the patient, the Mental Health Law Centre was contacted. A lawyer attended the hospital and left an authority form for the patient to sign, giving the lawyer consent to view the patient's file. The patient's doctor subsequently refused to allow the patient to sign the form. (Mental Health Law Centre lawyers cannot view the patient's file without this consent.) The lawyer was forced to attend the SAT hearing without being fully prepared and the patient was denied proper advocacy and support under the Act on the basis that they were a voluntary patient. As they were not staying on the ward voluntarily, this was clearly not the case.

If the Act were amended in accordance with the Holman Review recommendations, an Official Visitor could have advocated for the patient including checking their medical records.

¹ Holman CDJ, Titmus JS, Rapp J. *The Way Forward. Synthesis of the Review of the Mental Health Act 1996*. Perth: Government of Western Australia 2003.

Illustration 2: Voluntary but not allowed to go home

An elderly patient was made voluntary but not allowed home. The ward was locked so the patient could not leave. When the Official Visitor who had advocated for the consumer when they were involuntary attempted to view their file for the purpose of advocacy, they were denied access. A call was also made to Council office complaining that the Official Visitor had attempted to see the “voluntary” patient’s file.

Head of Council made some inquiries and discussions were held with the hospital service management. Nevertheless the Official Visitor was not allowed to assist the consumer nor obtain answers to inquiries.

Official Visitors often meet elderly patients on the wards who are voluntary but unable to go home. Such decisions are usually made in the patient’s best interest and sometimes in consultation with family members. The problem remains, however, that these patients do not have access to Official Visitors to advocate for them, should there be issues of concern.

Illustration 3: Expiry of form 1 but patient held on secure ward

A consumer, referred on a Form 1 complained that their form had lapsed at 10pm and that despite requests to do so, they were unable to leave. The Act allows a person on a Form 1 to be sent to an authorised hospital to be assessed by a psychiatrist **within strict time limits**. The following morning a new Form 1 was completed after the consumer made another request to leave. This was followed by the completion of a Form 6 making the consumer involuntary. Council followed up the complaint with the hospital and was advised that, although the patient had initially asked to leave, they had then agreed to stay on the ward overnight. The patient denied this but had no witness to support their version of events.

If the Act is changed in accordance with the Holman Review recommendations, the patient could have called the Council that night for advocacy assistance and there would be no question as to whether the patient’s rights were infringed.

Illustration 4: Voluntary patient on the locked ward without consent of guardian

Official Visitors were approached by a patient on a locked ward asking for assistance to get to an open ward. Official Visitors were told by staff that the patient was voluntary, and that their guardian had agreed to them being on that ward. As a result, Official Visitors could not assist the patient and had no power under the Act to check the consumer’s file to ensure their rights were being observed. However, because of questions raised by the Official Visitor, checks were made and it transpired that the guardian had not agreed to the patient being on a locked ward. The patient was then made involuntary.

While this meant that Official Visitors could now assist the patient, the case raises a number of questions about patient rights. It also exemplifies why Official Visitors should have the power to assist voluntary patients as well. Even if the guardian’s consent had been obtained, some guardians are not actively involved in the patient’s care leaving the patient disempowered and without advocacy support.

Illustration 5: Voluntary patient threatened with being made involuntary

A patient on an authorised mental health ward notified Official Visitors that they were voluntary but that the doctor had told them they would be made involuntary if they tried to leave the ward. Staff on the ward also expressed their concern about the situation. Official Visitors contacted the Office of the Chief Psychiatrist (OCP) because they were not authorised under the Act to check the patient’s file or advocate for the patient. Council understands that the OCP looked into the issue but Council is not aware of the final outcome.

Illustration 6: In and out of involuntary status

Official Visitors regularly see consumers who move in and out of involuntary status. In this example the consumer had been known to Official Visitors for many years. Administration Orders regarding the patient's finances were being reviewed and the consumer wanted support at the hearing. This request for assistance was made with a view to obtaining some control back over their finances, alternatively getting some changes made regarding the distribution of money. At this time, however, the consumer was voluntary so Council could not assist. Council arranged for the Mental Health Law Centre to attend but as the consumer was well known to the Official Visitor it would have been a better use of resources and the consumer would have been more comfortable had they been supported by their Official Visitor. In addition The Mental Health Law Centre is sometimes unable to assist as they have very limited resources and competing priorities.

Illustration 7: Voluntary patient made to live in accommodation against their wishes by guardian

A son who was his father's carer contacted the office of the Minister for Mental Health with concerns about his father being made to live in a particular facility against his and his father's wishes. The Minister's office contacted Council. The State Administrative Tribunal acting under the *Guardianship and Administration Act* had appointed an independent guardian who then made the decision regarding the father's accommodation. This was against the wishes of the father and son. The father was a mental health patient but was not involuntary and as a result Council could not assist. This caused a lot of distress to both father and son.

ISSUE 4: CHILDREN AND ADOLESCENTS

General observations and comment: For years Council has raised concerns about the Bentley Adolescent Unit (BAU). The 12 bed unit is the only facility where children and adolescents who need involuntary treatment can be cared for, but both voluntary and involuntary children are placed on the ward. Council's concerns include:

1. The physical structure of the unit. The design resembles a prison rather than a hospital and has too little internal and external space. Children on the ward often tell Official Visitors they believe they are there because they are being punished.
2. Lack of maintenance.
3. Inadequate effort to make the unit façade or interior welcoming and child friendly. These issues are raised at almost every inspection.²
4. The disparate ages of the children mixing on the ward.

Children with eating disorders having to be sent back on leave to Princess Margaret Hospital (PMH). These children have to go through the added trauma of being transported from PMH, sometimes under police escort, staying on the BAU only long enough for involuntary orders to be made (usually the same day) before being returned to PMH "on leave" from the BAU. This is done because the BAU does not have a dedicated eating disorders program or relevant specialist staff.

Children on supervised bail orders coming into the BAU from Rangeview Remand Centre (Rangeview) having apparently consented to stay on the unit. As stated in previous Annual Reports, the concerns are for these children's rights and the safety of the ward.

Issues and action taken by Council this year to advocate for children on the BAU and a "good news story" are outlined overleaf.

² The gazebo in the garden off the 'open' side was repaired in May 2010 and as at 30 June 2010 Council understood that some other money had been given to improve the ward including changing the entrance.

Illustration 1: Letter from a parent to the Council, the Office of the Chief Psychiatrist and the Ministers for Mental Health, Health, Child Protection and the Minister Assisting the Minister for Health (Waldron)

My daughter, was recently admitted into Bentley Hospital's adolescent unit. While having a teenage daughter suffering from a mental illness is hard enough, leaving her in a hospital ward that is substandard was extremely difficult for me.

This hospital ward has very little going for it, excepting the staff, who do a fantastic job considering their oppressive working conditions, and the good food that have made it tolerable for my daughter. It is long overdue for new paint, it is currently painted in a colour I can only describe as prison green except where there are a few graffiti type murals in heavy colours. There is a lot of penned graffiti on the walls that appear to not have been cleaned for some time. Graffiti on the bedside cabinet my daughter has states that "you won't get any help here". A great welcome for her!

The layout of the ward makes the passageway and the rooms quite dark with a lack of natural light. My daughter was lucky and could choose which bed she had and took the one under the small window.

The curtains are very old, falling down and do not fully cover the windows which face out to and are near the road. The carpet in her room is also long overdue for replacement or at least cleaning. We did not feel we could sit on the floor while playing a game with her whilst visiting.

This leads me to the furnishing. There is not one chair in her bedroom. The lounge room which is in similar décor to the rest of the ward, has a television on one wall with a few very old, dirty dining chairs and bean bags along the wall facing it. The dining room also has extremely old furnishings, although the table tops were clean.

Please tell me how this is conducive to allow adolescents to recover from mental illness?

Not withstanding allaying the anxieties of their parents who have to leave them in such a place. The staff tell me it is in that state due to a lack of funding. Some have said they have volunteered to spend some time doing the work necessary but the money is not there to provide the materials.

I find this difficult to accept as I have seen the recent renovations done to Princess Margaret Hospital, a hospital that is going to be rebuilt in a few years time. The psych ward at PMH is the complete opposite, bright, cheery with leather couches and a brand new kitchen. While this may have been sponsored from donated funding, there have also been complete renovations of other wards recently completed. I know because I was working there at the time. Surely there must be a happy medium that can be met between the two buildings. Bentley Adolescent Unit is still a hospital ward for children even though it is not so much in the public eye as PMH.

Bentley Adolescent Unit is a place where adolescents come when they are at their lowest point to start the process of getting well. Providing the funding to make this ward a bright cheery place and the provision of a few home comforts e.g. a sofa may help them to take the steps they need to begin their recovery and need less services of a similar nature as they progress into adulthood.

I fear that my daughter may act upon her wishes to suicide rather than be readmitted to Bentley Hospital. Please do not allow her to become another victim of Mental Illness.

I implore you to look around the Bentley Adolescent Ward and ask yourself could you happily leave your child there?

I left in tears.

Illustration 2: Structural issues, bed numbers and the new children's hospital

Shortly after the announcement of the new children's hospital (NCH), Head of Council approached a number of relevant parties and stakeholders from the BAU, PMH and the Infant, Child Adolescent and Youth Mental Health Service to inquire about the possibility of the BAU being moved to the NCH as a solution to some of the issues with the BAU. With support from the Mental Health Division and Children and Adolescent Health Services, Head of Council then organised and chaired a meeting of the various parties in October 2009.

At the meeting it was agreed that the aim was to make sure that:

- an inpatient unit would be included as part of the NCH Functional Review; and
- recommendations on the state-wide inpatient requirements including bed numbers and where they should be, age ranges of the unit(s), and the future of the BAU be determined as soon as possible with a view to being incorporated into the Mental Health Strategic Plan for 2010-2020.

It was acknowledged at the meeting that the need for inpatient beds was in part affected by the level of community services available and that there were concerns about the lack of "step-down" facilities (intermediate care and accommodation before returning home) but the aim of the meeting was to concentrate on the inpatient bed needs making sure that those needs and the BAU were not forgotten about in future planning.

Council has been involved in, and is aware that a number of meetings and discussions have been held since then regarding the BAU and the NCH and awaits the outcome.

Illustration 3: Children on supervised bail orders – the "bail bond kids"

During the course of the past year Official Visitors have become increasingly concerned about children on supervised bail orders. At one time there were three children from Rangeview staying at the BAU and it was the view of the Official Visitors that the BAU was not safe, despite the best efforts and intentions of staff. Other patients have had to be discharged from the BAU to free up beds for children from Rangeview and there are concerns about the rights of the "bail bond kids" who are not protected by the provisions of the Act.

Head of Council therefore held meetings with the Inspector of Custodial Services, Neil Morgan – as his office has a similar role to Council in relation to prisons including Rangeview, the Commissioner for Corrective Services - Ian Johnson, members of their respective teams responsible for the Youth Corrective Services' facilities Rangeview and Banksia Hill, and the BAU Consultant Psychiatrist, Dr Goscia Wojnarowska. An Official Visitor also attended Rangeview during the course of an inspection by that office, on the invitation of the Inspector of Custodial Services.

The aim of the meetings and visit to Rangeview was to clarify the facts and canvass possible solutions. There is no doubt that the "bail bond kids" need treatment and care in a hospital setting. In addition there is concern that there are many more children in Rangeview and Banksia Hill who also need better mental health care. Only those who are extremely unwell are admitted to the BAU and Rangeview is visited for only half a day once a fortnight by the BAU Consultant Psychiatrist. It should be noted that the majority of children coming into the BAU from Rangeview are indigenous so any denial of timely and appropriate mental health care for these children exacerbates their disadvantage.

Solutions to these concerns include establishing a forensic youth facility or providing an inreach service to the youth detention centres, perhaps jointly funded between the Mental Health Commission and Corrective Services. Council understands that the Mental Health Commission has begun investigating the options.

As at 30 June 2010, it was the intention of Head of Council to report to the Mental Health Commission and the Minister for Mental Health on the results of the meetings and investigations including making some interim recommendations designed to protect these children and to enhance safety on the BAU.

Illustration 4: Good news story

As a result of intervention by an Official Visitor supporting an indigenous patient and her family, the State Aboriginal Mental Health Services (SAMHS) became involved in the patient's care and organised a traditional healer to attend the ward. Approximately 50% of the involuntary children assisted by Official Visitors on the BAU are indigenous and Council understands that SAMHS is now regularly being used as a resource by BAU staff.

ISSUE 5: COMPLAINTS PROCESS AND SERIOUS ALLEGATIONS

General observations and comment: Council regularly raises concerns about the many and varied complaint processes across the Department of Health. Some of these concerns were relayed to the Ombudsman's Office during the course of the year as part of its, "Survey of Complaints Handling Practices in the Western Australian State and Local Government Sectors". Below are some other examples of issues raised during the year.

Illustration 1: Inappropriate handling of investigation

At Council's request the hospital organised for an independent investigator; however, the appointed investigator was a male, former policeman. This appointment was considered inappropriate as the complainant was a young indigenous girl with a history of sexual abuse and violence against her and the complaint was about the violent way in which she said she was handled by nurses in a restraint. In addition to the inappropriateness of the appointment, there were various other concerns about the way the investigator spoke to the girl, the Official Visitor and Council office staff. These issues have all been brought to the attention of the mental health service.

Illustration 2: Nurses Board investigation

Council complained about a nurse and his relationship with a consumer on the ward where he worked. Allegations included sexual impropriety as reported in the 2007-2008 Annual Report. This year the Nurses Board contacted Council asking for more information. The Board subsequently advised that its Complaints Assessment Committee had concluded that the nurse had acted improperly and carelessly. These actions were in breach of two sections of the *Nurses and Midwives Act 2006*. Council was advised that the nurse has been issued with a formal reprimand and entered into an undertaking with the Board. A part of this undertaking he has agreed to have direct supervised practice for a continuous period of 12 months. At the end of the 12 months the nurse will also be required to provide a report to the Board from his supervisor relating to his clinical and professional performance.

ISSUE 6: SECLUSION

General observations and comment: Under section 119 of the Act, seclusion can be authorised only when it is "necessary for the protection, safety or well-being of the patient or another person with whom the patient might come into contact if not kept in seclusion". Official Visitors check seclusion registers on every ward inspection.

Anecdotally seclusion practices have improved and a number of wards now have "comfort rooms" designed to ease patient distress before they become too agitated. Some hospitals also ask patients, as part of an orientation process, what sorts of things trigger agitation and what might help diffuse it. In addition "debriefing sessions" are held after seclusion. Official Visitors have reported witnessing ward staff engaging in lengthy and difficult but successful de-escalation negotiations with consumers. These have resulted in seclusion being avoided or the consumer agreeing to go into the seclusion room to allow them time to calm down. In the past the consumer would have been physically restrained and placed in seclusion by 5 or 6 staff members or security guards. However some concerns remain as illustrated below.

Illustration 1: Five day seclusion

The consumer was put into seclusion at 9am on Friday and was still there three days later, a fact that was discovered only when an Official Visitor was inspecting the ward. Nursing staff said that the consumer had been taken out of seclusion on Sunday for a shower and then put back into seclusion. According to staff, the consumer had spent most of the day sleeping due to increased medication.

No incident was reported during the showering process so there appeared to be no reason why the patient should be returned to seclusion. The Official Visitor was also told by the nursing staff that the consumer's psychiatrist had instructed them to keep the consumer in seclusion until Monday morning when he would review the position.

Nursing staff refused to allow the Official Visitor to talk to the consumer and, as a result she was not able to check the patient's file to verify the information given by nursing staff nor check the care being given. (Unlike Visitors in many other states, Official Visitors can only check consumer files after obtaining the consumer's consent because of the legal interpretation of the wording of the Act, although Council understands this was not the original intention of the Act.)

Council contacted the Office of the Chief Psychiatrist. A request was made for them to investigate immediately, with a

view to varying or rescinding the psychiatrist's decision pursuant to section 12 of the Act. Council made the following points:

The seclusion was in contravention of the Act because it could not be said to be "necessary for the protection, safety or well being" of the patient or another person. This was evident once the consumer was observed as calm, sleeping or able to have a shower without incident.

It was not possible to say 24 hours in advance that the seclusion was necessary as required by section 119.

The Office of the Chief Psychiatrist advised that they would visit the ward the following day. As the seclusion moved into its 4th day, the Official Visitor was told by nursing staff that they were now taking the consumer in and out of seclusion, sometimes for up to an hour. When asked why the consumer needed to be put back into seclusion, she was told that it was part of the "plan" and that the patient had to go back there as long as they were "uncooperative".

This statement was also reported to the Chief Psychiatrist as it suggested that the seclusion was not for the protection or safety of the consumer or anyone else but was being used as a behavioural management tool. Use of seclusion as a behaviour management tool does not accord with current Australian practice and guidelines or with the Act's requirement that treatment be given with the least restriction of their freedom and least interference with their rights and dignity.

The seclusion lasted five and a half days.

Subsequently Council received a letter from the Acting Chief Psychiatrist, Dr Geoff Smith, advising that they had met with the hospital management and clinical staff and reinforced the current policy on seclusion. Dr Smith said that they would be examining the consumer's records in more detail with a view to making recommendations to "assist the service in the continuous improvement of the management and documentation of the use of seclusion for patients who require that intervention".

Council also referred the consumer to the Mental Health Law Centre to take further advice. The consumer continues to be represented by an Official Visitor on request.

ISSUE 7: WARD ENVIRONMENT

General observations and comment: Mental Health consumers spend months and even years locked up on hospital wards. Unlike general patients, they are not so unwell that they stay in bed all day. This means far more wear and tear on wards, that furnishings need to be regularly replaced and walls regularly painted. Mental Health patients need pleasant, clean and comfortable surroundings including gardens where they can sit in the sun in winter and sit in the cool in summer.

Sadly, on so many wards this is not the case. Too many wards have badly chipped and marked walls, stained furnishings, mouldy bathrooms, inadequate beds and very neglected gardens full of weeds and dead plants. While some facilities are older than others, a regular, ongoing maintenance and refurbishment program should mean that all wards are kept in the same good condition.

When raising the issues with hospital management, Head of Council was told time and again that there have been cutbacks and that there was no extra funding for anything unless it could be categorised as an Occupational Health and Safety issue. Head of Council was also repeatedly told that there were no furnishings or bed replacement programs and that there had been cutbacks on staff to do things like paintwork, maintenance and gardening.

Council is hoping that the new commissioning process by the Mental Health Commission will see some changes in the future with hospitals being required to better maintain the wards. In the meantime, set out below is a summary of the state of Western Australia's authorised mental health wards as at 30 June 2010 as witnessed by Official Visitors. The list starts with the longstanding issue of the Alma Street bathrooms.

Illustration 1: Alma Street Centre bathrooms

Twenty-five bathrooms in two wards of the Fremantle's Alma Street Centre have been covered in mould for the past 3 years. This issue was first raised in the 2007-2008 Annual Report. Many of the bathrooms are now in such a state that they have peeling paint and crumbling plaster. Extractor fans and a full refurbishment of the bathrooms are required urgently. Apart from the bathrooms being unsightly and uncomfortable to use, mould is a known health hazard for some individuals.

Having raised the issue in meetings with hospital management, on 21 December 2009, Council wrote to Dr Mark

Platell, Executive Director, Fremantle Hospital reminding him of this long standing issue and asking to be told when the bathrooms would be rectified, alternatively to explain why mental health patients should have to put up with such conditions. On the same date Council wrote to Dr Steve Patchett, Executive Director, Mental Health Division, advising that Council had been told that the Alma Street Centre had obtained quotes to install ventilation and to renovate the bathrooms and that they had, or were, applying for funding from his office. The letter made clear that Council strongly supported the application.

In January 2010 Council received a reply from the Mental Health Division advising that a funding submission regarding the refurbishment had been endorsed and that the “*refurbishment work is to be completed by the end of the financial year 2009/10*”.

The work was not completed by 30 June 2010 (though Council understands it is underway) and Council has since learned that the funding will only cover the installation of extractor fans and not refurbishment of the bathrooms. Further funding has yet to be approved.

Illustration 2: Environmental audit

In June 2010 Official Visitors conducted an environmental audit of all authorised hospital wards. This was done by making observations using a checklist and speaking to consumers. On each monthly inspection Official Visitors also raise issues observed by them and check to see if previous issues have been rectified. Letters are sent to hospital management raising any concerns after each inspection. Extracts from the comments made by Official Visitors in their reports in June 2010 are set out below. Some of the issues have since been rectified but many have not.

ALBANY - None of the bedrooms have adequate wardrobes or shelving. Patients living out of suitcases or with their clothes on the floor. Similarly no shelving in the bathrooms for toiletries.

ARMADALE - HDU and open wards – walls chipped and marked, carpet stained and smelling, furnishings stained and marked and some with fabric ripped and torn, gardens unkempt; (the HDU did receive new lounge chairs in time for Christmas 2009 which were welcomed by consumers on this small locked ward); Banksia ward – furnishings stained and marked, no quiet area for visitors, garden needs attention, enclosed patio area too cold in winter and too hot in summer.

MILLS ST CENTRE, BENTLEY - All wards – walls badly chipped and marked, curtains hanging off rails in some rooms, many toilet roll holders missing, some bathrooms with damp and mould issues, some rooms noted as having sagging mattresses, the suitability of “pipeline” beds was queried, furniture stained and marked, some wards have chairs with bent legs, cupboards and drawers missing or damaged; all gardens badly neglected, outdoor furniture stained and marked, seclusion room mattress covers marked and stained in some wards and some seclusion rooms covered in graffiti scratched into the walls.

BUNBURY - Units presented well, although two-thirds of APU bathrooms have minor plumbing issues.

FRANKLAND CENTRE – Inadequate shade and seating, lack of sufficient water pressure and hot water in showers, some bathrooms with peeling paint, exhaust fans and vents need cleaning, the level of dust on some described as a fire hazard, décor generally barren and one ward needs refurbishment. A number of issues were rectified during the inspection, such as vomit found in one sink, faeces on a toilet bowl and lack of soap in the bathroom.

ALMA STREET CENTRE, FREMANTLE – (apart from the issue with the bathrooms raised above), ward 4. I have “pipeline” beds some of which were “rickety”, squeak with every move and are too small for larger patients (Official Visitors were told by some consumers that they put the mattress on the floor to get a good night’s sleep), outdoor areas need cleaning and refurbishing, chairs stained, walls stained and chipped, vents filthy, gardens need weeding and replanting and the table tennis table needs repair to be functional having been left for many months in a broken mess in the garden.

GRAYLANDS:

Murchison ward – generally in good state of repair but insufficient lounge type chairs for the number of patients and no disabled access.

Smith ward – water not hot enough and pressure too low in showers, day toilets often blocked and bathrooms need refurbishment including wall where a hand dryer had been removed, sitting room with a non-working TV which added to the general run-down feeling of the ward, seclusion room requires repainting.

Pinch ward – water from some bathrooms runs into patients’ bedrooms, complaints about the water pressure in showers, poor disability access, stained floor in the visitors’ room and the toilet next to the lounge was dirty.

Plaistowe ward – paint peeling in 4 bedrooms and all smelling musty with poor ventilation, one bedroom had no curtains and the blind could not be lowered, ceiling in the hallway in need of paint with large plaster cracks, the water fountain not working, the women’s bathrooms need refurbishment with mould growing, and outdoor furniture needs replacing.

Hutchinson ward – men’s bathroom needs regrouting and mould removed and vents cleaned, women’s bathroom needs total refurbishment including lights which were not working.

Ellis ward – walls chipped and marked, some had water damage and paint bubbles, there was an issue of inappropriate mattresses for incontinent patients on the ward, seclusion room had scratches on the inside of the door.

Dorrington ward – the major complaint, which Council has raised many times before, was a lack of access to the garden; there were also consumer complaints about the centrally controlled air conditioning not staying at a comfortable temperature and often getting too cold or too hot.

Casson ward – bedrooms need repainting and preferably new furnishings supplied, holes have been left in the hall wall from removal of door bolts, main bathroom has chipped tiles and wall heater not working properly, dirty plastic chairs in the garden need attention.

Montgomery ward – toilets have tiles missing and urine smell, all exhaust fans and vents need cleaning, some vents are missing covers, tiles are missing in the laundry, inadequate number of seats for consumers noted, entry carpet needs replacing, overall the ward described as stark and needing furnishings to make it more homely for these long term patients.

JOONDALUP – Described as in excellent condition and had a maintenance person working on the wards during the inspection. The extensions to this hospital also meant that there is a more generous garden area for consumers on the locked ward which was an issue raised in previous Annual Reports.

KALGOORLIE – Described by Official Visitors as in good condition.

KEMH - MOTHER & BABY UNIT – Although described as an “attractive facility” Official Visitors reported that the heating was inadequate, especially for small babies, a portable hot water system had been broken for 3 weeks and water damage, caused by the March storm, still needed fixing. Visitors were told it happened every year and is a design fault.

SELBY LODGE – This facility was badly damaged in the March storm, consequently renovations and repair were still in progress, including some that had started prior to the storm. Visitors reported that wardrobes and furnishings in a number of rooms have cracked and peeling veneer, some rooms lack privacy curtains, vents and exhausts in most bathrooms need cleaning, many shower cubicles have cracked and broken tiles, one showerhead is leaking and was taped up by staff.

SWAN ELDERLY UNIT – Dusty and blocked vents, some blown light bulbs, no sheltered outdoor area for patients to sit in.

SWAN ADULT – Some patients sleeping on ensemble bed bases without a mattress and others in “pipeline” beds with poor quality mattresses while mattresses were stacked in the gym; (it was explained later that the beds were new and there were mattresses to go on the bases but “Infection Control” had demanded that heavy duty vinyl covers be placed on the base and mattresses before use - despite the fact that mental health wards do not deal with the same sorts of issues as general health wards which might require such covers); vents in bathrooms dusty and clogged, an empty, broken aquarium in the lounge, some outdoor furnishings need replacing.

MERCY HOSPITAL - URSULA FRAYNE UNIT – Described as comfortable, clean and with flowers on the table.

ISSUE 8: SUPPORTED ACCOMMODATION

General observations and comment: The Act requires Official Visitors to ensure that licensed psychiatric accommodation facilities are “safe and suitable”, to ensure that residents’ rights are observed, and to seek to resolve residents’ complaints.

The licensed psychiatric accommodation sector covered by Council comprises 33 facilities. They range widely in style and standard of accommodation and care:

1. Small suburban houses or villas accommodating 3 to 5 people. These are mainly run by non government organisations (NGOs).
2. Government owned, purpose built cluster housing developments called Community Supported Residential Units (CSRUs). These usually have 25 beds in 1, 2 and 3 bedroom villa complexes. They are provided by the Government

but managed and operated by various NGOs.

3. Purpose built smaller cluster housing developments of 2 villas with 4 beds in each, called Community Options homes. These are designed for people who need a higher level of care than in the CSRUs. They are provided by the Government and operated by various NGOs.
4. Purpose built cluster housing in a villa complex format built and run by an NGO.
5. Hostel facilities, usually older and larger with between 30 and 84 residents. These are mainly owned and operated as private businesses and are often family run.

This year has seen the welcome addition of an extra 160 beds in the following new facilities:

- one new Community Options house;
- two new CSRUs;
- a 16 bed hostel for homeless youth with a mental illness operated by an NGO; and
- a privately run group of villas in Maddington.

According to Council's information there were 773 beds, as at 30 June 2010, funded for people with chronic mental illness. A list of the facilities, their address and their operators is provided in appendix 2. Council understands that all facilities receive funding from the Mental Health Division (now the Mental Health Commission) in addition to rent from the residents. The amount of funding received and rent charged varies between facilities.

A Ministerial Directive made pursuant to the Act also requires Official Visitors to inspect these facilities every two months. Visits are almost always carried out unannounced. Generally the Official Visitors speak to a supervisor or manager on site and residents. If there are any concerns they will be raised with the supervisor/manager. A reporting letter is also sent back to the facility after the visit noting any matters of concern to Official Visitors as well as providing positive feedback where appropriate. In some facilities there are very few issues; in a few facilities the issues are ongoing. The approach is to first try to work with facility staff to find a solution to the concern. On occasion the Head of Council also meets with the supervisor/manager or licensee to discuss the issues.

Where there are many concerns about a particular facility, or the concerns are serious, Council will inform the Licensing Standards and Review Unit (LSRU) and the OCP. The LSRU is responsible for licensing the premises, hostel design guidelines and overseeing compliance with the "Licensing Standards for the Arrangements for Management, Staffing and Equipment in Private Psychiatric Hostels". The OCP reviews the facilities for compliance with the "Service Standards for Non-Government Providers of Community Mental Health Services". These standards are also used by Official Visitors as a guide to whether the facility is "safe and suitable".

This year 3 of the 33 facilities have raised particular and ongoing concerns for Council. As a result of Official Visitors working with the licensee, two of the facilities have improved considerably and the licensee is to be commended in each case. Official Visitors are continuing to work with the third licensee but there have been improvements for residents in that facility. Council has also received a letter of thanks from the parent of a resident of one facility who has observed the changes.

Council has also raised issues with the Mental Health Commission, calling for a review of the accommodation sector generally including considering the various standards which apply. The standards of care and accommodation vary widely between the facilities. The Acting Commissioner advised Council that he intended to meet with each of the key stakeholders and then to convene a meeting in order to identify possible ways forward.

Illustration 1: Examples of some of the issues dealt with by Official Visitors in three facilities

1. Safety issues - Residents complained that they were unable to lock their bedroom doors so that they could feel safe, lock away personal possessions and stop other residents going into their rooms. One resident said they pushed their bed up against the door at night so no one could get in. Official Visitors spoke to the manager who refused to provide keys and said it was not a LSRU requirement. The reasons given were that residents would lose them and that it would be a safety hazard. Council then wrote to the LSRU whose officers met with the manager. LSRU advised Council that some rooms did have locks and that the hostel management allocated lockable rooms based upon risk assessment. The manager offered to risk assess any resident identified by Official Visitors. LSRU also noted that it was not a requirement of the Licensing Standards that residents' rooms be lockable.

2. Poor maintenance -

- Lighting - In one bathroom there was no light for weeks – eventually Official Visitors refused to leave the facility until the manager replaced it. According to the Official Visitors, most bedrooms had a main light and a bedside light, however, generally only one worked. Without both lights the bedrooms were very dark and it was, for example, difficult to read a book. Licensing Standards 6.4 and 6.5 require adequate lighting and that residents have access to individual bedside lighting if requested. Council has since been told by family members of a resident that they often replace lights for the resident.
- Missing window panes which took weeks to repair.
- Sanitation - Often there was no toilet paper and toilet paper holders were broken. Council has since been told by one family that they often brought in toilet paper.
- Climate Control - No heating or cooling in bedrooms. Additionally in winter, many bedrooms had insufficient bedding and residents complained of being cold.
- Pest Control – There weren't any flyscreens.
- Safety - Windows were chocked open with bottles as the sashes were broken. This created a safety hazard.
- Furnishings – Much of the furnishings were dirty and in need of repair or replacement.
- Showers – In June, only 2 out of 5 showers in one communal bathroom were fully functional.

In each case the issues were discussed with the facility manager and reports were sent after the inspection. Some issues have since been rectified.

3. Health care - It was estimated that about 60% of the residents in one facility required podiatry services. Many of them were a high priority as they are diabetics. The manager told Official Visitors that the local hospital service had advised that they could not increase the number of visits nor the amount of residents treated. The Official Visitors confirmed the hospital service position. Following investigation by the Official Visitors, the facility manager was advised that there was an agency which would provide on site podiatry services. Alternatively residents could be referred by a GP for 5 free podiatry consultations per year. Council understands the latter course is being followed. Official Visitors will continue to monitor the situation.
4. Poor hygiene of residents in general - The standard of clothing and hygiene was strikingly poor amongst the residents. Although this could be dismissed as a symptom of poverty or individual choice, it is not universal across all facilities catering for people with a chronic mental illness. This includes other facilities of a similar size and mix of residents. In this regard Council queried with the OCP and LSRU the interpretation of Regulation 12 of the *Hostels (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997*. This regulation says a licence holder has to ensure that “there is provided for each resident (a) all clothing necessary for that resident... and (b) basic toiletry itemsat no extra cost to the resident”. The “clothing necessary” has not been stipulated and Council was told that it is left up to the facility licensee to determine. Several licensees have told Official Visitors that they believe that if they do not charge the maximum allowed under the regulations, they do not have to comply with the regulation.³
5. Lack of social workers – Residents raised various issues with Official Visitors which required social or welfare worker assistance. When Official Visitors called the social work department at the local hospital service, they were told that the social workers had stopped visiting the facility. This issue has been raised with the Area Health Service.
6. No residency agreement as required by the Licensing Standards – This issue was raised with the LSRU which advised that the facility did have a pre-admission package including house rules and a “security of tenure” statement which was supplied to new residents. Council was told that copies would be supplied to all residents by 30 October 2010. The LSRU said the Licensing Standards did not require that there be a signed residency agreement only that a license holder developed a residency agreement and entered into such an agreement with each resident or guardian.
7. Poor care generally - Council received a call from a distressed woman who had visited the facility with a friend who had a family member living there. She said that she had just witnessed a man walk from the hallway to the bedrooms with faeces running down his legs. Staff were not assisting him and the caller brought it to the

³ Some facilities have an exemption from this regulation.

attention of the cook who was the only English speaking staff she could find. The cook's response was that he worked 70 hours per week on a minimum wage and he didn't need to deal with that sort of thing. When this was brought to the attention of the manager he said that there were at least 3 residents who had an incontinence problem and that he was currently negotiating with their treating teams. In his opinion they needed to find them nursing homes as they clearly required more care than the facility could offer.

8. Cleanliness - The grout in the showers and throughout the facility was so black that initially the Official Visitors assumed it was black grout. The manager had the floors in the showers and elsewhere steam cleaned which was a major improvement. Hand towels in the bathroom were also described as "almost black" in Official Visitor reports. Following further discussions with the manager he agreed that "the cleaners were not doing a good enough job". He later installed paper towels and Official Visitors reported that those hand towels still in use are replaced more regularly.
9. Food standards – Official Visitors received complaints that the food portions were too small, that all they were offered was "spam" and mashed potato or polony sandwiches, that there was either no fruit or not enough fruit, and that the weekly menu remained the same for over 4 weeks - in breach of regulation 10 of the *Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997*. In another facility the complaint was about sandwiches made with stale bread, food being served cold and not enough food. Various discussions have been held and there has been some improvement.
10. Heating and cooling – It was alleged that staff refused to turn them on saying it cost too much money, and there were complaints about inadequate bedding for winter. The issue was drawn to the attention of the manager.
11. Eviction issues - Residents were threatened with eviction but there was no process for warning residents in writing, no incident reports existed, there was no paperwork to support the eviction, residents were not given a reasonable opportunity to change their behaviour and residents could not defend their position or get help. Again discussions were held with the manager with a view to some new procedures being put into place.

Illustration 2: Good news stories

In 2006-2007 Devenish Lodge was named in Council's Annual Report. At the time Council and the OCP held concerns regarding this forty bed hostel. During the past two years Official Visitors have worked closely with Devenish staff and are keen to report on the vast improvements that have been made. Cleanliness and medication issues have been resolved and there has been a significant improvement in the ambiance of the facility which now has a more homelike feel. Residents are also being offered activities.

In the past year, Romily Hostel has paid for a personal trainer to conduct a safe exercise program designed by the Heart Foundation. It started as a 2 day a week program but quickly moved to 5 days a week as residents took it up with enthusiasm. Romily is a 70 bed hostel and approximately 50% of residents are involved. The level of enthusiasm is such that Residents wait for the personal trainer to turn up in the mornings. The hostel also transports residents to the beach and various parks to make the exercise program more enjoyable.

Vincetian Village at Woodbridge has been proactive in helping residents by promoting the engagement of private clinical psychologists through the Medicare system and employing an onsite Occupational Therapist.

Illustration 3: Consumers moving from hostels into CSRUs

Official Visitors were made aware that some hostel residents were interested in trying out CSRU accommodation. They were concerned that if they did not like it, they would lose their place at the hostel. The issue was raised with the then Mental Health Division which funded and contracted with the hostel licensees. They agreed to draft a policy statement regarding transitional arrangements for residents which would allow the person to retain a place at the hostel for 30 days. They also agreed to communicate this policy to the relevant service providers.

Illustration 4: Residents discharged from hospital

Official Visitors canvassed facility staff in May 2010 about issues relating to residents who had been in hospital and who were discharged back into the facility. The experiences were varied and there were many complaints. Much depended on the facility's relationship with the relevant community mental health service:

A number of the facilities complained that they were given insufficient advance notice when a resident was being discharged. Several said that residents often turned up in a taxi unannounced. Most said they only received a few hours' notice.

Several complained of residents being discharged too soon and then having to go through the Emergency Department again for re-admission.

Some facilities were provided with a discharge summary and treatment plan. Others received no information. One described being handed a paper bag with medications and no additional information. Another reported incomplete medication and management notes and doctor's handwriting which was difficult to read.

Illustration 5: No accommodation for first episode psychosis

A young consumer on a Community Treatment Order (CTO) who had experienced their first episode of psychosis was living unhappily at home with their mother. It was agreed that this exacerbated the consumer's mental illness and that they would gain from having supportive accommodation. The consumer's social worker advised that accommodation was only provided in the area for people with a persistent chronic mental illness. This was later confirmed with the accommodation provider.

It is acknowledged that there are many other people with a mental illness in greater need. The new Ngatti facility for young homeless people in Fremantle is welcomed but Council raises this issue because of the emphasis on prevention and early intervention and the very important role that suitable accommodation and support plays in both recovery and avoiding relapse of mental illness.

Illustration 6: CSRUs and people with drug and alcohol issues

Last year Council raised the issue of mental health consumers with a dual diagnosis involving drug and alcohol issues. There are concerns that they are either not being accepted at the new CSRUs or are being evicted because of strict no alcohol/no drugs policies. This issue is ongoing. Official Visitors have been told by hospital staff that they believe a patient will not meet the CSRU criteria because of such issues. Some NGO staff have also complained to Official Visitors that drug and alcohol issues have not been revealed to them prior to the consumer being accepted in the facility. Head of Council also met with one NGO to discuss a case where the issue did not appear to have been handled well.

Illustration 7: Problems with design of new youth facility

Council wrote to the Executive Director of the Mental Health Division (MHD) raising concerns about the design and fit-out of the new youth facility in Fremantle. The concerns included safety issues such as hooks and shower rails in the bathrooms and clothes hanging rails in the bedrooms. It was noted that, while no place could be made fail-safe where a person was determined to self-harm, this hostel was designed for 17 to 22 year olds who notoriously attempt suicide on impulse. It therefore seemed prudent that any obvious hanging points which might suggest, promote or encourage self-harm be either removed or amended to have a low weight breaking threshold.

Council also asked for information about the consultation process. This was requested with a view to ensuring that the mistakes of this building would not be replicated in the other new hostel which was being constructed. Council offered to be a part of any consultation process in the future. Council has previously commented on a number of hospital wards as part of their planning process most recently Broome and the Kalgoorlie ED.

The response received from the Executive Director stated that:

- the facility had been designed by the Department of Housing with support from the MHD to comply with the provisions of the Private Psychiatric Design Guidelines issued by the Department of Health's Licensing Standards and Review Unit which had approved the facility for occupation;
- the facility's operator would be reviewing the clothes hooks and rails in line with Council's comments;

- there would be close co-operation between clinical services and non-clinical services in identifying residents who have factors that may contribute to impulsive acts; and
- that it was too late to change the design of the East Perth facility.

In future, Council would like to see the service providers and consumers being more widely consulted in the design of these facilities.

Illustration 8 Relay interpreter for deaf mute consumer

A hostel resident approached Official Visitors to indicate they were unhappy living there but the resident was deaf and mute. The Official Visitor spoke to a visiting social worker and a family meeting was suggested. The resident was not fluent in sign language so it was determined that two sets of deaf relay interpreters would be used to communicate with the resident. The relay interpreters were used twice; first for the meeting with the family and social worker and secondly with the resident alone. This was done to ensure that the resident was happy with a proposed move to a new residence which had been identified. The result was that the resident was transferred to another hostel. The feedback from the resident's brother was that the resident was very grateful to have been treated as an adult making their own decisions.

ISSUE 9: SMOKING ISSUES

Smoking has been banned on public hospital sites for the past two and a half years. Council lobbied against the ban for involuntary patients and continues to argue for designated smoking areas.

There is no doubt that quitting smoking would be of benefit to mental health consumers but Council's argument is that it is cruel to make people who are already so unwell that they have been made involuntary, give up such a difficult addiction on admission.

It is not the right time to be asking people to go through the terrible nicotine withdrawal symptoms. Although nicotine replacement therapy (NRT) is offered to consumers, it does not alleviate all the withdrawal symptoms nor is it an adequate substitute for the emotional and social dependence of smoking. This is particularly evident amongst consumers who regularly complain to Official Visitors about the boredom they experience while on the wards.

The ban is also a further erosion of consumers' rights and not in accordance with section 5 of the Act which requires that people with a mental illness must receive care and treatment with the least restriction of their freedom and least interference with their rights.

Currently the smoking ban is being flouted in all authorised hospitals. For consumers on locked wards going out on ground access, this makes it even more difficult. It is also difficult for non-smokers and staff. Small designated smoking areas would overcome the problem of passive smoking by staff and non-smoking patients.

Illustration 1: Soaking nicotine patches in tea

Council received a complaint from a consumer on a locked ward that he had been forced to take medication because he had tried to stop another patient soaking his nicotine patches in tea. The other patient was drinking the resulting concoction in a desperate attempt to get more of a "nicotine fix". The other patient was also taking the filters out of the puffers and sucking on them. The incident was verified by a nurse who said the other patient's withdrawal was quite severe but not unusual and that they managed it by spending a lot of "one on one" time with the patient trying to distract them from the nicotine craving. This example shows the suffering imposed on patients by making them undergo nicotine withdrawal and how the withdrawal symptoms are not fully alleviated. In addition it shows how the issue impacts on other patients and on ward staffing ratios.

Illustration 2: More desperate measures

Official Visitors have received reports of patients using straightened paper clips in electricity outlets to obtain a spark to light a cigarette as lighters are usually confiscated.

Illustration 3: Removal of wall heater from bathroom

This was done to stop it being used by a particularly determined patient to light up cigarettes. It is another example of how the ban impacts on other patients.

Illustration 4: Consumers being denied ground access

Official Visitors are often told by consumers that their ground access has been denied or that they have been threatened with removal of ground access if they are caught smoking. Head of Council regularly raises the issue with hospital management and is always told that staff are not authorised to use punitive methods to stop smoking. In one case it was confirmed that ground access had been denied because the consumer had threatened both staff and other consumer if they did not give them a cigarette.

Illustration 5: Hospital staff issues

Council is aware that enforcement of the smoking ban is extremely difficult for staff. Making a patient stop smoking while on ground access impacts on the therapeutic relationship with the patient which is important to their recovery. Staff are being subject to pressure from both patients and hospital management. In one hospital, patients were being allowed to smoke within the ward environment, often in the company of staff members, as a result of which hospital management issued a memo reminding staff that if they were found to be “ignoring or facilitating patients smoking in these areas they will be subject to Performance Management and/or disciplinary action”.

Illustration 6: Smoking used to keep consumer involuntary

A consumer with asthma was put on a locked ward. At the Mental Health Review Board hearing it was argued that the consumer needed to be kept involuntary and on a locked ward to stop the consumer from smoking because of the asthma. The Official Visitor argued that the smoking and asthma had nothing to do with the consumer’s mental health and that it was the consumer’s right to make the decision to smoke or not. The consumer was made voluntary and discharged.

Illustration 7: UWA Research

During the course of the year Council was made aware of research on “Using admissions to a smoke-free hospital to promote cessation of smoking” by the University of Western Australia’s School of Psychiatry and Clinical Neurosciences, Unit for Research and Education in Drugs and Alcohol. Professor Hulse, who heads the team, was invited to speak to Official Visitors as a result of which it was agreed Council would assist in gathering information from mental health wards. This was done in one month as part of Official Visitors’ usual ward inspections and involved asking staff a list of questions prepared by the researchers. Council understands that the team is recruiting patients from both mental health and other wards until September 2010. Council awaits the outcome of the research.

Illustration 8: Lack of support on leaving hospital

A quick sample survey of 8 mental health clinics in November 2009 indicated that there is little or no support for consumers to give up smoking, or stay smoke free, after they have left hospital. While some clinics said the hospital would give the patient 1 or 2 weeks supply of Nicotine Replacement Therapy (NRT) on discharge, most said that the patient would be referred to their GP. Only one offered a specific in-house program. Several said they did not know what programs were on offer.

ISSUE 10: RIGHT TO AN OTHER OPINION - SURVEY AND REPORT

General observations and comment: Apart from access to Official Visitors, the two main legislative safeguards designed to protect the human rights of involuntarily detained patients are:

1. the right to an opinion from a psychiatrist who has not previously considered the matter (section 111 of the Act); and
2. the right to regular reviews and/or to apply for a review by the Mental Health Review Board (MHRB).

The Council has been raising concerns about both of these rights since its inaugural Annual Report in 1998-1999.

In September 2009, Official Visitors and Head of Council held a series of interviews with psychiatrists working in authorised hospitals about both the “Other Opinion” and MHRB processes. A Report and Discussion Paper by Head of Council was provided to the Minister for Mental Health in May 2010. (The second part of the report deals with the MHRB process and is discussed in Issue 11.) The report was based on the interviews, the collective experience of the Official Visitors, and a review of hospital response times to requests for Other Opinions by Council’s Executive Officer.

A summary of the issues raised by Head of Council and recommendations made in relation to the Other Opinion process, is set out below. A copy of the full report may be obtained from Council’s office.

1. The doctor giving the Other Opinion is not independent of the treating psychiatrist:

- 1.1 Approximately 95% of Other Opinions are provided by a colleague of the patient’s treating psychiatrist who works in the same hospital and is therefore not truly independent.
- 1.2 The treating psychiatrist organises the Other Opinion.
- 1.3 Very few doctors reported offering patients any choice of doctors.
- 1.4 There is some evidence that pairs or small clusters of doctors sometimes carry out Other Opinions for each other’s patients.
- 1.5 Some doctors seem to be called upon far more often than others to provide the Other Opinions—The reason for this is unclear. Council is unsure whether this is because some doctors more readily agree to do the Other Opinions, or because some doctors have more patients requesting Other Opinions and they always use the same other doctor to do the Other Opinion.

Recommendations:

- A pool of Other Opinion doctors administered by the new Mental Health Commission should be established. Patients would contact the organiser of the pool (preferably by a freecall number) and they would arrange for an independent doctor to attend by appointment. There would be a small increase in FTE required and some administration costs. Doctors from within the Department of Health and the private sector could be included as part of the pool roster.
- Alternatively separate pools could be established within each of the Area Health Services (AHS). This would include doctors in clinics as well as hospitals and perhaps some private doctors who are based in the catchment area. Doctors would be assigned sequentially from a list, provided they had not seen the patient before. The pool would be administered by the AHS. This would overcome doctors doing each others’ Other Opinions, and take the pressure off some doctors who seem to be doing more Other Opinions than others. Unfortunately it would not assist with the current pressures faced by doctors in finding time to do the Other Opinions and may compromise the goal of having doctors from another health service.
- A third alternative is to have the scheme run by the Office of the Chief Psychiatrist.
- The Act should be amended to refer specifically to an independent psychiatrist giving the opinion and that a definition of independent psychiatrist be included.

2. Patients are being disempowered by the process:

- 2.1 The patient has to ask their treating psychiatrist to organise the Other Opinion.
- 2.2 The patient is reliant on their treating psychiatrist organising the Other Opinion in a timely manner (see more below on delays).
- 2.3 The interview with the patient for the Other Opinion is usually conducted by the Other Opinion doctor when they happen to have a free moment and be on or near the ward.
- 2.4 The time taken by doctors to do Other Opinions tends to be only a couple of hours at most and more often about an hour.
- 2.5 A number of doctors have refused to allow the patient to have an Official Visitor present in the interview.

Recommendations:

- Having a pool of doctors where the doctor makes an appointment time to see the patient and allowing the

patient to call an independent party to arrange the Other Opinion would resolve most of the issues raised in paragraphs 2.1 to 2.4.

- The issue raised in paragraph 2.5 could be solved by legislative amendment noting that the patient has a right to have someone else present. In the meantime Official Visitors will continue to advocate on a case by case basis with doctors.

3. There is a lack of recognition that it is the patient's right to an Other Opinion and that the Other Opinion belongs to the patient:

3.1 The patient is rarely given a copy of the Other Opinion.

3.2 The patient's request for an Other Opinion has been refused by the treating psychiatrist on the basis that the treating psychiatrist had recently organised another opinion themselves.

Recommendations:

- The Act should be amended to require that the patient be given a copy of the Other Opinion or notes made on their file and to make clear that a patient's request for an Other Opinion must be complied with even if the treating psychiatrist has already obtained an Other opinion.
- Section 160 of the Act should also be amended to make it easier for involuntary patients to access documents on their medical files.

4. Delays in conducting the Other Opinion as reported by Official Visitors and consumers:

Recommendation:

Implementation of the pool proposal, outlined above would allow better monitoring and control of the time taken to conduct Other Opinions.

5. Meaning of "treatment" is not clear – what does the Other Opinion cover?

Recommendation:

A review of the wording of s111 is needed to clarify the meaning of treatment.

6. The number of times that a patient can request an Other Opinion is not clear:

Recommendation:

A review of the wording of s111 is needed to make it clear that there is no limitation.

7. Lack of access by public patients to private doctors to give the Other Opinion:

Recommendation:

The apparent inequity whereby public patients are not entitled to a Medicare rebate when the Other Opinion is provided by a private doctor should be raised with Medicare, alternatively private doctors should be provided as part of a pool arrangement paid for by the Department of Health.

8. Lack of a clear and accessible process which can be used by the patient if the Other Opinion is different to that of the treating psychiatrist:

Recommendations:

- The Act should be amended to provide that a copy of the Other Opinion must be given to the patient. Ideally there would be a provision requiring that copies of all Other Opinions be provided in writing to the Chief Psychiatrist (as well as to the patient) or perhaps to the Mental Health Review Board.
- Alternatively a provision could be drafted requiring the psychiatrist who provided the Other Opinion to give the patient and the Office of the Chief Psychiatrist a document noting whether or not their opinion wholly agreed with that of the treating psychiatrist.

ISSUE 11: MENTAL HEALTH REVIEW BOARD HEARINGS – SURVEY AND REPORT

General observations and comment: As noted above, apart from access to Official Visitors, and the right to an Other Opinion, the other legislative safeguard designed to protect the human rights of involuntarily detained patients is the right to regular reviews and/or to apply for a review by the MHRB.

As with the Other Opinion process, the Council has long raised issues with the MHRB processes in Annual Reports dating back to 1998-99. In addition a previous report on the MHRB process was given to the then Minister for Health, Mr McGinty, in July 2008 and copy was later provided to the Minister for Mental Health, Dr Jacobs, in November 2008.

In September 2009, Official Visitors and Head of Council held a series of interviews with psychiatrists working in authorised hospitals about both the Other Opinion and MHRB processes. The outcome of those interviews, along with the collective reported experience of Official Visitors, were then used as the basis of a Report and Discussion Paper by Head of Council provided to the Minister for Mental Health in May 2010.

A summary of the issues raised and recommendations made by Head of Council in relation to the MHRB process, as set out in the second part of the report, is set out below. A copy of the full report may be obtained from Council's office.

1. Failure to give the patient a copy of the medical report relied on by the MHRB and/or late provision of the report to the patient, their Official Visitor or lawyer – natural justice denied:

Recommendation:

The Act should be amended to require that the patient and their advocate be given a copy of the doctor's report at least 48 hours before the MHRB hearing and preferably by the treating psychiatrist or a member of the treating team. See also paragraph 2 below regarding other documents and the recommendation under paragraph 5 for a review generally of the legislative provisions relating to the MHRB.

2. The patient has no ready access to their medical file or documents relied on in the MHRB hearing (unlike most other states) – natural justice denied:

Recommendation:

The Act should be amended to make clear that involuntary patients have the right to see any documents being relied on in the MHRB hearing and the provisions should include a timetable for the provision of such documents. (See also the recommendation under paragraph 5 below for a review generally of the provisions relating to the MHRB.)

3. The contents of the report or statements made by doctors in reviews include hearsay and/or facts from many years ago:

Recommendations:

- Apart from ongoing education of doctors in relation to the conduct of hearings and writing of medical reports, it would be useful for the MHRB to have a practice direction or similar which requires (and reminds) doctors to limit their comments to facts within their own knowledge. Otherwise doctors should be required to provide copies of documents relied on by them for asserting facts. The documents must be made available to patients.
- Giving patients ready access to their file prior to a review hearing will also assist in overcoming this issue.

4. The contents of the medical report and statements made in the MHRB review include irrelevant statements and/or fail to properly address s26 of the Act:

Recommendation:

Although few doctors said they believed a template was worthwhile and there is a danger that a template might be too restrictive, consideration should be given to this.

5. The scope of the MHRB review is too limited:

Recommendations:

- There should be a review of the MHRB legislative provisions in the Act. This should include considering whether the MHRB should be involved in the monitoring and/or review of treatment/management plans and making it easier for the MHRB to make orders for transfer of patients and putting patients on a CTO.

- A review of the MHRB legislative provisions and process is long overdue. The Holman Review, which is being relied on for the drafting of the new Mental Health Act, concluded that its deliberations were “no longer current or necessarily applicable” and it would be inappropriate to make firm recommendations regarding the MHRB because it was anticipated that the MHRB was likely to become a part of the State Administrative Tribunal (SAT).
- The Holman Review did recommend that “before the third anniversary of the commencement of the jurisdiction of the SAT over the MHRB, an independent review” be undertaken. As SAT has not taken over the MHRB, a review of the provisions in relation to the MHRB is long overdue.
- Even if the MHRB is moved, or is about to be moved, into SAT, the issues raised in this report still need to be considered and amendments need to be made to the new Mental Health Act.
- As part of that review, reference could be made to an Australian Research Council research project being conducted in the eastern states led by Professor Terry Carney which is investigating the fairness and justice of mental health review boards in NSW, Victoria and the ACT and the review of the Victorian Mental Health Act.

6. The atmosphere and setting of reviews reinforces the powerlessness of involuntary patients:

Recommendations:

- Council will continue to raise these issues with the MHRB as they arise and an Official Visitor workshop session with members of the MHRB was held in June 2010.
- It would also be useful to have an open session or forum with MHRB members where feedback from consumers could be relayed to and discussed with them. The Mental Health Review Board of Victoria held a Consumer and Carer forum in 2008 co-sponsored by care and consumer organisations.
- Consideration of a form which patients can fill in and present as a report to the MHRB should also be considered.
- A review of the MHRB process as recommended above would also lead to discussion and further recommendations.

7. Last minute cancellation of hearings and increased waiting time for requested reviews:

Recommendations:

- Some of these issues would be resolved by amending the Act to require that medical reports be prepared and given to the patient earlier.
- Amendments to the Act requiring doctors to give at least 4 days written notice of their unavailability, with reasons, should also be considered as part of a review of the MHRB provisions proposed above.

8. Non-attendance at the MHRB review hearing by the treating psychiatrist:

Recommendations:

- This issue including its prevalence should be addressed in a review of the MHRB provisions and process.
- In particular, consideration should be given to amending the Act to require that the treating psychiatrist is required to attend and provide a report and, if they cannot attend, they must apply to be excused with written reasons explaining why they cannot attend, state who is to attend in their place, and confirm that the person replacing them is fully conversant with the patient and their medical status and is fully authorised to make decisions during the review.
- The review might also consider whether the appropriate person to advise the MHRB is necessarily always the treating psychiatrist.

9. Being made voluntary just before the hearing and being made voluntary just before the hearing and then made involuntary shortly afterwards:

Recommendations:

- A review of the MHRB process should include gathering statistics on this issue and a consideration of what, if anything, could be done about it.
- Reducing the time for the first and subsequent MHRB reviews, and requiring doctors to provide their medical reports at least 48 hours before the MHRB hearing, may also assist in encouraging doctors to make patients voluntary sooner if it is the case that the MHRB hearing is acting as a trigger to doctors reviewing patients' involuntary status.

10. Hearings after discharge or change to voluntary status – getting the involuntary record extinguished and making “complaints”:

Recommendations:

- A review of the MHRB provisions in the Act should consider whether patients should have the right to a MHRB hearing, even after they have been made voluntary or discharged from hospital, in order to challenge the validity of the original involuntary order.
- The review should also consider what can be done to protect the rights of patients who are told that they are voluntary but will be made involuntary if they leave the hospital grounds.
- Section 146 of the Act, which allows the MHRB to hear complaints but currently does not provide clear processes or remedies, should also be reviewed as part of the consideration of these issues.

OFFICIAL VISITOR REPRESENTATION AND SUPPORT AT MHRB HEARINGS

Official Visitor representation at MHRB hearings increased markedly from 152 last year to 191 this year. The increase reflects one of Council’s strategic plan goals to better identify patients who have MHRB hearings scheduled. (For further information see Part 4.)

Fifty consumers (4.4%) were made voluntary by the MHRB at the hearing. Ten were assisted by Official Visitors and 9 were represented by the Mental Health Law Centre (MHLC). In many cases, however, the Official Visitor’s main role was to provide support during and after the hearing.

MHRB representation				
	No. completed hearings	% represented (MHLC & Council)	% represented by Council	% represented by MHLC
2003/2004	1250	16.88%	8.48%	8.4%
2004/2005	1203	14.55%	6.73%	7.82%
2005/2006	1089	15.52%	7.25%	8.27
2006/2007	1174	20.87%	13.88%	6.99%
2007/2008	1103	26.84%	14.87%	11.97%
2008/2009	1141	20.6%	13.4%	7.2%
2009/2010	1131	27.3%	16.9%	10.4%

ISSUE 12: FORENSIC PATIENTS AND MANDATORY SENTENCING LAWS

General observations and comment: The Frankland Centre is the state's only forensic mental health inpatient unit. Consumers who are admitted to the Frankland Centre, either as an involuntary patient, pursuant to the *Mental Health Act*, or on Custody Orders, made pursuant to the *Criminal Law (Mentally Impaired Accused) Act*, are entitled to visits by Official Visitors. As an authorised hospital, Frankland's three wards are inspected monthly.

Illustration 1: Advocating for Custody Order consumers

In June 2009 the Head of Council and an Official Visitor met with the Chair of the Mentally Impaired Accused Review Board (MIARB), Her Honour, Justice Narelle Johnson. The six member MIARB deals with people on Custody Orders. These are people who have either been found unfit to plead or who are not guilty by reason of unsound mind. The MIARB meets privately to consider the doctor's report and patient file. Generally there is no attendance by the patient or anyone on their behalf. The aim of the meeting with Council was to advise Judge Johnson about Council's role and to inquire as to how Official Visitors could best advocate for mentally impaired accused (MIA) people who come under her jurisdiction.

As a result of this meeting Justice Johnson offered to provide Council with the dates of the reviews for Custody Order patients in Frankland so that Official Visitors could provide written submissions to the Board on behalf of consumers. While the number of Custody Order patients in Frankland is small, as most Custody Order patients are in prison, these people are detained "at the Governor's pleasure"; even if the Board recommends their release, the orders must be made by the Governor on recommendation of the Attorney-General's office. Many have spent more time locked up pursuant to the Custody Order than they would have done if they had gone to prison for the crime they were charged with.

Illustration 2: Influx of patients to Frankland from one area health service

It was brought to Council's attention that there had been a significant number of patients admitted to Frankland from one particular area health service. A number of these patients or their families had asserted that they had not been able to access mental health services. This had resulted in deterioration in their health which had led to police charges and being sent to Frankland. Head of Council raised the issue with the Chief Psychiatrist, Dr Rowan Davidson, and it was understood that Frankland management was also raising the matter with the health service. Dr Davidson later advised that the health service had acknowledged that there had been an increase in the number of their patients in Frankland. They had looked into it, and any issues that might have added to that increase had been "solved".

Illustration 3: Civil patients on Frankland

For many years Council has argued that "civil patients" (i.e. patients without any charges pending and not serving a sentence) should not be detained in Frankland, as it is a forensic unit. In recent times civil patients on the unit have mainly been those who had been admitted to the Frankland Centre as a forensic patient, who had finished serving their sentence, but who remained an involuntary patient under the *Mental Health Act*. Consequently they had continued to need care in a mental health inpatient setting. Generally the difficulty in these cases has been getting another hospital service to take the patient.

This year Frankland admitted an involuntary civil patient from Graylands who did not have any charges pending and was not serving a sentence at the time (though the patient did have a criminal history and had previously been treated in Frankland). The patient and their guardian strongly opposed the transfer with the support of an Official Visitor and the MHLC. Various submissions were made to the Chief Psychiatrist, the MHRB and the new Director of the Frankland Centre, Dr Edward Petch, who had endorsed the admission. The patient remained in Frankland.

Dr Petch was also invited to talk to Official Visitors to explain his view that Frankland should admit some civil patients where they are assessed as particularly high risk to the safety of others. As at 30 June 2010 Council maintained a watching brief on this development.

Illustration 4: Lack of forensic unit for under 18 year olds

See Issue 4, Illustration 3 regarding the “bail bond kids”.

Illustration 5: Mandatory sentencing

Council wrote to the Minister for Mental Health and the Attorney-General to raise concerns about the impact on people with a mental illness of mandatory sentencing legislation passed by Parliament in September 2009. The legislation applied a mandatory jail sentence of 6 months for adults who assaulted and caused bodily harm to police officers, ambulance officers, transit guards, court security officers or prison officers with juveniles aged between 16-18 to go to jail for no more than three months.

Council argued that:

- Many, if not most, people who are made involuntary are brought into hospital either by ambulance or police van. As they are very unwell they have a lack of insight into their illness, and are brought in forcibly. It was therefore a fair assumption that a lot of people with a mental illness would be subject to the mandatory sentencing legislation.
- There appeared to be no suitable defence available to a person with a mental illness. The so called defence of “unsound mind” can be very difficult to prove, takes up considerable court and medical resources, and results in the Court being able to impose indefinite incarceration. More often than not, this means the person is detained for much longer than the sentence for the crime committed. In short, it is of little practical use in this situation.
- People who are unwell enough to require transportation under a Transport Order are unlikely to modify their behaviour/actions because of legislation. Implications exist for mental health planning as mandatory sentencing could exacerbate the existing problem of having people convicted of relatively minor crimes being incarcerated in a high secure unit alongside people who have committed far more serious crimes.
- The legislation would also make family members and carers of people with a mental illness more reluctant to call for an ambulance or police assistance. They would reasonably be concerned that it might result in the mentally unwell person being sent to jail for 6 months. (Note: Head of Council has been told by carers that this is happening.)
- The legislation should be amended to allow for a defence where the person was under a Transport Order and was being transported to hospital for a mental health assessment, or where they could show they were mentally unwell at the time.
- As a minimum requirement the legislation needed to be reviewed within 12 months time. The suggestion was also made that Mental Health Minister be kept informed of the details of every case where the new legislation was invoked so that the impact on mental health patients and the mental health system could be assessed.
- The withdrawal of charges against the first person charged under the new legislation appeared to leave all the discretion with the prosecution. As such it was not likely to be of much comfort to mental health consumers, their families and loved ones.

The response from the Attorney-General was that Guidelines had been prepared by the Commissioner of Police which would provide discretion for the prosecution to determine when the mandatory imprisonment laws would apply in order to avoid undesirable outcomes.

Council will maintain a watching brief on this issue.

ISSUE 13: DOCTOR SHORTAGES

General observations and comment: Throughout the year Council has had concerns regarding doctor shortages, in particularly Consultant Psychiatrists. The concerns arose from delays in obtaining other opinions, non-appearance by Consultants at MHRB hearings and delays in providing medical reports, Official Visitors also regularly hear complaints by consumers about not seeing their psychiatrists frequently enough.

As a result of the concerns during the year about doctor workload and the impact on consumers, Head of Council wrote to the Chief Psychiatrist, Dr Davidson. He was asked whether there were benchmarks or guidelines for doctor workload and whether he monitored doctor numbers and their case loads.

Dr Davidson advised that he was not aware of any specific guidelines and referred to the team approach taken on wards with a number of people having delegated responsibilities for the monitoring and reporting to the psychiatrist on patient care. He said some consultants also had other responsibilities such as teaching, outpatient work and so on which would make it difficult to set benchmarks. He expected the psychiatrist to continuously monitor their case load and any impact on standards of care and advise the clinical director accordingly.

While his office does not hold data on doctor numbers and patient load, Dr Davidson said it does have a monitoring role and they take part in Mental Health Operational Review Committee meetings. Clinical Governance Reviews, Selective Reviews, serious incident reporting and complaints management system data collected and reviewed by his office also “examine the system data for similar issues supporting a process to understand how the system is coping with demand and possible indicators of concern such as psychiatrist to patient numbers impacting on standards of care”.

Illustration 1: Other Opinion delays

The Other Opinion follow-up process instituted by Council this year (see issue 10) highlights the issue of doctor shortages. To quote one doctor (names removed):

“I will not do the second opinion today. It is an impost on my time that I cannot afford as it will mean either not seeing some of my own patients or rushing clinical reviews. I have more than 30 patients under my supervision today (I am covering Dr W), and no registrar on my team and I am backing up after not being in the hospital yesterday. I have no team secretary today. I will have no registrar next week as Dr X is extending her leave in England. The second opinion may be done by me next week subject to workload issues, but I will be out of the hospital Monday and Tuesday. Dr Y is on leave and Dr Z also has an extraordinarily high workload with 20+ patients of his own and the cover for Dr Y to provide too. It would be unfair and possibly clinically unsafe to ask him to do the 2nd opinion because of the workload it imposes on him.”

Illustration 2: Regional areas without an authorised psychiatrist

In February 2010 Council advocated for a consumer in a regional authorised hospital who the hospital wanted to send to Graylands because there was no authorised psychiatrist available to make the patient involuntary. The patient had been in hospital voluntarily but wanted to leave because she had just had a baby. There are strict timing requirements under the Act in these circumstances and the hospital considered that the only alternative was to send the patient to Perth which would have meant a Royal Flying Doctor service, probably sedation for the patient, and time away from her new born child. The consumer remained in Kalgoorlie. This issue was caused in part because the only psychiatrist at the hospital at that time had to wait until the next meeting of the WA Medical Registration Board for their official review and acceptance of his credentials. The doctor was sanctioned to practice in the interim but could not sign off on forms under the Act.

Illustration 3: Doctor failing to turn up for MHRB hearing or provide a medical report

The consumer was on a Community Treatment Order and wanted to be made voluntary. A hearing was scheduled but the treating psychiatrist had not seen the consumer, who lived in a regional area, for some time and was on leave up until 2 days before the hearing. It was agreed to postpone the hearing to a later date, however, 2 days before the hearing the psychiatrist advised that she had another meeting that day and could not attend. The hearing went ahead in the presence of the consumer’s case manager from the clinic using various clinical notes. The psychiatrist had been asked by the Official Visitor to provide a report but had refused to do so. The MHRB refused to make the consumer voluntary. It was felt by the consumer and the Official Visitor that old case notes were relied on and that comments by the case manager in the consumer’s favour were not given sufficient weight.

After the MHRB hearing, the Official Visitor explained to the consumer their options which included an appeal and obtaining an other opinion pursuant to section 111 of the Act. The latter course was followed as a result of which the consumer was made voluntary. Inquiries by Head of Council indicated that the real issue here was that the psychiatrist’s case load was too big. Information was passed on informally to the Chief Psychiatrist.

Illustration 4: Consumer said they had not seen their psychiatrist for weeks

In a metropolitan hospital consumers told Official Visitors they had not seen their psychiatrist for weeks. They were seen by a doctor, usually a medical officer or junior registrar, but many patients wanted to see the psychiatrist. Only the psychiatrist can make orders under the Act which affect the patient's rights such as whether they are made voluntary and phone and visitor restrictions. Council wrote to the Clinical Director about the issue.

Illustration 5: Shortage of specialists in youth psychiatry, Huntington's disease and autism

Council is concerned that there is apparently only one doctor in WA with expertise and an interest in child forensic psychiatry and a shortage of child psychiatrists generally. As noted at Issue 2, there appears to be a shortage of doctors with expertise in Huntington's disease and autism.

Illustration 6: Graylands doctor shortage

In May 2010, Council was advised that Graylands would be facing a serious shortage of senior medical staff between 24 May and 25 June 2010. This was due to recruitment delays caused by the public sector process standards which had meant that there were inevitable gaps between previous doctors resigning and new recruited doctors commencing. The recruitment issues combined with mandatory exam requirements meant that Graylands would be short three full time Consultant Psychiatrists for this period, and to a lesser extent a moderate shortage one month either side of this period.

ISSUE 14: OTHER ISSUES

Illustration 1: Drug search and kiosk restrictions

Last year Council reported that it had complained that a search for drugs on a hospital ward had been conducted without the patients being present in their rooms at the time of the search, contrary to hospital policy. Council was also concerned that immediately after the search patients on ground access had been told they could no longer visit the hospital kiosk or local shops. The hospital eventually advised that they "had learned a few lessons from the search" and that it did not follow the hospital policy. They also advised that the restrictions on going to the kiosk and local shops had stopped. Although this had seemed to be a punishment in response to the drug issue, Council was advised that it was a coincidence.

Illustration 2: Confidentiality

Council dealt with two serious complaints about breaches of confidentiality. In one matter the consumer complained that their mother had been told that they had been discharged and given the address of the accommodation. This was contrary to the consumer's wishes. The hospital looked into the matter and advised that there was no evidence that the mother had been given the information by a staff member. They suggested the mother may have obtained the information from another patient.

In the second case the consumer complained about being in a hospital where their spouse worked. They said they had seen their doctor talking to the spouse contrary to clear instructions not to. The spouse had also made statements which were noted on the Form 1 referral for psychiatric assessment and the subsequent involuntary admission. In this case the relationship between the consumer and their psychiatrist was very antagonistic. Council successfully argued that the consumer should be moved to another hospital to overcome the confidentiality issue and the consumer's complaint about the lack of a therapeutic relationship with the psychiatrist.

Illustration 3: Failure to observe rights pursuant to sections 156 and 157 of the Act

In April 2010 Official Visitors questioned hospital ward staff as to whether or not patients were being told their rights when put on leave of absence from hospital as required by section 156(1)(c). Official Visitors also asked if an explanation of the consumer's rights was being given to a relative, guardian, friend or other person nominated by the consumer as

required by section 156. A significant number of hospital wards were not observing these rights. Hospital management was advised and the issue will be followed up again next year.

Illustration 4: Health Care needs

For some years Official Visitors have been raising concerns about the substantial number of consumers with obviously poor teeth. Two Official Visitors therefore met with the Executive Director of Public Health and Ambulatory Care and the Acting Director of Dental Health Services to discuss the services available. Official Visitors were told that dental care for mental health consumers has been recognized as one of the three areas of greatest need under the WA Oral Health Plan. Long term involuntary patients at Graylands have access to a clinic on campus that operates 3 days a week which offers a full range of dental services. Other mental health facilities can access locally based state government clinics, as long as the patient is eligible. Cases deemed urgent are generally seen within 24 hours – where possible - however the waiting time for a non urgent appointment across all clinics state-wide is an average of 11 months. Other concerns were that there was no follow up register held on wards, which meant that regular dental checks did not occur for long term patients and the dental clinic did not have access to the general patient records to determine the whereabouts of patients when they left Graylands as an inpatient.

As a result of concerns raised about particular patients, Murchison Ward at Graylands introduced a spreadsheet system to ensure that long term patients are given regular health care checkups including dental care.

Illustration 5: Discharge planning – lack of patient input

Official Visitors spoke to consumers and staff in May about discharge planning. Particular focus was given to patient and carer input into the discharge plan and if/when “estimated discharge dates” (EDD) were being given to patients. Most authorised hospital wards introduced the concept of a “Journeyboard” last year.

One of the elements of the Journeyboard is that an EDD is noted on the board from the beginning of the admission so that all members of the clinical team are working towards discharge on that date. When the concept was introduced Council was told that the date could change from time to time and that patients would be told the date (with occasional exceptions).

Council learned from the interviews in May that:

1. discharge planning varied from ward to ward and hospital to hospital but was said to commence on admission in most hospitals. In others the start time was variable;
2. not all wards filled in the EDD on the journeyboard;
3. although most wards said that they advised the patient of the plan, very few referred to the patient being fully involved or consulted. Few patients spoken with were aware of planning for their discharge; and
4. a number of the hostels and other care/accommodation providers complained about the lack of information they were given (see Issue 8 at Illustration 6).

Illustration 6: Use of security guards and police to restrain patients

This year Council received complaints about security guards being used on a metropolitan ward and the unavailability of security guards at a country hospital.

In the metropolitan hospital the concern was that security guards were being used regularly for restraint. In particular, the concern was that they were using a particular wrist/thumb lock restraint technique which relied upon the application of pain if the person moved. In addition to this, Council was also notified that a doctor had requested that 2 security guards be present in an interview with a female patient, without sufficient cause or the application of a proper risk assessment. The concern was for the patient’s confidentiality and their own sense of safety. It is also disturbing and intimidating for other patients to have security guards attend a ward regularly.

The hospital responded by advising that a work instruction regarding the use of security guards and their behaviour had been circulated. This required guards to stand outside the room if they had been requested to attend when a doctor was interviewing a patient. The guards had been instructed not to use the wrist/thumb lock technique and were only to be called in for an interview situation when there was a direct threat or risk to the doctor. If a patient needed restraining the nurses should be doing it unless it escalated to a code black, in which case security guards would respond.

In the case of the country ward, a patient was in seclusion overnight and no security guards were available to assist when the seclusion needed to be broken every 2 hours (to allow the doctor to reassess the patient and offer food and toileting facilities). The result was that the police were called in to do the job but, every 2 hours, 4 policemen came onto the very small ward. It was acknowledged that there was nothing the ward could do about the situation on the night but Official Visitors requested that the issue of unavailability of the security guards be raised with the company.

Illustration 7: Boredom on the wards

One of the common complaints made to Official Visitors by consumers is that they are bored. Consumers complain that there is nothing to do on the weekends, that there are not enough Occupational Therapists (OTs), that nurses have been given the job of OTs and that OTs just do “finger painting” and not much more. The issue is raised time and again at management level, and has been for years. There is some “good news” though: Swan Mental Health Service advised Council that during the year a Rehabilitation Review had taken into account Council’s comments about lack of Occupational Therapy activities and things for patients to do, particularly in the acute setting.

Illustration 8: The value of Council’s weekend roster⁴ and good advocacy

A consumer rang Council’s freecall number from the ward on the weekend explaining that they were very distressed at being made involuntary. The consumer was a highly sought after professional who had flown to WA to oversee a major contract for a large company. The consumer said they had been sleeping poorly and went to an emergency department near their hotel hoping to get some sleeping tablets but had been made involuntary. The Official Visitor spoke with the consumer’s psychiatrist on the weekend and explained the consumer’s concern about potential damage to reputation if their employer were to find out that they had been made involuntary and that this in turn could affect future employment opportunities.

The doctor agreed to meet with the Official Visitor and the consumer on Monday afternoon following which the patient was made voluntary.

The doctor agreed that the consumer did not require anti-psychotic medication but was suffering from extreme exhaustion. The doctor also agreed to provide a medical certificate citing the patient had been admitted to hospital for treatment for a serious medical condition. This alleviated the consumer’s concerns that their reputation might be tarnished by the involuntary admission. The doctor informed the Official Visitor after the meeting that he felt the consumer was able to speak more honestly and openly with him due to the Official Visitor’s presence.

Illustration 9: Getting home in time for Christmas – a good news story

A patient on a locked ward was told by one doctor on the evening of 23 December 2009 that they probably didn’t need to be in hospital; the next morning a different doctor decided the consumer should remain in hospital but said he would review the position on Christmas morning. The consumer had family and friends due for Christmas lunch. Council’s Executive Officer contacted the hospital’s Clinical Director and the consumer was discharged on Christmas Eve.

⁴ Official Visitors are rostered to check phone messages on the weekend and deal with urgent matters.

PART THREE

ONGOING ISSUES RAISED IN PREVIOUS ANNUAL REPORTS THAT STILL REQUIRE REMEDY

BELOW IS A YEAR BY YEAR SUMMARY OF ISSUES WHICH HAVE BEEN RAISED IN PREVIOUS ANNUAL REPORTS AND WHICH REMAINED UNRESOLVED DURING 2009-2010.

1998-1999

1. Need to expand the definition of “affected person” in s175 of the Act so that Official Visitors can advocate for voluntary consumers, referred persons and Hospital Order patients. See Issue 3 in Part 2 of this report.
2. Overcrowding in authorised hospitals with pressures on beds in all hospitals. See Issue 12, Illustration 2 in Part 2 of this report. Pressure is likely to remain on beds while there are long term and other patients inappropriately being detained on hospital wards. See also Issues 1 and 2 about patients stuck on wards and Issue 13 regarding doctor shortages.
3. Lack of system wide policies that have a direct impact on consumers. Council can never assume that policies are the same between hospitals or clinics, even when they are in the same area health service. Council understands that an agreed set of forms for use in hospitals is to be introduced which will be welcome.
4. “Second” opinions process not providing truly independent opinions and related issues. See Issue 10 in Part 2 of this report.
5. Hostel issues including minimal health care and support services, need for review of the standards, lack of proper facilities and lack of privacy and security in bedrooms. There have been improvements since 1998-99, but see Issue 8 in Part 2 of this report regarding ongoing concerns and a call for a review of the sector.

1999-2000

6. Concerns about the Bentley Adolescent Unit – maintenance, furnishings, décor, structure, outdoor areas, number of beds, mixture of ages. This has been raised in almost every report since then. See issue 4 in Part 2 of this report.
7. More respect and facilities needed for human relations and intimacy. Although no specific cases have been illustrated in this report, this remains an issue with ward phones often broken, different attitudes across hospital wards to allowing mobile phones, lack of insufficient visitor and family rooms on locked wards and some patients unable to access their rooms during the day.
8. Boredom on the wards and lack of access to on-site gyms, or to exercise equipment etc. While there have been some improvements, consumers continue to complain about boredom especially on weekends. See Issue 13 Illustration 9 in Part 2 of this report.

2002-2003

9. Lack of access to allied health professionals/multi-disciplinary teams, in particular social workers and welfare workers. Issue 8 Illustration 1 in Part 2 of this report contains one example. Official Visitors regularly report how difficult it is to reach social workers and welfare workers and how over-worked they seem to be.
10. Need to improve opportunities for socialisation for people with a long term illness. See Issues 1 and 8 in Part 2 of this report.
11. Specific areas for visitors are inadequate or non-existent in many inpatient facilities especially locked wards. The new secure ward at Joondalup has a welcomed family room but otherwise this remains an issue.

2003-2004

12. Ward environment and lack of maintenance and appropriate furnishings. This has been raised in every report since then. See Issue 7 in Part 2 of this report.
13. Need for new initiatives in Indigenous services. It was noted in 2003-2004 that there was a desperate need for a range of new initiatives. In 2004-2005 Council welcomed the initiatives in the W.A. Mental Health Plan and stated it would participate in any consultative processes established for this purpose. Council has not been invited to take part in any processes and is unaware of what, if anything, has been done. Council would like to see more use of the State Aboriginal Mental Health Service and notes that approximately 50% of the children in the BAU seen by Official Visitors are indigenous. See Issue 4 Illustrations 3 and 4 in Part 2 of this report.
14. Issues with the MHRB process. In 2003-2004 Council first raised the failure of medical staff to attend MHRB hearings or provide reports at all or in a timely manner. In 2007-2008 Council called for an ad

hoc committee to be established to try to address this and various other issues. The then Health Minister asked the Head of Council to convene and chair a committee but this did not go ahead following a change in government. Head of Council has called for a review of the MHRB process and changes to the Act. See Issue 11 and Issue 13 Illustration 3 in Part 2 of this report.

15. Community Treatment Order breaches and potential breaches of the Act. These issues have been cited every year since 2003-2004. Although no cases are cited in this report Official Visitors continue to deal with complaints.
16. Treatment of people with a mental illness in hospital Emergency Departments (EDs). Although there have been improvements in relation to treatment in EDs, Council continues to hear about people not being treated with respect or dignity and is also concerned about the impact of the 4 hour rule so this issue is being kept in the Annual Report. There needs to be separate statistics kept for people with a mental illness and the length of time they wait in EDs.
17. People with Acquired Brain Injury (ABI) on mental health wards. It remains the case that secure mental health units are often used as a solution to house this group of people because there is nowhere else for them to go.

2004-2005

18. Low levels of representation in MHRB hearings. The representation and support levels have steadily increased over the past few years as a result of Council initiatives, reaching 27% this year. The issue remains on the list however as there are many more consumers who do not have representation. See Issue 11 in Part 2 of this report.
19. Smoking ban causing distress to consumers particularly on locked wards. This was first raised in 2004-2005 when smoking was prohibited within 5 metres of the doors to government buildings and 10 metres of air conditioning units. It was raised again in 2007-2008 when the full smoking ban was applied to Department of Health sites. See Issue 9 in Part 2 of this report.

2005-2006

20. Failure to comply with section 157 of the Act requiring that "another person" be advised of the consumer's rights. See Issue 14 illustration 3 in Part 2 of this report.
21. Neglect of dental health, hygiene and treatment - see Issue 8 Illustration 1 and 2 and Issue 14 Illustration 4 in Part 2 of this report.
22. Ageing of the population of Licensed Private Psychiatric Hostels. This remains a concern as physical health issues are not well managed by some hostels. See Issue 8 Illustration 1 in Part 2 of this report. Council therefore continues to recommend that Aged Care Assessment Team (ACAT) assessments for all older psychiatric hostel residents over the age of 65 are undertaken and that all hostel residents over 60 are examined and assessed by a psycho-geriatric team.
23. Seclusion practices. While there has been considerable improvement in seclusion practices across hospitals as a result of the Beacon Project aimed at reducing seclusion rates and the time spent in seclusion, Official Visitors still regularly get complaints from consumers arising out of seclusion. See Issue 6 in Part 2 of this report.

2006-2007

24. Inconsistent and inappropriate complaints processes. See Issue 5 in Part 2 of this report.

2007-2008

25. Long term and inappropriate placements on wards. See Issue 1 in Part 2 of this report.

2008-2009

26. "Bail bond kids" – children on supervised bail orders. See Issue 4 in Part 2 of this report.
27. Transportation by Royal Flying Doctor Service – patients being so sedated that they need to have a catheter. While Council has not received any consumer complaints about this issue this year, Official Visitors are aware of patients who have been brought into hospital this way, including children.

PART FOUR

ACTIVITY MEASURES, BUDGET, STRATEGIC PLAN AND OTHER ACTIVITIES

CONSUMER NUMBERS

Annual data collected by Council, the Department of Health⁵ and the Mental Health Review Board⁶ for 2009-10 show increases in all key measures (with the previous year's figures in brackets):

Number of consumers seeking assistance from Council: **957 (850) - 12.6% increase**

- Number of issues dealt with by Council (formerly called requests): **2,863 (2,775) - 3.2% increase**
- Number of new consumers (ie consumers making their first contact with Council): **446 (365) - 22.2% increase**
- Number of people detained in hospital under the Act (on forms 6, 9 and 11 as recorded by the MHRB – excludes mentally impaired accused): **2,688 (2,475) – 8.6% increase**
- First time on a form 6 (ie first time made involuntary in WA as recorded by the MHRB): **922** (Note: Council has only been collecting this data since January 2009 but a comparison of 6 monthly data shows steady increases:
 - January to June 2009 – 341
 - July to December 2009 – 457
 - January to June 2010 - 465
- Number of consumers represented by Official Visitors at MHRB hearings (as recorded by the MHRB): **191 (152) – 25.7% increase**
- CTOs issued (as recorded by the MHRB): **907 (843) - 7.6% increase**
- Voluntary patients (as recorded by DOH): **10,160 (9,594) – 5.9% increase**

(See also appendices 8 to 11.)

The number of consumers seeking assistance from Council increased by 107, most of which is explained by new consumers, as opposed to former consumers, getting back in contact with Council. There were 81 more new consumers in 2009-10 compared with the previous year. This is consistent with the apparent increasing trend in the number of people on a form 6 for the first time.

	COV consumer nos	Invol/voluntary inpatients (DOH data)	Invol inpatients (MHRB data)	No of CTOs (MHRB data)
2003-2004	744	NA	2,664	903
2004-2005	800	NA	2,794	970
2005-2006	891	NA	2,663	951
2006-2007	979	NA	2,639	827
2007-2008	1,052	2,536 / 9,485	2,580	771
2008-2009	850	2,563 / 9,594	2,688	843
2009-2010	957	2,888 / 10,160	2,688	907

ANALYSIS OF CONSUMER AND REQUESTS INPATIENT DATA

As can be seen from the data in appendix 8, the biggest increases in numbers of inpatient consumers contacting Council were at Joondalup Hospital, the Ursula Frayne unit at the Mercy Hospital, Kalgoorlie and Albany hospitals and the Mills Street Centre in Bentley. Corresponding increases in the number of issues raised by consumers were also seen at these facilities.

⁵ Department of Health data represents the number of separations from public mental health facilities where the person was involuntary at the time of separation. This data includes those referred for assessment on Form 1. This figure cannot be compared directly with the MHRB data due to different data parameters.

⁶ Mental Health Review Board data represents the number of forms 6, 9 and 11 received by the Board, making people involuntary.

The data is difficult to analyse because some hospitals will have far more patients moving in and out of wards than others and some hospitals have a higher percentage of involuntary patients than other hospitals.

Joondalup increased its bed numbers from 31 to 42 in April 2009. Appendix 9 also shows that, while Joondalup had 7% of the beds in 2009-2010, the number of consumers requesting Council assistance by reference to the bed numbers was only 5.9%. This indicates that the increase was largely due to increased bed numbers.

The increases at the other hospitals cannot be explained by bed numbers but in the case of Ursula Frayne, Kalgoorlie and Albany hospitals the patient numbers are relatively low and comparisons with figures given in previous annual reports suggests that the number of a consumers assisted by Council in these facilities can vary widely from year to year.

The Mill Street Centre's increase largely appears due to an unexpected drop in consumer numbers contacting Council last year. It reflects a return to previous years' figures. With 18% of the beds the number of consumers contacting Council as a percentage of the bed numbers was significantly less (11.4%).

ANALYSIS OF ISSUES AND REQUESTS

The data provided in appendix 12A is derived from individual consumer reports prepared by Official Visitors. The data is limited in scope because it is based on a very old software program which cannot be amended and which was never designed specifically for mental health patient complaints or use by Council. As a result, a number of complaints are difficult to classify and so are listed as "unknown" (1,070, slightly down from last year's figure of 1,450). Council is hoping that an independent review planned for early 2010/2011 will recommend funding for a new system in the very near future.

The data does reflect the role of Official Visitors in assisting with MHRB applications and attendance at MHRB hearings with the largest number of requests relating to these issues (350 and 281 respectively)⁷.

The data breakdown is also very similar to last year's data except for:

- a 125% increase in issues relating to discharge or transfer arrangements;
- a 35% increase in complaints about "incompetent" treatment; and
- an overall increase of 12% increase in complaints about quality of care.

After MHRB applications and attendances, the next 4 areas with the highest number of complaints were in relation to:

- inadequate diagnosis (195, last year 177) – consumers complaining that they should not be in a hospital or should not be involuntary;
- requests for a "second opinion" (102, last year 103) - including information regarding the process;
- inadequate treatment (101, last year 98) – usually related to the choice and level of medication but also including complaints about not getting access to other therapies such as counselling; and
- administrative practice (71, last year 97) – this item number has been adapted by Council to include complaints about not being allowed to smoke.

It should also be noted that many complaints are made by consumers to Official Visitors when they are carrying out inspections of the wards. These may be referred to in the inspection reports but not made the subject of an individual consumer contact report and so do not get counted in these figures. Smoking is a good example of this as Official Visitors report that whenever they visit an authorised hospital, smoking is raised by consumers as an issue.

⁷ There are a number of reasons why these figures are different. One relates to the making of applications and the other to attendance at MHRB hearings, both for applications and scheduled reviews. However, hearings are often cancelled because the consumer was made voluntary prior to the hearing. In some cases MHLC lawyers will have attended although an Official Visitor helped with the application. The figure for attendance may also include other issues such as assisting the MHLC to prepare or following up on issues arising out of an attendance.

BUDGET AND RESOURCING ISSUES

Council was allocated a budget of \$826,500 which was a reduction of 13% on the previous year's budget. With increased numbers of consumers it became clear part way through the year that, despite having made cutbacks in expenditure, Council would exceed the budget. Head of Council and the Executive Officer therefore met with the Director General of the Department of Health and further monies were allocated.

The Council's expenditure for the 2009-2010 financial year was \$1,052,057, of which 41% was spent on administration costs and 59% on payments to Official Visitors. As required under the *Electoral Act 1907* section 175ZE (1), during 2009-2010 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: \$5,750.

It should be noted that Official Visitors are entitled to remuneration (section 180 of the Act) but the remuneration rates have not been increased for 4 years having been last reviewed and increased as of 17 October 2006. Official Visitors are paid on a sessional (half day/full day) basis which often does not reflect the way they work or the hours worked. There is an increasing amount of paperwork and phone calls following up on consumer complaints and requests, they are not paid for travel time, and most do not claim the costs of phone calls, parking tickets or for things like printing off documents from their home computers.

The support provided to Official Visitors by the Council office has also been limited due to staff shortages during the year and, as noted in last year's Annual Report, Council's office is significantly under-resourced (even when it has the full staffing complement), and this continued in 2009-2010.

By way of comparison, today Council has 32 Official Visitors, nearly triple the number of consumers and 6 times the number of issues as when it started in 1998 yet the administrative staff support numbers have increased by only 0.25 FTE. There were also more facilities to be inspected this year (and there will be more again next year).

	Consumers	Issues	Official Visitors	Administrative staff
1998-1999	362	439	19	2.75
2009-2010	957	2,863	32	3

Having nearly three times the number of consumers and six times the number of requests/issues means more than triple the number of phone calls from consumers and to Official Visitors as well as more than triple the amount of correspondence and administrative work related to Official Visitors' reports and pay claims. In addition, the reporting requirements have increased over the years and Council's computer database and recording software is slow and cumbersome and badly needs replacing. No time is left to monitor and report on trends, conduct research or update position statements to assist Council and the office staff struggle to keep up with the reporting requirements.

As a result of raising these issues last year, the Department of Health agreed to fund an independent review beginning in July 2010. Terms of reference for the review are to consult with key stakeholders to gather views, information and evidence sufficient to:

1. evaluate operations management and negotiate the use of or capacity to adopt helpful tools and/or streamlined processes;
2. pave the way for implementation of recommended staffing changes and advise on necessary staffing resources and associated costs;
3. examine costs, expenditure, financial performance and advise on the operation budget requirements;

4. conduct a desk top review of the Kirwan 2007 Review Report, and, in conjunction with discussions with key informants, provide the client with an updated perspective on the priority issues and recommendations; and
5. scope a comprehensive implementation project for the Department suited for immediate execution.

STRATEGIC PLAN

The goals, strategies and outcomes of the 2008-2009 Strategic Plan are set out below. Most of the strategies were implemented but a number had to be abandoned as a result of delays in the new legislation and lack of resources and funds.

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

1.1. *Ensure that each authorised hospital is visited at least once in each month.*

The practice of having formal inspections with a specific focus and informal inspections or mail box runs continued in 2009-2010. On each visit Official Visitors check the ward for safety and suitability issues including checking the seclusion register and for any new patients to ensure they have been informed of their rights. In addition questions based on a specific focus area are asked of staff and consumers. The focus areas in 2009-2010 were:

- Handling of consumer finances
- Access and availability to therapy and allied health services
- Other Opinions and Mental Health Review Board processes
- Fire and security issues
- Smoking issues
- Relationship issues
- Care plans
- Clothing and footwear
- Physical care
- Rights under the Act
- Discharge planning
- Environmental audit

There were 414 authorised hospital visits this year compared with 399 last year. In accordance with Council's usual practice, no visits were announced. Appendix 6 sets out the visits and timing of visits. Those hospitals with more wards are visited more often because Official Visitors are not able to visit every ward in one session.

1.2. *Ensure that at any time the Minister so directs a place where any affected person is detained cared for or treated under this Act is visited by an Official Visitor in accordance with that direction.*

This refers to hostels and other accommodation facilities. They are inspected in the same way as hospitals but visits take into account that the hostels are people's homes. There were 275 visits this year compared with 225 last year. The increase is partly due to the opening of 5 new facilities.

In accordance with Council's usual practice, most visits were unannounced. Larger facilities tend to get more visits because of the number of residents. From time to time extra visits were scheduled where there was a running issue or concern to be followed up or where Council received a complaint about the facility. Appendix 7 sets out the visits and timing of visits.

1.3. *Ensure that an affected person is visited as soon as practicable after a visit is requested.*

All calls were responded to within 48 hours of being made and visits made as soon as practicable thereafter if requested in accordance with Council's policy. Most new consumers calling Council for the first time were responded to within 24 hours.

1.4. Report to the Minister or refer and make reports to the Chief Psychiatrist as required.

A number of matters were referred through the year to the Chief Psychiatrist and Minister for Mental Health as noted in Part 2 of this report including two major reports on the Other Opinion and Mental Health Review Board processes.

2. To work towards improving the standards, safety and suitability of licensed hostels by continuing accessibility of residents to Official Visitors and endeavouring to work collaboratively with hostel licensees.

2.1 Continue allocation of teams of Official Visitors to designated hostels and group homes with a view to increasing contact and relationships with hostel/ home residents.

During the year it was decided to maintain the teams only for facilities of concern. The number of consumers requesting contact was down from 61 in 2008/2009 to 60 in 2009/2010. See appendix 8.

2.2 Conduct detailed inspection(s), and liaise and attempt to work with licensees in an effort to improve standards.

This work continued throughout the year (see Issue 8 Illustrations 2 and 3 in Part 2 of this report). In addition Head of Council met with several licence holders or their staff and with the Private Psychiatric Hostel Owners Association.

2.3 Executive Officer to write to licensees offering to host information presentations or attend residents' meetings at hostels and group homes.

This was completed.

2.4 Continue liaison with the LSRU on regulations governing hostels and group homes including discussing current regulations and concerns over the compliance with these.

Two meetings were held in October 2009 and April 2010 and there was various correspondence and telephone communications.

3. Input into and monitoring of the strategic direction of Mental Health services in Western Australia.

3.1 Be involved in strategic planning initiatives of the Health Department and others.

Head of Council:

- continued her role as a member of the Project Steering Committee overseeing the Review of Mental Health Services and development of the WA Mental Health Policy and Strategic Plan 2010-2020;
- organised and chaired a meeting about the Bentley Adolescent Unit and planning for the new children's hospital (see Issue X in Part 2); and
- met regularly with the Minister for Mental Health (every 2 months) and the head of the Mental Health Division and, later, the Acting Mental Health Commissioner.

In addition the Deputy Head of Council:

- was a member of the 4 Hour Rule Communications Liaison Group;
- was a member of Smoking Cessation in Mental Health Implementation Working Group; and
- gave a presentation to the Liberal Party room on the impact on involuntary persons of smoking ban in authorised hospitals smoking issues.

3.2 Monitor and report on initiatives in community mental health care and service delivery.

Attempts were made to monitor this area via monthly inspection focus areas but further work is needed.

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

4.1 Identify and liaise with key organisations who support people on CTOs.

Lack of resources hampered work on this strategy.

- 4.2 *Visit or contact (as appropriate) selected clinics from time to time including offering to undertake educational sessions with clinic staff on the role of the COOV.*

Clinics were written to but Council is finding it difficult to find ways of making itself more accessible to the significant number of people who are on a CTO.

5. To improve the Mental Health Review Board process.

- 5.1 *Review and provide feedback on the MHRB process to the Minister, Department of Health and relevant others to improve the problems with the process.*

In September 2009, Official Visitors and Head of Council held a series of interviews with psychiatrists working in authorised hospitals about the MHRB process. The outcome of those interviews, along with the collective reported experience of Official Visitors, were then used as the basis of a Report and Discussion Paper by Head of Council provided to the Minister for Mental Health in May 2010. A summary of the issues raised and recommendations made is set out at Issue 11 in Part 2 of this Report.

- 5.2 *Continue to promote and offer Official Visitor representation in MHRB hearings to consumers via various means including having a standing question on formal inspection forms asking consumers if they have a review coming up.*

This was completed and the success of the strategy is reflected in the 3.5% increase in the level of representations at MHRB hearings by Official Visitors. The overall figure of 16.9% representation by Official Visitors is the highest in Council's history – see Issue 11 in Part 2 of this report.

In addition, Council has been trialling joint attendance at selected MHRB hearings with the Mental Health Law Centre. This will continue next year as early indications are that it works well in selected cases involving breaches of rights and is an efficient use of joint, publicly funded, resources.

- 5.3 *Continuing education for Official Visitors on how best to advocate for consumers at MHRB hearings.*

The June training session included a panel discussion on the “Do’s and Don’ts of MHRB Hearings” with the Chair of the MHRB, Murray Allen, and Board Members, Daniel Stepniak and Maxinne Sclanders. This was followed by a workshop with case scenarios on how to prepare for and conduct a MHRB hearing led by Health Consumers’ Council Advocate, Maxine Drake, and the Principal Solicitor of the Mental Health Law Centre, Sandra Boulter.

- 5.4 *Explore ideas for ways of better identifying people coming up for periodical review with a view to letting them know Official Visitors are available to assist in the preparation and/or hearing.*

Considerable work was done on this during the year and arrangements have been finalised with some hospitals which enable Official Visitors to better identify those consumers who have MHRB reviews coming up and to offer them support in the hearing. The results are reflected in the increased representations in hearings noted above.

6. To improve the process of accessing the right to “an Other Opinion” under the Act.

- 6.1 *Educate doctors and services about Council’s Position Paper on Other Opinions and the problems with delays being experienced.*

In September 2009, Official Visitors and Head of Council held a series of interviews with psychiatrists working in authorised hospitals about the Other Opinion process. The outcome of those interviews, along with the collective reported experience of Official Visitors, were then used as the basis of a Report and Discussion Paper by Head of Council provided to the Minister for Mental Health in May 2010. A summary of the issues raised and recommendations made is set out at Issue 10 in Part 2 of this report.

In addition the Executive Officer now alerts psychiatrists and hospitals to requests for Other Opinions and monitors the time taken to conduct the other opinion.

- 6.2 *Identify private psychiatrists who are willing to give Other Opinions on a Medicare rebate only basis.*

As will be seen in the report on Other Opinions summarised in Part 2, there are complications with

Medicare which mean that Medicare rebates will not be given to public hospital patients who obtain a second opinion from a private practitioner.

7. To plan for changes which will be brought in by the new Mental Health Act, in particular in relation to the Council being responsible for the Youth Advocate and voluntary consumers and its involvement with the new Mental Health Commission.

7.1 Obtain a copy of and review the draft provisions of the new Act.

No further provisions of the draft Bill for the new Act were provided prior to 30 June 2010. Head of Council met with the Department of Health lawyer who is instructing Parliamentary Counsel and provided comments on sections of the Bill which were provided to her in April 2008 (which were limited to Council's role).

7.2 Strategy planning process involving all OVs be developed if and when the time comes.

Not applicable.

8. Refine data capture, collection and reporting.

8.1 To monitor completed inspection reports and report trends and issues to Executive.

From January 2010 the Focus Area Person (FAP) has been compiling a summary of all inspection reports which is to be continued. The Executive Officer also now provides an inspection action sheet to assist in the following-up of issues raised at previous inspections.

8.2 Monitor consumer complaints data and report trends and issues to Executive.

Lack of resources has meant that individual consumer complaint reports are not being monitored and the data base used to record the types of complaints is cumbersome, not particularly useful or accurate. It urgently needs replacing if we are to better use the information being collected by Council.

8.3 Conduct at least one survey as determined by the Executive Committee in consultation with the Focus Group committee.

Surveys were conducted on the MHRB and Other Opinion processes. Council also assisted in a smoking survey (see Issues 9, 10 and 11 in Part 2 of this report.)

8.4 Explore options and draft business case for a new software package dealing with data capture and collection (ie to replace VTS and the complaints classification system).

Council sought funding to upgrade the software package as part of the budget submission.

9. Establish better COV procedures and protocols to improve COV service and OV skills and safety.

9.1 Maintain Induction Manual for Official Visitors.

The Manual was revised at the beginning of 2010.

9.2 Official Visitors to have refresher Safety Procedures training.

A safety presentation was given at the June Full Council Meeting and Official Visitors were required to refresh their familiarity with ward alarm systems.

9.3 Review of Council Policy and Position Statements as determined by review dates (subject to office administrative resources made available).

- Work began, and is continuing, on a Position Statement on computer and mobile phone access.
- Council suspended its long held position opposing civil patients on the forensic ward and is monitoring the situation with a view to drafting a Position Statement in the future (see Issue 12 Illustration 3 in Part 2 of this report).
- Several Position Statements were reviewed and reindorsed without amendment.

- A number of Position Statements need review and amendment but lack of resources has meant that this work cannot be carried out. The Position Statements are important because they help in training new Official Visitors and to ensure consistency of approach and standards by Official Visitors.

9.4 Review Code of Conduct and whether other policies are needed (subject to administrative resources).

This work could not be carried out due to lack of resources.

9.5 Investigate training needs of Official Visitors individually and collectively.

Completed in part and ongoing. Official Visitors receive collective training twice a year alongside Full Council Meetings. In December 2009 the focus was on advocacy training and in June 2010 the focus was on preparation for and advocacy in MHRB hearings, writing inspection reports, as well as a session on safety. Newly appointed Official Visitors received two days training. Previously appointed Official Visitors were able to attend these sessions if they felt a need for refresher training. In addition occasional speakers were invited to make presentations to metropolitan Official Visitors at their joint meetings from time to time. This included presentations by:

- the new Clinical Director of the Frankland Centre, Dr Edward Petch, on his proposal for the admission of civil patients to the forensic facility;
- the then Clinical Director of Graylands Hospital, Dr Nathan Gibson, on the changes at Graylands; and
- Winthrop Professor Gary Hulse, University of Western Australia, about his research on smoking.

9.6 Identify and take advantage of Official Visitor training opportunities with at least 3 metropolitan Official Visitors and all regional Official Visitors attending (subject to budget limitations).

Apart from the training provided twice a year at Full Council Meeting gatherings and the training for new Official Visitors, a number of Official Visitors and/or Head of Council and the Executive Officer attended:

- the “Nurses Winter Sunshine Symposium” at Bentley in July 2009;
- the MHS conference held in Perth in September 2009;
- the “What Was, What Is, & What Now?” workshop, for Aboriginal consumers in October 2009;
- two workshops with Gregor Henderson who leads a program of work on Well-Being and Population Mental Health for the National Mental Health Development Unit in the UK, in May 2010; and
- a forum on seclusion and restraint in Floreat in June 2010.

Several regional Official Visitors also attended the Rural and Remote Mental Health Conference in Kalgoorlie in November 2009.

10. Raise the profile of the Council with people working and using Mental Health Services in Western Australia to ensure that people who Council can help know about us.

10.1 Investigate improving the Council’s website.

Lack of resources prevented this being completed.

10.2 Produce new Council Brochure.

Work was begun on this but it has not been completed – partly due to resourcing issues and partly because Council was anticipating a move to new premises.

10.3 Improve the profile of the Council to people working and using mental health Services.

Council had hoped to put together a DVD or powerpoint package about Council’s role which could be used by people working in the sector but lack of resources have prevented this.

10.4 Write to various bodies offering presentations on the role of the Council including those responsible for training student nurses, assistants in nursing, nurses and psychiatrists.

This was partially completed with a number of presentations conducted at Graylands on Dorrington and Plaistowe wards, Frankland and Fremantle hospitals. In addition Head of Council gave a presentation at a Nurses Leadership Breakfast in July 2009 and to law students and others at a educational session run by the Mental Health Law Centre.

10.5 Identify potential media opportunities and provide media comment as appropriate

Council had intended running “tables” at the TheMHS and Rural and Remote Conference but the costs and budget cuts meant the idea had to be abandoned. A table was run at the Indigenous Our Mob conference in Fremantle and brochures were given out in a Schizophrenia Week workshop. Head of Council was also interviewed on a local Fremantle radio station about the role of the Council.

OTHER ACTIVITIES

Liaison with Services and other agencies

Regular meetings are held by the Head of Council with the Minister for Mental Health, Chief Psychiatrist, Executive Director of the Mental Health Division now the Mental Health Commissioner, Executive Directors of the North and South Metropolitan and Country Mental Health Services, and Clinical and Nursing Directors of metropolitan authorised hospitals and the Licensing Standards Review Unit

In addition this year Head of Council met with a number of other relevant parties including:

- Parliamentary Secretary to the Minister for Mental Health
- Director General of the Department of Health
- Executive Director Child and Adolescent Services
- Clinical Director of Infant, Child, Adolescent and Youth Mental Health Services
- Inspector and Deputy Inspector of Custodial Services
- Commissioner for Corrective Services
- Hon. Alison Xamon, MLC.
- Ombudsman’s Office
- the Public Trustee and office staff
- the President of the Mental Health Review Board
- Co-ordinator/Principal Solicitor the Mental Health Law Centre
- the Commissioner for Children and Young People
- Senior Advocate for the Health Consumers Council
- Licensed Private Psychiatric Hostel Owners Association
- Richmond Fellowship of WA Inc.
- St Bartholomew’s House Inc.

Head of Council and the Executive Officer also visited facilities in Albany and Bunbury meeting with authorised hospital and licensed hostel staff. Both visits were timed to coincide with interviews for new Official Visitors.

Relevant matters are taken to these meetings, advocating both on behalf of individual consumers and also for systemic change.

Consultation processes / requests

Council representatives continued their participation in a number of sector committees throughout 2009-2010, including:

- Project Steering Committee overseeing the Review of Mental Health Services and Development of the WA Mental Health Policy and Strategic Plan 2010-2020: attended by Head of Council
- Smoking Cessation in Mental Health Implementation Working Group
- 4 Hour Rule – Communications Liaison Group – attended by either Head of Council or the Deputy Head of Council.

RECORDS MANAGEMENT

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

QUALITY ASSURANCE

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

Codes of Conduct and Ethics

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

Complaints Regarding Council Operations

There were three complaints received about two Official Visitors. All were settled informally and all were made by health services and not by consumers. The subject matter of the complaints concerned boundary issues where the health service felt that the Official Visitor had got too close to the patient and/or was advocating inappropriately. These issues were canvassed at the December training session.

The Office of the Chief Psychiatrist also advised of a complaint it had received from a hostel manager who said that Official Visitors had asserted they were inspecting on behalf of his office. Official Visitors denied the assertion.

A complaint was also received from the guardian of a consumer who wanted to change the Official Visitor but the consumer advised that he did not want a change. In such cases the Council follows the wishes of the consumer.

Consumers occasionally ask to change the Official Visitor allocated to them, usually because they hope that a different Official Visitor will be able to get them out of hospital but this may also reflect the need for individual rapport between a consumer and their advocate. Council's policy is that the consumer will automatically be given another Official Visitor on the first request. They will be asked why they want to change and if any serious issues are raised these would be passed on to Head of Council for further investigation. If the consumer does not want to say why they want to change the Official Visitor allocation, the change will be made in any event. If the consumer then asks for the second Official Visitor to also be replaced, inquiries are made by Head of Council.

PRIORITIES FOR 2010-2011

Council decided to streamline its Strategic Plan for 2010-2011 to remove those goals which were administrative or were required under the legislation (for example, goals 1, 7, 8 and 9 in the 2009-2010 Strategic Plan referred to above). The aim is to focus more on consumers concerns.

A copy of the Strategic Plan is provided in appendix 13. The goals reflect the 4 issues of greatest concern to Official Visitors:

1. To improve the Mental Health Review Board process for consumers.
2. To improve the standards, safety and suitability of licensed hostels, group homes, Community Supported Residential Units and Community Options homes.
3. To improve the quality of life and care on authorized hospital wards and in supported accommodation to ensure that consumers receive the best care and treatment with the least interference with their rights and dignity (s5 of the Act).
4. To monitor, improve and raise the emphasis on consumers' rights to receive the best care and treatment with the least restriction of their freedom (s5 of the Act) and in particular early and safe discharge to, and support in, the community.

APPENDIX I. Authorised Hospitals.

Hospital, Wards and Address	No of Beds
Albany Regional Hospital, Albany Mental Health Unit Hardie Road, Albany	9
Fremantle Hospital and Health Service The Alma Street Centre Alma Street, Fremantle	64
Armadale Health Service, Leschen Unit Albany Highway, Armadale	41
Bunbury Regional Hospital Acute Psychiatric Unit (APU) and Psychiatric Intensive Care Unit (PICU) South West Mental Health Service, Bunbury Health Campus, Bunbury	27
Frankland Centre State Forensic Mental Health Services Brockway Road, Mount Claremont	30
Graylands Hospital Adult Mental Health Services Brockway Road, Mount Claremont	176
Joondalup Health Campus Joondalup Mental Health Unit Shenton Avenue, Joondalup	42
Kalgoorlie Regional Hospital Mental Health Inpatient Service Piccadilly Street, Kalgoorlie	7
King Edward Memorial Hospital Mother and Baby Unit Loretto Street, Subiaco	8
Mercy Hospital, Ursula Frayne Unit Thirlmere Road, Mount Lawley	12
Bentley Hospital and Health Service Mills Street Centre Mills Street, Bentley	111
Selby Older Adult Mental Health Service Lemnos Street, Shenton Park	48
Swan Health Service Swan Valley Centre & Boronia Inpatient Unit Eveline Road, Middle Swan	40
TOTAL	615

APPENDIX 2. Licensed Psychiatric Hostels, Group Homes, Community Supported Residential Units (CSRUs) and Community Options Homes.

Name, Licensee and Address	No of beds
Albany CSRU	
Albany Halfway House Association Inc. (licensee) Ballard Heights, Spencer Park, Albany	11
Burswood Psychiatric Hostel	
Teresa Norwicki (licensee) 16 Duncan Street, Burswood	22
Casson Homes Inc. (licensee)	
Casson House 2-10 Woodville Street, North Perth	84
Woodville House 425 Clayton Road, Helena Valley	25
Devenish Lodge	
AJH Nominees Pty Ltd (licensee) 54 Devenish Street, East Victoria Park	41
Franciscan House	
Meski International Pty Ltd (licensee) 16 Hampton Road, Burswood	75
Romily House	
Judith Balfe (licensee) 19 Shenton Road, Claremont	70
Ngurra Nganhungu Barndiyigu (CSRUs)	
Fusion Australia Ltd (licensee) 30 Onslow Street, Geraldton	14
Salisbury Home	
Legal Accounting and Medical Syndicate Pty Ltd and Calder Properties Pty Ltd (licensee) 19 James Street, Guildford	35
Ngatti, Fremantle Supported Accommodation for Homeless Youth	
Life Without Barriers (licensee) 5-9 Alma St Fremantle Inspected from 23 March 2010	16
Pu-Fam Pty Ltd (licensee)	
St Jude's Hostel 26, 30-34 Swan Street, Guildford	52
East St Lodge 53B East Street, Guildford	3

Rosedale Lodge David Wortley (licensee) 22 East Street, Guildford	32
Richmond Fellowship of WA Inc. (licensee) 56 and 58 Glyde Street 56 and 58 Glyde Street, East Fremantle	10
Mann Way 4 - 6 Mann Way, Bassendean	12
Queens Park Service 21-23 Walton Street, Queens Park	10
Bunbury CSRU 12 Jury Bend Carey Park	15
Busselton CSRU Unit 5, 1 Powell Court, West Busselton	10
Kelmscott Community Options 25 Hicks Road, Kelmscott	8
Roshana Pty Ltd (licensee) Honey Brook Lodge 42 John Street, Midland	35
BP Luxury Care 22 The Crescent, Maddington Inspected from 19 February 2010	36
Southern Cross Care (WA) Inc (licensee) Mount Claremont House Units 1 and 2, 60 Mooro Drive, Mt Claremont	7
St Bartholomew's House Inc. (licensee) Bentley Villas (CSRU) 1 Channon Street, Bentley	25
Arnott Villas (CSRU) 20 Arnott Court, Kelmscott	22
Sunflower Villas (CSRU) 15 Limosa Close, Stirling Inspected from 23 March 2010	25
Swan Villas (CSRU) 91 Patterson Drive, Middle Swan Inspected from 19 February 2010	25

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

Vincentcare Bayswater House

65 Whatley Crescent, Bayswater 6

Vincentcare Coolbellup House

66 Waverley Road, Coolbellup 4

Vincentcare Duncraig House

270 Warwick Road, Duncraig 4

Vincentcare South Lakes House

9 Plumridge Way, South Lake 3

Vincentcare Swan View House

8 Wilgee Gardens, Swan View 4

Vincentcare Vincentian Village

2 Bayley Street Woodbridge 28

Vincentcare Warwick House

39 Glenmere Road, Warwick 4

Total 773

Note. Stirling Community Options, 4 & 6 Limosa Close, was licensed for 8 residents on 8 June 2010 but the Ministerial directive requiring Council to visit the facility was not made under s.186 until 16 July 2010.

APPENDIX 3. Appointments to the Council of Official Visitors.

Head of Council	Commencement		Expiry of Term	
Ms Debora COLVIN	1 February	2007	31 March	2011
Official Visitors				
Mr Bruce AMBROSIUS	21 January	2003	7 April (passed away 27 September 2009)	2012
Dr Michael ANDERSON	12 May	2005	7 April (resigned effective 26 February 2010)	2012
Mrs Sherril BALL		2002	1 February	2013
Miss Denise BAYLISS	7 March	2006	7 April	2012
Ms Helen BRESLOFF-BARRY	2 February	2010	1 February	2013
Ms Sharon BRIGGS	7 April	2009	7 April	2012
Mr Donald COOK	2 February	2010	1 February	2013
Ms Alessandra D'AMICO	1 February	2007	1 February	2013
Mrs Marie DAVIES	1 February	2007	1 February	2013
Mr Richard DESOUZA	2 February	2010	1 February	2013
Mr Michael DIXON	18 January	2008	1 February	2011
Mr Gerard DOYLE	18 January	2008	1 February	2011
Ms Gillian EVANS	7 March	2006	7 April (resigned effective 1 September 2009)	2012
Mr Adrian GAVRANICH	August	1998	1 February (did not reapply)	2011
Mr Rodney HAY	1 February	2007	1 February	2013
Mrs Naka IKEDA	7 March	2006	7 April	2012
Ms Kirsten JOHNSTON	18 January	2008	1 February (resigned effective 30 November 2009)	2011
Mr Damian JOLLY	18 January	2008	1 February (on extended leave for 2009/2010)	2011
Mrs Denise KAY	1 February	2007	1 February	2013
Mrs Kerry LONG	23 March	2005	1 February	2011
Ms Kelly-Ann LETCHFORD	2 February	2010	1 February	2013
Ms Ann McFADYEN	7 April	2002	7 April	2012
Ms Edana McGRATH	22 July	1999	1 February	2011
Mrs Melinda MANNERS	1 April	2007	1 February	2013
Mr Gary MARSH	23 February	2010	7 April	2012
Mr Bruce MORRISON	2 February	2010	1 February	2013
Ms Val O'TOOLE	21 January	2003	7 April	2012
Mrs Theresa PIPER	23 March	2005	1 February	2011
Mr Graham PYKE	3 December	2009	7 April	2012
Ms Sheila RAJAN	7 April	2009	7 April	2012
Ms Patricia RYANS-TAYLOR	3 December	2009	7 April	2012
Mr Jeff SOLLISS	7 April	2009	7 April	2012
Ms Kelly SPOUSE	1 August	2009	7 April	2012
Ms Helen TAPLIN	7 March	2006	7 April	2012
Mrs Judith TAYLOR	23 March	2005	1 February	2013
Mrs Kathryn TONCICH	1 February	2007	1 February	2013
Ms Catriona WERE-SPICE	14 August	2000	1 February	2011
Mrs (Angela) Leonie WILSON	1 February	2004	1 February	2011
Ms Brooke WITHERIDGE	1 February	2007	1 February (did not reapply)	2010

APPENDIX 4. Council of Official Visitors' Attendance at Meetings

OFFICIAL VISITOR	FULL COUNCIL - 2 meetings		EXECUTIVE GROUP – 8 meetings	
	Present	Apologies	Attended	Apologies
Ms Debora Colvin (<i>Head of Council</i>)	2	0	7	1
Mr Bruce Ambrosius (<i>Passed Away 27/9/2009</i>)	0	0		
Dr Michael Anderson (<i>Resigned 26/2/2010</i>)	1	0		
Ms Sherril Ball (<i>Executive Group Representative – Kalgoorlie</i>)	2	0	6	2
Miss Denise Bayliss (<i>Executive Group Representative to July 2009 – A Group</i>)	2	0	1	0
Ms Helen Bresloff-Barry (<i>Appointed 2 February 2010</i>)	1	0		
Mrs Sharon Briggs	1	1		
Mr Don Cook (<i>Commenced 2 February 2010</i>)	1	0		
Ms Alessandra D'Amico	2	0		
Mrs Marie Davies (<i>Leave as of 31/5/2010</i>)	1	1		
Mr Richard Desouza (<i>Appointed 2 February 2010</i>)	1	0		
Mr Mike Dixon	0	2		
Mr Gerry Doyle ⁸	2	0	4	1
Ms Gillian Evans (<i>Resigned 1/9/2009</i>)	0	0		
Mr Adrian Gavranich (<i>Did not reapply 1/2/2010</i>)	0	1		
Mr Rodney Hay (<i>Executive Group Representative to January 2010 – B Group</i>)	1	1	4	1
Mrs Naka Ikeda (<i>Executive Group Representative from August 2009 – A Group</i>)	1	1	7	0
Ms Kirsten Johnston (<i>Resigned 30/11/2009</i>)	0	0		
Mr Damian Jolly (<i>Leave As Of 1/11/2009</i>)	0	2		
Mrs Denise Kay (<i>Extended Leave</i>)	0	2		
Ms Kelly-Ann Letchford (<i>Appointed 2 February 2010</i>)	1	0		
Mrs Kerry Long	2	0		
Ms Ann McFadyen	1	1		
Ms Edana Mcgrath (<i>Executive Group Representative from February 2010 – B Group</i>)	0	2	4	0
Mrs Melinda Manners ⁸	0	2	2	0
Mr Gary Marsh (<i>Commenced 23 February 2010</i>)	1	0		
Mr Bruce Morrison (<i>Commenced 2 February 2010</i>)	1	0		
Ms Val O'Toole (<i>Deputy Head</i>)	2	0	6	2
Mrs Theresa Piper (<i>Executive Group Representative - Bunbury</i>)	1	1	3	5

Mr Graham Pyke (Appointed 3 December 2009) (Joint Executive Group Representative from February 2010 – Albany)	2	0	2	0
Ms Sheila Rajan	2	0		
Ms Patricia Ryans-Taylor (Appointed 3 December 2009) (Joint Executive Group Representative from February 2010 – Albany)	2	0	2	0
Ms Kelly Spouse ⁸	2	0	2	0
Mr Jeff Solliss	2	0		
Ms Helen Taplin	2	0		
Mrs Judith Taylor (Executive Group Representative to January 2010 - Albany)	1	1	3	2
Mrs Kathryn Toncich	1	1		
Ms Catriona Were – Spice	1	1		
Mrs Leonie Wilson (Focus Area Person)	2	0	7	1
Ms Brooke Witheridge (Did not reapply 11/2/2010)	0	1		
Ms Donna Haney (Executive Officer – commenced 3 August 2009)	2	0	7	0
Ms Cate Wray (A/Executive Officer July, minute taker)	1	0	4	3
Ms Kate Hodges (Minute taker)	1	0		

⁸ The OV has attended an Executive Group meeting as a proxy for another OV.

APPENDIX 5. State Records Commission Compliance Requirements.

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

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

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

An evaluation of the record keeping plan was last completed in 2008-09 and will be completed again in 2010-2011.

2. The organisation conducts a recordkeeping training program.

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

Official Visitors' induction program and Manual includes record keeping requirements.

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

The training program is reviewed annually to ensure its adequacy.

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

The Code of Conduct includes the roles and responsibilities of employees regarding laws and policies.

APPENDIX 6. Authorised Hospital Inspections.

AUTHORISED HOSPITAL	TOTAL NUMBER OF INSPECTIONS (INFORMAL) INSPECTIONS)	TIME OF INSPECTION		
		Weekdays 9am to 5pm	Weekdays 5pm – 9am	Weekends and Public Holidays
Albany Regional Hospital – Mental Health Unit	12 (6)	12 (6)	0	0
Alma Street Centre	48	35	11	2
Armadale Health Service – Leschen Unit	42	33	7	2
Bunbury Acute Psychiatric Unit & Psychiatric Intensive Care Unit	24	24	0	0
Frankland Centre	12	12	0	0
Graylands Hospital	108	97	5	6
Joondalup Mental Health Unit	12	12	0	0
Kalgoorlie Mental Health Unit	12 (15)	9 (12)	3 (3)	0
KEMH – Mother and Baby Unit	12	11	0	1
Mercy Hospital, Ursula Frayne Unit	12	10	1	1
Mills Street Centre	60 (3)	45 (3)	11	4
Selby Lodge	12	11	1	0
Swan Health Service Boronia Unit and Swan Valley Centre	24	22	2	0
TOTAL	390 (24)	333 (21)	41 (3)	16

Note – Informal inspections are provided in brackets.

APPENDIX 7.

Licensed Psychiatric Hostel, Group Homes, CSRU and Community Options Homes Inspections.

LICENSED HOSTEL, GROUP HOME, CSRU AND COMMUNITY OPTIONS HOMES	NUMBER OF INSPECTIONS	TIME OF INSPECTION		
		Weekdays 9am to 5pm	Weekdays 5pm – 9 am	Weekends and Public Holidays
Albany CSRU	6	5	1	0
Arnott Villas CSRU	10	10	0	0
Burswood Psychiatric Hostel	12	9	2	1
Bentley Villas CSRU	9	9	0	0
BP Luxury Care ⁹	3	3	0	0
Casson House	9	8	0	1
Casson - Woodville House	10	10	0	0
Devenish Lodge	11	10	0	1
Franciscan House	12	12	0	0
Fusion – Geraldton CSRU – Ngurra Nganhungu Barndiyigu	6	6	0	0
Honey Brook Lodge	12	12	0	0
Mount Claremont Community Options	7	7	0	0
Ngatti Fremantle Supported Accommodation for Youth Homeless ¹⁰	4	4	0	0
Richmond Fellowship – 56 and 58 Glyde Street, East Fremantle	12	12	0	0
Richmond Fellowship – Mann Way	9	9	0	0
Richmond Fellowship – Queens Park Service	8	8	0	0
Richmond Fellowship – Bunbury CSRU	6	6	0	0
Richmond Fellowship – Busselton CSRU	7	7	0	0
Richmond Fellowship – Kelmscott Community Options	9	9	0	0
Romily House	12	12	0	0
Rosedale Lodge	12	11	1	0
St Jude's Hostel and East Street Lodge	12	11	0	1
Salisbury Home	12	11	1	0
Sunflower Villas ¹⁰	2	2	0	0
Swan Villas ⁹	3	3	0	0
Vincentcare – Bayswater House	7	7	0	0
Vincentcare – Coolbellup House	9	9	0	0
Vincentcare - Duncraig House	9	9	0	0
Vincentcare - South Lakes House	8	8	0	0
Vincentcare - Swan View House	8	7	1	0
Vincentcare – Vincentian Village Woodbridge	10	9	1	0
Vincentcare – Warwick House	9	9	0	0
TOTAL	275	264	7	4

⁹ Ministerial directive received 19 February 2010.

¹⁰ Ministerial directive received 23 March 2010.

APPENDIX 8.

Number of Consumers and Issues by Facility – 2008-2009 and 2009-2010.

FACILITY	NUMBER OF BEDS	NUMBER OF CONSUMERS		NUMBER OF ISSUES ¹¹	
		2009-2010 (% change from 2008-09)	2008-2009	2009-2010 (% change from 2008-09)	2008-2009
Albany Mental Health Unit	9	18 (+ 50%)	12	55 (+ 53%)	36
Alma Street Centre, Fremantle	64	95 (- 1%)	96	305 (- 2%)	311
Armadale Health Service – Leschen Unit	41	72 (+ 9%)	66	194 (- 16%)	231
Bunbury Acute Psychiatric Unit & Psychiatric Intensive Care Unit	27	53 (- 23%)	56	124 (- 19%)	154
Frankland Centre	30	58 (- 19%)	72	189 (- 3%)	194
Graylands Hospital	176	326 (+ 17%)	278	1,081 (+ 0.5%)	1,076
Joondalup Mental Health Unit	42	50 (+ 178%)	18	110 (+ 124%)	49
Kalgoorlie Mental Health Unit	7	9 (+ 50%)	6	24 (+ 300%)	6
KEMH – Mother and Baby Unit	8	3 (- 40%)	5	6 (- 25%)	8
Mercy Hospital - Ursula Frayne Unit	12	11 (+ 175%)	4	35 (+ 192%)	12
Mills Street Centre, Bentley	111	97* (+ 49%)	65	292 (+ 47%)	198
Selby Lodge	48	6 (- 25%)	8	24 (+ 60%)	15
Swan Health Service - Swan Valley Centre and Boronia	40	53 (+ 20%)	44	159 (+ 43%)	111
Metropolitan clinics		22 (- 48%)	42	58 (- 71%)	201
Regional clinics		6 (- 40%)	10	34 (+ 3%)	33
Psychiatric hostels	773	60 (- 1.6%)	61	129 (+ 5%)	122
Other		18 ¹²	7	44 (+ 318%)	18
TOTAL	1,388	957	850	2,863	2,775

¹¹ The “number of issues” was previously termed the “number of requests”. The number of issues is the number of separate complaints by a consumer during one or multiple visits.

¹² Includes 5 involuntary consumers who were being treated at Princess Margaret Hospital.

APPENDIX 9.

Percentage of Authorised Hospital Beds Compared with the Percentage of Inpatient Consumers¹³ by Facility Requesting Visits 2009-2010.

AUTHORISED HOSPITAL	NUMBER OF BEDS	% OF AUTHORISED BEDS	NUMBER OF INPATIENT CONSUMERS WHO REQUESTED A VISIT	% OF INPATIENT CONSUMERS WHO REQUESTED A VISIT
Albany Regional Hospital	9	1.5%	18	2.1%
Alma Street Centre	64	10%	95	11.2%
Armadale Hospital	41	7%	72	8.5%
Bunbury Regional Hospital	27	4%	53	6.2%
Frankland Centre	30	5%	58	6.8%
Graylands Hospital	176	29%	326	38.3%
Joondalup Health Campus – Mental Health Unit	42	7%	50	5.9%
Kalgoorlie Regional Hospital	7	1%	9	1.1%
KEMH – Mother and Baby Unit	8	1%	3	0.4%
Mercy - Ursula Frayne Unit	12	2%	11	1.3%
Mills Street Centre	111	18%	97	11.4%
Selby Lodge	48	8%	6	0.7%
Swan Districts Hospital	40	6.5%	53	6.2%
TOTAL	615		851	

¹³ Excludes consumers living in supported accommodation and attending clinics on CTOs.

APPENDIX 10.
Total Consumers Contacted By Facility -
2004-2005 to 2009-2010.

FACILITY	NUMBER OF CONSUMERS					
	2004 - 2005	2005 - 2006	2006 - 2007	2007 - 2008	2008 - 2009	2009 - 2010
Albany Mental Health Unit	12	14	21	8	12	18
Alma Street Centre, Fremantle	88	107	95	112	96	95
Armadale Health Service – Leschen Unit	36	45	53	80	66	72
Bunbury Acute Psychiatric Unit & Psychiatric Intensive Care Unit	19	26	25	36	56	53
Graylands Hospital – including Frankland Centre	373	352	439	456	350	384
Joondalup Mental Health Unit	19	20	35	18	18	50
Kalgoorlie Mental Health Unit	7	9	12	14	6	9
KEMH Mother and Baby Unit	0	0	0	4	5	3
Mercy Hospital– Ursula Frayne Unit	6	4	6	5	4	11
Mills Street Centre, Bentley	60	130	104	103	65	97
Selby Lodge	2	6	3	5	8	6
Swan Health Service - Swan Valley Centre & Boronia	40	45	45	52	44	53
Metropolitan Clinics	54	58	58	58	42	22
Non – Metropolitan Clinics	13	10	18	23	10	6
Psychiatric Hostels	59	58	57	70	61	60
Other (including Private Practice)	12	7	8	8	7	17
TOTAL	800	891	979	1052	850	957

APPENDIX I I.

Total Consumers Contacted and Issues¹⁴ Raised – 2003-2004 to 2009-2010.

FINANCIAL YEAR	NUMBER OF CONSUMERS	NUMBER OF ISSUES¹⁴
2009 - 2010	957	2,863
2008 - 2009	850	2,775
2007 - 2008	1,052	2,676
2006 - 2007	979	2,257
2005 - 2006	891	1,891
2004 - 2005	800	1,600
2003 - 2004	744	1,415

¹⁴The "number of issues" was previously termed the "number of requests". The number of issues is the number of separate complaints by a consumer during one or multiple visits.

APPENDIX 12A.

Total Consumer Issues¹⁵ by Category.

<p>1. ACCESS - Refers to availability of services in terms of location, waiting times, and other constraints that limit the service.</p>	
<p>1.1 Delay in Admission or treatment Delays occurring after consumer is at the point of service.</p> <ul style="list-style-type: none"> • No beds available (eg held in ED) - see 1.4 for civil consumers being admitted to Frankland • No psychiatrist available to admit a consumer (as distinct to a delay in treatment once admitted or those items covered under 1.4) • The length of time taken for a psychiatrist to attend triage to admit a consumer is not acceptable 	0
<p>1.2 Waiting list delay Unreasonable wait for elective surgery, lack of review if a case becomes acute, further postponement after a date has been set.</p> <ul style="list-style-type: none"> • Delay in referring to Medical Specialist or Doctor • Delays in scheduling required surgery • Delay in seeing dentist, podiatrist, dietician or other allied health personnel 	6
<p>1.3 Non-attendance Provider fails to keep an agreed appointment, or to attend to give emergency treatment.</p> <ul style="list-style-type: none"> • Request to see a psychiatrist does not eventuate in a timely fashion (via ward list, nursing staff etc.) • Medical doctor did not attend to injury/medical concern 	4
<p>1.4 Inadequate or no service Resource complaints about inadequacy or lack of service.</p> <ul style="list-style-type: none"> • No beds available in civil wards, admitted to Frankland • Put on mattress on floor • Boarded in medical wards overnight, using Mental Health Unit during the day • Being sent on extended leave due to shortage of facilities/resources • No psychiatrist available (as distinct from a delay). For example, when there is only fly-in fly-out psychiatric services • No allied health professionals available (eg psychologist, social worker, welfare officer) – as distinct from delay • Inadequate services provided during seclusion (eg providing drinks, toilet facilities, blanket) • Lack of recreational/OT services • Inadequate access and frequency of visits of treating personnel • Lack of trained personnel to administer certain injections (eg insulin) – this applies to hostels • Not assisting consumers in their recovery (eg assisting to gain employment, referral to appropriate services) • Delay in seeing medical practitioner, or allied health staff after requesting to see them 	32
<p>1.5 Refusal to admit or treat Refusal by a hospital/health service to admit a patient/consumer or by a provider to accept a patient/consumer for treatment.</p> <ul style="list-style-type: none"> • Requests for admission refused (would normally be a complaint from consumer on CTO) because there were no beds available (as distinct from a delay) • Refused admission (ie sent home) - as distinct from having to be accommodated in ED until a bed was available • Hostel/group homes - refused accommodation due to reputation of past behaviour 	4
<p>1.6 Discharge or transfer arrangements Premature discharge from treatment, inadequate discharge planning or lack of continuity of care.</p> <ul style="list-style-type: none"> • Does not feel well enough to be discharged from hospital • Feels insecure in being discharged – inadequate discharge planning • Has not been introduced to treating team at clinic prior to discharge • Does not feel he/she has the skills to cope with being discharged • Does not feel comfortable about going to a Clinic, not knowing new treating staff • Moved from one hospital to another against consumer's will • Refusal to transfer consumer to hospital of choice 	106

¹⁵The “number of issues” was previously termed the “number of requests”. The number of issues is the number of separate complaints by a consumer during one or multiple visits.

<p>1.7 Access to transport All ambulance and patient/consumer transit complaints should be listed here, including inter-hospital/health service transfers and family travel problems.</p> <ul style="list-style-type: none"> • Has/had to pay own ambulance costs • Unable to access RFDS when required • Hostel/group home residents – difficulty getting to health, OT, MHRB etc. related appointments • Hostel/group home residents - difficulty getting to work, rehabilitation, church and other activities 	4
<p>1.8 Physical access/entry An impediment to entry to a hospital/health service because of inadequate lighting, signage, distance, ramps or public transport accessibility.</p> <ul style="list-style-type: none"> • Consumers accommodated in inappropriate wards because of physical disabilities • Hostel/group home issues for physically disabled people 	0
<p>1.9 Parking Inadequate, short term, discharge, visitors, external health provides, disabled parking.</p> <ul style="list-style-type: none"> • No parking for consumer's car whilst in hospital 	0
Subtotal (TOTAL)	156

2. COMMUNICATION - Refers to the quality and quantity of information provided about treatment, risks and outcomes.	NUMBER
<p>2.1 Inadequate information about treatment options Insufficient information provided to a patient/consumer on prognosis and options for treatment. Use 'failure to consult patient/consumer' when the issue is one of decision making rather than information provision.</p> <ul style="list-style-type: none"> • Not given any information/explanation of medications prescribed • Has not been informed of any other treatment options 	41
<p>2.2 Inadequate information on services available Lack of discussion between provider and patient/consumer on which services are available.</p> <ul style="list-style-type: none"> • Has not been informed of access to a psychologist • Has not been informed of OT alternatives • Has not been informed about Religious Services, access to pastor/priest etc. • Has not been informed about the process on how to vote in a State or Federal election 	14
<p>2.3 Misinformation or failure in communication Wrong, confusing or misleading information (but not 'failure to consent').</p> <ul style="list-style-type: none"> • Unable to understand what the doctor is saying (eg doctor has poor English skills) • Consumer unsure about their diagnosis/insufficient information provided about diagnosis • Didn't understand generally what they were told about treatment etc. • Not given the reason for the treatment or admission to hospital • Breach of CTO because of misunderstanding of the conditions under a CTO 	30
<p>2.4 Failure to fulfil statutory obligations (Note: this item deals with information about rights. See also 9.5 which deals with breaches under the Mental Health Act) Failure to comply with the requirements of the Mental Health Act (1996) in respect of provision of information about rights, documentation about involuntary status and other legislation.</p> <ul style="list-style-type: none"> • Has not received a Form 6, 9 etc. • Has not received a copy of Property Report • Rights have not been explained • Has not been given a copy of Rights • Not informed about COOV, MHLC or MHRB • Was not informed of their right of access to another psychiatrist for a second opinion 	3

<p>2.5 Access to records Restriction or refusal of access to information in any personal health record.</p> <ul style="list-style-type: none"> Request for medical records via s160 refused or taken too long (including being refused because of doctor's opinion that it may have an adverse effect on consumer or others) Request for medical records via FOI refused or taken too long Refused access to CCTV tape (eg to ascertain if consumer was injured whilst in seclusion) 	6
<p>2.6 Inadequate or inaccurate records Personal information in a health record held by a hospital/health service is incomplete or inaccurate.</p> <ul style="list-style-type: none"> Consumer alleges incorrect information in their medical records (often raised in preparation of MHRB hearings. substantial, list under this category as a separate entry as well as 9.1 for a MHRB application) 	1
<p>2.7 Failure to provide interpreter Lack of information about right to an interpreter, lack of availability of interpreter, or lack of assistance to make arrangements for interpreter to attend when required.</p> <ul style="list-style-type: none"> Staff used instead of an independent interpreter Relatives used instead of an independent interpreter (for MHRB hearings etc.) COV used instead of an independent interpreter Failure to provide an interpreter for the parent of a child 	2
<p>2.8 Certificate or report problem Failure to provide a correct certificate or report. Claims that a provider/hospital/health service has falsified a certificate, or failed to certify in accordance with the law. Failure to pass on information.</p> <ul style="list-style-type: none"> Unable to read photocopy of Forms provided (bad photocopying) Photocopy of forms seem to have been tampered with No end of detention date on Form 	1
Subtotal (TOTAL)	98

3. DECISION MAKING - Refers to the consultation with the consumer in the decision making process	NUMBER
<p>3.1 Failure to consult consumer Lack of discussion and consultation by the provider with the patient/consumer in the decision making process.</p> <ul style="list-style-type: none"> Psychiatrist not seeing consumer for weeks – relying on opinions of Medical Officer, nurses 	19
<p>3.2 Consent not informed Failure to provide sufficient information so that the patient/consumer can make an informed decision about treatment.</p> <ul style="list-style-type: none"> A person with a learning disability/brain injury consenting (not informed) to treatment without knowing the full repercussions Consent obtained when unwell (eg in hostel) 	0
<p>3.3 Consent not obtained (most likely to apply to hostels residents or voluntary consumers because informed consent is not necessary for involuntary consumers).</p> <ul style="list-style-type: none"> Failure to obtain informed consent Consumer being forced to take medication against their will Medication requiring consent (eg Clozapine) not obtained 	0
<p>3.4 Private/public election Classification as a private rather than public patient/consumer, or failure of a hospital/health service to explain options for choice of status, or confusion between fee-for-service and public status.</p> <ul style="list-style-type: none"> Consumer not being told that they can be transferred to a private psychiatric hospital (fee for service. If not covered privately, possibly some cost) 	1

<p>3.5 Refusal to refer or assist to obtain a second opinion Refusal by provider to refer patient/consumer to another provider. Lack of information about right to a second opinion, and/or refusal by a provider to assist patient/consumer to make arrangements for a second opinion. (Note: see also 9.3 where a consumer requests assistance to ask for a second opinion. 9.3 deals with the problems which can arise after second opinion has been requested by or on behalf of the consumer).</p> <ul style="list-style-type: none"> • Informed (wrongly) that requests for a Second Opinion have to be in writing • Requests for a Second Opinion refused • Refusal of a request for a Second Opinion from another psychiatrist who is not employed by the mental health service who is providing care and treatment for the involuntary patient (Clinician's Guide 5.2.4) • Delay in providing second opinion (on the basis that it is in effect a refusal to assist) 	7
Subtotal (TOTAL)	27

4. QUALITY OF CARE - Refers to diagnosis, testing, medication, and other therapies provided	NUMBER
<p>4.1 Inadequate diagnosis Condition or injury has been missed, overlooked, wrongly identified or diagnosis is inadequate.</p> <ul style="list-style-type: none"> • "I want to go home – I shouldn't be in here" To be used where the consumer says they do not have a mental illness and should not be in the hospital or should not be involuntary. If they ask for a MHRB application then put it under that heading instead (9.1) • Non psychiatric medical condition not identified/diagnosed 	195
<p>4.2 Inadequate treatment Insufficient use of therapy of choice but not 'negligent treatment' or 'incompetent treatment'.</p> <ul style="list-style-type: none"> • Insufficient medication provided • Medication of choice denied (eg cheaper drug used) • PRN not provided when asked for • Refusal of medication for other health conditions usually provided by private GP • Consumer's request to be transferred to an open ward denied • Denying access to counselling, access to psychologist (Note: not due to resources issues where item 1.4 should be used) 	101
<p>4.3 Rough treatment Roughness or unnecessary pain inflicted during an examination or treatment.</p> <ul style="list-style-type: none"> • For eg when put into seclusion • For eg when admitted • For eg when given PRN 	12
<p>4.4 Incompetent treatment Clumsy unskilled or substandard performance of a treatment, but not alleging negligence in the legal sense.</p> <ul style="list-style-type: none"> • Being put into seclusion too often and without attempting alternatives • Being refused access to phone or visitors too often or improperly ie abuse of the power under Act (use if the proper paperwork is in place – if it isn't then list under 9.5) • Being moved between secure and open wards as a form of behaviour management • Being denied ground access as a form of behaviour management • Won't allow access to pens or paper; holding onto sunglasses or books in the nurses station 	65
<p>4.5 Negligent treatment Explicit allegations of legal liability (distinguish from 'incompetent treatment').</p> <ul style="list-style-type: none"> • Given wrong medication (such as where the file noted that there were significant negative side effects to a drug, but this has been ignored) • Where a drug was required, but not given • Where consumer sustained a reasonably serious injury (eg when being put into seclusion and requiring hospitalisation) but consumer was ignored and not treated for many hours) 	19
<p>4.6 Wrong treatment</p>	45
Subtotal (TOTAL)	437

5. COSTS - Refers to information about costs and fee structures	NUMBER
5.1 Inadequate information about costs <ul style="list-style-type: none"> Not enough information was offered prior to treatment, or the information was partial or misleading 	0
5.2 Unsatisfactory billing practice <ul style="list-style-type: none"> Item numbers used in a disadvantaging way, extra fees for services normally included in a global fee, unreasonable penalties for late payment, refusal to consider financial circumstances, etc. 	0
5.3 Amount charged <ul style="list-style-type: none"> The size of a fee or account. 	0
5.4 Over servicing Too frequent visits, ordering of unnecessary tests, recurrent brief bulk-billed visits to hostels, etc. <ul style="list-style-type: none"> Coerced into having blood tests 	3
5.5 Private health insurance <ul style="list-style-type: none"> All complaints about private health insurance and claim handling. 	0
5.6 Lost property and/or reimbursement Failure to acknowledge loss, replacement or reimbursement of property. Unsatisfactory facilitation of the reimbursement process. Unsatisfactory process for maintaining patient/consumer property. <ul style="list-style-type: none"> Failure to assist in searching for lost property Report to nurses of lost property and nothing done 	14
Subtotal (TOTAL)	17

6. PRIVACY / CONSIDERATION / DISCOURTESY - Refers to the individuals right to be treated with respect and dignity	NUMBER
6.1 Inconsiderate service/lack of courtesy Rudeness, discourtesy, negative attitude, and a patronising or overbearing manner. Includes complaints about lack of politeness, kindness and courtesy. <ul style="list-style-type: none"> Talking to other consumers or staff about a consumer in a derogatory manner (not breaching confidentiality) Won't allow access to pens or paper; holding onto sunglasses or books in the nurses station (usually on the grounds of safety, but we would say it is really negative attitude and lack of caring etc.) Staff ignoring consumers 	22
6.2 Absence of caring A lack of regard or consideration of the patient/consumer and their circumstances. <ul style="list-style-type: none"> Not taking cultural issues into consideration (excluding diet – see 8.2) Provision not made for those in married or de facto relationships Insufficient instruction on contraception and STDs Forming of intimate relationships discouraged Unable to entertain friends (especially opposite sex) in hostel, group homes, bedroom Restrictions on access to menstrual products Insufficient time to form relationship with psychiatrist, nursing staff (relates to staff turnover, moving from wards to a different treating team) Lack of/inadequate access to children (not DCP issue) Moving consumers from ward to ward too frequently Moving consumers at an inappropriate hour 	17
6.3 Failure to ensure privacy Lack of personal privacy, failure to offer appropriate clothing/cover, demeaning or humiliating treatment. <ul style="list-style-type: none"> Punitive treatment to resolve an issue (had to sit in a corner facing the wall) Clothing removed when in seclusion Personal clothing not provided Inappropriate clothing supplied No privacy curtains in shared bedroom No privacy curtain on window in bedroom door 	2
6.4 Breach of confidentiality Provision of information to a third party without consent. <ul style="list-style-type: none"> Disclosing personal information to others (excluding staff) without consent. This includes talking to staff where others can overhear 	4

6.5 Discrimination Less favourable health treatment on one of the civil grounds (race, sex, age, religion, colour) in anti-discrimination law or covenant.	0
6.6 Discrimination of public consumer Public patient/consumer treated less favourably than private patient/consumer. <ul style="list-style-type: none"> Private patients receiving more services than public patients (eg seeing psychiatrist or receiving OT daily when public patient doesn't) 	0
6.7 Sexual impropriety Behaviour such as gestures or comments that are sexually demeaning to a patient/consumer. <ul style="list-style-type: none"> Sexual harassment by staff or another patient 	1
6.8 Sexual transgression or violation Any touching of a sexual nature and any sexual relationship with a patient/consumer whether or not initiated or consented to by the patient/consumer.	4
6.9 Assault Physically aggressive or violent actions (use 'sexual transgression or violation' for sexual assault).	14
6.10 Unprofessional conduct Unethical actions or failures of professional responsibility affecting health rights (except sexual transgression or violation). <ul style="list-style-type: none"> Individual nurse taking out Violence Restraining Order against a consumer and hence cannot care for patient Staff smoking on grounds in front of or near to consumers Unprofessional conduct against OVs (eg telling them to leave, talking to them rudely) 	0
Subtotal (TOTAL)	64

7. GRIEVANCES - Refers to the individual's right to have timely and fair management of the complaint	NUMBER
7.1 Inadequate response to a complaint Inadequate or non-existent response to a complainant. Use 'Reprisal following a complaint' when action is taken against the complainant.	2
7.2 Reprisal following a complaint Any action causing detriment to a patient/consumer as a result of the complaint, or disadvantage in employment for staff who give information about a complaint. <ul style="list-style-type: none"> Nurse refusing to work with a consumer after a complaint has been made 	1
Subtotal (TOTAL)	3

8. OTHER - Refers to Administrative (rather than treatment) actions of a hospital/health service.	NUMBER
8.1 Administrative practice Administrative (rather than treatment) actions of a hospital/health service. <ul style="list-style-type: none"> Smoking ban issues/complaints Consumers wanting to return to prison so that they can smoke Delay in providing written response to COV letters 	71

<p>8.2 Catering Unsatisfactory provision of food services, food selection and failure to involve the patient/consumer in decision on preferences that complement treatment.</p> <ul style="list-style-type: none"> • Dietary needs not considered (cultural needs, vegetarian etc.) • Food unappetising • Food presentation is lacking • No changes in the menus • No input in menu design • Food available has adverse effect related to medication • Meal served was not the one ordered (or for Hostels, not on the menu) • Requests for particular food not provided (brown bread not white) • Not sufficient quantities of food 	14
<p>8.3 Facilities Inadequate provision of space and facilities for patient/consumer and their belongings. Unsafe equipment, noise, inadequate lighting and temperature control.</p> <ul style="list-style-type: none"> • Not enough space provided for belongings • Furniture not in good condition • No heating, bedrooms freezing cold etc. • Lack of air-conditioning, air-conditioning not working properly • Lumpy mattress, not enough blankets • TV not working • Inadequate shelter to cater for inclement weather (eg patios) 	8
<p>8.4 Security Inadequate security measures for patient/consumer, visitors and staff relating to People, Personal belongings.</p> <ul style="list-style-type: none"> • No lockable wardrobe • Fear of other consumers on the ward (standover tactics, threats of violence) 	3
<p>8.5 Cleaning Inadequate provision and maintenance of a clean environment.</p> <ul style="list-style-type: none"> • Toilets not clean • Ward has not been cleaned • Outside areas need cleaning (brick paving needs steam cleaning) • Nurses did not attend to mess in toilet cubicle 	1
<p>8.6 Fraud/illegal practice Claim that a provider has tried to make a profit dishonestly, or gain an unjust financial advantage, or become a beneficiary of a vulnerable person's will, or commit Medicare fraud.</p> <ul style="list-style-type: none"> • Eg hostel owners, Murchison staff wrongly withholding monies • Assisting consumer to contact MHLC or Legal Aid re: legal issues other than MHRB hearings • Assisting consumer to contact DCP 	11
Subtotal (TOTAL)	108

9. MENTAL HEALTH ACT 1996	NUMBER
<p>9.1 Mental Health Review Board Application Consumer requests for:</p> <ul style="list-style-type: none"> • Information regarding MHRB • Assistance to make MHRB application • Assistance with preparing for MHRB hearing • OV lodging application on behalf of consumer 	350
<p>9.2 Mental Health Review Board Attendance (Note: items other than MHRB attendance are also listed under this heading where they arise out of the hearing such as incorrect information on the file or failure to provide an interpreter) which is why this figure is different to the actual attendances recorded</p> <ul style="list-style-type: none"> • Official Visitor attendance at MHRB hearing with consumer 	281
<p>9.3 Second Opinion Request (not 3.5) Request for assistance to obtain second opinion, including information regarding the process (Note; item 3.5 deals with the situation when the request has been refused or not acted upon).</p>	103

9.4 Mental Health Act 1996 Information Covers all areas of MHA	52
9.5 Mental Health Act 1996 Non - Compliance (not 2.4) Complaints related to actions taken without the appropriate authorisations required by the Mental Health Act 1996 (eg restriction of visitors, telephone calls, use of seclusion). <ul style="list-style-type: none"> Failure to provide access to phone/post in breach of ss 166/167 of the MH Act (if access has been denied – check to see if properly denied – if it has been denied properly in accordance with the MH Act, but it is believed that it is being abused or used wrongly, then list under 4.4) Failure to allow visitors in breach of MH Act (as per phone access) Failure to provide toilet facilities while in seclusion in breach of s120 Any failure to comply with the requirements of the MH Act in relation to seclusion, mechanical restraint or ECT Being held as involuntary after expiry date/time of form (eg Form 1,3 etc) 	5
9.6 SAT Appeal Application/Process Consumer requests for: <ul style="list-style-type: none"> Help in getting reason for MHRB decision Information regarding SAT appeal of Mental Health Review Board decisions Assistance to make SAT appeal application Attending SAT hearing to challenge MHRB decision 	11
9.7 SAT (review of MHRB) Attendance	3
Subtotal (TOTAL)	805

10. CRIMINAL LAW (MENTALLY IMPAIRED ACCUSED) ACT 1996	NUMBER
10.1 Mentally Impaired Accused Review Board <ul style="list-style-type: none"> Attendance at a MIDRB 	9
Subtotal (TOTAL)	9

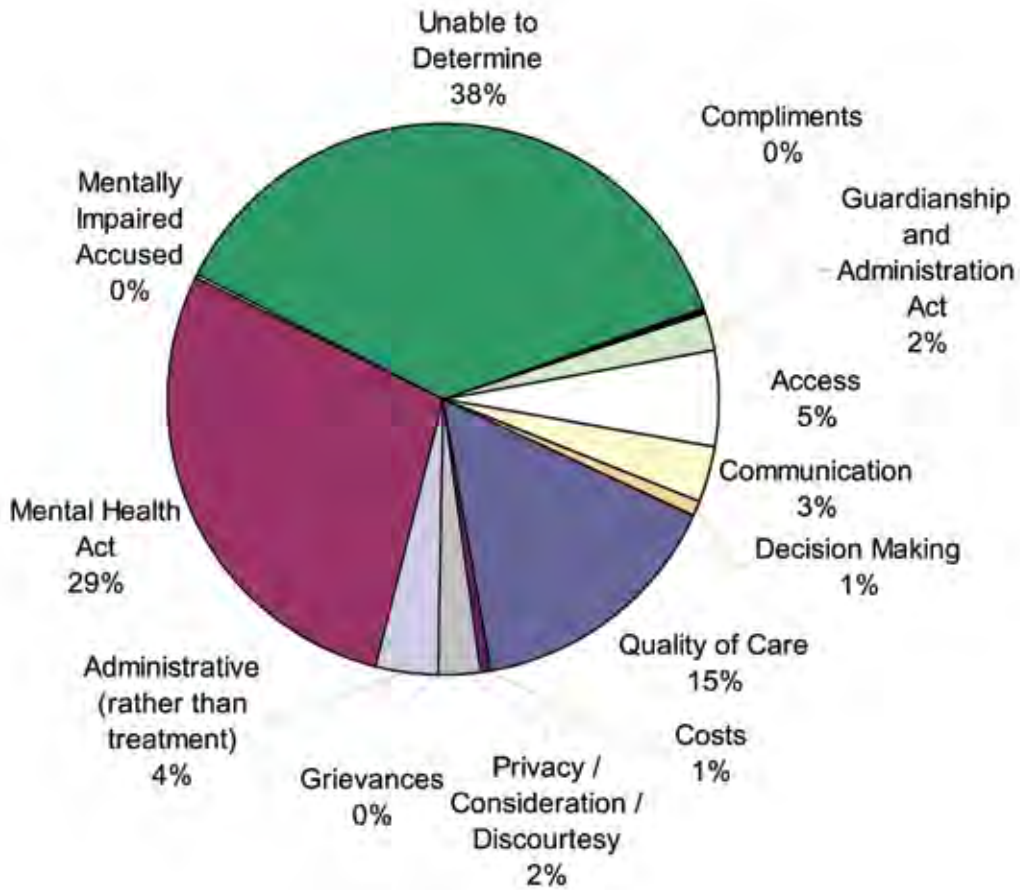
11. UNABLE TO BE DETERMINED	NUMBER
11.1 Unknown request either illegible or not able to be determined	1070
Subtotal (TOTAL)	1070

12. COMPLIMENTS	NUMBER
12.1 Compliments General <ul style="list-style-type: none"> A compliment received through the Mail Boxes or when a consumer specifically states that (s)he wants staff to know of a compliment 	5
Subtotal (TOTAL)	5

13. GUARDIANSHIP AND ADMINISTRATION ACT 1990	NUMBER
13.1 Information on processes Consumer request for information regarding Guardianship and Administration orders and/or applications for such through the State Administrative Tribunal (SAT).	22
13.2 SAT Attendance (Guardianship & Administration Act) Official Visitor attendance at SAT (Guardianship and Administrative) hearing with consumer.	5
13.3 Public Trustee <ul style="list-style-type: none"> • Consumer request for assistance and / or information regarding management of finances by the Public Trustee. • Consumer does not want to have finances managed by the Public Trustee • Consumer would like another to manage finances 	36
Subtotal (TOTAL)	63

APPENDIX 12B.

Percentage of Consumer Issues¹⁶ by Category – 2009-2010.



¹⁶“Issues” was previously termed the “requests”. Issues are separate complaints by a consumer raised during one or multiple visits.

APPENDIX 13.
Council of Official Visitors Strategic Plan - 2010 - 2011
(as accepted by FCM on 25 June 2010)

VISION/STATEMENT OF PURPOSE:

To protect and promote the rights and quality of life, and advocate for and on behalf, of affected persons (as defined by the Mental Health Act 1996) using mental health services in Western Australia

GOAL 1 - MHRB	
To improve the Mental Health Review Board (MHRB) process for consumers.	
STRATEGIES	Measures of implementation
1.1 Continue to review and provide feedback on the MHRB process to the Minister, Mental Health Commission (MHC), MHRB and relevant others to improve the reported problems with the process including advocating for, and taking part in, a review of the MHRB process and provisions as per the report and recommendation made by Head of Council (HOC) in May 2010.	<ol style="list-style-type: none"> 1. HOC to maintain liaison and keep raising issues with the MHRB, MHC and Minister. 2. Official Visitors (OV's) to report cases to HOC where issues have arisen that should be brought to the attention of the MHRB or others. 3. Council to take part in a review, if conducted, of the MHRB process and provisions.
1.2 Continue to promote and offer OV representation in MHRB hearings to consumers via various means.	<ol style="list-style-type: none"> 4. OV groups to consider how they can better identify people coming up for a MHRB review (for example by getting access to the ward diary or ward clerk and/or to make arrangements with the hospital to get such access as has been done at Graylands and offered by Armadale). 5. OVs to seek to identify and speak to all consumers who have a review hearing scheduled and to offer assistance in the hearing. 6. Executive Officer (EO) to monitor and report to all Executive meetings on the number of consumers who sought and received representation by OVs at MHRB hearings.

<p>1.3 Continue to trial joint Mental Health Law Centre (MHLC) and COV attendance at selected hearings (with approval by HOC or the EO) to see if it improves the quality of hearings and decisions from the consumer's perspective.</p>	<ol style="list-style-type: none"> 7. Continue to trial joint attendance at MHRB hearings with MHLC. 8. Executive to consider at its August or September 2010 meeting the current parameters of the trial. 9. Copies of the consumer reports by OVs where there has been joint attendance will be provided for consideration by the Executive Group. 10. Prior to 30 June 2011, an assessment of the value of joint MHLC and OV attendance, including the budget and other implications and whether joint attendance should be limited by guidelines, be conducted by the Executive Group. 11. Assuming the review concludes that joint attendance is worthwhile and can be justified but should be limited to certain types of cases, guidelines be drafted by the Executive Group to determine the cases which warrant joint attendance. 12. Council to consider at its June 2011 Full Council Meeting whether to adopt the joint attendance guidelines.
<p>1.4 Continuing education for OVs be provided on how best to support consumers at MHRB hearings.</p>	<ol style="list-style-type: none"> 13. Continuing Education sessions conducted including focussing on preparation for hearings and debriefing after.
<p>1.5 Trial a template letter for use by consumers to present to the MHRB as in Queensland with a view to empowering consumers in the MHRB process.</p>	<ol style="list-style-type: none"> 14. Draft template to be devised based on the Queensland version. 15. OVs to survey consumers to see if they would be interested and how easy it is to use and report back to the EO for consideration by the Executive Group. 16. Assuming the template is considered worthwhile, HOC to speak to the MHRB to ask how they would view such a letter.
<p>1.6 Monitor and report on the number of MHRB hearings being cancelled within 24 hours and consumers being made voluntary but required to stay in hospital against their wills alternatively being made involuntary again shortly afterwards.</p>	<ol style="list-style-type: none"> 17. OVs to report cases to EO who will collate numbers and report to Executive.

<p>1.7 Consideration be given to encouraging consumers to apply under s160 for access to their file prior to MHRB hearings and OVs to report back on the ease of use of this process. (This is in anticipation of a review of the MHRB process and HOC's submission that the Act should be amended in accordance with the Victorian Mental Health Act where consumers have ready access to their files.)</p>	<p>18. OVs to consider suggesting to consumers that they make a s160 application prior to their MHRB hearing (including assisting with the making of the application).</p> <p>19. OVs to report to the EO on such applications including as to the time taken to get access, and in particular whether it was provided prior to the MHRB hearing, the amount of the file that has been censored, any difficulties consumers have had in obtaining access and any other issues arising.</p> <p>20. The EO to determine what information is needed and how best to collect and collate the information on the ease of use of s160 process and advise OVs.</p> <p>21. HOC to advise OVs on how the process works in other states and to draft a report on the COV experience of the s160 process with a view to COV making a decision whether to always recommend s160 applications prior to MHRB hearings.</p>
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GOAL 2 - SUPPORTED ACCOMODATION
To improve the standards, safety and suitability of licensed hostels, group homes, Community Supported Residential Units and Community Options housing.

STRATEGIES	Measures of implementation
<p>2.1 Continue to visit selected “hostels of concern” monthly with designated “campaign” OV team leaders endeavouring to work firmly but closely and collaboratively with hostel licensees.</p>	<p>1. “Hostels of concern” be identified and designated from time to time by OVs in consultation with HOC and the EO.</p> <p>2. The campaign team leaders to keep their group, EO and HOC informed on the progress of the campaign.</p> <p>3. HOC and the EO to visit the licensee and raise the issues with the MHC, Licensing Standards Review Unit (LSRU) or Office of the Chief Psychiatrist (OCP) as appropriate.</p>
<p>2.2 Conduct detailed inspection(s) and liaise and attempt to work with all licensees in an effort to improve standards.</p>	<p>4. Inspections conducted and issues identified.</p> <p>5. OV teams or HOC to meet with licensees to discuss inspection findings at least once per year.</p> <p>6. HOC to meet with the Hostel Owners Association and NGOs at least once a year.</p>

<p>2.3 Executive Officer to write to licensees offering to host information presentations or attend residents' meetings at hostels and group homes.</p>	<p>7. Presentations offered</p> <p>8. Presentations conducted</p>
<p>2.4 To continue advocating for an improvement in the standards and regulation of the hostel sector and the need for a review of the LSRU standards.</p>	<p>9. HOC to continue talking to the MHC, LSRU and OCP re COV concerns.</p>
<p>2.5 OVs to be trained in the "new" OCP standards</p>	<p>10. Training conducted.</p>
<p>2.6 An analysis of the eviction rates and process from CSRUs and Community Options houses be conducted to consider if consumers' dignity and rights are being upheld.</p>	<p>11. Information regarding evictions (collected in June 2010) be collated and reported on.</p> <p>12. Executive group to consider what further action, if any needs to be taken.</p>

GOAL 3 - LIFE AND CARE ON THE WARDS AND IN SUPPORTED ACCOMODATION - BOREDOM AND RESPECT FOR DIGNITY

To improve the quality of life and care on authorized hospital wards and in hostels in accordance with consumers having the best care and treatment with the least interference with their rights and dignity (s5 of the Act).

<p>STRATEGIES</p>	<p>Measures of implementation</p>
<p>3.1 To survey and report on boredom on the wards and in hostels ie lack of activities and freedom including:</p> <p>3.1.1 access to physical activities;</p> <p>3.1.2 access to rehab, educational and other services;</p> <p>3.1.3 access to computers.</p>	<p>1. Focus Area Person (FAP) to prepare questions in relation to each area for monthly inspections with input from Executive and collate OV findings.</p> <p>2. A Position Statement on access to computers be finalised and agreed on by Council.</p>
<p>3.2 Consideration be given to how Council can assess and report on dignity issues.</p>	<p>3. Executive to consider whether it is appropriate for FAP to prepare a focus area on this issue for a monthly inspection by OVs.</p> <p>4. OVs to make a point of noting all inappropriate staff attitudes and to raise them with senior management and where appropriate HOC.</p>

<p>3.3 OVs to seek to increase the level of involvement by consumers in their Management plans.</p>	<p>5. OVs to make it a practice of talking to consumers about their management plans – asking to see them, asking if the patient can see them and offering to take part in treatment team meetings where management plans are being discussed/agreed.</p> <p>6. FAP to draft questions re the level of involvement of patients in management plans and this to be compared with the answers in 2010.</p>
<p>3.4 The use of care plans by hostels and the involvement of consumers in the plans be monitored and reported on.</p>	<p>7. FAP to prepare questions and collate answers.</p> <p>8. OVs to make it a practice of talking to consumers about their care plans – asking to see them, asking if the resident can see them and offering to take part in team meetings where care plans are being discussed/agreed</p>

GOAL 4 – GETTING BACK INTO THE COMMUNITY

To monitor, improve and raise the emphasis on consumers’ rights to receive the best care and treatment with the least restriction of their freedom (s5 of the Act) and in particular early and safe discharge to, and support in, the community.

<p>STRATEGIES</p>	<p>Measures of implementation</p>
<p>4.1 To survey and report on:</p> <p>4.1.1 the discharge process for patients including patients’ knowledge of and input into discharge plans;</p> <p>4.1.2 access to rehabilitation services on the wards and made available to people on CTOs or resident in hostels;</p> <p>4.1.3 access to housing and the extent to which housing issues continue to delay discharge; and</p> <p>4.1.4 the lack of step-down facilities in country areas.</p>	<p>1. FAP to draft relevant questions for inspections to be considered by Executive.</p> <p>2. OVs to report back following inspections raising the issues and FAP to collate answers and report back to Executive.</p> <p>3. OVs to report all cases they become aware of where housing is causing a delay in the consumer being discharged or made voluntary to the EO.</p> <p>4. Country OVs to report on lack of step-down facilities and the impact of this.</p> <p>5. HOC to consider the information provided by OVs and if appropriate to draft a report on access to Housing .</p>
<p>4.2 Clinics be surveyed regarding services availability for people on CTOs.</p>	<p>6. Survey to be drafted and sent to clinics and responses collated.</p>
<p>4.3 Executive to consider other ways that Council can provide better support to people on CTOs.</p>	<p>7. Executive members canvass OVs and report back and discuss at Executive meeting</p>