

# Council of Official visitors



Annual report 1999 – 2000

*Artwork produced through the Creative Expression Unit at Graylands Hospital.  
Front Cover painting (centre) by Roch Dziewaltowski-Gintowt.  
Background and boarder paintings by Craig Wood.*

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

Dear Minister

In accordance with section 192(3) of the *Mental Health Act 1996* I submit for your information and presentation to Parliament the Annual Report of the Council of Official Visitors for the financial year ending 30th June 2000.

As well as recording the operations of the Council for the 1999 - 2000 year the report once again reflects on some of the trends and issues affecting consumers of mental health services in Western Australia.

Yours sincerely



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Stuart Flynn

HEAD  
COUNCIL OF OFFICIAL VISITORS

# CONTENTS

	Page No.
1. INTRODUCTORY REMARKS .....	1
2. LEGISLATIVE FRAMEWORK.....	2
3. WHO ARE THE OFFICIAL VISITORS?.....	2
4. ROLE AND METHOD OF OPERATION.....	2
5. ADMINISTRATIVE ISSUES .....	5
5.1 APPOINTMENT OF OFFICIAL VISITORS .....	5
5.1.1 Council Composition 1999 - 2000.....	5
5.2 ACCOMMODATION .....	6
5.3 STAFFING .....	6
5.4 BUDGET.....	6
5.4.1 Remuneration .....	6
5.4.2 Expenditure.....	7
6. THE ACTIVITIES OF THE COUNCIL DURING 1999 - 2000 .....	7
6.1 FACILITY INSPECTION VISITS .....	8
6.1.1 Facility Inspection Visit - Statutory Requirements.....	8
6.1.2 Summary of Issues raised .....	11
6.2 CONSUMER VISITS AND CONTACTS.....	12
6.2.1 Requests .....	12
6.2.2 Summary of Issues raised .....	15
6.3 POLICY DEVELOPMENT AND ADVOCACY .....	20
6.3.1 Position statements.....	21
6.3.2 Submissions.....	22
6.4 QUALITY ASSURANCE .....	23
6.4.1 Complaints regarding Council Operations .....	23
6.4.2 Customer Survey.....	23
6.5 OTHER ACTIVITIES.....	24
6.5.1 Communications Strategy .....	24
6.5.2 Presentations to Community Groups.....	24

7. MAJOR ISSUES.....	25
7.1 MAJOR ISSUES RAISED DURING 1998 - 1999 AND STILL	
AWAITING SATISFACTORY RESOLUTION .....	25
7.1.1 Limitations on the Role of the Council.....	25
7.1.2 Planning Rations and Bed Availability - Adult Authorised Hospitals .....	28
7.1.3 Office of the Chief Psychiatrist and Metropolitan Health Service Board .....	29
7.1.4 "Search the Person" .....	30
7.1.5 Lack of Standards in Licensed Private Psychiatric Hostels .....	31
7.1.6 Support Services to Residents of Licensed Private Psychiatric Hostels.....	32
7.1.7 Consumers with Dual Disabilities .....	32
7.1.8 Duty of Care in Authorised Hospitals.....	33
7.1.9 Second Opinions - <i>Mental Health Act 1996</i> , sections 111 & 164(2) .....	33
7.1.10 Consumer Access to Personal Records - <i>Mental Health Act 1996</i> , sections 160 & 161 .....	35
7.1.11 <i>Criminal Law (Mentally Impaired Defendants) Act 1996</i> .....	36
7.2 MAJOR ISSUES IDENTIFIED DURING 1999 - 2000 .....	37
7.2.1 Mechanical Bodily Restraint - <i>Mental Health Act 1996</i> , Division 9 sections 121-124.....	37
7.2.2 Voluntary Patients Detained in Secure Units.....	39
7.2.3 Medical Treatment may be approved by the Chief Psychiatrist - <i>Mental Health Act 1996</i> , section 110 .....	41
7.2.4 Staff/Facility Compliance with <i>Mental Health Act 1996</i> .....	42
7.2.5 Planning Ratio and Bed Availability - Adolescents' Access to Age Appropriate Services .....	45
7.2.6 Security of Consumers' Belongings .....	46
7.2.7 Access to Culturally Appropriate Services .....	47
8. PRIORITIES FOR 2000 - 2001.....	48
APPENDICES.....	50
APPENDIX 1A - Authorised Hospitals.....	50
APPENDIX 1B - Licensed Private Psychiatric Hostels .....	51
APPENDIX 2 - Council of Official Visitors.....	52

## INDEX OF TABLES & CHARTS

	Page No.
Table One ATTENDANCE AT COUNCIL OF OFFICIAL VISITORS' MEETINGS 1999 - 2000 .....	4
Table Two AUTHORISED HOSPITAL INSPECTIONS BY HOSPITAL & TIME & DAY OF INSPECTION 1999 - 2000.....	9
Table Three LICENSED PRIVATE PSYCHIATRIC HOSTEL INSPECTIONS BY HOSTEL & TIME & DAY OF INSPECTION 1999 - 2000.....	10
Table Four TOTAL CONTACTS WITH CONSUMERS BY FACILITY 1999 - 2000.....	13
Table Five TOTAL CONSUMER CONTACTS BY ISSUE CATEGORY - ALL FACILITIES 1999 - 2000.....	17
Chart One EXPENDITURE 1999 - 2000 .....	7
Chart Two PERCENTAGE OF TOTAL CONSUMERS BY FACILITY 1999 - 2000.....	14

## 1 INTRODUCTORY REMARKS

There is no doubt that considerable progress has been and continues to be made in expanding the range of public mental health services and in trying to improve the quality of such services. The comments in this report should be read in the context of that progress and the commitment to continuous improvement which it reflects.

Unfortunately, even a cursory reading of this report will demonstrate that such progress masks an attitude of 'second best is good enough' which is all too prevalent.

The following issues illustrate conclusively that a patient in a public mental health service may very well experience a level of treatment which would not be accepted in any other type of hospital or health facility.

- The patient may have to sleep on a mattress only, not in a bed.
- The room which the patient is sharing could be accommodating more patients than it was designed for.
- The patient's "bedroom" may in fact be a seclusion room or lounge room.
- If the patient has a bed he/she may be woken several times a night and moved somewhere else.
- The patient may be required to remain in a locked ward after he/she no longer requires that level of supervision and, in the interim, his/her access to areas outside the ward will be limited due to staffing numbers.
- Whilst the patient is feeling particularly unwell his/her credit card, clothes and other possessions could get lost. The hospital will not pay compensation even though he/she was in the care of its staff without his/her consent.
- If the patient is a teenager he/she could be placed in a ward with seriously ill adults.
- If the patient is old he/she may be locked in or physically restrained in breach of the very laws enacted to protect him/her.
- The patient may have nowhere to keep his/her belongings.
- If the patient does have somewhere it may not be lockable.

All of the above were experienced by consumers of public mental health services in Western Australia during 1999/2000.

That such situations have been allowed to develop and are, apparently, readily accepted by many who work in the system, reflects a fundamental problem. On average 1 in 5 adults will access mental health services at some time in their life. At some stages of their illness people may have problems of coherence and effective recall. This reality should not be translated to a carte blanche conventional wisdom that whatever these consumers say can be discounted basically because they are unwell. It has been the experience of the Council that most of the improvements it has helped to achieve had their origins in the observations and comments of these very consumers.

Consumers of public mental health services have as much right to quality care and a fair hearing as other health service users.

They are the 1 in 5.

Any West Australian may enter this system at any time and all West Australians should be asking whether they think it is good enough for their children, their parents or themselves.

## 2 LEGISLATIVE FRAMEWORK

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

## 3 WHO ARE THE OFFICIAL VISITORS?

Section 177 (1) of the Act provides that the Minister for Health appoints a person to be 'Head of the Council of Official Visitors' and such numbers of persons as seems appropriate to be members of the Council, known as 'Official Visitors'.

The Official Visitors "are to be appointed from amongst the general community;" and "are not required to have any particular experience or qualifications" (the Act section 177 (2) (a) & (b)). In the appointment process the Minister is "to have regard to the usefulness of any experience or qualifications that the person may have" (the Act section 177 (3)).



*Council members at 30 June 2000.*

*Standing (left to right) Sheila Stephens, Noreen Paust, June O'Connor, Diane Annear.  
Seated (left to right) John Rooney, Kevin Hogg, Edana McGrath, Adrian Gavranich, Kevin Guhl, Stuart Flynn, Sandra Brown. Absent Jean Ellis, Gary Hulse, Maxinne Sclanders, Brenda Van Zalm.*

## 4 ROLE AND METHOD OF OPERATION

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

The major focus of the Council's role is to ensure that 'affected persons', as defined in section 175 of the Act, are aware of their rights, that those rights are respected and that the quality of care they receive is of the highest possible standard. The Council also has a responsibility as a complaint management avenue for 'affected persons'.

'Affected person' under the Act (section 175) includes:

- an involuntary patient, including a person subject to a Community Treatment Order;
- a mentally impaired defendant who is in an authorised hospital;

- a person who is socially dependant because of mental illness and who resides, and is cared for or treated, at a private psychiatric hostel; and
- any other person in an institution prescribed for the purposes of this section by the regulations.

The Council is required to inspect and/or visit all hospitals authorised under the Act each month and licensed private psychiatric hostels as per a direction from the Minister for Health (the Act section 186 (1) (a) & (b)). The Minister, under "Functions of the Council of Official Visitors Direction 1997", (gazetted in the Government Notices of 21 November 1997), has directed that the specified hostels be visited by an Official Visitor or panel at least once every two months. A list of facilities visited by the Council is contained in Appendices 1A and 1B.

An 'affected person', or any person on his/her behalf, can request a visit from an Official Visitor (section 189 the Act) and this is arranged as soon as is practicable (section 186 (c)).

The Council has a free call 1800 number for all callers contacting the office to improve access. A roster of Official Visitors operates to respond to calls that occur on weekends and public holidays where a message is left on the office answering machine. The Council also has a Reply Paid number to assist in forwarding written requests to the Council.

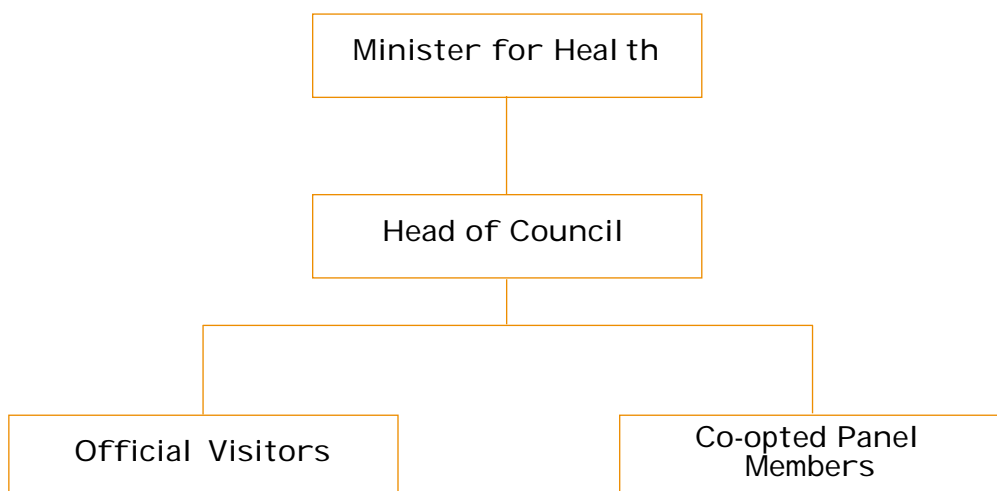
Since its inception, the Council has delegated to its members, Official Visitors, the authority to follow up and endeavour to resolve issues raised by consumers or identified at inspection visits at the lowest possible organisational level.

## REPORTING LINES

The Council and its individual members report to the Minister for Health. The Head of Council is required to provide a written report to the Minister on the Council's activities as soon as practicable after the end of each financial year (the Act section 192 (3)).

Under section 192 of the Act any Official Visitor, or person on a panel, who considers that the Minister for Health or the Chief Psychiatrist should consider a matter may make such a report. In practice the Council has adopted a process whereby the Head of Council predominantly makes reports on behalf of the Council members.

Therefore in the practical operation of the Council the reporting lines are:



## EXECUTIVE OFFICER & OTHER STAFF

It is important to note that the Executive Officer and other staff are public servants (as per section 182 of the Act) and employed by the Health Department of WA. The Executive Officer is thus formally accountable to the Director, Corporate Management, Health Department of WA. In practice she is also responsible to the Head of Council for the day to day operation of the Council. Other support/administration staff are responsible to the Executive Officer.

## COUNCIL MEETINGS

Following an internal review of the operation of the Council in July 1999 a decision was made by Council to cease the Policy & Professional Issues meetings and, effective August 1999, to conduct bi-monthly business meetings of the full Council. The meetings were held in Perth and all members of the Council, metropolitan and regional, were expected to attend. The purpose of these meetings was to discuss the operation of the Council and issues of interest or concern to the Council.

A summary of the meetings attended by Council members is contained in Table One below.

TABLE ONE

### ATTENDANCE AT COUNCIL OF OFFICIAL VISITORS' MEETINGS 1999 - 2000

OFFICIAL VISITOR	BUSINESS MEETINGS		POLICY & PROFESSIONAL ISSUES MEETING	
	Attendance	Apologies	Attendance	Apologies
Di Annear	6	0	1	0
Sandra Brown	6	0	1	0
Rita Burgess <sup>1</sup>	4	0	0	1
Jean Ellis	4	2	0	1
Stuart Flynn (Head of Council)	6	0	1	0
Adrian Gavranich	3	3	0	1
Kevin Guhl	6	0	1	0
Amara Hogeveen <sup>1</sup>	4	0	0	1
Kevin Hogg	6	0	1	0
Gary Hulse	3	2	0	1
Manjit Kaur <sup>1</sup>	4	0	1	0
Edana McGrath <sup>2</sup>	4	1	-	-
June O'Connor	6	0	1	0
Noreen Paust	5	1	0	1
John Rooney	6	0	1	0
Rosalind Sawyer <sup>1</sup>	4	0	0	1
Maxinne Sclanders	5	1	1	0
Sheila Stephens <sup>2</sup>	6	0	-	-
Brenda Van Zalm <sup>2</sup>	2	4	-	-

<sup>1</sup> Appointments expired 7 April 2000

<sup>2</sup> Appointments commenced 22 July 1999

## GROUP MEETINGS

The Council members were divided into groups with primary responsibility for providing services to consumers in specific geographical areas. The individual groups met on a monthly or bimonthly basis as determined by the members. The purpose of these meetings was to arrange routine inspections and discuss issues of specific concern to the group. The Executive Officer attended these meetings as required. Feedback from these groups was provided to full meetings of the Council.

## ORIENTATION

A one day orientation session was conducted on 17 November 1999 at Bunbury Health Campus for recently appointed members living in the South West Health Service area. Additional sessions were held in conjunction with attendance at Council meetings in Perth.

## CODE OF CONDUCT

In October 1999 the Council adopted a Code of Conduct to complement the already established Code of Ethics. The Code of Conduct was based on the "*Template Code of Conduct*" initially produced through the Office of the Public Sector Standards Commissioner. The Code of Ethics and Code of Conduct are provided to all Official Visitors at the time of their appointment and are binding on all members of the Council.

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

## ONGOING EDUCATION AND DEVELOPMENT

The Council is committed to ensuring that all Official Visitors are provided with appropriate training and development opportunities to enable them to carry out their functions efficiently and effectively. As part of this process a number of Official Visitors attended lectures, workshops and conferences external to the Council during 1999 - 2000. These included:

- Health Consumers' Council conference, "For Crying Out Loud";
- "Dealing with the Behaviour of Difficult People" workshop;
- Office of the Public Advocate "Service Provider Training"; and
- Mental Health Review Board "Seminar Series".

# 5 ADMINISTRATIVE ISSUES

## 5.1 APPOINTMENT OF OFFICIAL VISITORS

### 5.1.1 Council Composition 1999 - 2000

Mr Stuart Flynn continued in his appointment as the Head of Council during the 1999 - 2000 financial year. At 1 July 1999 the Council comprised 17 members, including the Head of Council. One Official Visitor resigned in mid July 1999.

Following a call for 'Expressions of Interest' in March/April 1999 three individuals who resided in the South West Health Service area were appointed to the Council during July 1999. Their appointment was to ensure that a locally based service could be provided to the authorised hospital in Bunbury and to individuals subject to Community Treatment Orders living in the South West Health Service area.

Four Council members' terms of appointment expired in April 2000. In December 1999 the Council recommended that members whose terms expired not automatically be nominated for reappointment. It was recommended that these individuals, who were entitled to express their interest in reappointment, be considered along with other individuals who nominated their interest. The Minister for Health endorsed this process.

Following a review of the composition of the Council, 'Expressions of Interest' for appointment to the Council were called for, during March 2000, from individuals living in the metropolitan and Lower Great Southern Health Service areas. Interviews were conducted in Albany and Perth during April 2000 and recommendations forwarded to the Hon. Minister for Health for consideration.

Further action will be undertaken during the 2000-2001 financial year to ensure that the Council's composition more widely reflects the general community. The Council is particularly concerned regarding the lack of Aboriginal representation in its membership. The Council will actively work towards addressing this gap, including liaison with appropriate services in an attempt to identify interested and appropriate members of the community to be recommended for appointment.

Appendix 2 lists the members of the Council during the 1999 - 2000 financial year.

## 5.2 ACCOMMODATION

Since its commencement, the Council had shared accommodation with the Mental Health Review Board at 937 Wellington Street, West Perth. The facility proved inadequate in many respects, including the lack of disabled access and the lack of space for Council staff and members. In December 1999 the Council relocated to new premises at Unit 1, 1076 Hay Street (cnr Harvest Terrace) West Perth. The new premises are centrally located and have addressed the issues of lack of access for people with disabilities and adequate and appropriate space for staff and Council members.

## 5.3 STAFFING

The staffing for the Council's office consisted of a full time Executive Officer (Level 6), Ms. Catherine Stevenson (centre); a full time Administrative Officer (Level 2), Ms Leah Knapp (left); and a part time (0.75 FTE) Clerical Officer (Level 1), Ms Elsie Ekstrom (right).



## 5.4 BUDGET

The Council was allocated a budget of \$352,000 for 1999 - 2000. Due to a number of 'one off' expenses associated with relocation to new premises and the development of an appropriate records management system and database this proved insufficient and an additional \$38,000 was granted to the Council by the Health Department of WA.

### 5.4.1 Remuneration

Official Visitors are remunerated for the work undertaken on behalf of the Council (section 180 (1), the Act). They are also reimbursed for the costs incurred in the performance of their role (for example, travel expenses). People who are employed by State or Commonwealth government departments or tertiary educational institutions are not eligible for payment of sitting fees but can be reimbursed for other expenses.

The remuneration rates for members of the Council are determined in accordance with the recommendations of the Ministry of the Premier and Cabinet, Public Sector Management Office.

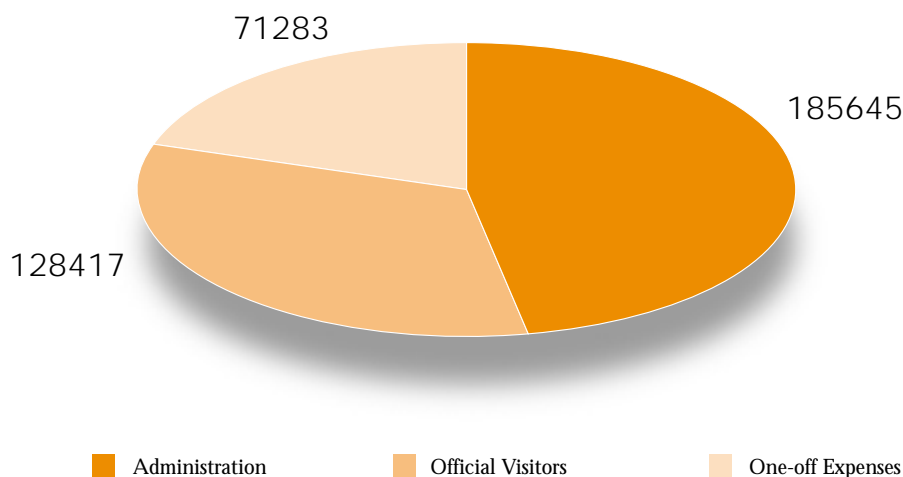
#### 5.4.2 Expenditure

Expenditure for the Council of Official Visitors for the financial year 1999 - 2000 totalled \$385,345.52. Chart One below provides a summary breakdown of the expenditure of the Council for the financial year.

\$128,417.00 (33.5%) was spent on the sitting fees and associated expenses, including travel, for members of the Council undertaking Council business, primarily visits with consumers and inspection visits and training. This amount only reflects payments processed during the 1999 - 2000 year and does not account for all activities by Official Visitors.

\$185,645.00 (48%) was accounted for by the administrative costs associated with the operation of the Council including employment of staff, telephone charges and production of pamphlets and posters.

CHART ONE: EXPENDITURE 1999 - 2000



A sum of \$71,329.00 (18.5%) was accounted for by 'one off' expenses including relocation costs and the development and purchase of software for the Council's database and records management system.

## 6 ACTIVITIES OF THE COUNCIL

The priority areas of work undertaken by the Council are:

- responding to requests for contact from consumers; and
- undertaking inspection visits to authorised hospitals and licensed psychiatric hostels.

The Council's commitment to being responsive and flexible in meeting the needs of consumers has continued. Details related to consumer contacts are contained in 6.2 below.

The majority of inspection visits are unannounced and the Council has undertaken more inspection visits outside standard working hours. This has not resulted in difficulties for Official Visitors fulfilling their responsibilities under the Act. This practice will continue and its frequency increased in 2000 - 2001.

Details related to facility inspections are contained in 6.1 below.

## PANEL APPOINTMENTS

During the 1999 - 2000 financial year five individuals were appointed by the Council as Panel Members, as prescribed in section 187 of the Act.

### 6.1 FACILITY INSPECTION VISITS

#### 6.1.1 Facility Inspection Visit - Statutory Requirements

The *Mental Health Act 1996* (the Act) states:

*"186. It is a function of the Council of Official Visitors -*

- (a) to ensure that each authorized hospital is visited at least once in each month by an official visitor or panel;*
- (b) to 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 or panel, in accordance with that direction;".*

The Minister for Health, under "Functions of the Council of Official Visitors Direction 1997", gazetted in the Government Notices of 21 November 1997, has directed that the specified hostels be visited by an Official Visitor or panel at least once every two months.

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

Given the broad mandate of the Council in relation to inspection visits it was determined to trial a process of systematically focusing on specific areas during inspection visits in an attempt to develop a whole of system perspective for those areas. This process was beneficial however it requires fine tuning to ensure that the information is collected in a consistent and meaningful manner. It is also recognised that, at times, staff in facilities were required to spend significant amounts of time with Official Visitors and this requires review.

Areas focused on during 1999 - 2000 included:

- Compliance with *Mental Health Act 1996* requirements (Authorised Hospitals);
- Clothing (Hostels);
- Access to Recreational and Vocational Activities;
- Privacy;
- Choice;
- Furnishings.

As a result of this trial, a separate process and procedure to audit compliance with *Mental Health Act 1996* requirements is being developed by the Council. This will be informed by the National Mental Health Standards, in conjunction with the Act.

Tables Two and Three below provide a breakdown of the total number of formal inspections to authorised hospitals and licensed private psychiatric hostels, respectively, by the time and day of the week.

The Council has determined to conduct approximately one quarter (25%) of its formal inspection visits at times other than Monday to Friday 9.00 am to 5.00 pm. Affected persons are cared for and treated in these facilities 24 hours per day, seven days per week, therefore it is important to visit the facilities at various times. Other visits, including responding to consumer requests also occur outside normal working hours. These visits are not reflected in Tables Two and Three below.

During 1999 - 2000 approximately twenty one percent (20.6%) of the total inspection visits to authorised hospitals occurred outside 'normal working hours'. Similarly for the licensed private psychiatric hostels approximately twenty per cent (19.8%) of the total inspection visits occurred outside these hours. A further 9.7 % for authorised hospitals and 2.6% for licensed private psychiatric hostels were recorded as having occurred on a weekday (Monday - Friday) but no time was noted.

The timing of inspection visits is an area in which the Council is not performing at an acceptable level.

**TABLE TWO**

**AUTHORISED HOSPITAL INSPECTIONS BY HOSPITAL &  
TIME & DAY OF INSPECTION  
1999 - 2000**

AUTHORISED HOSPITAL	TOTAL NUMBER OF INSPECTIONS	TIME OF INSPECTIONS			
		Mon - Fri 9am - 5pm	Mon -Fri 5pm - 9am	Sat/Sun/ Pub Hol	Not recorded
Albany Regional Hospital - Mental Health Unit	12	7	2	3	-
Alma Street Centre	26	16	2	-	8
Boronia Inpatient Unit <sup>1</sup>	11	11	-	-	-
Bunbury Acute Psychiatric Residential Unit	12	9	1	2	-
Graylands & Special Care Health Services	40	29	6	4	1
Joondalup Mental Health Unit	12	9	1	2	-
Mills St Centre	30	19	5	-	6
Selby Lodge	12	8	3	1	-
<b>TOTAL</b>	<b>155</b>	<b>108</b>	<b>20</b>	<b>12</b>	<b>15<sup>2</sup></b>
	<b>(100%)</b>	<b>(69.7%)</b>	<b>(12.9%)</b>	<b>(7.7%)</b>	<b>(9.7%)</b>

**Notes:**

<sup>1</sup> Previously known as La Salle Hospital, Swan Lodge. Visit did not occur in September 1999.

<sup>2</sup> 'Not Recorded' visits occurred during Monday to Friday but time of inspection not noted.

TABLE THREE

LICENSED PRIVATE PSYCHIATRIC HOSTEL INSPECTIONS BY  
HOSTEL & TIME & DAY OF INSPECTION  
1999 - 2000

LICENSED PRIVATE PSYCHIATRIC HOSTEL	TOTAL NUMBER OF INSPECTIONS	TIME OF INSPECTIONS			
		Mon - Fri 9am - 5pm	Mon -Fri 5pm - 9am	Sat/Sun/ Pub Hol	Not recorded
175 Anzac Tce & 6 Mann Way 1 Bassendean	7	5	2	-	-
Casson Homes <sup>2</sup>	6	4	1	1	-
Casson House	6	4	1	1	-
Devenish House	6	5	1	-	-
Dudley House	6	6	-	-	-
Franciscan House	7	6	1	-	-
Gildercliffe Lodge <sup>3</sup>	3	2	-	1	-
Glyde Street Hostel	6	6	-	-	-
56 & 58 Glyde Street East Fremantle <sup>4</sup>	6	2	3	-	1
John Wilson Lodge	6	4	1	1	-
Maude Armstrong	6	5	1	-	-
Milgreys House <sup>5</sup>	5	4	-	1	-
Romily House	6	3	3	-	-
Rosedale Lodge	6	5	1	-	-
Salisbury Home	6	5	1	-	-
Shannon House	6	6	-	-	-
Sherwood House	6	5	1	-	-
Success Hill Lodge <sup>6</sup>	5	4	-	1	-
2 & 13 Teague Street Victoria Park <sup>7</sup>	5	3	-	-	2
Woodville House	6	6	-	-	-
<b>TOTAL</b>	<b>116</b> <b>(100%)</b>	<b>90</b> <b>(77.6%)</b>	<b>17</b> <b>(14.6%)</b>	<b>6</b> <b>(5.2%)</b>	<b>3<sup>8</sup></b> <b>(2.6%)</b>

Notes:

- <sup>1</sup> 6 Mann Way previously known as "Delta" - Richmond Fellowship.
- <sup>2</sup> 'Casson Homes' includes Aitken House, Gormley House, Violet Major House & Yates House as per Appendix 1B.
- <sup>3</sup> Gildercliffe ceased operation on 02 February 2000.
- <sup>4</sup> Previously known as "Jansen" and "Kingston" - Richmond Fellowship.
- <sup>5</sup> Milgreys House ceased operation 30 April 2000.
- <sup>6</sup> A number of visits occurred in December 1999, other than formal Inspection Visits, where no formal inspection report was completed.
- <sup>7</sup> Previously known as "Hillview" and "Shepperton House" - Richmond Fellowship.
- <sup>8</sup> 'Not Recorded' visits occurred during Monday to Friday but time of inspection not noted.

## 6.1.2 Summary of Issues Raised

### LICENSED PRIVATE PSYCHIATRIC HOSTELS

The major difficulty experienced by the Council in relation to the licensed private psychiatric hostels is the lack of a consistent approach across the industry. The majority of hostels are privately run businesses with individual methods of operation. The lack of standards related to quality of care, financial record keeping and management of medication are of ongoing concern to the members to the Council. The lack of consistency in support services provided to residents of the hostels by the local mental health services adds to this concern. These issues are addressed in more detail in sections 7.1.5 and 7.1.6 of this report.

Examples of lack of consistency across the industry include:

- Residents' access or availability to beverages across the industry. In some hostels there is limited opportunity for residents to have a hot drink when they wish, as other members of the community do in their own homes. The hostel is the person's home and this limited availability suggests inappropriate institutionalised methods of operation. In addition it was noted that a significant number of hostels only provide powdered milk to residents with no alternative offered be it for adding to cereals, drinks etc.
- The facilities available for residents to make and receive telephone calls also vary between hostels. The majority of hostels report allowing the residents to utilise the office telephone if required.
- The facilities available for residents to lock their bedrooms or a cupboard within their room to secure their belongings.

A number of concerns were referred to other agencies including local councils, the Office of the Chief Psychiatrist and the Private Sector Licensing Unit of the Health Department of WA during 1999 - 2000. These included issues related to management of a resident's finances, leaking wastewater pipe in a bedroom and quality of care issues.

### AUTHORISED HOSPITALS

#### **Consumer Rights**

Overall there appeared to be compliance with the requirements of the *Mental Health Act 1996* in relation to consumers' rights. A number of issues were identified and are addressed in the following sections of the report:

7.2.1 Mechanical Bodily Restraint - *Mental Health Act 1996*, Division 9 sections 121-124

7.2.4 Staff/Facility Compliance with *Mental Health Act 1996*.

#### **Recreational / Vocational Activities**

The limited access to recreational and vocational activities for consumers in authorised hospitals continues to be of concern to the Council. Consumers often raise complaints during inspection visits regarding boredom, especially on weekends. Limited, or lack of, access to gym type facilities has been noted as an issue particularly for individuals in secure units.

### **Amenities**

Numerous complaints and observations were received in relation to the hospitals' menus, including:

- lack of choice and variety;
- quality of food and presentation;
- quantity of food.

In one facility where the provision of food is via an external contractor problems have been identified in ensuring that food received is of a consistent quality, the quantity of food available is adequate for the consumers and that choice is available. The Council has raised this with the facility involved and will continue to work with them in an endeavour to address the problem.

The privacy provisions for making and receiving telephone calls were also identified as requiring attention in number of the authorised hospitals. *Refer to 6.3.1 Position Statements Access to Telephones - Privacy Provisions.*

### **Physical Facilities**

The appropriateness of furniture including comfortable lounges or seating was raised. In one unit where the dining chairs were of the plastic outdoor variety a more suitable alternative was provided when the issue was raised.

The lack of ready access to pamphlets, for example on a pamphlet rack, was raised as a concern in one secure unit. Issues of risks associated with the installation of such racks had been addressed in other secure units to allow consumers' access to pamphlets without having to request staff assistance.

## **6.2 CONSUMER VISITS AND CONTACTS**

Requests from consumers or from people on their behalf form a significant part of the Council's work. These contacts are initiated via a number of mechanisms including:

- Telephone contact to the Council's office;
- Letter either posted to the Council's office or placed in the mail boxes installed in some hospitals; or
- Approaching Official Visitors when they are attending a facility.

### **6.2.1 Requests**

Table Four below comprises a record of the number of consumers seen by Official Visitor/s in response to a request and where a report was forwarded to the Council's office. Many contacts occur with consumers when Official Visitors are present at a facility for which no report will be drafted as no specific action was required or the matter was of a minor nature and addressed at the time.

### Non-Identifiable Action:

The Council received a number of items of correspondence from consumers that could not be identified and/or did not require further action. This non-action was due to there being insufficient detail to allow an investigation.

For Graylands Hospital, a total of 49 non-identifiable letters were received. For Alma Street Centre a total of five non-identifiable letters were received.

TABLE FOUR

### TOTAL CONTACTS WITH CONSUMERS BY FACILITY 1999 - 2000

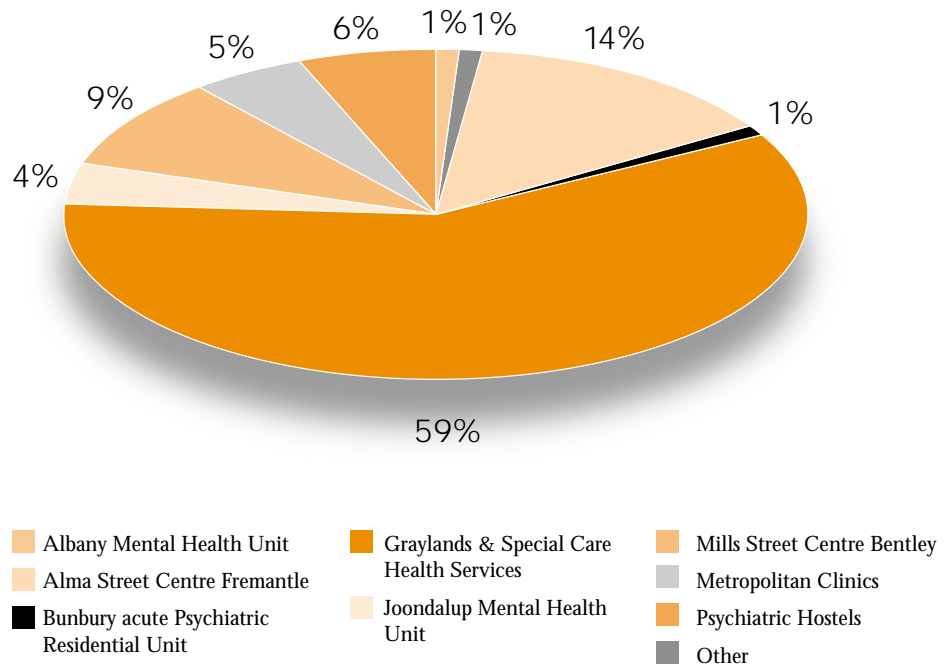
FACILITY	NUMBER OF CONSUMERS	CONTACT TYPE			
		VISIT	TELEPHONE CALL	LETTER	MHRB <sup>1</sup> ATTENDANCE
Albany Mental Health Unit	2	3	4	1	0
Alma Street Centre Fremantle	48	70	33	5	3
Boronia Unit <sup>2</sup> Swan	0	0	0	0	0
Bunbury Acute Psychiatric Residential Unit	3	6	3	0	0
Graylands & Special Care Health Services	203	327	173	71	3
Joondalup Mental Health Unit	13	13	17	3	0
Mills Street Centre Bentley	29	41	34	3	1
Selby Lodge	1	2	0	2	0
Metropolitan Clinics	16	5	46	2	5
Psychiatric Hostels	22	46	63	4	0
Other	2	2	1	2	0
<b>TOTAL</b>	<b>339</b>	<b>515</b>	<b>374</b>	<b>93</b>	<b>12</b>

<sup>1</sup> MHRB Mental Health Review Board

<sup>2</sup> Previously known as La Salle Hospital, Swan Lodge

## CHART TWO

### PERCENTAGE OF TOTAL CONSUMERS BY FACILITY 1999 - 2000



N.B. Boronia Unit, Swan and Selby Lodge recorded 0%

Whilst there has been a slight decrease (6%) in the total number of individual consumers having contact with the Council (Table Four), following consumers' requests from 362 in 1998 - 1999 to 339 in 1999 - 2000, the total number of visits to consumers has remained stable. Contacts via telephone have almost doubled from 189 in 1998 - 1999 to 374 during the period covered by this report. This is in part due to a concerted effort to follow up with consumers regarding their concerns and multiple contacts with service providers in dealing with issues.

Importantly there has been a significant increase (300%) in individual contacts with consumers in the licensed private psychiatric hostels from seven in 1998 - 1999 to twenty two in 1999 - 2000.

As in 1998 - 1999 the majority of individual consumers having contact with the Council were from Graylands Hospital (59%) (Chart Two). There has been a decrease in relation to consumers at Mills Street Centre from nineteen percent of the total in 1998 - 1999 to nine percent in 1999 - 2000. There has been a slight increase for the same periods in relation to Alma Street Centre from eleven percent of the total to fourteen percent. The reasons for the decrease in relation Mills Street Centre are unknown. Strategies to ensure that consumers in this facility are aware they can contact the Council will be emphasised during 2000 - 2001.

### 6.2.2 Summary of Issues Raised

As in 1998 - 1999 the Council of Official Visitors' contact with consumers fell within two broad categories:

1. complaints; and
2. consumer rights and the *Mental Health Act 1996*.

The Council continued its practice of utilising the same categorisation of complaints as that adopted by the Office of Health Review and individual Mental Health Services. The category introduced by the Council in 1998 - 1999 entitled "Miscellaneous" has been renamed "*Mental Health Act 1996 - Other*" to reflect its content, i.e. contacts related to consumer rights and the *Mental Health Act 1996* where the contact was not complaint based. Additional categories of "*Criminal Law (Mentally Impaired Defendants) Act 1996*" and *Unknown* have also been introduced. The former accounts for non-complaint based contacts that relate to the operation of the *Criminal Law (Mentally Impaired Defendants) Act 1996*, primarily related to the Mentally Impaired Defendants Review Board and the latter those where the issue type of the complaint was unable to be determined.

The Council continued to experience some difficulty in identifying the most appropriate category for a number of its complaint types, in particular complaints regarding involuntary admission and treatment. The Council has attempted to be consistent with its categorising of these complaints.

Table Five below provides a summary of complaint categories dealt with by members of the Council. The categorisation is based on the content as stated by the consumer.

#### 1 Access

Complaints relating to transfer to open wards or discharge accounted for approximately twenty percent of complaints. These included:

- (a) delays in transfer to open wards due to lack of beds in those wards;
- (b) delays in discharge due to a lack of appropriate supported accommodation in the community; and
- (c) multiple transfers of consumers between wards, not due to the needs of consumers but rather to a shortage of beds.

This latter situation disrupts the consumer and interferes with continuity of care. For one consumer four transfers between wards occurred within seven days due to bed shortages not her clinical needs (refer to 7.1.2 below). This would be a cause for public outrage in any other type of hospital setting.

Difficulties or delays in accessing allied health services or medical treatment for non-psychiatric conditions continued to be experienced and remain of concern. This occurred in both the authorised hospitals and for the licensed private psychiatric hostel residents.

## **2 Communication**

The majority of complaints in this category (4.1%) related to misinformation or failure in communication. This included failure to provide discharge information to a hostel regarding a resident.

Approximately two percent of complaints related to:

- (a) failure to provide copies of orders made under the Act;
- (b) failing to advise consumers of their rights; or
- (c) failing to document.

In a small number of instances these complaints were substantiated. This is of ongoing concern (refer to 7.2.4 below).

## **3 Decision Making**

"Consent not obtained" complaints accounted for approximately three percent of complaints. These related to consumers complaining that they were receiving medication or other treatments against their wishes. In three instances this related to the planned use of electroconvulsive therapy. In all these instances the requirements of the *Mental Health Act 1996* had been complied with by the authorised hospitals however the individuals involved and their families expressed concern that consent was not obtained. In a number of instances it was negotiated that staff provide additional information and time to consumers and their families.

## **4 Quality of care**

Complaints regarding quality of care primarily related to inadequate treatment of both psychiatric and medical conditions. A number of complaints were also received related to "rough treatment", often occurring at the time a person was being given an injection or restrained.

## **5 Costs**

A small number of complaints (less than one percent) related to costs. This included both authorised hospitals and licensed private psychiatric hostels. In relation to authorised hospitals, this related to the charging of fees to an involuntary inpatient. This is being further investigated.

## **6 Privacy / Consideration / Discourtesy**

Complaints regarding staff being rude or patronising or lacking in care accounted for approximately ten percent of complaints received. Failure to ensure privacy (less than one percent) related to restricted access to clothing whilst in seclusion and being required to wear pyjamas rather than day clothes.

Breaches of confidentiality complaints related to releasing information to family or other agencies without the consumer's consent. A number of these are ongoing (refer to 7.2.4 below).

Allegations of assault either by staff or other consumers accounted for approximately three percent of complaints. In a number of instances involving alleged assaults between consumers the complainants reported the matter to the Police Service for investigation. The Council was unable to identify any evidence to substantiate complaints regarding alleged assaults by staff on consumers.

The complaints relating to sexual impropriety or transgression were either not able to be substantiated or were withdrawn by the complainant.

### 8 Other

Complaints regarding food (Catering), accounted for approximately three percent of complaints received. These included complaints regarding quality and appropriateness - age and cultural - of the food served.

The lack of security for a person's belongings accounted for approximately four percent of complaints. This is of particular concern in secure units (refer to 7.2.6 below).

Lack of facilities, especially recreational facilities, accounted for approximately five percent of complaints dealt with. This is an ongoing concern.

### 9 Mental Health Act 1996 - Other

Providing assistance with Mental Health Review Board applications and/or attendance at Board hearings accounted for approximately eleven percent of issues dealt with by the Council. Issues of non-compliance (not "2.4 Failure to fulfil statutory obligations") accounted for approximately two percent of issues. This included lack of adequate privacy provisions for telephones (refer to 6.3.1 & 7.2.4 below) and failure to comply with the Act's requirements related to mechanical bodily restraint (refer to 7.2.1 below).

TABLE FIVE

TOTAL CONSUMER CONTACTS BY ISSUE CATEGORY –  
ALL FACILITIES  
1999 - 2000

1. ACCESS	Number	Percentage (%) of Total
1.1 Delay in Admission or treatment	20	3.9
1.2 Waiting list delay	1	0.2
1.3 Non-attendance	0	0
1.4 Inadequate or no service	16	3.1
1.5 Refusal to admit or treat	0	0
1.6 Discharge or transfer arrangements	105	20.5
1.7 Access to transport	0	0
1.8 Physical access/entry	0	0
1.9 Parking	0	0
<b>TOTAL</b>	<b>142</b>	<b>27.7%</b>

<b>2. COMMUNICATION</b>	<b>Number</b>	<b>Percentage (%) of Total</b>
2.1 Inadequate information about treatment options	3	0.6
2.2 Inadequate information on services available	1	0.2
2.3 Misinformation or failure in communication	21	4.1
2.4 Failure to fulfil statutory obligations	13	2.5
2.5 Access to records	1	0.2
2.6 Inadequate or inaccurate records	0	0
2.7 Failure to provide interpreter	1	0.2
2.8 Certificate or report problem	0	0
<b>TOTAL</b>	<b>40</b>	<b>7.8%</b>

<b>3. DECISION MAKING</b>	<b>Number</b>	<b>Percentage (%) of Total</b>
3.1 Failure to consult consumer	1	0.2
3.2 Consent not informed	2	0.4
3.3 Consent not obtained	17	3.3
3.4 Private/public election	0	0
3.5 Refusal to refer or assist to obtain a second opinion	0	0
<b>TOTAL</b>	<b>20</b>	<b>3.9%</b>

<b>4. QUALITY OF CARE</b>	<b>Number</b>	<b>Percentage (%) of Total</b>
4.1 Inadequate diagnosis	2	0.4
4.2 Inadequate treatment	29	5.6
4.3 Rough treatment	12	2.3
4.4 Incompetent treatment	0	0
4.5 Negligent treatment	0	0
4.6 Wrong treatment	5	1
<b>TOTAL</b>	<b>48</b>	<b>9.3%</b>

<b>5. COSTS</b>	<b>Number</b>	<b>Percentage (%) of Total</b>
5.1 Inadequate information about costs	1	0.2
5.2 Unsatisfactory billing practice	1	0.2
5.3 Amount charged	2	0.4
5.4 Overservicing	0	0
5.5 Private health insurance	0	0
5.6 Lost property and/or reimbursement	0	0
<b>TOTAL</b>	<b>4</b>	<b>0.8%</b>

<b>6. PRIVACY/CONSIDERATION/DISCOURTESY</b>	<b>Number</b>	<b>Percentage (%) of Total</b>
6.1 Inconsiderate service/lack of courtesy	26	5
6.2 Absence of caring	24	4.7
6.3 Failure to ensure privacy	4	0.8
6.4 Breach of confidentiality	4	0.8
6.5 Discrimination	0	0
6.6 Discrimination of public consumer	0	0
6.7 Sexual impropriety	1	0.2
6.8 Sexual transgression or violation	2	0.4
6.9 Assault	14	2.7
6.10 Unprofessional conduct	0	0
<b>TOTAL</b>	<b>75</b>	<b>14.6%</b>

<b>7. GRIEVANCES</b>	<b>Number</b>	<b>Percentage (%) of Total</b>
7.1 Inadequate response to a complaint	0	0
7.2 Reprisal following a complaint	0	0
<b>TOTAL</b>	<b>0</b>	<b>0%</b>

<b>8. OTHER</b>	<b>Number</b>	<b>Percentage (%) of Total</b>
8.1 Administrative practice	11	2.2
8.2 Catering	14	2.7
8.3 Facilities	27	5.3
8.4 Security	23	4.5
8.5 Cleaning	5	1
8.6 Fraud/illegal practice	0	0
<b>TOTAL</b>	<b>80</b>	<b>15.7%</b>

<b>9. MENTAL HEALTH ACT 1996 (OTHER)</b>	<b>Number</b>	<b>Percentage (%) of Total</b>
9.1 Mental Health Review Board Application	43	8.4
9.2 Mental Health Review Board Attendance	12	2.3
9.3 Second Opinion Request (not 3.5)	11	2.2
9.4 Mental Health Act 1996 Information	7	1.4
9.5 Mental Health Act 1996 Non-Compliance (not 2.4)	8	1.6
<b>TOTAL</b>	<b>81</b>	<b>15.9%</b>

<b>10. CRIMINAL LAW (MENTALLY IMPAIRED DEFENDANTS) ACT 1996</b>	<b>Number</b>	<b>Percentage (%) of Total</b>
10.1 Mentally Impaired Defendants Review Board	1	0.2
<b>TOTAL</b>	<b>1</b>	<b>0.2%</b>

<b>11. UNABLE TO BE DETERMINED</b>	<b>Number</b>	<b>Percentage (%) of Total</b>
11.1 Unknown / Undetermined	20	3.9
<b>TOTAL</b>	<b>20</b>	<b>3.9%</b>

### 6.3 POLICY DEVELOPMENT AND ADVOCACY

The Council's role involves both contacts with consumers receiving services from a significant number of psychiatric services and facilities, and attendance at these facilities. This enables the members of the Council to develop an overview of myriad issues confronting consumers and trends and patterns in the total system. This insight informs the Council's work in raising issues related to policy development and advocacy at both a local and systemic level.

The Head of Council meets with the Chief Psychiatrist, the Director, Metropolitan Mental Health Service and the Executives of the major authorised hospitals on a regular basis. He also corresponds with and has access to the Minister for Health and the Metropolitan Health Service Board. A process for formal liaison with the representatives of the Private Psychiatric Hostel Association is being developed. Representatives of the Council met with the Police Commissioner to discuss the Council's role and its potential for interaction with the Police Service.

A number of issues were raised with the Chief Psychiatrist during the year including:

- use of mechanical bodily restraint in authorised hospitals;
- detention of voluntary patients in authorised hospitals;
- policies on personal searches particularly strip searching;
- resident 'contracts' for individuals residing in licensed psychiatric hostels; and
- administration of hostel subsidy payments.

The following issues have been raised with the Metropolitan Health Service Board or Metropolitan Mental Health Service:

- pressure on metropolitan inpatient mental health beds;
- contingency plan for adolescent admissions when WAY Centre at capacity;
- supply of pharmacy services to mental health consumers and differences in practice between different area health services.

Generally, serious consideration is given to the Council's views and in a number of situations positive changes have resulted. A number of the issues above are discussed in detail in Section 7 of this report.

### 6.3.1 Position Statements

During 1999 - 2000 the Council adopted positions in relation to two consumer related issues. In both instances the Council was approached by service providers and asked, "What is the Council's position on ...?". The requests covered the position in relation to privacy provisions for making and receiving telephone calls in authorised hospitals and the use of video monitoring in authorised hospitals.

#### *Access to Telephones - Privacy Provisions*

The Act, section 167 provides inpatients with the right to have the opportunity to make and receive telephone calls, "*in reasonable privacy ..... so far as reasonably practicable*". From Official Visitors' observations and complaints from consumers in authorised hospitals it was identified that the facilities available to consumers varied across facilities.

Given its role in ensuring the rights of 'affected persons' are observed and the requirement to set a minimum standard for "*reasonable privacy*" it was determined that the Council of Official Visitors adopt a position in relation to section 167 of the Act.

At the October 1999 meeting of the Council the following position was adopted.

#### **Position Statement - Access to Telephones - Privacy Provisions**

*"The Council's position is that the minimum acceptable standard to ensure compliance with section 167 of the Mental Health Act 1996 is:*

- provision of public telephone(s), which can be accessed without requesting staff permission/assistance, in all wards;*
- telephones to be located in a position which allows for 'reasonable privacy', i.e. not in public access way or near to staff offices where conversations can be overheard or disturbed; and*
- privacy devices e.g. sound proof booths to be installed around any consumer access telephones which are placed in above areas due to lack of appropriate alternate locations."*

The Council also recommended that consideration be given to:

- installing public telephones which accept both coins and cards;
- installation in position to allow consumers to be comfortable/sit whilst using the telephone;
- installation of desk or similar at the telephone; and
- purchase of cordless phone to assist consumers taking incoming calls through the ward office phone.

#### *Use of Video Monitoring*

In May 2000 the manager of a mental health service approached the Council regarding its position on the use of video monitoring in inpatient units. The question of video monitoring was raised in relation to its use in observation/surveillance situations. It was not raised in relation to the taping of interviews for educational or research purposes. The term 'video monitoring' was taken to include the use of machines with the capacity to record or closed circuit cameras with no capacity to record.

Following a literature search and review of the current use of video monitoring within inpatient units in Western Australia, the Council considered the issue at its June 2000 meeting. The following position was adopted in relation to the use of video monitoring:

#### **Position Statement - Use of Video Monitoring**

- "1 The Council does not view the use of video monitoring for observation/surveillance in consumer care areas (high dependency units, internal day areas) as preferred. The Council is opposed to surveillance in non-public areas such as bedrooms or bathrooms.*
- 2 Any use of video monitoring must be based on the principles of maximising consumer privacy whilst maximising consumer and staff safety. Video monitoring use is not acceptable if based on staff or management convenience or budgetary reasons.*
- 3 The development and implementation of policy/guidelines regarding its use must accompany use of video monitoring in consumer care areas. These guidelines must reflect best practice standards. The recommendations cited in D Olsen's 1998 article entitled "Ethical Considerations of Video Monitoring Psychiatric Patients in Seclusion and Restraint" are indicative of the guidelines to be included.*
- 4 The Council does not endorse the taping of video footage, nor the use of audio monitoring.*
- 5 Use of video monitoring in public areas (perimeters of buildings) must be obvious and signified as in use."*

Whilst the Council has adopted the above positions it is important that other relevant agencies, including consumer groups, are consulted by service providers regarding their position on such issues.

#### **6.3.2 Submissions**

The Council provided comment and submissions in relation to:

- *Draft Standards for Documentation and Financial Record keeping in Licensed Private Psychiatric Hostels* to the Private Sector Licensing Unit (PSLU) of the Health Department of WA;
- *Psychiatric Hostel Design Guidelines Draft September 1999* to the PSLU;
- *Review Of Legal Representation For Persons Who Are The Subject Of Applications Before The Guardianship And Administration Board* to the Ministry of Justice;
- *Review of the Mental Health Act 1996* pamphlet series issued by the Mental Health Division;
- *Quality and detail of information provided to consumers regarding their rights, in particular in relation to the Mental Health Act 1996 and associated regulator requirements to the Office of the Chief Psychiatrist; and*
- *Quality and detail of information contained on forms completed in relation to the Mental Health Act 1996 to the Mental Health Review Board and the Office of the Chief Psychiatrist.*

The Council was invited to provide comment during the Clinical Review undertaken by the Office of Chief Psychiatrist of the South West Mental Health Service.

## 6.4 QUALITY ASSURANCE

The Council of Official Visitors is committed to continuous quality improvement in its service delivery. Receiving feedback regarding the operation of the Council and/or the conduct of individual Official Visitors or staff from customers of its service at all times is essential to this process. Feedback of an informal and formal nature is welcomed.

The Council of Official Visitors is also committed to the fair and efficient resolution of all complaints made regarding the operation of the Council and/or the conduct of individual Official Visitors, in accordance with the *Australian Standard® Complaint Handling AS4269-1995* (Standards Australia, NSW, 5 Feb 1995).

The Council has adopted policies that reflect these commitments.

### 6.4.1 Complaints Regarding Council Operations

During 1999 - 2000 four complaints were received from service providers regarding the operations of the Council. The complaints related to both the operation of the Council and the perceived attitude of the Official Visitors. In part, these complaints were based on misinformation or misunderstanding of the role of the Council of Official Visitors, in particular as it varies from the previous Boards of Visitors system. In one situation it was acknowledged that the Official Visitor involved could and should have dealt with the situation more appropriately.

### 6.4.2 Customer Survey

In February 2000 the Council of Official Visitors determined to obtain feedback from 'customers' of its service including consumers and service providers. In the first stage survey forms were developed for distribution to service providers at facilities following contact with Official Visitors. The process for obtaining feedback from consumers is under consideration.

The first round of surveys was distributed during the period 20 March 2000 - 16 June 2000. Official Visitors provided a survey form and reply paid return envelope to staff they had contact with during a visit to a facility and requested their assistance in the completion of form. The contacts were during inspection visits and visits in response to consumer requests.

A total of twenty-seven responses were received from staff. Whilst not designated on the form, the majority of responses appeared to be received from hospital staff. A small number were able to be identified as received from hostel staff.

Overall the responses received were positive, with the majority of service providers rating their contact with Council members as good or excellent. Comments associated with this rating indicated that the Official Visitors were keen to advocate for consumers. Ninety-two per cent of respondents also stated that they would suggest that others contact the Council for assistance.

A full summary of the survey results is available from the Council's office.

## 6.5 OTHER ACTIVITIES

### 6.5.1 Communications Strategy

The Council identified the need to increase the general and mental health communities' knowledge and awareness of the role and availability of the Council. An independent facilitator conducted two separate focus groups with consumers and service providers during December 1999 and January 2000 to obtain a baseline understanding of the current perceptions of the Council and possible strategies to address these issues.

As a first step in increasing its profile as an independent body the Council produced its own pamphlet and poster. Mr Craig Wood and Mr Roch Dziewaltowski-Gintowt, artists involved with the Creative Expression Unit, Graylands Hospital and Health Service, granted the Council permission to use their artwork for these publications. The Hon. Minister for Health launched the poster and pamphlet on 02 February 2000 with very positive media coverage.

### 6.5.2 Presentations to Community Groups

Members of the Council and the Executive Officer continued the process of presentations to community groups during the 1999 - 2000 year. Presentations were made to a variety of groups including:

- staff at metropolitan and rural community mental health services;
- Mental Health Act Action Group;
- volunteer training at the Mental Health Law Centre;
- Sir Charles Gairdner Hospital Department of Psychiatry Continuing Education meeting; and
- medical staff orientation at Graylands Hospital.

An Official Visitor also staffed an information stall at the opening of Mental Health Week 1999.

The Council wrote to all Members of Parliament to introduce the Council and inform them of its potential to assist their constituents. A number of members of Parliament or their staff met with members of the Council. Subsequent to one of these visits, the staff in one member's office, who were previously unaware of the Council, were able to appropriately refer an individual, subject to a Community Treatment Order, to the Council.

The Executive Officer of the Council also met with the managers of the Rural and Remote Mental Health Services to discuss the Council's role and begin to develop mechanisms for ensuring the Council fulfils its responsibilities in relation to 'affected persons' living in rural and remote areas. This will be continued during 2000 - 2001.

The Council was pleased to be able to provide information regarding its establishment and method of operation to project officers in Tasmania's Department of Health and Human Resources and the Northern Territory to assist in the development of Official Visitor programmes in those jurisdictions.

## 7 MAJOR ISSUES 1999 - 2000

### 7.1 MAJOR ISSUES RAISED IN 1998 - 1999 AND STILL AWAITING SATISFACTORY RESOLUTION

The following issues were raised in the Council's 1998 - 1999 Annual Report. The majority remain unresolved either in whole or in part. Given the serious nature of these issues the fact that they remain unresolved suggests that the level of commitment to improving service provision and quality is inadequate.

- **LIMITATIONS ON THE ROLE OF THE COUNCIL**
- **PLANNING RATIOS AND BED AVAILABILITY - Adult Authorised Hospitals**
- **OFFICE OF THE CHIEF PSYCHIATRIST AND METROPOLITAN HEALTH SERVICE BOARD**
- **"SEARCH THE PERSON"**
- **LACK OF STANDARDS IN LICENSED PRIVATE PSYCHIATRIC HOSTELS**
- **SUPPORT SERVICES TO RESIDENTS OF LICENSED PRIVATE PSYCHIATRIC HOSTELS**
- **CONSUMERS WITH DUAL DISABILITIES**
- **DUTY OF CARE IN AUTHORISED HOSPITALS**
- **SECOND OPINIONS - *Mental Health Act 1996*, sections 111 & 164(2)**
- **CONSUMER ACCESS TO PERSONAL RECORDS - *Mental Health Act 1996*, sections 160 & 161**
- **CRIMINAL LAW (*MENTALLY IMPAIRED DEFENDANTS*) ACT 1996**

#### 7.1.1 Limitations on the role of the Council

Section 175 of the *Mental Health Act 1996* defines 'affected person' or those consumers in relation to whom the Council has a role as:

"In this Part -

**"affected person"** means -

- (a) *an involuntary patient;*
- (b) *a mentally impaired defendant who is in an authorized hospital;*
- (c) *a person who is socially dependant because of mental illness and who resides, and is cared for or treated, at a private psychiatric hostel; or*
- (d) *any other person who is in an institution prescribed for the purposes of this section by the regulations."*

#### **Authorised Hospitals**

As reported in the Council's 1998 - 1999 Annual Report, persons referred for assessment by a psychiatrist under section 29 and then detained in an authorised hospital (sections 36(1), 37(1)(b) or 40(1)) (referred persons) are not within the definition of 'affected person' and are therefore outside the jurisdiction of the Council. Further, persons detained in an authorised hospital under section 5 of the *Criminal Law (Mentally Impaired Defendants) Act 1996* subject to a Hospital Order also appear to be outside the jurisdiction of the Council.

To quote from the Council's 1998 -1999 Annual Report:

*"Of particular concern is the limitation on the Council's role with consumers who have been referred for assessment and are detained in an authorised hospital. An order to change their status from a referred person to an "involuntary patient" may not occur for up to seventy-two hours after reception at the hospital. During this period a number of their rights are removed under the Act, similar to involuntary patients, including the right to leave. Similarly, mentally impaired defendants may be kept in an authorised hospital for up to seven (7) days before being admitted as an involuntary patient or being returned to the court. Neither group has legislated access to the Council and its role to ensure rights are respected.*

*If protection is considered necessary for people once admitted as an involuntary patient or a mentally impaired defendant, it is Council's view that protection should be afforded to all people who have had their freedom or liberty reduced by detention in an authorised hospital. "*

It is of interest that section 175 was amended in *Statutes (Repeals and Minor Amendments) Act (No 2) 1998* section 48. The original wording had been as above with subsection (d) mistakenly named (c) and including "**any other person detained against that person's will in an authorized hospital**" (emphasis added) as well as the prescribed institutions. This original wording, altered without consultation with the Council, would have enabled the Council to assist the groups of consumers listed above.

The inability of the Council to assist other than involuntary patients has been raised with the Chief Psychiatrist. In particular discussion concerned the Council's inability to assist individuals referred for assessment under section 29 of the Act. During February 2000, the Chief Psychiatrist offered to issue an instruction to authorised hospitals supporting the Council's advocacy for patients in these vulnerable circumstances. Whilst the Council appreciated the support offered by the Chief Psychiatrist it was of the view that the solution to the problem was not the issuing of an instruction but an amendment to the legislation. If the Official Visitors used their powers in relation to people referred under section 29 of the Act then they would be acting outside the provisions of the Act and, rightly, would be open to criticism for this.

Voluntary inpatients in authorised hospitals also do not fall within the definition of 'affected person' and therefore are outside the mandate of the Council. Individuals in hospital access similar services and interact with many of the same staff irrespective of their legal status under the Act. In addition, throughout their admission, an individual's legal status may change. Limiting access to the Council appears to be an arbitrary and artificial restriction and not a reflection of the reality for consumers.

On a number of occasions, Official Visitors have again encountered individuals whose status was voluntary but who reported that they had been advised that if they refused medication or left the hospital their legal status would be changed to involuntary. For these individuals this was not perceived as a negotiated element of their treatment but a restriction of their freedom. This was compounded by the fact that they did not have access to the in-built safe guards in the Act, including the Council of Official Visitors and Mental Health Review Board.

### Case Study

RA was a voluntary patient in an authorised hospital. He contacted the Council stating that he wished to leave but was unable to do so. RA had a psychiatric disability and a cognitive impairment affecting his memory. This meant that he behaved in ways that posed a danger to himself, e.g. walking onto roads without looking for traffic. Staff advised the Official Visitors that RA would be stopped should he try to leave the hospital without an escort. His status remained "voluntary". Official Visitors noted their concerns regarding his status with staff. The Council was unable to assist RA.

### Case Study

MM a patient in an authorised hospital contacted the Council requesting the Council's assistance. On interview it was identified that MM was a voluntary patient. MM reported that she was being detained against her will as she had been told that she was not allowed to leave the hospital nor to refuse medication. The Official Visitor endeavoured to explain to MM that the Council was unable to assist her and would have to refer her to more appropriate agencies. MM was not able to understand this information.

MM recontacted the Council a week later requesting assistance again. She had not contacted the other agency as she did not see why the Council could not assist her and did not trust that the other service would be free of charge despite reassurance regarding this. The Official Visitor raised concern with the staff regarding MM's legal status and the restrictions to her freedom. The Council understands that MM's status was ultimately changed to involuntary.

**The Council's submission in relation to amendments to the Act included that all persons detained in authorised hospitals, whatever their status, should fall within the jurisdiction of the Council. To date there have been no amendments to the Act.**

### *Licensed Private Psychiatric Hostels*

As reported in the Council's 1998 - 1999 Annual Report, the majority of hostel proprietors are co-operative and willing to implement any reasonable proposal put forward by the Council. There remains a minority of facilities which continue to lack minimum standards related to the privacy, dignity and safety of residents in what is their home.

#### **Examples include:**

- toilet cubicles with no doors or locks;
- showers without screens or locks on doors;
- landings with no night lights;
- lack of locks on bedroom doors for privacy or secure lockers for safe keeping of belongings;
- lack of plugs in hand basins where there are separate hot and cold taps.

The Council has no power to enforce compliance with its recommendations related to such issues. Obtaining the power to compel, where there are no agreed standards (refer to 7.1.5 below), would be fraught with difficulties and a simplistic response to a complex situation.

### **Other Accommodation**

The Council's role in relation to community accommodation services is restricted to only those which have been gazetted by the Minister and which, by definition, are licensed and receive subsidies from the Health Department of WA. A large number of community accommodation services, including boarding houses, provide accommodation to those who have a history of mental illness. Under the current legislation the Council is unable to assist individuals residing in these facilities.

**The rights of consumers who are considered "socially dependant because of mental illness" can be infringed in any type of accommodation facility. The Council believes that its role should be defined solely according to the needs of groups of consumers, not whether the facility is licensed by the Health Department of WA.**

#### **7.1.2 Planning Ratios and Bed Availability**

##### **Adult Authorised Hospitals**

During 1999 - 2000 the issues associated with the availability of mental health inpatient beds, particularly in the metropolitan area, continued. A number of major concerns were again raised by the Council regarding the strategies being adopted by hospitals in response to the problems of bed availability. These were identified in complaints from consumers and as a result of Official Visitors' own observations.

The **examples** quoted in its 1998 - 1999 Annual Report continued in 1999 - 2000 including:

- placement of additional beds in already crowded rooms resulting in restrictions to privacy and lack of facilities for storing belongings in bedrooms;
- conversion of lounge rooms, seclusion rooms and other rooms to bedrooms;
- consumers required to remain in closed wards when ready for transfer to open wards due to lack of beds (least restrictive alternative);
- consumers being moved from one open ward to another to make room for other consumers (up to 4 moves) and the subsequent disruption to continuity of care;
- locking of an open admission ward resulting in all consumers, regardless of status under the Act, being detained in a locked ward.

The Council is aware that longer term planning associated with the reorganisation of mental health services is occurring and that changes cannot occur overnight. However, it has a brief to comment on the impact the current system has on individual consumers. Being told that the situation will improve in a number of years is of no assistance to a consumer who is currently required to sleep in a seclusion room, without somewhere to store his/her belongings, due to a lack of a bed.

One can only imagine the public outcry if a patient in a non-psychiatric public teaching hospital was accommodated in such circumstances, particularly if they then had to be moved in the middle of the night to make way for a patient who genuinely requires seclusion.

### ***Inpatient Bed Numbers***

The Council understands that it is planned to transfer beds from Graylands Hospital to the new adult inpatient unit at the Swan Health Service site. While there will be, in effect, no decrease in the total number of beds available, the Council is concerned that the pressure on the other units, such as Graylands Hospital, will continue. Similar transfers of beds occurred with the opening of units in Bunbury and Joondalup. In the short term there may have been a decrease in admission rates from those areas to other hospitals such as Graylands, however in the longer term the pressure on these units has remained resulting in the adoption of the strategies described above.

### ***Community Accommodation Services***

Official Visitors also encountered a number of individuals who were considered ready for discharge from an authorised hospital but for whom this was not possible due to the lack of appropriate accommodation in the community. These individuals appeared to fall within two broad groups, older people with a psychiatric disability who required accommodation in residential aged care facilities and younger adults requiring a greater level of support than could be provided in the psychiatric hostels and groups homes.

Historically there has been some reluctance for aged care facilities to accommodate people with psychiatric disabilities, particularly those with challenging behaviours, other than people with dementia in dementia specific units. In part this has been due to a perceived or actual lack of skill in working with this resident group. The development of stronger links between aged care providers and mental health services for older people would appear essential in addressing this issue.

The second group of younger people appeared to require less than acute care but, due to the complexity of their problems, could not live in the community without the support of trained/professional staff for up to twenty four hours per day. This lack of appropriate services appeared to result in delays in discharging the individuals from hospital. Given the continued pressure on inpatient beds this is an area that may warrant review. The Council will raise this matter with the Director of Metropolitan Mental Health Services.

#### **7.1.3 Office of the Chief Psychiatrist and Metropolitan Health Service Board**

In its 1998 - 1999 Annual Report the Council commented that there appeared to be an absence of clear leadership and direction in relation to decision making about mental health services. The arrangements, particularly in Perth, with the split between one body which purchases services and sets overarching policy and a second, which is responsible for the operation of services had not been conducive to responsiveness, clarity, accountability or timely and decisive action. In practice the distinction between policy and operations was difficult to draw.

In January 2000 the Metropolitan Health Service Board introduced the Metropolitan Mental Health Service (MMHS) as an Integrated Clinical Service under its auspices. The MMHS is responsible for the public mental health services provided within the Perth metropolitan area. This provides one point of reference for systemic issues relating to the public metropolitan mental health services.

The responsibilities of the Chief Psychiatrist for psychiatric care under the *Mental Health Act 1996* (the Act) are:

- "9. (1) The Chief Psychiatrist has responsibility for the medical care and welfare of all involuntary patients.*
- (2) In respect of other patients, the Chief Psychiatrist is required to monitor the standards of psychiatric care provided throughout the State."*

**It appears that the current practice of the Office of the Chief Psychiatrist is to refer all issues that appear to be operational to the Metropolitan Mental Health Service (MMHS), however this only addresses those issues for services in the metropolitan area. It does not serve to address the same issues in services not covered by the MMHS such as privately operated hospitals with authorised beds and authorised hospitals in rural and remote areas.**

#### **Example**

The Office of the Chief Psychiatrist referred the issue of variations in practice associated with searching consumers to the Metropolitan Health Service Board (MHSB) to be addressed. The development of the MHSB policy "Search of Patient's Belongings and / or Person" (refer to 7.1.4 below) has addressed the issue in relation to the health services under its auspices. It has not ensured that a system wide approach is adopted. Any system wide approach must involve private authorised hospital(s) and authorised hospitals and mental health services outside of Perth metropolitan area.

Council concurs that if issues are related to current practices utilised in services under the auspices of the MMHS, the MMHS must be involved in addressing these issues. However it is concerned that the current practice fails to ensure that all involuntary patients' care and treatment are addressed according to system wide policies.

**The Council is of the opinion that given the Chief Psychiatrist's role under section 9 of the Act it is appropriate for that Office to take a leadership role in this area.**

#### **7.1.4 "Search the Person"**

As reported in its 1998 - 1999 Annual Report the Council raised concerns with the Office of the Chief Psychiatrist in November 1998 regarding the lack of a system wide policy related to the searching of consumers admitted to authorised hospitals. The Council is of the opinion that the likelihood of being subjected to this type of intrusive action should not increase based purely on a consumer's geographical location as appeared to be the case.

The Office of the Chief Psychiatrist considered this an operational issue and therefore referred the matter to the Metropolitan Health Service Board (MHSB). Subsequently a policy regarding the "Search of Patient's Belongings and / or Person" was developed and adopted by the MHSB in September 1999.

A number of elements of this policy were of concern to the Council, in particular the exemption for one authorised hospital. The Council raised its concerns with the MHSB in February 2000. It is the Council's understanding that a number of other groups, including the hospital involved, voiced concern regarding this exemption and subsequently it was excised in February 2000.

In May 2000 the Council became aware that individual health services in the metropolitan area appeared to consider the MHSB policy a "draft guideline" and hence not binding. In effect this meant that health services could amend the policy and reinsert the exemption previously excised. In early June 2000 the Council raised its concern regarding the possible reinsertion of the exemption and the status of the policy with the MHSB.

In June 2000 Dr Aaron Groves, Director, Metropolitan Mental Health Service advised the Council that:

*"...the Interim Clinical Advisory Committee, Metropolitan Mental Health Service (MMHS) has re-endorsed the Search of Patient's Belongings and / or Person policy without any exemptions, at its scheduled meeting on the 6 June 2000. The MMHS will write to metropolitan mental health services reminding them of their obligation to comply with this directive and seeking confirmation that this directive is in place."*

The Council welcomes the adoption and implementation of this policy. The Council's concerns regarding the likelihood of being searched varying due to geographical location rather than variations in behaviours of consumers remain for those services not covered by this directive (i.e. non-metropolitan health services and private authorised hospitals). The adoption of a system wide policy would appear appropriate. The Council will endeavour to have this matter addressed via the Office of the Chief Psychiatrist.

#### **7.1.5 Lack of Standards in Licensed Private Psychiatric Hostels**

The licensed private psychiatric hostel industry continues to operate in a system that has no agreed standards related to quality of care / quality of life issues for residents. As reported in 1998 - 1999 the lack of objective, mutually agreed standards in relation to quality of care *"poses a major difficulty for the Council in attempting to ensure that such care is adequate and that operators will co-operate in achieving reasonable benchmarks"*. This is an area of ongoing concern for the Council as is the apparent lack of enthusiasm regarding the development of such standards.

The Mental Health Division (the Division) of the Health Department undertook a consultancy to review the financial costs of hostel care. Following this the Council understands a process has been initiated to more clearly define what personal care services the Division will purchase from the hostels in relation to residents of the facilities.

During 1999 - 2000 the Private Sector Licensing Unit (PSLU) of the Health Department of WA did draft a number of standards related to the industry, including *Financial Standards for Psychiatric Hostels; Documentation Standards for Psychiatric Hostels Medication Standards and Psychiatric Hostel Design Guidelines*. At 30 June 2000 the draft standards are yet to be finalised or implemented.

**The Council welcomes the review of the funding arrangements in relation to the hostel industry to more clearly define what personal care services individual residents are to receive and the standards being developed through the PSLU. The Council is concerned that the lack of objective quality of care / quality of life standards remains, with no indication of a time frame for their development.**

The Council is in the process of arranging a meeting with representatives of the Private Psychiatric Hostels Association to discuss issues of mutual concern, including resident contract/agreements and security/privacy provisions for residents.

**The Council looks forward to the development of a positive working relationship with the Association and trusts that improvements in the industry may be able to be progressed with the Association's assistance.**

#### **7.1.6 Support Services to Residents of Licensed Private Psychiatric Hostels**

Access to support services by residents of the licensed private psychiatric hostels continues to be area of concern to the Council. The geographical location of the facility continues to determine the type and degree of services that are available to residents. Examples include access to psychotropic medication provided free of charge by one local health service and not by another and range of and access to social/recreational/rehabilitation services available.

The provision of social/recreational services for individuals who have a high level of disability, including limited motivation, remains of concern to the Council. Few, if any, activities are provided in the majority of hostels and, therefore, residents are dependent on local mental health or other community services. With restricted funding it is not inconceivable that this client group is excluded from services due to the resource intensive nature of working with them. If the funding focus is on quantifiable outcomes over short periods of time focusing on people with lower levels of disability who are more likely to have positive outcomes may appear more attractive to service providers.

In a number of hostels, the resident group is elderly and experiences many of the difficulties associated with ageing in addition to their mental illness. Problems associated with mobility and continence are not unfamiliar. The Council was concerned that the residents, due to their current place of abode, were not regularly reviewed in relation to their care needs, in particular whether they required a higher level of support, for example high level residential aged care. These concerns were raised and local health services arranged for assessments of some residents by the local Aged Care Assessment Teams. This needs to be an ongoing process as residents' care needs will alter.

#### **7.1.7 Consumers with Dual Disabilities**

As reported in the 1998 - 1999 Annual Report the admission to authorised hospitals of people with dual disabilities and/or behavioural problems associated with an intellectual or other disability continued. An acute mental health setting may be an inappropriate environment for these individuals, with staff lacking the appropriate specialist skills to deal with their conditions.

A number of the individuals encountered by Official Visitors had limited verbal and/or social skills. They exhibited behaviours such as screaming, pacing and touching which was challenging for other consumers in the ward. The effect of these behaviours on others may have placed the individuals at risk.

In two of the instances the admission appeared to have been precipitated by a breakdown in, or lack of, appropriate community accommodation options for the individuals involved.

Representatives of the Council and the Mental Health Division of the Health Department of WA met to discuss the Council's concerns regarding this issue. The Council representatives were assured that there is ongoing dialogue between the Mental Health Division and Disability Services Commission to discuss policy and service delivery issues associated with this client group.

**This dialogue, to the Council's knowledge, has been quite ineffectual in that it appears to have produced no discernible benefits for consumers.**

### 7.1.8 Duty of Care in Authorised Hospitals

In July 1999 the Council raised its concerns regarding a number of issues related to the employment of mental health nursing staff in authorised hospitals, with Mr Phillip Della, Principal Nursing Adviser, Health Department of WA. It was the Council's view that the practices in place raised major issues of duty of care for both consumers and staff.

The concerns raised were the:

1. wide scale use of agency nurses;
2. use of extended or double shifts;
3. apparent ease with which nurses employed in public mental health facilities obtain permission to work for agencies or in other 'second' jobs; and
4. practices of such nurses undertaking shifts as part of their employment at a hospital followed by another shift at the same or a different facility as an agency nurse.

On 31 March 2000 a meeting was held with Mr Della and representatives from the Nurses Board of Western Australia, including Ms Margaret Watson, Chief Executive Officer/Registrar, to discuss this issue.

Following this meeting Mr Della advised the Council of the following:

1. the use of double shifts had been discussed with the Directors of Nursing who indicated that every effort is undertaken to discourage this practice; and
2. a review is planned of the nursing workforce including employment arrangements and the Council's comments would be forwarded to the reviewers.

**At the time of this report no further information has been provided regarding the review.**

**The concerns expressed in the Council's 1998 - 1999 Annual Report about the potentially damaging implications of current practices remain.**

### 7.1.9 Second Opinions

The *Mental Health Act 1996* (the Act) contains two specific provisions relating to consumers' rights to be interviewed and examined by a psychiatrist, other than the treating psychiatrist. Section 111 of the Act allows for a patient, if they are dissatisfied with the treatment being received, to request the opinion of another psychiatrist via the Office of the Chief Psychiatrist. Section 164 (2) grants the individual the right to request, via the treating psychiatrist, an interview with and examination by "*a psychiatrist who is not for the time being the treating psychiatrist*".

The Council requested legal opinion from the Crown Solicitor's Office regarding the practices adopted by authorised hospitals to enact the provision under section 164(2). The accepted practice was to refer the matter to a psychiatrist in the same hospital, sometimes on the same team. Alternatively if the consumer wished a psychiatrist other than one based at the hospital to provide the opinion, the whole responsibility for arranging this was placed with the consumer. Crown Solicitor's Office advice regarding section 164 of the Act was that:

*"... an inpatient in an authorized hospital is entitled to an interview with, or to be examined by, a psychiatrist, but is not entitled to limit that psychiatrist to a person nominated by the patient. Accordingly, the practice described in your letter of authorized hospitals leaving patients with the responsibility for arranging their examination by a psychiatrist not based in their hospital, appears to me to be consistent with section 164."*

The Council acknowledges that the practices are considered consistent with section 164 of the Act.

**The Council's opinion remains however that the practice of referring to another psychiatrist in the same hospital, and more particularly the same treating team, presents at the very least an impression of a lack of impartiality and true independence.**

### **Case Study**

WG, an involuntary patient in an authorised hospital was unhappy with her treatment. She requested a second opinion via her treating psychiatrist as per section 164(2) of the Act. The psychiatrist arranged for another medical practitioner, not a psychiatrist as defined under the Act, to interview and examine her. When WG complained that the second medical practitioner was not a psychiatrist and she wished another opinion by a psychiatrist she was reportedly advised that she had had her second opinion. This would appear to place the staff involved in breach of the Act and failing to observe the rights of the individual under the Act. A formal request for an examination and interview with a 'psychiatrist', as required by the Act, has been made on WG's behalf.

Section 3 of the Act defines "psychiatrist" as:

*"a medical practitioner whose name is contained in a register of psychiatrists prepared and maintained under section 17 by the Medical Board."*

Further section 17 of the Act states:

- "17. (1) The Medical Board appointed under the Medical Act 1894 is to prepare and maintain, for the purposes of this Act, a register of psychiatrists.*
- (2) The register is to contain the names of every medical practitioner practising in the State who -*
- (a) has made a special study of, or who has gained and maintained special skill in the practice of, psychiatry, and*
  - (b) is recognised by the Medical Board as a specialist in psychiatry."*

It is of grave concern to the Council that two and a half years after the Act commenced, experienced staff appear to lack awareness of, or regard for, its requirements.

**The practice of arranging opinions for involuntary patients by other than a 'psychiatrist', including psychiatric registrars and medical officers who may be called "acting Psychiatrists", fails to observe the rights of the consumers and places staff in breach of the Act.**

**7.1.10 Consumer Access to Personal Records,  
Mental Health Act 1996, sections 160 & 161**

The *Mental Health Act 1996* (the Act), sections 160 & 161, makes provision for any person whose civil rights have been altered by the Act to have access to official records relating to his/her contact with the hospital/treating facility with certain limited exceptions. Section 161 (3) of the Act allows for a consumer to nominate a "suitably qualified person" to exercise his/her right of access to records in certain circumstances.

The initial interpretation of the term "suitably qualified person", determined by the Office of the Chief Psychiatrist in August 1998, restricted this to 'Consultant Psychiatrists'. Council raised its concern that this was a very narrow interpretation of the term "suitably qualified person" and not, in the Council's opinion, within the spirit of the Act.

Commenting on plans to determine other classes of people deemed to be "suitably qualified" the Council, in its 1998 - 1999 Annual Report, stated:

*" it was stated that the Chief Psychiatrist and Legal Services of the Health Department would take carriage of determining other classes of people who would be deemed "suitably qualified". This was to occur either through the process of preparing amendments to the Act and/or by the convening of a working party specifically to develop guidelines for operating this section of the Act."*

Further the Council commented:

*"The delay in progressing this issue is of particular concern given legal practitioners' role in representing consumers before the Mental Health Review Board. The Council understands that the current practice is for legal practitioners to apply for access to medical records and for the treating Psychiatrist to then determine whether access will be granted. There is no avenue for appeal in this process. Lack of access to these records faces consumers with the potential denial of natural justice, particularly as their legal representatives are unable to be fully prepared for the hearing."*

It was noted in the Mental Health Review Board Annual Report 1999 (page 13) that of all completed reviews only six percent resulted in the discharging of the involuntary patient order. Council is of the view that lack of timely access to medical records and reports prior to Mental Health Review Board hearing does adversely affect the ability of the consumer or his/her legal or other representative to fully prepare.

**Whilst it is not possible to draw a definite conclusion, the question that must be asked is whether the lack of access to information and the very low discharge rate are an unfortunate correlation or causally linked.**

Again, this appears to be a situation where mental health consumers receive second class treatment which would not be tolerated in other areas of law or other legal jurisdictions. The Council trusts that its concerns would be shared and articulated by those charged with implementing the Act, not least the Mental Health Review Board itself.

**At the time of this report the Council had not been advised of any progress in this matter by the Chief Psychiatrist or the Legal Services of the Health Department of WA.**

### 7.1.11 *Criminal Law (Mentally Impaired Defendants) Act 1996*

The Council of Official Visitors has responsibility for mentally impaired defendants who are in an authorised hospital. Graylands Hospital and Health Service, including the Frankland Centre, is the authorised hospital at which the Council provides a service to mentally impaired defendants.

A mentally impaired defendant is a person in respect of whom a custody order has been made under the *Criminal Law (Mentally Impaired Defendants) Act 1996*. The lack of jurisdiction for the Council over defendants held in the Frankland Centre for up to seven days under a hospital order made pursuant to section 5 of the *Criminal Law (Mentally Impaired Defendants) Act 1996* remains of concern to the Council (refer to 7.1.1 above).

#### **Exercise and Recreational Opportunities**

Consumers in the Frankland Centre expressed concern to the Council that there was a lack of adequate and appropriate exercise and recreational opportunities available to them. An Official Visitor met with groups of consumers in Frankland to discuss their concerns and identify possible solutions. Discussions also occurred with the Occupational Therapist and Clinical Nurse Specialist of the unit.

The consumers were eager to make suggestions for new types of activities including:

- guest speakers;
- budgeting and other life skills;
- relaxation and meditation;
- increased sports and games; and
- barbecues.

The Council perceived this as a beneficial process as it engaged the consumers in the ward in raising suggestions in a structured fashion that could then be forwarded to staff for consideration and implementation as appropriate.

#### **Restricted Access**

Concern was also expressed by consumers that their access to the outside area of the unit was restricted on occasions due to the lack of staff. Lack of escorted ground access for consumers who had this right occurred on occasions due to pressure on staff numbers. It is acknowledged that there are clinical or legal requirements for staff to be present in these situations however it is of concern that a valued part of an individual's programme can be restricted due to staffing availability rather than other clinical reasons. In some instances this lack of access may be detrimental for consumers.

#### **Treatment of Prisoners**

In February 2000 the Council raised concerns regarding the perceived practice of prisoners receiving treatment against their will in the Frankland Centre. The Council was advised of situations where it was alleged that prisoners in the Frankland Centre were required to receive psychiatric treatment despite withholding consent. It appeared that these individuals were not made subject to the *Mental Health Act 1996*. Whilst prisoners not subject to the *Mental Health Act 1996* are not within the definition of 'affected person' (section 175 of the Act) the Council wished to clarify the current practice. It appeared that prisoners were transferred to the

Frankland Centre via authority under the *Prisons Act 1981* however the authority to deliver psychiatric treatment was unclear. Professor Greenberg, Chair and Professor of Forensic Psychiatry advised the Council in May 2000 that prisoners were made subject to the *Mental Health Act 1996* when transferred to the Frankland Centre.

### **External Review Process**

The *Mental Health Act 1996* provides specified rights and review processes for consumers receiving treatment under that Act. Provisions for mentally impaired defendants detained under the *Criminal Law (Mentally Impaired Defendants Act) 1996* are limited, with no specific section on rights and access to review by the Mentally Impaired Defendants Review Board established under Part 6 of that Act. Unlike the Mental Health Review Board (*Mental Health Act 1996*) in practice mentally impaired defendants are not present during review hearings nor do they have automatic right to and ease of access to representation before this Board. Mentally impaired defendants are not eligible for assistance from the Mental Health Law Centre and access to Legal Aid is limited. The Council has been involved in assisting consumers to present, via written correspondence, issues they wished considered by the Mentally Impaired Defendants Review Board.

This whole area appears to require review.

The *Criminal Law (Mentally Impaired Defendants Act) 1996*, unlike the *Mental Health Act 1996*, does not have a statutory review period designated. Review after five years of operation, as is the case for the *Mental Health Act 1996*, would also appear to be appropriate for the *Criminal Law (Mentally Impaired Defendants Act) 1996*.

The Council has yet to receive advice regarding the outcome of the draft report a *National Approach to Forensic Mental Health* (November 1998) cited in its 1998 - 1999 report.

## **7.2 MAJOR ISSUES IDENTIFIED DURING 1999 - 2000**

The following issues were identified during 1999 - 2000. These major areas of concern were often identified as a result of an individual consumer or Official Visitor raising the issue.

### **7.2.1 Mechanical Bodily Restraint -**

#### ***Mental Health Act 1996, Division 9, sections 121-124***

The *Mental Health Act 1996* (the Act) Division 9, sections 121-124 and the *Mental Health Regulations 1997* (the Regulations) regulations 15-17 outline the provisions to be complied with when authorising the use of mechanical bodily restraint.

Following an inspection visit to an authorised hospital in July 1999 Council members became aware of a number of shortcomings in compliance with the legislation relating to the use of mechanical bodily restraint. In addition the Council's attention was drawn to "Chief Psychiatrist Instruction No.3 *MECHANICAL BODILY RESTRAINT*". **The Council was of the view that Instruction No.3 was contrary to the provisions of the Act.**

In mid August 1999 the Council wrote to the Chief Psychiatrist advising him of the its concerns related to compliance with the legislation associated with the use of mechanical bodily restraint. Further, it requested a withdrawal of the Chief Psychiatrist Instruction No.3 and a reaffirming of the need to comply with all aspects of the Act. A response was received from that office in early September 1999 noting the Council's correspondence and promising a **'review in due course'**.

At the end of October 1999 the Council wrote to the Honourable Minister for Health and the Office of Public Sector Standards Commissioner formally advising them of the issue and the **apparent lack of action on the part of the Office of the Chief Psychiatrist.**

In November 1999 the Council requested legal opinion from the Crown Solicitor's Office regarding the validity of the Chief Psychiatrist Instruction No.3. Verbal advice received from the Crown Solicitor's Office on 26 November 1999 confirmed the Council's view that Instruction No.3 was invalid. The written advice, received on 8 December 1999 stated:

*"The Instruction, if followed, would have the effect of allowing patients in situations coming under Section 123(1)(b)(i) to be restrained by a mechanical bodily restraint without the authorisation prerequisite and other requirements of the Act and Regulations having been complied with. This would have constituted a breach of Section 122 of the Mental Health Act 1996.*

*I understand that the instruction has now been withdrawn."*

In early January 2000 the Council received a copy of correspondence from the Office of the Chief Psychiatrist, dated 6 December 1999, regarding withdrawal of the Instruction No.3. Examination of the notice highlighted that the Instruction was:

*"now rescinded in its application to **involuntary** patients in authorised hospitals" (emphasis added).*

Further opinion was sought from the Crown Solicitor's Office regarding whether the provisions of the Act in relation to mechanical bodily restraint related to **all** patients, not only involuntary patients. In addition advice was sought to confirm that an authorisation was required for each application of restraint rather than the providing of an authorisation for "use as required" over a period of time e.g. 6 months.

The advice received in March 2000 confirmed that:

- 1 the requirements of the Act related to **all** patients in authorised hospitals, irrespective of their status; and
- 2 all requirements of the Act and Regulations must be complied with for each separate authorisation thus it was not possible to provide a "general" authorisation to apply restraint "as required".

The Council is most concerned that it took approximately **seven months** for this issue to be resolved and apparently only after it had requested legal opinion independently of the Office of the Chief Psychiatrist. The advice from the Crown Solicitor's Office was received within **seven days** of the Council's request.

The issue of Chief Psychiatrist Instruction No.3 has raised the questions for the Council regarding the process undertaken prior to issuing such instructions. Instruction No. 3 placed hospital staff in the position where they believed their actions were authorised by the Instruction but were in fact in breach of the Act. The Council is of opinion that, prior to the issuing of any instructions, advice must be sought to ensure that the instructions are valid and do not contravene the Act. It would appear that this did not occur in this instance.

**Issuing instructions directing contravention or non-compliance with the provisions of the Act to address shortcomings of the Act is neither legal nor appropriate whatever the motivation. If there is a deficiency within the Act, or its requirements are problematic, then the appropriate course is to request amendments to the Act.**

According to correspondence to the Council dated 8 August 1999 the Office of the Chief Psychiatrist was "soon to review all suggestions submitted for amendments to the Act in preparation for making recommendations to the Minister as to which to proceed". It stated that the intention was to consult with bodies such as the Council prior to recommendations going to the Minister. To date no further advice has been received in relation to this matter.

### 7.2.2 Voluntary Patients Detained in Secure Units

Under the *Mental Health Act 1962* only selected beds in some of the psychogeriatric lodges were 'approved' for the detention and treatment of involuntary patients. The approved beds were all based in separate wings (e.g. Lemnos Hospital at Selby campus and La Salle at Swan campus) of the units. The other areas of the lodges were not 'approved' and individuals were treated and not permitted to leave on the basis of "duty of care".

With the commencement of the *Mental Health Act 1996* a decision was made to 'authorise' (as per section 21 of that Act) all beds in Selby Lodge and Swan Lodge, now the Boronia Unit, to allow for the assessment, detention and treatment of individuals under that Act. All psychogeriatric beds at the Alma Street Centre (Ward 4.3) and the Mills Street Centre (Wards 9 and 10 - 'Bentley Lodge') at were also authorised and are locked/secure.

In practice this meant that some consumers whose legal status was voluntary were being detained in an authorised hospital without the requirements of the *Mental Health Act 1996* being satisfied.

The Criminal Code s 337 states:

***"Unlawful detention or custody of persons who are mentally ill or impaired"***

**337.** *Any person who detains, or assumes the custody of, a person suffering from mental illness (as defined in the Mental Health Act 1996) or mental impairment, contrary to that Act or any law relating to mental impairment, is guilty of a misdemeanour and is liable to imprisonment for 2 years."*

Provisions of the *Mental Health Act 1996* relating to detention, with the exclusion of transport orders, specify that the individual can be detained in an "authorised hospital" (e.g. sections 36, 37 43, & 45). Therefore it is illegal to detain people in authorised hospitals other than under the legislated provisions.

In response to the Council's concern two arguments have been put forward to justify the current situation. Firstly, "duty of care" and secondly that the consent of family could be obtained to detain the patient.

#### ***Duty of Care***

It has been argued that the hospital staff have a "duty of care" to ensure the physical safety and well being of the consumers (for example to stop the person wandering away from the hospital) therefore it is permissible to detain them in a locked ward.

Whilst the Council acknowledges this "duty of care" it would contend that "duty of care" does not arise as a reason to detain an individual in an authorised hospital because the Criminal Code replaces the common law as the Code has two specific provisions:

Section 262 that imposes a duty of care irrespective of the means by which the person became detained; and

Section 337 prohibiting detention except as authorised as above.

### *Consent of another*

It has also been suggested that for those individuals who lack the capacity to consent that the obtaining of "consent" from next of kin/family members 'authorises' the person's treatment and detention.

It is the Council's view that a relative, and indeed any person, cannot consent to detention in an authorised hospital and most of the patients concerned do not have the capacity to consent. The lack of a 'will to leave' is not consent. The lack of a 'will to leave' does not override the Criminal Code by somehow 'authorising' the detention.

**The Council does not know whether the Health Department sought a legal opinion prior to the authorising of all beds in the above units. In its discussions with the Chief Psychiatrist no such opinion has been produced or quoted.**

The Council is aware that Dr Neville Hills, Psychiatrist previously in charge of Selby Lodge, raised similar concerns regarding the authorisation of Selby Lodge and the treatment of those who could not give consent with the Office of the Chief Psychiatrist in November 1998. Selby Lodge was authorised in January 1999. The Council does not know if any legal opinion was sought following Dr Hills raising these concerns with the Chief Psychiatrist and prior to the authorisation of the unit.

Dr Hills also raised his concerns with Mr Neville Barber, President of the Mental Health Review Board in February 1999 and Ms Julie Roberts of the Office of the Public Advocate in June 1999. In the latter he specifically expressed his concern that staff may be exposed to the "risk of litigation on this matter".

The time involved in endeavouring to have this issue considered and action taken to clarify the legal situation is of grave concern to the Council. As noted above, Dr Neville Hills initially raised the issue as early as November 1998. The Council first raised its concerns with the Office of the Chief Psychiatrist in September 1999. In early October 1999 a response was received from that office advising that when Prof. G Lipton returned from leave, he would convene a meeting of relevant agencies. A meeting between the Head of Council and the Office of the Chief Psychiatrist occurred in November 1999 during which the Head of Council was advised that that office was awaiting legal opinion.

In early January 2000 a subsequent meeting occurred where the Council representatives were advised that no action would be taken by the Office of the Chief Psychiatrist regarding this issue. No comment was offered regarding legal opinion being received in relation to this issue. In February 2000 the Council advised the Minister for Health of this meeting and registered concern regarding this issue and requesting co-operation to ensure that appropriate action would be taken as soon as possible to effect a remedy.

In early May 2000, as it appeared that no action was being taken and having received no advice, the Council, as authorised under section 188 (f) of the Act, contacted the Police Commissioner, Public Sector Standards Commissioner (PSSC), State Ombudsman and Anti-Corruption Commission seeking advice on how best to proceed and for investigation if deemed appropriate. As at 30 June 2000 those bodies had replied as follows:

- Police Commissioner - comment being sought from the Commissioner of Health and advice will be provided following this.

- Commissioner for Public Sector Standards - issues relate to administrative decision making therefore more appropriately fall within the Ombudsman's jurisdiction. Ombudsman's office to advise PSSC if any issues concern the conduct of public sector employees and warrant the PSSC's involvement.
- Ombudsman - Investigations of matters that are still under consideration normally do not occur. Once a reply has been received from the Minister for Health prepared to consider becoming involved at that stage.
- Anti-Corruption Commission - The Commission requires specific details including identification of individuals involved and specific conduct that forms the basis of the complaint before it could consider the concerns raised.

Subsequent to this correspondence a meeting involving the Minister for Health, the Commissioner for Health and the Head of Council occurred on 29 May 2000 to discuss the issues. It was advised that a meeting was to be arranged by the Office of the Chief Psychiatrist to discuss the issue as a matter of urgency. A meeting of agencies identified as relevant by the Office of the Chief Psychiatrist occurred on 13 June 2000. The outcome of this meeting was that a draft protocol for the management of the elderly in locked facilities would be developed and that the Chief Psychiatrist would discuss the matter with the Commissioner of Police.

It was also intended to reconvene the group approximately one month later to discuss findings.

The Council of Official Visitors' concern has arisen not because there has been a change in clinical practice but because an administrative decision was made, (i.e. to authorise all beds in the units), which has now placed the previous practices in breach of the relevant legislation.

**The basis of the Council's concern is its interpretation of the legal situation. At no time has it been suggested that this interpretation is flawed. The Council would suggest that had a legal opinion been sought when this issue was first raised then it might well have been more expeditiously resolved.**

### **7.2.3 Medical Treatment may be Approved by the Chief Psychiatrist - *Mental Health Act 1996, section 110***

Mental Health Act 1996 (the Act), section 110 provides for the Chief Psychiatrist to approve, in writing, the giving of medical treatment to involuntary patients or mentally impaired defendants in an authorised hospital. The Act does not define "medical treatment".

In part this relates to the concern raised in the Council's 1998 - 1999 Annual Report regarding the perception that pharmaceutical contraception, in particular depo provera, was being prescribed to involuntary patients without their informed consent. Associated with this was the reported perception by some women consumers in secure wards that, if they consented to the depo provera and did not argue, they would be transferred to an open ward sooner.

To assist the Council in its deliberations on this and the broader issue of consent to "medical treatment", advice was requested from the Crown Solicitor's Office on two points relating to the operation of section 110 of the Act.

Firstly, advice was sought on whether the prescription of pharmaceutical contraception falls within the meaning of "medical treatment" under the Act. The Crown Solicitor's advice was that whilst pharmaceutical contraception does **not** fall within the definition of "psychiatric treatment" it would be considered, at law, to be medical treatment.

This advice supports the prescribing of depo provera to an involuntary patient or mentally impaired defendant in an authorised hospital without that person's consent. It also makes it clear that depo provera is not a 'psychiatric treatment' and therefore should not be included as part of the treatment plan in a Community Treatment Order.

Secondly, advice was also sought regarding whether section 110 allows the Chief Psychiatrist to consent to medical treatment only when the involuntary patient or mentally impaired defendant is unable to consent. That is, the involuntary patient retains the right to withhold consent if they have that capacity. The advice received stated:

*"... in my view section 110 of the Act does allow the Chief Psychiatrist or his delegate to approve medical treatment for an involuntary patient or mentally impaired Defendant against that person's will, even if the person would have the capacity to consent if he or she were not an involuntary patient or a mentally impaired Defendant."*

It is the Council's understanding that the Chief Psychiatrist has delegated the authority prescribed under section 110 to the Psychiatrists in Charge of the authorised hospitals. It is the Council's view that the intention of placing the authority to approve medical treatment for involuntary patients and mentally impaired defendants in authorised hospitals in the Office of the Chief Psychiatrist was to ensure that an external review of decisions regarding medical treatment occurred prior to their implementation. **The Council is of the view that this is not seen to be done if, in fact, it is the Psychiatrist in Charge of the authorised hospital where the individual is detained who approves such treatment.**

The Council's concerns are not related to the professionalism or competency of the individuals who are in charge of the authorised hospitals. They relate in particular to those types of treatment that may be considered contentious, including contraception, to the intent of the legislation and to whether, by the delegation of this power without limitations to the psychiatrists in charge of the authorised hospitals, this has been circumvented.

#### **Case Study**

BN, an involuntary patient in an authorised hospital, complained that she had been advised that Depo Provera would be prescribed and administered to her, without her consent. Her recollection of the conversation was that "just the approval of another psychiatrist" was needed for this to occur. An Official Visitor clarified with the treating psychiatrist who advised that it was conceivable that BN would be prescribed Depo Provera without her consent, with the written authority of the psychiatric in charge of the authorised hospital, as per the Chief Psychiatrist's delegation.

BN's perception was that there would be no external review of the decision to prescribe a long acting contraceptive as the psychiatrist granting approval was employed by the hospital where she was being treated. Her only real avenue for recourse would be an application to the Mental Health Review Board under section 142 (1) (e) of the Act.

#### **7.2.4 Staff/Facility Compliance with *Mental Health Act 1996***

As reported in the Council's 1998 - 1999 Annual Report some staff in facilities appear to lack the required level of knowledge of the legislation and, by default, place themselves in breach and subject to penalties.

The examples cited in the 1998 - 1999 report continued to occur in 1999 - 2000 including:

- failure to inform consumers of their rights each time an order is made;
- failure to document such action in medical records; and
- refusal to allow Official Visitors access to affected persons' records.

These serve to highlight the need for ongoing education and training for **all** staff in facilities.

A number of examples where individual staff, or facilities as a whole, have, in the Council's opinion, failed to comply with the Act are described more fully below.

#### **7.2.4.1 Issuing of Orders and Explanation of Rights**

Section 156 of the Act requires that an explanation of rights is given to a person both verbally and in writing when he/she is admitted to an authorised hospital, an involuntary patient or community treatment order is made or he/she is granted leave. In addition section 158 (2) requires that a record of this explanation being given is made. The detail contained in the "Your rights under the Mental Health Act 1996 card" issued by the Mental Health Division, appears to be the basis for the explanations given. Whilst providing an overview, the use of this card alone in the giving of the explanation does not, in the Council's opinion, provide adequate details, *"having regard to the particular situation of the person"* (Mental Health Act 1996 Mental Health Regulations 1997 Regulation 18). It is also not uncommon for Official Visitors to find that there is no notation of the explanation having been given to the person.

The Council is also concerned that consumers often report that they have not been informed of their rights. In some instances patients' records confirm that this is true and Official Visitors have requested that this be done immediately. In other instances, according to the records, this has occurred and it appears that the individual has not remembered this occurring. Whether an individual consumer is asked, at times subsequent to the issuing of the explanation, whether they understand or remember appears to be dependent on individual staff. On occasions staff have advised Official Visitors, when asked if it has occurred, that in effect it is not the current staff's responsibility but the staff in, for example, the admission ward.

**The Council does not believe that this is within the spirit of the Act and has suggested that strategies be developed to ensure that subsequent to explanations being given it is clarified with consumers whether they remember and understand these rights.**

##### **Case Study**

DS, an involuntary patient in an authorised hospital was, as part of his management plan granted a 'period of trial leave' with no minimum or maximum time limit. There was no written approval for the granting of leave by a psychiatrist under section 59 of the Act, in DS' medical record. There was no notation that DS' rights had been explained to him at that time.

Subsequently there was a notation in DS' medical record that he had been returned from the community accommodation setting as he was absent without leave (AWOL). There was no written cancellation of his leave in his record (section 60(1) of the Act).

The Council's view was that DS could not be considered AWOL unless the time specified in the order granting leave had elapsed and the patient had not returned to the hospital. There was no formal granting of leave and there was no fixed time period noted in DS' management plan. Alternatively DS could have been termed AWOL if a psychiatrist had cancelled the leave by notice in writing served personally on DS. The medical record did not contain any written cancellation nor any notation that such notice had been served.

The paucity of information contained in some of the orders completed under the *Mental Health Act 1996* has been of concern to the Council. Comments such as “*person suffers from a mental illness as defined under the Act and warrants involuntary hospital management for own health and safety*” are not uncommon. Comments such as this fail to specify the facts or observations on which the opinion is based nor address matters in section 26(1) (c) or (d) of the Act. The use of generalised terms fails to provide meaningful information and would appear not to reflect the intent of the Act. Council has raised these concerns with the Mental Health Review Board and the Office of the Chief Psychiatrist.

In addition, Council has expressed concern that on occasions the designated treatment on a Community Treatment Order (CTO) has been extended to include other than psychiatric treatment, for example treatment of a physical illness. Council’s concern is that failure to adhere to an element of the treatment plan that is not directly related to treatment for a mental illness, can result in the individual’s CTO being revoked and his/her detention as an involuntary patient in a authorised hospital. This has also been raised with the Mental Health Review Board for comment.

#### **7.2.4.2 Second Opinions - Mental Health Act 1996 section 164 (2)**

This issue is detailed above (refer to 7.1.9 above) however it is important and of concern to note that occasions continue to occur where experienced staff arrange for interviews and examinations by medical practitioners who are not psychiatrists, as defined in the Act.

#### **7.2.4.3 Telephone Privacy Provisions - Mental Health Act 1996 section 167**

The Act, section 167, provides that patients have the opportunity, in 'reasonable privacy', to make and receive telephone calls as far as is 'reasonably practicable'. The Council adopted a position in relation to its opinion on 'reasonable privacy' (refer to 6.3.1 above). It was identified that in some hospitals little or no privacy was, in effect, afforded to consumers making and receiving telephone calls due to the physical location of public telephones, for example in the corridor directly in front of the staff office.

Graylands Hospital, in response to concerns from consumers, had initiated a working group involving clinical staff, engineering staff and consumer representatives to review the provision of telephone facilities available to consumers. This was a very positive step that addressed both consumers' identified needs and clinical concerns. A number of strategies were developed to improve the degree of privacy available including the purchase and use of cordless telephones and the relocation of some telephones.

It is of concern that despite the Council's suggestion that similar working groups be established in other authorised hospitals action has been slow to occur and many still appear to be lacking in facilities to ensure 'reasonable privacy'.

#### **7.2.4.4 Confidentiality and Mental Health Act 1996**

The Council members encountered a number of examples where it would appear that the actions of the staff in a facility may have been in breach of the confidentiality provisions of the *Mental Health Act 1996* (section 206).

### **Consumers' Names/Details Displayed**

During November 1999 the Council advised all authorised hospitals of its concern that the placement of consumers' full names on whiteboards visible from public areas of the ward could be considered a breach of confidentiality. In some instances other details relating to the consumer, including legal status under the Act, were also noted on these boards. The boards served an administrative function for staff. The physical location of the boards in an area where any person entering a ward could view the details was a design issue and the point of concern. The majority of facilities undertook steps to rectify this including listing consumers' first names only and ensuring no other details relating to the individual were recorded there. At 30 June 2000 at least one authorised hospital continued to display consumers' full names on publicly visible boards. This is being pursued with that facility.

### **Release of Information to Third Party without Consent**

The Council also received complaints from separate consumers that personal information relating to them had been released to a third party without their consent. In the first instance an independent agency had been contracted to conduct a patient satisfaction survey. The survey forms were posted to individuals' home addresses and noted "MHU", an apparent abbreviation for Mental Health Unit. The consumer involved was distressed that personal details had been released. The facility endeavoured to address the complaint directly with the individual but it was unable to be resolved to the consumer's satisfaction. Whilst the Council understands the value of consumer feedback the provision of patient details to a third party appeared to place the facility in breach of section 206 of the Act. In accordance with section 188 (f) of the Act the Council referred the matter to the Commissioner of Health for further investigation. At the time of the report the outcome of this referral is unknown.

In a separate instance a consumer complained that details relating to his/her treatment had been released to the professional board with which they were registered. A staff member at the facility where the consumer was receiving treatment believed that they had a professional responsibility to refer concerns regarding fitness to practice to the registration board. The information on which the concern was based had been received whilst the consumer was a patient not a colleague. This was done without the consumer's knowledge or consent. The Council sought and obtained legal opinion from the Crown Solicitor's Office, which indicated that it appeared that breach of the provisions of section 206 of the Act had occurred. In accordance with section 188 (f) of the Act the Council is to refer the matter to the Commissioner of Health for further investigation.

#### **7.2.5 Planning Ratios and Bed Availability - Adolescents' Access to Age Appropriate Services**

The Council was very concerned with the number of admissions of adolescents to adult authorised hospitals during 1999 - 2000. In one adult unit the incidences were as follows:

September 1999	15 year old	1
October 1999	15 year old	2
	16 year old	1
	17 year old	3
November 1999	13 year old	1
	15 year old	3

### Case Study

JF, aged 14, was admitted to Princess Margaret Hospital. JF was assessed as requiring a secure unit that Princess Margaret Hospital was unable to provide. The specialist adolescent unit's secure section (four beds) was full. Approximately six hours later she was transferred to Graylands Hospital in the early hours of the morning where she was admitted to the secure admissions ward. At the time of her admission there were eleven inpatients in the unit that is designed for a capacity of eight.

The Council does not support the overcrowding of units however it was of concern that JF was admitted to an adult unit that was already over capacity rather than to the specialist secure adolescent unit which was also at capacity but not overcrowded.

Adolescents have also been admitted to the forensic unit at Graylands Hospital.

The WAY Centre was established as a statewide service for adolescents. It is the only adolescent specific unit that is authorised under the *Mental Health Act 1996* and therefore able to detain and treat individuals as inpatients. The Council understands that there are instances when the WAY Centre is at capacity. However the Council takes a serious view of the fact that younger consumers should be receiving treatment and care in appropriate facilities. Staff in adult units do not necessarily have the skills and expertise to work with adolescents.

The Council first raised its concern regarding this issue with the Metropolitan Health Service Board in November 1999 and requested advice regarding the development of a contingency plan for when the WAY Centre is at capacity. A similar plan had been developed in relation to adult authorised hospitals. In May 2000 the Council was advised that a draft contingency plan was under development. At the time of this report no advice has been received regarding the adoption of a plan.

In addition, the absence of a forensic facility for adolescents is also a matter of concern and requires review.

Most people view the prospect of entering any hospital with trepidation. It is not difficult to imagine the degree to which such trepidation is increased when a person is committed to a hospital when they are very unwell but against their will. The effects on adolescents thus committed when their new location is with equally unwell adult patients must be distressing.

**That the system allows this practice to persist is an indictment.**

#### 7.2.6 Security of Consumers' Belongings

Security of consumers' belongings has been raised with the Council on a number of occasions during the 1999 – 2000 financial year. Authorised hospitals have policies in place in an attempt to ensure that consumers' belongings are kept safe. In practice however this raises questions related to the individual's right to choose to have belongings including money with him/her without restriction, and the question of his/her ability to make an informed decision relating to this. The notion of 'all care, no responsibility' appears to be adhered to in authorised hospitals.

In at least one instance the loss of belongings involved a substantial amount of clothing and shoes, not just one item.

The Council does not accept the somewhat dismissive attitude of management to this issue. When credit cards and large amounts of personal property are lost in what are euphemistically referred to as "secure" wards, one has to question the performance of staff and the adequacy of their supervision by management.

The use of property sheets is an attempt to keep track of an individual's belongings but is only as effective as the consistent approach to the completion of the forms. The process involves noting all the property the consumer has and where it is stored, for example with the consumer, in the hospital property office, with a staff member. One copy is given to the consumer, one attached to his or her file and one sent to the property office. It is accepted that staff will not always know when belongings are either provided to consumers or taken away by family and friends. It is of concern however that when staff are aware of these actions that an accurate record of this is not made.

#### **Case Study**

PA complained to the Official Visitors that his Visa card had been lost following his transfer from one ward to another. The Official Visitor noted that the file copy of the property sheet had not been adequately completed with no record of where this item was stored. The copy of the form kept by the property office however had the relevant section completed. Apparently this had been done once the sheet arrived in the property office and the staff there requested the relevant information from staff on the ward. Had the changes been made on all copies, or a new sheet issued then there would have been no confusion regarding the location of the card.

#### **Case Study**

MA complained that she did not have access to her keycard. There was no record on a property sheet of the location of that card. The card was being held by a staff member however given the lack of notation it was dependent on another staff member knowing and reporting this fact to the Official Visitor.

### **7.2.7 Access to Culturally Appropriate Services**

The Council received a number of complaints from consumers regarding lack of access to facilities to observe religious beliefs. In particular this related to religions other than Christian based ones. Whilst the Council is aware that it is not possible to provide separate facilities for all religions it is imperative that facilities are designed to ensure appropriate access for other than Christian based groups, for example, the provision of basins for the washing of hands prior to entering a place for religious observance. This is an area that must be considered in the designing of new mental health and health facilities.

## 8 PRIORITIES FOR 2000 - 2001

The Council is a watchdog set up by Parliament and members of the Council are committed to ensuring that Parliament's action is supported by a rigorous approach to the fulfilment of that watchdog role. The Council must remain passionate and partisan on behalf of consumers but at the same time display professionalism and objectivity.

Advocating for improvements in the mental health system including authorised hospitals, community mental health services and the licensed private psychiatric hostels, is integral to the Council's raison d'être. Whilst there have been improvements and additional funding has been made available in the mental health system in WA this report highlights the ongoing need for improvements. The experience of individual consumers receiving services is, at times, patently less than acceptable.

Given its unique position, the Council's ability to bring these matters to the attention of those who have the power to modify the system must continue to form a significant element of its work.

A number of priority areas in the mental health system have been identified for attention during 2000 - 2001. These include continued advocacy for:

- Development and implementation of standards related to quality of life/care issues in the licensed private psychiatric hostel industry.
- Development of strategies to address the issues of overcrowding in authorised hospitals and the immediate impact on consumers.
- Amendments to the *Mental Health Act 1996*, in particular, the definition of "affected person" under section 175.
- Improved access to age appropriate services for adolescents.
- Development of system wide policies covering all mental health services - public, private, metropolitan, rural and remote - regarding issues impacting on consumers, including search the person.
- Improved procedures for the security of consumers' belongings.
- Review of the *Criminal Law (Mentally Impaired Defendants) Act 1996*, in particular in relation to consumers' rights.

The following areas of the Council's own operation also require priority attention during 2000 – 2001:

- Increasing the percentage of formal inspection visits which occur at times other than Monday to Friday 9.00 am to 5.00 pm.
- Implementation of a formalised process to audit whether the requirements of the *Mental Health Act 1996* associated with the issuing of Community Treatment Orders is occurring.



## APPENDICES

### APPENDIX 1A: AUTHORISED HOSPITALS

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

**Albany Mental Health Unit**

Albany Regional Hospital  
Albany

**Alma Street Centre**

Fremantle Hospital and Health Service  
Alma Street  
Fremantle

**Boronia Inpatient Unit<sup>1</sup>**

Swan Health Service  
Eveline Road,  
Middle Swan

**Bunbury Acute Psychiatric Residential Unit**

Bunbury Health Campus  
Bunbury

**Graylands Hospital**

Graylands Selby Lemnos and Special Care Health Services  
Brockway Road  
Mount Claremont  
Including: Frankland Centre (forensic)

**Joondalup Mental Health Unit**

Joondalup Health Campus  
Shenton Ave.  
Joondalup

**Mills St Centre**

Bentley Health Service  
Mills St,  
Bentley  
Including: Mills St Lodge  
WAY Centre (previously Bentley Adolescent Unit)

**Selby Lodge**

Graylands Selby Lemnos and Special Care Health Services  
Stubbs Tce  
Shenton Park

## APPENDIX 1B: LICENSED PRIVATE PSYCHIATRIC HOSTELS

(As per "Functions of the Council of Official Visitors Direction 1997")

<b>Aitken House</b>	55 View Street North Perth
<b>Anzac Terrace<sup>1</sup></b>	175 Anzac Tce, Bassendean
<b>Casson House</b>	2-10 Woodville Street, North Perth
<b>Delta House<sup>1 &amp; 2</sup></b>	4 Mann Way, Bassendean
<b>Devenish Lodge</b>	54 Devenish Street East Victoria Park
<b>Dudley House</b>	24 Dudley Street Midland
<b>Franciscan House</b>	16 Hampton Road Victoria Park
<b>Gildercliffe Lodge<sup>3</sup></b>	180 Gildercliffe Street, Scarborough
<b>Glyde Street Hostel</b>	48 Glyde Street, Mosman Park
<b>Gormley House</b>	25 View Street, North Perth
<b>Hillview<sup>1</sup></b>	13 Teague Street Victoria Park
<b>Jansen<sup>1</sup></b>	56 Glyde Street, East Fremantle
<b>John Wilson Lodge</b>	38 Hamilton Street, East Fremantle
<b>Kingston<sup>1</sup></b>	58 Glyde Street, East Fremantle
<b>Maude Armstrong</b>	16 Davies Road, Claremont
<b>Milgrey House<sup>4</sup></b>	181 Grey Street, Albany
<b>Romily House</b>	19 Shenton Road, Claremont
<b>Rosedale Lodge</b>	22 East Street, Guildford
<b>Salisbury Home</b>	19-21 James Street, Guildford
<b>Shannon House</b>	23 Coolgardie Street, Subiaco
<b>Shepperton House<sup>1</sup></b>	2 Teague Street, Victoria Park
<b>Sherwood House</b>	5 Kalamunda Road, South Guildford
<b>Success Hill Lodge</b>	1 River Street, Guildford
<b>Violet Major House</b>	47 View Street, North Perth
<b>Woodville House</b>	425 Clayton Road, Helena Valley
<b>Yates House</b>	34 Camellia Street, North Perth

<sup>1</sup> Richmond Fellowship altered the house names in January 2000 to reflect street address rather than those cited in Direction Notice.

<sup>2</sup> Residents relocated from 202 Anzac Terrace into new purpose built accommodation at 4-6 Mann Way in March 2000.

<sup>3</sup> Ceased operation 02 February 2000.

<sup>4</sup> Ceased operation 30 April 2000.

## APPENDIX 2: COUNCIL OF OFFICIAL VISITORS

### 1999 - 2000 MEMBERSHIP

<b>Head of Council</b>	<b>Expiry Date of Term</b>
Mr Stuart FLYNN	15 February 2001
<b>Official Visitors</b>	
Mrs Di ANNEAR	06 April 2002
Ms Sandra BROWN	07 April 2001
Mrs Rita BURGESS	07 April 2000
Mrs Jean ELLIS	30 August 2001
Mr Adrian GAVRANICH	07 April 2001
Mr Kevin GUHL	30 August 2001
Ms Amara HOGVEEN	07 April 2000
Mr Kevin HOGG	07 April 2001
Mr Gary HULSE	06 April 2002
Ms Manjit KAUR	07 April 2000
Ms Edana MCGRATH	07 April 2001
Ms June O'CONNOR	30 August 2001
Mrs Noreen PAUST	30 August 2001
Dr John ROONEY	30 August 2001
Mrs Rosalind SAWYER	07 April 2000
Mrs Maxinne SCLANDERS	07 April 2001
Mrs Sheila STEPHENS	07 April 2001
Ms Brenda VAN ZALM	07 April 2002
Ms Janet WAUCHOPE	(Resigned 12 July 1999)