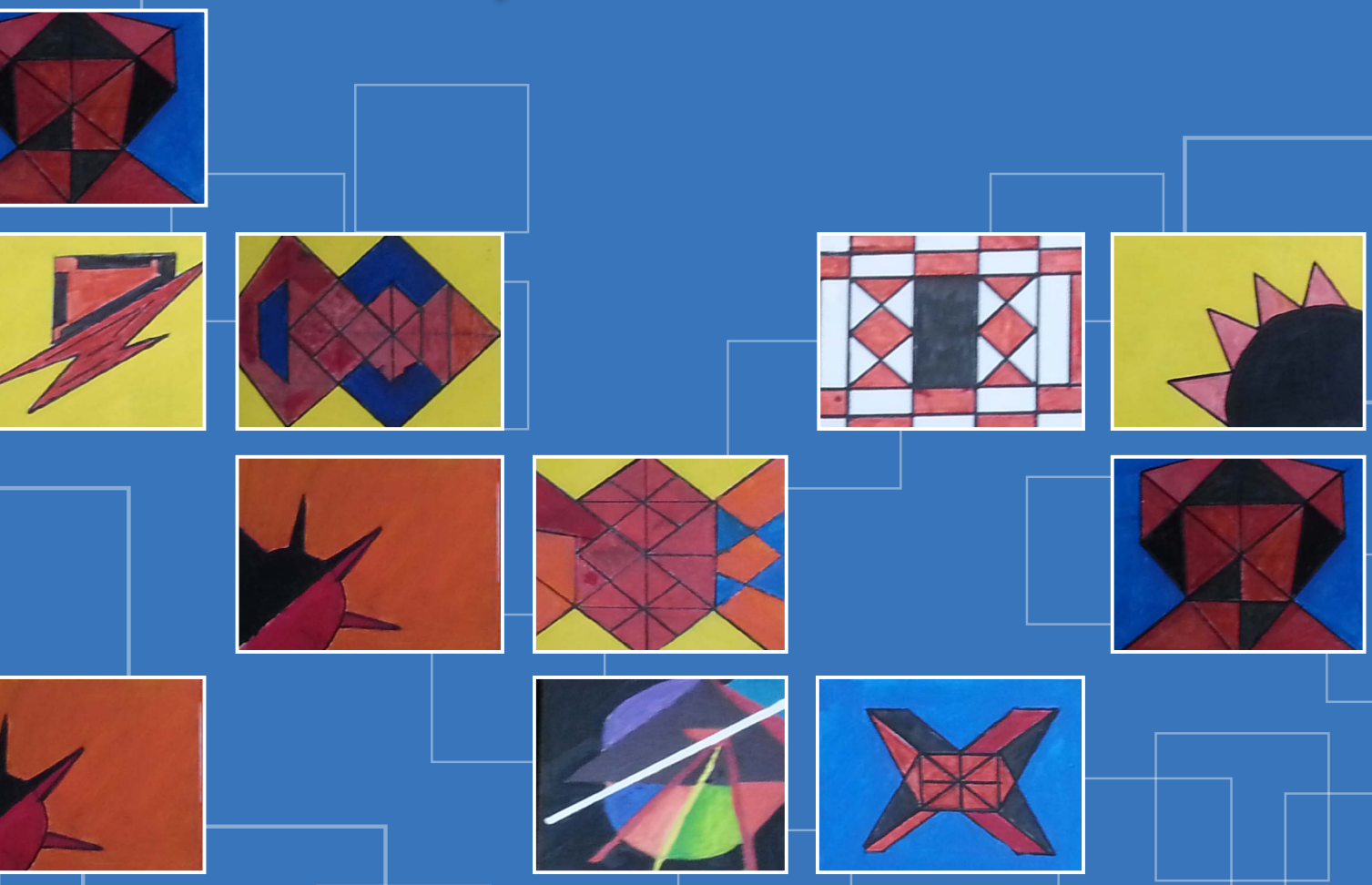
COUNCIL OF OFFICIAL VISITORS

ANNUAL REPORT
July to November 2015



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Hon Andrea Mitchell MLA

MINISTER FOR MENTAL HEALTH

In accordance with section 192(3) of the former *Mental Health Act 1996* and section 666 of the *Mental Health Act 2014,* I submit for your information and presentation to Parliament the Annual Report of the Council of Official Visitors for the period 1 July to 29 November 2015. This is also the final report for the Council of Official Visitors. Effective 30 November 2015 the Council of Official Visitors ceased and the Mental Health Advocacy Service was established by the Chief Mental Health Advocate appointed under the *Mental Health Act 2014*.

As well as recording the operations of the Council in 2015, this Annual and final report reflects on the work of the Council of Official Visitors over its 18 years as well as a number and range of issues that continue to affect consumers of mental health services in Western Australia.

Debora Colvin
HEAD, COUNCIL OF OFFICIAL VISITORS

September 2016

Cover Image

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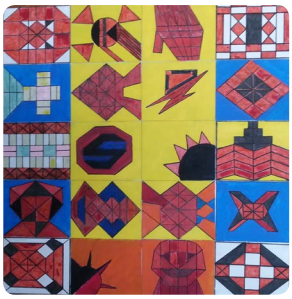

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INTRODUCTION

The Council of Official Visitors (Council) was established by the Mental Health Act 1996. It came into existence on 13 November 1997 and ended at midnight on 29 November 2015 having been replaced by the statutory position of the Chief Mental Health Advocate on 30 November 2015 pursuant to Part 20 of the *Mental Health Act 2014* (the 2014 Act).

This is therefore the last Annual Report of the Council. It is mostly written by Norma Josephs, Deputy Head of Council, as I was appointed the new Chief Mental Health Advocate on 21 September 2015 and spent the remaining 2 months establishing the new Mental Health Advocacy Service.

The report reflects on Council's 18 years of operation under the *Mental Health Act 1996*, in addition to being the final report of the Council of Official Visitors for the period 1 July 2015 to 29 November 2015 (as required by section 666 of the *Mental Health Act 2014* which provided transitional arrangements). Demand for Official Visitors continued during the five months and 867 consumers were assisted and 348 hospital and hostel inspections occurred.

The concept of visitors has a long and established reputation as protectors of rights. As a precursor to the Boards of Visitors and then the Council of Official Visitors, "Visitors" were established by the *Lunacy Act 1871* and were required to visit every "asylum" once a week. These "Visitors" enquired into "systems of non-coercion", the condition of "pauper" patients, and occupations or "amusements" for patients.

The contemporary role of the Official Visitor was to ensure involuntary mental health patients in hospital and in the community, as well as people living in a psychiatric hostel and those who were mentally impaired accused, were aware of their rights and their rights observed. They also held an inspection function and had a role to identify gaps in the mental health system.

Thankfully the importance of the role was recognised and it continues and has been expanded in the 2014 Act.

The success of any organisation can be marked by the consistency of enacting its values. From its inception as an organisation in 1997 and through its 18 years of operation the Council has maintained a strong focus on consumer rights and person-centred practice, recognising their strengths and goals of individuals, and advocating steadfastly for least restrictive practice and the highest standard of care and support.

During this period there have been three Heads of Council: Mr Stuart Flynn, Dr Judyth Watson and myself. I believe that we have successfully built on each other's work, providing a seamless transition of leadership, so that significant issues and priorities of Council have not been lost over the years. Major issues continue to plague the mental health system, however, as listed in Part 3 of this report, these long standing systemic issues will form the continuing work of the Advocacy Service.

One of the most significant safeguards to consumers' rights is the implementation of a more person-centred, recovery-based treatment and support approach in hospitals and the community. The 2014 Act offers the opportunity for enhanced consumer rights including the right to have, and be involved in, a treatment, support and discharge plan and to have one's wishes heard. The new Mental Health Advocacy Service will be one of three pillars of protection for consumers along with the Mental Health Tribunal and Chief Psychiatrist.

There was extensive recruitment for the Mental Health Advocacy Service during September and October with some 200 applicants for the new Advocacy positions. Twenty seven Mental Health Advocates were appointed, 19 of whom were current Official Visitors and eight were new appointments. Two Senior Mental Health Advocates were also appointed.

Appreciation is extended to former Official Visitors and a welcome to the new Advocates. We are confident that the Advocates will stay firm to the needs of each individual and their rights under the 2014 Act, and will work collaboratively with others to identify gaps in the mental health system and assist in working towards creative solutions.

Debora Colvin
HEAD, COUNCIL OF OFFICIAL VISITORS
September 2016

Norma Josephs
DEPUTY HEAD, COUNCIL OF OFFICIAL VISITORS
September 2016

"All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person."

PART ONE

The Legislative and Operational Framework

FUNCTIONS AND POWERS OF COUNCIL AND OFFICIAL VISITORS

The functions and powers of the Council and its members, called Official Visitors, were set out in ss175 to 192 of the *Mental Health Act 1996* (the Act).

On 30 November 2015 the *Mental Health Act 2014* (the 2014 Act) superseded the Act and the Council was replaced by the statutory position of the Chief Mental Health Advocate who established the Mental Health Advocacy Service (MHAS). The transitional provisions to the 2014 Act required that a final Annual Report be produced after 30 November 2015.

Pursuant to s186 of the Act, Council was required to ensure that an Official Visitor or panel visited:

- each hospital authorised under s21 of the Act at least once per month. In practice, visits took place more often. Official Visitors visited consumers on request, conducted formal and informal inspections and checked Council mailboxes on the wards for correspondence from consumers
- each private psychiatric hostel at the direction of the Minister for Mental Health (Minister). The Direction stated visits were to take place at least once every two months, but visits were also made in response to consumer requests or where an ongoing issue had been identified requiring follow up
- all consumers who requested a visit as soon as practicable after the visit was requested. Council policy was to respond within 24 hours to a new consumer or otherwise within 24 to 48 hours.

The functions of Official Visitors (s188 of the Act) were to:

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

The term 'affected person' was defined by s175 of the Act to mean any one of the following:

- an involuntary patient, including a person subject to a Community Treatment Order (CTO)
- a mentally impaired accused person in an authorised hospital
- a person who is socially dependent because of mental illness and who was residing, and cared for or treated at a private psychiatric hostel.

Affected persons were referred to by Council and hereafter in this Annual Report as 'consumers' when they requested assistance from an Official Visitor, or 'residents' if they resided in a psychiatric hostel.

RIGHTS PROTECTION

The rights which the Official Visitors sought to protect were derived from:

- the United Nations *"Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care"* adopted in 1991 (the United Nations Principles), and in particular Principle 2 which reads:

  "All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person"

- the Act, which accorded a set of legal rights to consumers in Western Australia (WA)
- the *"Licensing Standards for the Arrangements for Management, Staffing and Equipment: Private Psychiatric Hostels"* prepared by the Licensing and Accreditation Regulatory Unit (LARU) of the Department of Health (DOH) as regulated by the *Hospitals and Health Services Act 1927*; and various standards including *"Service Standards for Non-Government Providers of Community Mental Health Services"*
- the *"National Standards for Mental Health Services"* designed to guide policy development and service delivery in each of the states.

The United Nations Principles recognise that the role of community and culture is important, with each consumer having the right to be treated and cared for, as far as possible, in the community in which he or she lives. The Objects of the Act (s5) reflected, but did not elaborate on, international principles. Section 5 specified, however, that there must be:

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

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

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

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

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

POWERS OF OFFICIAL VISITORS

In order to ensure that consumers' rights were observed and that they had been informed of their rights, Official Visitors had the power pursuant to s190 of the Act to:

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

INDIVIDUAL ADVOCACY APPROACH OF OFFICIAL VISITORS

Council articulated the 'pure advocacy' approach in its Code of Conduct in 2012 which meant that Official Visitors did not take a 'best interest' approach when advocating for individual consumers. Consumers have many other people making decisions in their 'best interest'. Instead Official Visitors acted as a mouthpiece for the consumer and were partial to the consumer. The Official Visitor would tell the consumer their rights and options as well as consequences of taking particular actions and then would act according to the consumer's wishes.

Where a consumer was not able to say what they wanted and the Official Visitor was concerned that rights were being infringed, they would take action as required under the Act to ensure that the consumer's rights were observed. Official Visitors would, in such cases, use 'non-instructed advocacy' as described in Council's Code of Conduct.

OPERATIONAL FRAMEWORK - REPORTING LINES

Official Visitors

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

In practice, Official Visitors dealt with issues at ward and hospital level to the extent that they could. If the issue could not be resolved at that level or if, for example, it involved a serious or systemic issue, it was taken to the Head of Council. Head of Council would then draft a letter, call for a meeting, telephone or email appropriate parties (examples included the Clinical Director of the hospital or service concerned, the Chief Psychiatrist, the Mental Health Commissioner and, when warranted, the Minister).

Similarly with hostels, Official Visitors first tried to deal with issues by speaking to the hostel supervisor or Licensee. Sometimes, however, Head of Council would also meet with the Licensee or raise issues with other bodies such as the Office of the Chief Psychiatrist or LARU.

In addition, the Head of Council met with or contacted the Minister, the Mental Health Commissioner, the management teams of each of the authorised hospitals, as well as the Chief Psychiatrist, the Executive Directors of North and South Metropolitan and Country Mental Health Services, the President of the MHRB and various others from the government and non-government sectors involved in the protection of consumer rights and the provision of mental health services in WA. At these meetings, various significant and ongoing issues identified by Official Visitors were raised and discussed with the aim of resolving them through effective and timely action.

Administrative support – Executive Officer and other staff

Council was provided with an Executive Officer and three fulltime equivalent staff members, all of whom were public servants employed under Part 3 of the *Public Sector Management Act 1994*. Their role was to provide administrative support as required by s182 of the Act. Staff were employed by the Mental Health Commission (MHC) under s65(2) of the *Public Sector Management Act 1994*.

The Manager (as the Executive Officer) was legislatively responsible for the Council records (ss183 and 184) and taking requests from affected persons for visits by Official Visitors (s189). The Manager also had the delegated responsibility for ensuring that the Official Visitors visited authorised hospitals, complied with Ministerial directions and visited affected persons as soon as practicable after a visit was requested in accordance with s186 of the Act.

COUNCIL COMPOSITION 2015

A list of individuals who were members of the Council from July to November 2015 and their terms of appointment are contained in Appendix 3. As at 29 November 2015, Council had 34 Official Visitors, of which 26 were active plus Head of Council (down from 27 active Official Visitors at 30 June 2015) with eight on an extended leave of absence.

PANEL APPOINTMENTS

Section 187 of the Act allowed the Council to appoint two or more persons, at least one of whom is an Official Visitor, to form a panel for the purposes of that part of the Act. The Act was silent on who may be empanelled and the purpose of panels, but individuals appointed to be members of a panel generally fell into four categories:

1. expert – appointed when issues arose and direct access to professional or expert advice during a visit or contact was required
2. interested community members – appointed when members of the community sought a greater understanding of the role of the Council
3. interim appointments – preliminary to being made an Official Visitor
4. Council support staff – for the purposes of better understanding the work of Official Visitors.

There were seven panel appointments in 2015:

- Royce Zanetic, newly appointed Mental Health Advocate
- Shane Hewerdine, newly appointed Mental Health Advocate
- Yvette Jennings, newly appointed Mental Health Advocate
- Michelle D'Silva, newly appointed Senior Mental Health Advocate
- Nikki Kovacs, newly appointed Youth Mental Health Advocate
- Mr Edwin (Mike) Seward, newly appointed Senior Mental Health Advocate
- Pierre Sauzier, Project Officer, Council of Official Visitors.

COUNCIL MEETINGS

Full Council Meetings

Council usually held two Full Council Meetings per year, however, following the announcement that the 2014 Act was expected to commence on 30 November 2015, it was decided that no meetings would be held.

Executive Group

The Executive Group was delegated the responsibility of making decisions in between Full Council Meetings and conducted most of the strategic and developmental work of Council, though major decisions were usually referred back to Full Council for ratification. The Executive Group comprised representatives from each of the teams (regional and metropolitan), Head of Council, Deputy Head of Council, and the Manager (non-voting).

No Executive Group meetings were held between July and November 2015 due to the impending proclamation of the 2014 Act.

Country and Metropolitan Meetings of Council

Official Visitors were allocated to one of eight teams:

- four teams in regional areas based on the location of authorised hospitals: South West (Bunbury/Busselton), Lower Great Southern (Albany), Goldfields (Kalgoorlie) and Kimberley (Broome)
- four teams in Perth and the outer suburbs (from Joondalup to Armadale to Swan to Rockingham) based roughly on north, south, west and east geographical regions of the metropolitan area.

The four metropolitan and four regional teams met on 4 occasions with Official Visitors in regional areas taking part by video link. The Official Visitors also met separately in their teams. The joint meetings were used to discuss issues identified by Official Visitors across the metropolitan or regional areas and for training.

"Access to appropriate care is a fundamental right and remains an ongoing issue in mental health, whether the care is in a hospital or in the community."

PART TWO

Visits, inspections, issues and outcomes in 2015

The issues listed in this Part reflect the work conducted by Official Visitors during the year from 30 June 2015 to 29 November 2015 arising from their advocacy and inspection functions under the Act prior to the new MHAS starting on 30 November 2015.

Individual Advocacy – Visits on Request (s186(c) of the Act)

Official Visitors assisted 867 consumers during this period. Data on the types of complaints and issues raised is not available because the new Integrated Client Management System (ICMS) was still being developed, tested and implemented in stages.

Monthly and Bimonthly Inspections (ss186 (a) and (b) of the Act)

In accordance with the Act, Official Visitors inspected authorised hospital wards monthly and licensed psychiatric hostels every second month. The prime purpose of these visits was to ensure the safety and suitability of conditions and to make Official Visitors accessible to consumers as required by ss188(c) and (d) of the Act.

The inspections utilised questions based on particular "focus areas" for consumers and staff based on consumer rights, known or suspected systemic issues, and the goals of Council's Strategic Plan. A copy of the Strategic Plan is at Appendix 8.

Focus topics for hospitals during this reporting period were:

- July - Consumer feedback regarding rights
- August – Outstanding issues from environmental audit and previous inspections
- September – Allied health services
- October - Finance and accommodation
- November – Transition to the new MHAS.

Focus topics for hostels (inspected every 2 months) during this reporting period were:

- July/August - Environmental audit
- September/October - Finance and accommodation
- November - Transition to the new MHAS[1].

ISSUE 1 – ENSURING CONSUMERS KNOW THEIR RIGHTS (s188(a) of the Act)

Official Visitors were required to ensure that consumers have been informed of their rights. This was done in part through the monthly and bimonthly inspection process and whenever a request to visit a consumer was received.

1 Only half the hostels received this visit in November so the new MHAS visited the other half in December. Letters were also sent in late October to all hostel licensees explaining the changes to Council.

Illustration 1 – Compliance with ss156 and 157 of the Act – Explanation of Rights

The focus of the July 2015 hospital inspection was consumer feedback regarding rights. Being made involuntary and confined to a locked area is extremely difficult for consumers and they are often overwhelmed and frightened. The experience can be less daunting if consumers know their rights and have an Official Visitor who is there for them. The same is true for family members of the involuntary patient. Issues arising from the inspection pertaining to rights included the following points.

- Official Visitors reviewing consumer files during the July inspection could not consistently find evidence that the consumers were given an explanation of their rights, a copy of their Form 6 involuntary patient order, or that a copy of the Form 6 was given to a relative, guardian or friend as required by the Act.

  Consumers often complain that they are not informed of their rights and that they do not receive copies of their forms. Some, but not all, hospitals had a sticker placed in the consumer's medical file identifying that they had been informed of their rights, provided with a brochure explaining their rights and been given a copy of their involuntary order. Other staff indicated that a form was given but lost or destroyed by the patient. Official Visitors have stressed the need to document if this has occurred and to try and present the forms when the consumer is feeling a bit better.

  Official Visitors are aware that there can be tension between medical and nursing staff about who should inform consumers about their detention and their rights. This is an issue to be sorted out by the hospital, however, Official Visitors were concerned that it be done consistently. The 2014 Act has similar requirements.

- Another issue pertaining to forms is that the writing is not always legible. Official Visitors are often asked to decipher what is written on forms. This should not be necessary and is frustrating for the consumer. Consumers have a right to know why they are being detained under the Act and this should be stated comprehensively and legibly on the form.

- An issue regarding Restriction of Rights Forms (when a person is not being allowed visitors or to make phone calls) was that psychiatrists were not always making notations in the file that the restriction had been reviewed and signed each day as required by the Act. When this occurred it was difficult for Official Visitors to determine if consumers' rights were being breached or whether it was purely an oversight. In any event, the practice needed to be improved. Again the 2014 Act has similar requirements though the rights have been extended to electronic communication and particular forms must be used every 24 hours to review the restriction.

- Consumers have a right to make a complaint about any aspect of the service they are receiving. It was evident from the inspections that it was not always clear how a consumer might do this. Official Visitors have advocated that hospital admission packs contain information about the Council and about the hospital complaints system and the Health and Disability Services Complaints Office (HaDSCO).

  In response to raising this issue, some staff said that consumers had ripped up the material pertaining to making the complaint. The Official Visitors' position was that this should be documented on the consumer's file and information provided again when the consumer is feeling better. It is also essential that any written complaint completed by a consumer or family member is automatically forwarded to the hospital Complaints Officer and not screened by staff as has occurred in at least one hospital. A formal process which ensures documentation of all complaints demonstrates that the feedback is valued and that the hospital has a genuine culture of quality improvement.

- On a positive note, one family stated that the senior nurse (a CNS) on the ward had taken the time to explain the ward processes to them, including a full explanation of the rights and entitlements of patients as required under s157 of the Act. They were provided with written information and said they were comforted by the explanation and felt that their fears were respectfully heard.

In preparation for the new Act (2014) Official Visitors have been advocating that consumers be provided with a folder in which to keep their admission material, forms, information about their illness and medications as well as their treatment, support and discharge plan. It is their right as well as best practice to have this information and it sets the scene for consumers to take responsibility for the documentation from their admission through to discharge and facilitates their involvement in the development of their treatment, support and discharge processes and plan.

ISSUE 2 – ACCESS TO CARE AND LEAST RESTRICTION OF FREEDOM (s188(b) of the Act)

Access to appropriate care is a fundamental right and remains an ongoing issue in mental health, whether the care is in a hospital or in the community. It is an object of the Act that such care be provided with the least restriction of rights. Some illustrations of issues are set out below.

- Official Visitors advocate that the consumer needs to be central to their treatment, support and discharge plans. In one instance a consumer asked the Official Visitor to attend a review with her. The Official Visitor left her mobile number so that staff could ring when the psychiatrist arrived on the ward to conduct the review. Despite the consumer indicating she wanted the Official Visitor to attend, the psychiatrist went ahead with the review and no effort was made to contact the Official Visitor who was on site. This is not uncommon.
- In another instance, a psychiatrist did not tell the patient about a family meeting and it was by chance that the Official Visitor happened to arrive on the ward to be told by nursing staff about the meeting. Although the patient was told she could not attend, at least the Official Visitor attended on the consumer's behalf. These instances do not represent open and transparent processes and have the potential to leave the consumers untrusting of the treating team. The 2014 Act ensures that consumers must be notified of all events pertaining to their treatment, support and discharge so hopefully this type of practice will cease. The Chief Psychiatrist's Standards of Clinical Care indicate that "the consumer will be a partner in the care planning process."
- An important aspect of care is the right to have the time to make important decisions. Consumers often say that they feel pressured to have a test or take medication that they are not sure about. Sometimes providing the information both orally and in writing about medication, for example, and ensuring the consumer has the ability to talk it through can be helpful. This is in sharp contrast to a pressured approach where, if consumers don't say they will take the medication, staff threaten to ring security who will then, with nursing, surround the consumer and restrain them if necessary. This scenario has been recounted to Official Visitors during visits and inspections far too often.
- The inspection pertaining to allied services conducted in September revealed improvements could be made regarding consumer's physical needs. It has been recommended that the physical assessment include podiatry and dental needs so that they are highlighted early in order for referrals to be made as soon as possible after admission. Some patients may not be aware of the allied health services that they might benefit from whilst an inpatient unless informed of this through the treating team.
- The smoking issue arose again during this reporting period and continues to be a complex one. Council has always held the position that, while smoking is not good for one's health, quitting smoking while so seriously unwell that they are on a secure ward, is cruel. Preventing people from smoking is also not the least restrictive approach, and of no use in terms of assisting them to quit smoking in the long term.

Council successfully argued for a designated smoking area in the courtyard of secure wards and an exemption to the smoking prohibition was made in January 2013. The new hospitals however are refusing to implement the exemption and consumers regularly voiced their complaints about this to Official Visitors. Consumers say they are more unwell because of the added stress of not being allowed to smoke and several have said they have had to take more medication (with unwanted side effects) to help with this. They also point out that as soon as they are moved to the open ward, they can and will leave the ward to smoke. Evidence of people smoking outside the walls of every public hospital in WA can easily be found. It is particularly difficult for nursing staff to manage when there are involuntary patients on the open wards and they watch the voluntary patients leave the ward to smoke. Involuntary patients believe the system is not fair.

ISSUE 3 – RIGHT TO RESPECT AND DIGNITY (s188(b) of the Act)

Respect and dignity issues are a common feature of complaints by consumers and often reflect the culture of the ward and/or stressed staff. Apart from consumers having a right to be treated in a respectful manner, such treatment will reduce re-traumatisation on the wards, enhance recovery and lead to a calmer ward environment. Some illustrations are noted below.

- One way the right to respect and dignity is witnessed on the wards by Official Visitors is through the level of engagement staff have with consumers. Sadly on some wards engagement, other than passing contact, is rarely seen. This creates and solidifies the "them and us" culture and perpetuates the scene very familiar to Official Visitors of nursing staff in the nursing station and patients outside knocking on the glass to get their attention.
- Some wards have instigated an "activities person" and this has had a positive impact in reducing boredom. The October hospital inspections focussing on allied health services received positive comments about the wards that had regular occupational therapist input. One hospital had an occupational therapist rostered on for some weekends which was appreciated by consumers. Official Visitors also commented on therapeutic groups utilising a recovery oriented approach where consumers had the opportunity to learn more about themselves, their illness and to develop coping mechanisms with input from both staff and other patients. Successful groups of this nature can pave the way from inpatient to outpatient programs.
- Holding family meetings is good practice. However, it has been noted by Official Visitors that they can be held in meeting rooms that have no curtains or blinds on the windows. As well as the meeting itself often being confronting because of the number of people attending, consumers comment that they feel like they are in a fish bowl and everyone on the ward is looking at them. The feelings are intensified if the consumer becomes upset.
- There was a great deal of care and respect shown recently to patients moving to the new Midland hospital. Staff ensured that a group of older adult consumers visited the new hospital prior to the closure of the old one so that they were familiar with the new environment, had an opportunity to give feedback and talk about it and this effort resulted in a less traumatic move for consumers.
- Official Visitors advocated strongly for the reinstating of a companion dog program on an older adult ward. Some two years later the program was reinstituted as a trial. Official Visitors reported that the dog (a golden retriever/German shepherd cross who is large but very gentle) was a huge hit on the ward when he lay his head on several laps.

ISSUE 4 – RIGHT TO HAVE THE LAW FOLLOWED AND STANDARDS MET (s188(b) of the Act)

Consumers have the right to have the law followed and standards met, particularly when people are being detained and required to take medication against their will. Many of the issues dealt with by Official Visitors involve advocating for such rights and standards to be met. Below are some examples.

- An Official Visitor raised concerns about the legal status of a consumer. The consumer was transferred from one hospital to another and placed in a secure ward under a Form 7 (transfer of a detained person). The Official Visitor was informed the patient was under a Form 4 (order to continue detention for further assessment in an authorised hospital). Two days later and after the form 4 had expired the day earlier, nursing staff informed the Official Visitor that the patient was on a Form 6 (involuntary patient order). The form 6 was not valid because the form 4 had expired prior to the form 6 being made and the consumer should have been told at that time that they were voluntary. Several questions were raised by the Official Visitor and directed to the hospital. It is a powerful act to take away someone's liberty. While this example may be viewed as a simple mistake, it demonstrates the need for all involved to ensure that consumers are treated properly under the law, that we must be diligent about detention and consumers need to know their rights at all times.
- An issue that the Council has raised on behalf of consumers for 18 years is the lack of lockable storage for consumers in their hospital bedrooms. This is standard for any patient in a general hospital and should be the same for authorised hospitals. Under the 2014 Act patients are entitled to have electronic devices with them so it will be essential to have this provision. Without lockable storage in their rooms, consumer possessions are kept by nursing staff. Consumers must request what they want each time they want something. This is disempowering, a waste of staff time, causes consumers endless frustration, does not comply with the requirement of least restriction of their freedom and maintenance of dignity and has the potential to create institutionalisation. It is pleasing to note that older hospitals are investigating various options for lockable storage and that it is available in newer hospitals.
- Official Visitors have noted that there have been several instances of medical officers overlooking and not signing the seclusion form to record that they have carried out patient reviews. As a result of raising the issue the hospital involved has started to audit completion of seclusion forms and is encouraging the ongoing improvement of their documentation. In one hospital it was noted during the September inspection that the last entry in the Seclusion Register was July. The hospital undertook to get the Register up to date.

ISSUE 5 – SAFETY AND SUITABILITY OF THE WARD (s188(c) of the Act)

The Act required Official Visitors to inspect places where people are detained, cared for or treated under the Act, and to ensure that these places were kept in a safe and suitable condition. Safety and suitability included the environmental and physical conditions of the ward as well as other matters such as sexual and physical safety.

In order to meet this function Official Visitors have been conducting environmental audits annually in authorised hospitals for six years. The required improvements were listed on Action Sheets and continually followed up until the required changes were evident to the Official Visitor. Official Visitors followed up on outstanding issues from the February 2015 environment audit (reported in the 2014-2015 Annual Report) in August.

It was pleasing to note that the number of issues on the Action Sheets for authorised hospital wards in WA have markedly decreased over the years.

In addition, there have been efforts in many hospitals to make the ward more inviting by ensuring beds are comfortable (with some wards doing regular bed audits), that there are suitable lounge chairs, that televisions are in working order, and that there are things for consumers to do such as reading the newspaper, playing pool or doing art type activities and playing games.

While some wards have been able to make major improvements, there remain a significant number of courtyards that are not inviting to consumers, families or staff. Being confined to a ward and not having access to an adequately shaded outdoor area with decent furniture misses the opportunity to provide recovery-enhancing conditions. There are some courtyards where Official Visitors have never seen a patient despite their many visits. In some areas staff and consumers are forced to drag furniture from inside to the outside areas as there is an inadequate supply of outdoor furniture. This is an occupational health and safety issue that requires attention. When hospitals do have the funds to improve the courtyards it is evident from consumer and staff reactions that is greatly appreciated. It provides a pleasant, relaxing space with plants, fountains and comfortable chairs that has a substantial therapeutic value.

Some hospitals have taken the more contemporary approach of involving the patients in the planning and development of courtyards. In such cases patients have enjoyed the opportunity to contribute. There is a recent example where a local artist has covered the four walls of the courtyard with a stunning mural showing the key features of Fremantle and its beaches.

An area that has improved over the past five years in some hospitals is the quality and quantity of food. Official Visitors used to be plagued with complaints about the food and conducted many inspections around meal times. There seems to be more choice for consumers and they have the ability in some hospitals to order a larger meal or two main courses. The food on most wards seems to be at a suitable temperature. Tea and coffee with biscuits or sandwiches are available between meals. A comment recently was that the tea trolley was not always left on the ward long enough for all consumers to avail themselves of it. Consumers are pleased when there is an option during the week for a cooked breakfast or BBQ and they always comment positively when this is available. This is especially important for consumers with a longer length of hospital stay.

Consumers have less complaints about the quality and cleanliness of furniture as it has been replaced on many wards. Those wards where the furniture is not in good repair or clean now stand out. Complaints are received, however, that lounge areas in some hospitals are regularly used for clinical meetings, leaving little time for consumers to have access.

Heating and cooling systems in most hospitals, even the newer ones, remains an ongoing issue. Staff are usually very good about putting in requests for improvements, but in some hospitals it remains a problem as consumers are either too hot or too cold.

In one hospital the Official Visitor raised the issue of the transfer of sound, particularly voices, through the air conditioning duct. The Official Visitor witnessed first-hand the distress caused to three visitors in the open ward when they were exposed to very loud, disturbing shrieks and screams coming from the secure area into the kitchen-dining room area of the open ward. Conversations can also be heard and this poses a significant danger of inadvertent breaches of confidentiality. This type of environment is definitely not suitable for patients dealing with hearing voices or patients needing quiet, low stimulus surroundings.

The noise level particularly in newer hospitals is a concern. Some areas, including a dining room, sound like an echo chamber and efforts are being made to correct this.

It was concerning to note in one hospital that consumers are no longer being provided with detergent to wash their clothes. It is almost inconceivable to think that a person must remember to bring detergent for a hospital stay and impossible for someone who is being brought in by ambulance or police when very unwell and who has no ability to leave the ward to make the purchase. This practice, disguised as a cost saving measure, does not show respect for the dignity of the consumer.

Another issue the Official Visitors take very seriously is that of the privacy of the consumer. Yet again the Council has had to point out the need for curtains on a quiet room that looks out into the courtyard. At one hospital Official Visitors have repeatedly raised the issue that four bedrooms do not have curtains and others that do are of poor quality.

It is encouraging to see carpets being replaced with materials that can be properly cleaned.

The Council advocates strongly for same sex toilets on wards to increase privacy and safety.

ISSUE 6 – PSYCHIATRIC HOSTELS – RIGHT TO PROPER CARE (s188(b) of the Act)

Psychiatric hostel residents may request visits from Official Visitors and inspections of these facilities are conducted every second month pursuant to Ministerial direction. Focus topics for this reporting period included outstanding issues from the environmental audit, finance and accommodation, and transition to the new service.

Stuart Flynn, the inaugural Head of Council of Official Visitors, wrote in the 1998-99 Annual Report:

> ***"unfortunately there is a minority of hostel proprietors who appear unwilling to satisfy what to the layman would seem to be minimum standards to protect the dignity and safety of residents in what is intended to be a person's home. It is a matter of deep regret to the Council that some of the facilities concerned have been notorious for many years and that the Council has no power to enforce compliance with its recommendations".***

Many of Stuart Flynn's concerns are still unresolved today. Hostels can look quite similar from the outside, some having been built in the same era. However, one doesn't have to go far inside to see stark differences. Hostels that have developed an improvement culture will have painted walls, carpets will have been replaced with washable surfaces, a regular building maintenance program and upgraded areas. Not surprisingly, the facilities that appear in better condition often have the better menu with simple things like a variety of fruit available for residents at all times in addition to a choice of tea and coffee. The hostels range greatly in the funding received from the MHC and the size and type of care provided.

Concerning areas for this reporting period include:

Administration of medication: Official Visitors had a complaint from a consumer that when medications are dispensed in the dining room, residents who do not bring their own water have to drink out of a plastic "communal cup". This issue was raised with management and Official Visitors were assured that this practice did not happen. A week later, Official Visitors asked 12 residents if they have had to drink out of a "communal cup", or witnessed other residents having to do so. All 12 residents said they had. The Official Visitor was present on four previous occasions when medications have been administered and there have not been any disposable cups on the trolley, only the "communal cup".

Food: In one facility, comments included, "not enough vegetables, not enough fruit, cold at weekends, too many chips, not nutritious". Official Visitors observed the quality of food over six weeks and noticed that the food actually being served was not what was shown on the menu. Examples of the poor nutritional content of the food included four meatballs and garlic bread; hot dogs and potato wedges; and scrambled eggs and garlic bread. This would not meet the dietary guidelines set by the relevant regulations.

In some facilities, residents do not get a choice of tea or coffee, or of sugar or no sugar, or of milk or no milk. There are examples of coffee, pre-mixed with milk and sugar, being provided for the entire resident population whether they like it or not. Some facilities only use powdered milk and insist it is the preference of the consumers.

Clothing and Toiletries: Some facilities are required to supply residents with clothing and toiletries. Many of the residents that Official Visitors speak with are not aware that they are entitled to receive clothing from the facility. There are examples of residents being provided with shoes that do not fit properly and being informed that there is no other option. By contrast, another facility puts a concerted effort into securing suitable clothes and footwear for its residents. Residents present well and are proud of their clothes, and a flow-on effect is that they are more concerned about their hygiene and appearance.

Dental Services: As well as pointing out issues and gaps in the system, Official Visitors endeavour to come up with creative solutions. An example of this is the hostel dental team project. A small team of dedicated dentists who usually work in Western Australia's North, including with indigenous people, and in the metropolitan area with vulnerable people including the aged and homeless, agreed to visit two hostels to get an idea of the dental services required. Once they have completed a needs analysis, the plan is to work with the new MHAS to find resources to meet the needs of those living in hostels. As dental issues affect one's physical health, this is an important intervention.

ISSUE 7 – SAFETY AND SUITABILITY OF PSYCHIATRIC HOSTELS (s188(c) of the Act)

Hostels need to be safe and suitable. Many, if not most, hostel residents are on a disability pension and up to 87.5% of their pension is required to be paid to the hostel owner. They are entitled to decent conditions. Funding is also provided by the MHC though the amount of funding varies greatly between hostels. There is a licensing regime conducted by LARU and the MHC has evaluators who are scheduled to visit every 3 years. Despite this regulatory regime there are always issues with safety and suitability as highlighted in previous reports and here.

- An issue that is coming up more often is the need for psychiatric hostels to be well supported by the local community mental health service. Over several years the Council has seen a significant number of residents discharged from the community mental health service. This is good news on one hand because it means that the resident has been well for a period of time. However, the resident still has a mental illness and, if they have an unwell episode, hostel managers can have difficulty getting the resident access back in to the service. In addition, if the resident is well and wishes to move to a more independent setting, they do not have the assistance of a case manager. The situation has the appearance of punishing those who become well and stable.

  The majority of non-government agencies that provide Community Supported Residential Unit type hostels will not accept a new resident unless they have a case manage in the local community mental health service. Yet the residents who move into this model of care are intended to be higher functioning and more stable than those living in other hostels so the latter are prejudiced by the lack of access to the community mental health service.

- Under current Licensing and Accreditation standards, hostel supervisors are only required to have a First Aid Certificate and the usual clearance checks. This means that staff may not be trained to work with residents with mental health issues and even cleaning staff are accredited as supervisors. Such supervisors are not always best placed to determine if someone is becoming unwell, or to know how to de-escalate situations, or to know when to seek assistance. Added to this is the situation of some clinics not having enough staff to visit regularly, and to stay on site long enough, to see if residents are showing symptoms of becoming unwell. Official Visitors are observing more issues that could have been resolved had trained people been available to assist in setting up an individual management plan to deal with the behaviour/situation. This is a major issue which needs to be addressed to ensure all licensed psychiatric hostels are safe and suitable.
- A serious situation arose during this reporting period where a resident made an allegation against a hostel supervisor. Ultimately it was found that there was insufficient evidence to support the allegations but there was little appreciation at the hostel that firstly these issues will arise from time to time, secondly that Official Visitors and mental health services staff have an obligation to report such allegations, and finally that they need to be fully and independently investigated. In addition, there was no mechanism in place to do a thorough root cause analysis in order to make the necessary environmental changes to reduce opportunities for similar issues to arise; and, should similar issues arise, to handle them efficiently and effectively. Without making changes, hostels will be reluctant to accept any consumer who has made an allegation. Situations are less likely to occur in environments where there are both male and female staff, where there are strict protocols about entering the private areas of the residents and there is the opportunity to develop effective consumer management plans in conjunction with clinics.

ISSUE 8 – HELPING RESOLVE COMPLAINTS (ss188(d) and (e))

Much of the work of Official Visitors is assisting consumers to resolve complaints. They will usually attempt to resolve a complaint by dealing in the first instance directly with the treating team and ward or hostel staff. Sometimes the complaint needs to be reported and investigated. Official Visitors may help consumers to write up the complaint or draft it in consultation with them. Part of this process involves informing the consumer of their rights, the options they have, and their consequences, such as the formality of the process and the time likely to be taken.

Working out the complaint processes in mental health can be difficult as each area health service does things slightly differently. Council has long complained about delays in responding to complaints, or even acknowledging complaints, poor quality responses, and lack of procedural fairness and transparency in the investigation process.

To more effectively deal with hostels in particular the Council of Official Visitors is working more closely with LARU and the MHC. Each organisation has a significant role in ensuring quality services to this vulnerable group. By working together the group can have a united approach, and agreement on what standards should look like in practice and how to ensure improvements are made.

As well as dealing with complaints, Official Visitors are in unique position to walk with consumers during difficult times. While we are there for the lows, we get to glimpse the real person, their strength and their resilience.

Karen's story illustrates this point. Karen was a resident at a hostel and died in October 2015. She gave the Official Visitor permission to share her story and the phenomenal support she received from another resident where she lived. The story below contains excerpts from the eulogy at her funeral.

Karen was a beautiful lady who had what some would call a normal childhood; she was the older of two children. Karen told us that there was always food on the table and clothes' on their back. Her father worked hard as a principal, so as a young girl she moved around a lot, seeing at least six schools.

As a young lady she did what was expected of a lady and many more things there were not. Karen had her first love, and many adventures best untold. She was married and gave birth to her two children and became a grandmother of three.

Karen worked as a house mother for a while and completed her nursing training in 1983 as a nurse she could do the thing Karen did best, supporting those in need, fixing those who were broken and giving love to those who had none.

But there was one job she spoke about the most, it was not a highly paid one, it had little glory, but to the day she left us it filled her heart with joy when she thought of those days. It was when she worked as a deck hand on a cray fishing boat. Karen had many stories to tell us, the time she almost fell overboard, the time she almost got bitten by a blue ringed octopus and the many nights sitting on the deck looking over the carpet of opal blue waters.

Karen reminded us how fragile life is. How easy it can be to get off track and how hard it is to get back on track again. Karen knew herself well, mistakes and regrets, things she did well and things she wished she would get another chance at. Through it all she developed life wisdom. She was incredibly sharp and articulate. She could see all sides of a situation and she could tell if someone was genuine a mile away. She was helpful and kind to the people around her.

The Community Supported Residential Unit (CSRU) hostel was her home. She fought hard to get into it and she fought hard to stay as long as she could. She told me a year ago that she felt like her body was imploding and try as she did she couldn't seem to get as well as she would have liked. She was clear however that she did not want to move from her home and now she doesn't have to.

We can all say that we remember Karen for her unselfish desire to help those who needed a kind hearted lady to talk with or just a stern shoulder to lean on. We can all remember Karen for at least one kind act that she did for us, she was a mother figure to some, a face of joy to others and loved friend to us all.

Karen asked me if anything happened to her to make sure her next of kin/another resident knew how much she appreciated his kindness. He visited her during many hospital admissions and brought her what she needed and ensured the TV was hooked up. He was there visiting when Karen was able to converse and when she was in ICU and couldn't communicate. He made all the state funeral arrangements which in itself is a lonely experience. She chose her next of kin, a true friend wisely.

The issues the Official Visitor dealt with regarding Karen's death included:

- the role of the hostel when someone is terminally ill
- the need for consumers living in hostels to have health care directives and wills
- the rights of the next of kin
- the need for hostels to have policies pertaining to the death of a consumer
- the need to ensure funerals paid for by the State, as in this case, are conducted with adequate resourcing and dignity.

ISSUE 9 – ASSISTING WITH MENTAL HEALTH REVIEW BOARD AND STATE ADMINISTRATIVE TRIBUNAL APPLICATIONS AND HEARINGS (s188(g))

Official Visitors continued to assist and support people on involuntary orders at hearings before the MHRB and in applications relating to Guardianship and Administration orders before the State Administrative Tribunal (SAT). We are unable to provide data however as the ICMS was still under development during the reporting period. Council has relied for the past few years on the MHRB's data regarding hearings but they were also implementing a new database during this period.

MHRB hearings are one of the three main protections for consumer under the Act – the other two being the right to an Official Visitor and the right to an other opinion.

The issues for consumers remained as reported in previous years, with ongoing lack of procedural fairness due to psychiatrists' reports being provided too late or not at all so that patients attend hearings not knowing what the MHRB members are reading and no time to properly prepare or instruct their lawyer or Official Visitor. Too often the patient file contains comments which are written as facts but are misleading or without evidence. Mental Health Law Centre lawyers also have difficulty accessing the patient files in time for hearings.

There were some innovations as the MHRB got ready for the 2014 Act with carers being invited to hearings and a trial ECT application. Those Official Visitors appointed as Advocates also attended a MHRB Professional Development Day which focussed on the changes in the 2014 Act, primarily around the new test of capacity and ECT hearings.

There were also ongoing meetings with the Mental Health Law Centre in an endeavour to improve communication and working protocols between the two organisations given the limited resources of both.

"Council continues to lobby for a review of the hostel sector including the governance, oversight, and quality assurance of supported accommodation facilities".

"It is a goal of Council to improve the variety and standards, safety and suitability of supported accommodation facilities".

PART THREE

Ongoing issues raised in previous annual reports that still require remedy

Below is a year by year summarised list of systemic and ongoing issues which have been raised in previous annual reports.

1998-1999 ANNUAL REPORT

1. **Need to expand the definition of "affected person" in s175 of the Act so that Official Visitors can also advocate for voluntary consumers, referred persons and Hospital Order patients.** It remained the case that Official Visitors could not assist voluntary patients. The 2014 Act will include referred persons awaiting psychiatric assessment under the 2014 Act and people on a Hospital Order, but the new Mental Health Advocates replacing Official Visitors will not be able to assist any other voluntary patients unless the relevant Minister has made a direction to that effect.

    - Approval was gained by the Minister to work with a voluntary youth in October 2015. This was a complex case involving a multitude of organisations and it was essential that, through the Official Visitor, her voice was heard. All other parties involved in the case had approved (and indeed some had requested) the Official Visitor involvement. Official Visitors' powers could not be used and any costs had to come from existing funding. Most young people under 18 years in the Bentley Adolescent Unit are locked in and cannot leave but are voluntary patients so could not be assisted by Official Visitors and will not be able to be assisted by Mental Health Advocates under the 2014 Act. Many elderly people are in a similar situation.

    - The other issue is when an Official Visitor has been working closely with a consumer about a serious complaint where the outcome and negotiations in relation to the complaint are ongoing. Often the time taken is so long that the consumer becomes voluntary and the Official Visitor has to advise the consumer that they can no longer support them. Usually the consumer is referred on to another body like the Health Consumers' Council. This is often distressing and prejudicial for the consumer who remains vulnerable dealing with their ongoing recovery, a waste of public resources as the other government funded agency picks up the issue, and a deterrent to proper practice for complaint handling as the consumer often just gives up as it is all too hard.

2. **Overcrowding in authorised hospitals with pressures on beds in all hospitals.** Even with the opening to new hospitals including Sir Charles Gairdner, Fiona Stanley and St John of God Midland hospitals, some consumers have had to wait significant periods of time in the Emergency Department (ED) before being transferred to an authorised hospital. The new referral process under the 2014 Act only allows for 3 days instead of 7 days so it will be interesting to see if hospitals manage to transfer a person to an authorised hospital for assessment within 3 days. The WA *"Mental Health, Alcohol and Other Drug Services Plan 2015-2025"* acknowledges (at page 66) that both expansion and realignment of hospital beds is required.

3. **Lack of system wide policies and documents that have a direct impact on consumers**. The Statewide Standardized Clinical Documentation (SSCD) remains largely unused because it is not on PSOLIS (the mental health database) and area health services continue to "do their own thing" with no centralised control. This includes care plans, policies generally and complaints handling. Even hospitals within the same area health service can have slightly different policies and practices in relation to issues. North and South Metropolitan area mental health services have different organisational structures and operational controls and the WA Country Health Service and Child and Adolescent Mental Health Service are different again. On top of this there are now two private hospitals (at Joondalup and Midland) servicing large numbers of psychiatric patients. It is hoped that the 2014 Act will lead to improvement and more consistency in the treatment, support and discharge plans required for each patient and their involvement in it. Similarly, it is hoped that there will be templates for further opinions and medical reports to the new Mental Health Tribunal which will improve the quality of these reports across the sector. The number of approved forms under the 2014 Act will also add to consistency in areas like seclusion and restraint.

4. **Other Opinions process not providing truly independent opinions and related issues.** The ongoing issue of consumers having to ask their psychiatrist to organise an Other Opinion for them, the inability to get a truly independent psychiatrist from outside the hospital to give the other opinion, and delays, remained major issues impacting on the value of this important consumer protection. There are some improvements proposed in the 2014 Act - primarily the right to receive a written copy of the opinion and some rights to carers. Council does not believe, however, that the "Operational Directive" drafted for the 2014 Act will see any improvement and remains very disappointed that this protection has not received funding support to allow a panel, or at least an organised roster of psychiatrists between hospitals, to be developed.

5. **Hostel issues including minimal health care and support services, need for review of the standards, lack of proper facilities and lack of privacy and security in bedrooms.** This remains a major area of concern for Council. There is a review of the LARU standards underway but Council would like to see amendments to the Hospital and Health Services Act 1927 and associated regulations as well. There is also wide disparity in the amount of funding and type of support offered amongst licensed hostels which results in some of the most vulnerable and severely disabled residents being discriminated against. Without that funding, licensees say they cannot afford to do more and threaten closure of the hostel if forced to do so, which would leave residents homeless. A lot more funding support for in-reach programs and residents in some hostels based on the recovery model is needed. (See also item 9 below.) The WA "*Mental Health, Alcohol and Other Drug Services Plan 2015-2025"* was disappointing in what it offered this group of people, though a housing strategy is to be developed in collaboration with key stakeholders by the end of 2017 (see page 42). Council hopes that the new MHAS will be involved in that process. Mental health community support services are also to be increased but whether this will include this group remains unclear.

1999-2000 ANNUAL REPORT

6. **More respect and facilities needed for human relations and intimacy.** This continues to be an issue particularly in older and poorly maintained premises but even newer wards where the room is either glassed like a fish bowl or families have trouble getting out of the locked room in which they have been put. Female only wards would promote children visiting but there were none in WA as at 30 June 2015.

7. **Boredom on the wards and lack of access to on site gyms, or to exercise equipment etc.** This remains an ongoing issue and a lot depends on the ward staff and their input into activities**.** In relation to gym equipment, Official Visitors are often told that occupational health and safety requirements include the need for trained staff which cannot be covered by the budget....or, for example, an exercise bike on the ward because it is a safety risk.

2002-2003 ANNUAL REPORT

8. **Lack of access to allied health professionals/multi-disciplinary teams, in particular social workers and welfare workers.** These issues continue and form much of Official Visitor work and seem to be increasing with expenditure review cuts across health. Social workers and welfare workers are crucial on mental health wards as people are often brought in with only the clothes they are wearing and length of stay can be weeks to months. There are bills to be paid, animals to be looked after and often the issue of finding accommodation which holds up discharge – alternatively the person is discharged into a boarding house or backpackers. If held in hospital for a lengthy period of time leading to "institutionalisation" people also need help to reskill. The WA "*Mental Health, Alcohol and Other Drug Services Plan 2015-2025*" (at page 162) states that, by 2017 it is planned to develop and commence a comprehensive mental health , alcohol and other drugs, planning and workforce development strategy that includes key priorities to build the right number and appropriately skilled mix of staff so Council looks forward to that. (See also Item 22 below.)

9. **Need to improve opportunities for socialisation for people with a long term illness.** The issue continues particularly in relation to lack of activities and programs for many long term hostel residents in the older style, lower funded facilities**.** While there are programs such as the Commonwealth funded Personal Helpers and Mentors Program (PHaMs) hostel residents in these types of facilities are usually denied access to this and similar programs. (See item 5 above.) The WA "*Mental Health, Alcohol and Other Drug Services Plan 2015-2025*" refers to *"Keeping people connected and close to home"* (pages 35-55). Council hopes that increased mental health community support services planned for the end of 2017 (page 42) will reach such hostel residents.

2003-2004 ANNUAL REPORT

10. **Ward environment and lack of maintenance.** This is an ongoing issue but there have been improvements. Gardens sadly remain lacking which Council considers to be a wasted opportunity for recovery. The state's newest authorised mental health ward at Midland Hospital is unfortunately on the fourth floor with very small courtyards on the secure ward. Access to courtyards is often limited in some hospitals . Official Visitors are told there is insufficient staffing so courtyards can be locked for considerable periods of time.

    Council is always concerned that funding cutbacks result in reduced maintenance. Mental Health wards do not require expensive equipment like other wards – but they do need to feel like something more than a prison. They need to look and feel safe and comforting and not be bare and grotty. Consumers are often locked up on a ward for weeks or months but they are there for support and care, not to be punished, so the ambience and maintenance of the ward is therapeutically important. The WA "*Mental Health, Alcohol and Other Drug Services Plan 2015-2025*" does not deal with this issue and ongoing funding cutbacks are of concern for the future.

11. **Issues with the MHRB process, in particular doctor non-attendance and failure to provide medical reports in a timely manner or at all.** There have been some small improvements in the availability of medical reports prior to the hearing at some facilities, however, discussing the report with the consumer prior to the hearing and attendance at the hearing, ideally by the psychiatrist otherwise by a member of the treating team remains an ongoing issue as does the quality of the report. It is hoped that retraining for the 2014 Act and the new processes under the Mental Health Tribunal will see some improvements. A template is needed to encourage good quality medical reports. Doctors will usually cite overwork as the issue and some complain that the process is adversarial but apart from being a right of the patient, the preparation process for a hearing involving the patient can build patient trust and understanding if done properly.

12. **CTO breaches and potential breaches of the Act.** Council continued to hear about consumers on a CTO not getting a monthly review as required by the Act and confusion over the definition of "authorised medical practitioner" relating to CTOs. Retraining for the 2014 Act may see improvements.

13. **Treatment of people with a mental illness in hospital EDs including delays and not being treated with dignity and respect.** Delays continued to be an issue and are likely to remain so. Mental Health Advocates under the 2014 Act will be able to assist people in EDs who have been referred for assessment which we hope will include podiatry and dental considerations.

2004-2005 ANNUAL REPORT

14. **Low levels of representation in MHRB hearings.** While Council had no data available for the 5 months covered by this Annual Report, we believe that this continues to slowly improve and will continue to do so under the 2014 Act as Mental Health Advocates will be required to contact all involuntary patients and have better access to ensure consumers know their rights in relation to the hearings.

2005-2006 ANNUAL REPORT

15. **Neglect of dental health, hygiene and physical care treatment**. This continues to be an issue that Official Visitors responded to both in hospitals and hostels. Council is involved in a dental initiative with some hostels (see Issue 6 above). The 2014 Act will make it mandatory for people admitted to hospital to be offered a physical condition assessment which we hope will include podiatry and dental considerations.

16. **Ageing of the population of licensed private psychiatric hostels.** This continues to be a concern but not just in the hostel sector. **(See also Item 30 below.)** The WA "*Mental Health, Alcohol and Other Drug Services Plan 2015-2025*" (at page 61) states that, by 2017 it is planned to increase the subsidy for non-acute long-stay (nursing home) places for older adults with mental illness by 63 places so Council looks forward to that.

17. **Seclusion practices.** Seclusion practices have undoubtedly improved and the number of seclusions and length of time in seclusion has diminished over the past few years. Complaints to Official Visitors are generally around the restraint process prior to the seclusion. The 2014 Act deals with this issue (whereas the 1996 Act did not). There also seems to be increasing use of security guards and pepper spray which is of concern.

2006-2007 ANNUAL REPORT

18. **Inconsistent and inappropriate complaints processes in hospitals.** This continues to be a significant problem and issues include lack of independent investigators for serious issues, consumer awareness about how to make a complaint and access to complaint forms, and clarity about which government agency handles complaints. Council signed a partnership agreement with HADSCO, the DOH and MHC in August 2015 which aims to streamline complaints processes to ensure that they are clear and easy to navigate – a need that became clear through extensive consultation with mental health consumers and service providers. This work is ongoing and will involve the new MHAS.

2007-2008 ANNUAL REPORT

19. **Long term and inappropriate placements on wards.** There remains a shortage of varied and suitable accommodation in the community particularly for people with a serious or chronic mental illness. We have people stuck in hospitals for many months and in some cases for years. For example, in Graylands there are 31 patients who have been there for 2-5 years; 10 patients who have been there for 5-10 years; and 6 patients for over 10 years.

    Clearly this is not conducive to their recovery and reintegration into the community, nor is it cheap on the government budget. Sub-acute or step-up/step-down facilities would allow the person to gain their strength and confidence back and continue their recovery while also provide time to prepare for full discharge, including finding an appropriate place to live. People with a mental illness do not need the added stress of not having a secure and stable place to call home and backpacker hostels are not secure nor stable. The link between mental health issues and homelessness is well established.

    The MHC's 2015-25 plan acknowledges the need for subacute facilities especially in the regions and for youth and older adult and makes reference to planning for this but funding is needed. A 6 bed ward at Fiona Stanley remained empty at 29 November due to lack of funding and a 4 bed older adult ward at Rockingham was closed also due to lack of funding. Both could be used as sub-acute or step-up/step-down facilities if the money was made available.

    In many cases though, people who have been held in hospital for such a long time are heavily institutionalised, have lost a lot of cognitive functioning, and may need several steps down before being able to live in the community which for them, can be a lonely and scary place after living in a hospital ward for so long.

    There is also a small group who, sadly, may never be able to re-integrate and who perhaps still need a secure facility but it should be in the community and with intensive rehabilitation programs to optimise their prospects of being able to live in a place that doesn't have permanently locked doors.

20. **Smoking ban.** Council lobbied very hard to allow patients in secure wards to be able to smoke resulting in a partial exemption to the DOH Smoke Free Policy for involuntary patients in secure psychiatric wards in 2013. The transition to the exemption was very smooth. Despite this, the Frankland Centre is still to provide a designated smoking area. Consumers often prefer to return to prison where they can smoke. It is made worse for Frankland consumers because they rarely get ground access. Council was also still waiting for a policy from the new Sir Charles Gardiner Hospital which opened in August 2015. The Fiona Stanley mental health unit has faced difficulties with a mixture of ages on the youth ward as people aged under 18 cannot be supplied legally with cigarettes. For the safety of the ward they have been trialling the removal of the smoking exemption on that ward. They did this in consultation with Council. The new St John of God Hospital in Midland which opened on 23 November 2015 has a no smoking policy which caused problems for both consumers and staff in the opening week of the new hospital. A lot more could be done to support people to give up smoking than is happening on wards and in particular discharge. A new and funded approach to this issue is needed as many of Council's consumers are on a disability pension and cannot afford to smoke either from a health or finance perspective.

2008-2009 ANNUAL REPORT

21. **"Bail bond kids" – young people on supervised bail orders and lack of a forensic unit for youth.** Bail bond kids are no longer happening as far as Council is aware and we understand that there have been improvements in care in the prisons. The numbers of young people under the age of 25 in Frankland are substantial however and the issue of lack of a forensic unit for youth remains an issue of concern. The WA "*Mental Health, Alcohol and Other Drug Services Plan 2015-2025*" (at page 92) states that the number of forensic beds in the state (for all age groups) is less than half what it should be and (at page 94) that dedicated forensic services for young people are a high priority. The Plan however is not projecting any new facilities until 2025, though community services are to be increased by the end of 2017.

2009-2010 ANNUAL REPORT

22. **Doctor and other staff shortages.** This continues to be a major issue of concern and not only in country regions. It is usually seen in complaints from consumers about not seeing their psychiatrist, doctors not producing good quality medical reports on time, use of agency nurses who are not so familiar with ward processes and patients, and restrictions on things like ground access. Mistakes are also more likely when staff are stressed due to shortages. Perhaps the biggest concern is the impact on the level of care that is not so easily measured – the time taken to spend with patients and families giving them information and reassurance, and stressed staff find it more difficult to be courteous and respectful. The WA "*Mental Health, Alcohol and Other Drug Services Plan 2015-2025*" (at page 162) states that, by 2017 it is planned to develop and commence a comprehensive mental health , alcohol and other drugs, planning and workforce development strategy that includes key priorities to build the right number and appropriately skilled mix of staff so Council looks forward to that.

23. **Mandatory sentencing law and need for amendment to exclude people who were mentally unwell at the time**. This law remains unchanged.

2010-2011 ANNUAL REPORT

24. **Imposition of phone, post and visitor restrictions in breach of the Act**. This remains a regular source of complaint by consumers. The 2014 Act introduced new rights to electronic communication in keeping with the modern world where people often keep in touch with friends and family via texting, Facebook and similar media. This is welcomed by Council, as currently there are usually blanket bans on such access, but the increased access will introduce new challenges.

2011-2012 ANNUAL REPORT

25. **Locked open wards.** Having been raised as a serious concern four years ago that the practice would become widespread such that most mental health wards would be locked, we now have the 3 newest mental health wards in the state locked – Fiona Stanley, Sir Charles Gardiner Hospital and Midland Hospital. In each case voluntary patients have to find a nurse and ask to be let off the ward. It imposes a restrictive, disempowering and stigmatising environment on all patients on that ward.

26. **Lack of procedural fairness for Custody Order patients, a "declared place" and community facilities and accommodation for forensic patients.** The *Criminal Law (Mentally Impaired Accused) Act* 1996 (CLMIA Act) remains badly in need of reform and the very long awaited and promised review had still not been released as at 30 November 2015. Everyone agrees this Act needs amending. The WA "*Mental Health, Alcohol and Other Drug Services Plan 2015-2025"* (at page 92) also states that declared places are urgently needed in the community for mentally impaired accused persons. A Declared Place has now been established in Caversham for people on a Custody Order who have as their primary diagnosis an intellectual impairment. The Council (and the new MHAS from 30 November) is required by the enabling legislation to provide advocates for residents of the Declared Place which is known as the Disability Justice Centre. It opened in August 2015. A separate annual report will be published in relation to Official Visitor and Mental Health Advocate activities in the Centre.

2012-2013 ANNUAL REPORT

27. **Care plans and recovery principles. Issues with inconsistent quality of care plans, and lack of involvement by consumers and families and regular review of the plans**. This is an ongoing issue as was reflected in the Official Visitors' survey of care plans in June 2015 (see previous Annual Report). The issue goes to the centre of good practice and care. Without it both consumers and carers are significantly disempowered and treatment is more likely to be haphazard and narrow in focus which limits recovery prospects and more likely to lead to readmission. It is very much hoped that requirements under the 2014 Act regarding treatment, support and discharge plans and the notification and involvement of personal support persons will see some substantial changes in relation to this issue.

28. **Long term patients and hostel resident issues about lack of co-ordination about, and access to, their money which could improve quality of life and open up doors to recovery.** This issue came to the fore in the Coronial Inquiry into Graylands deaths where patients had considerable money that could have been spent improving their quality of life but it was not being spent because of the lack of communication between the Public Trustee and hospital welfare officers. It remains an issue and not just for hospital patients. People are not sent regular statements and the statements that are sent are difficult to read. Trustee officers also have to deal with hundreds of files which makes it difficult to allow personal attention. Official Visitors are regularly asked by consumers to help them negotiate just a little bit more money to spend.

29. **Police interviews with involuntary patients and concerns about natural justice (see page 26)**. This issue is ongoing.

30. **Older adult mental health care and lack of access to long term accommodation** This issue continues and as far as Council is aware nothing has changed since last year's Annual Report (at page 13). The WA "*Mental Health, Alcohol and Other Drug Services Plan 2015-2025"* (at page 61) states that, by 2017 it is planned to increase the subsidy for non-acute long-stay (nursing home) places for older adults with mental illness by 63 places so Council looks forward to that.

2013-2014 ANNUAL REPORT

31. **Lack of sexual safety and gender sensitivity on wards.** The state's sole female-only ward changed to an open mixed ward in 2013-2014. Plans to convert a smaller ward into a female-open ward never eventuated. Issues include consumers not feeling safe due to past history of abuse and disinhibited behaviour caused by the mental illness. A number of incidents reflecting lack of sexual safety on wards are reported each year and this year was no exception. An Official Visitor monthly inspection survey on sexual safety and gender sensitivity in 2014-2015 showed much more could be done to make wards safe.

32. **Unfair psychiatric hostel evictions.** Increasingly Official Visitors have been dealing with cases of hostels trying to evict residents without good cause or procedural fairness. Lack of Residential Agreements or reasonably drafted agreements dealing with eviction issues and not having an exit plan for residents as required by the National Standards for Mental Health Service are part of the issue. There should be better control and oversight over this given the government funding received by hostel licensees and the disempowerment of the resident.

33. **Discrimination against residents of "for-profit" hostels.** Residents in these type of hostels are often the most chronically unwell but get much lower funding from the MHC. Official Visitors noted that the hostel conditions were generally much poorer with few recovery or psycho-social programs on offer. An Official Visitors inspection survey also confirmed that many more residents in the for-profit hostels do not have case managers in comparison to the residents of the better funded NGO run hostels, further compromising their recovery prospects and access to quality care. A review and overhaul of the funding is required to ensure equity.

"It is a goal of Council to improve consumers' lives on the wards by highlighting, and attempting to reduce, unnecessary restrictions on their freedom and unnecessary interference with their rights and dignity".

PART FOUR
Activity measures, budget, strategic plan and other activities

CONSUMER NUMBERS

In the five months from 1 July 2015 to 29 November 2015 Council recorded the following figures (with the figures for the previous 12 months recorded in brackets):

- number of consumers assisted by Council: 867 over 5 months **(1,772 over a full year)**
- number of new consumers (i.e., consumers making their first contact with Council): 362 over 5 months **(774 over a full year).**

ANALYSIS OF ISSUES AND REQUESTS

During 2013–2014 Council was advised that a new database system would be up and running by 1 July 2014 so a decision was made to stop coding complaints in the old database system which was largely manual. The new Integrated Case Management System (ICMS) was phased in from September 2015 but did not become operational until 30 November 2015 so Council remained unable to access information on the types of complaints made to Official Visitors to inform its operations or report on complaints. Information could not easily be reconciled between the old data system and the new ICMS, and there has been significant difficulty extracting data from ICMS. Council is therefore not able to report even the basic statistics usually provided such as number of consumers assisted by the type of order. Council's operations were reduced to simply ensuring that a request for assistance was forwarded to the Official Visitor, and the Official Visitor contacted the consumer.

BUDGET AND RESOURCING ISSUES

Council was allocated a budget of $2,477,000 for the 2015–2016 financial year. This included funding for the MHAS, which commenced operations on 30 November 2015. Submissions were made to the MHC due to the transitional requirements for the new MHAS and to establish a new computer system (ICMS). Ultimately a further $432,000 was provided which included $124,000 for transition expenses and additional $303,000 for remuneration for the Chief Mental Health Advocate and Senior Advocates for part of year (although the funding for remuneration for the Chief did not include superannuation).

Up to 29 November 2015 Council expended $909,608 which included transition costs (ie training new Advocates, recruitment costs, setting up an internet site for MHAS, developing procedures, brochures etc), remuneration for the Chief Mental Health Advocate and Senior Advocates who commenced in September and October respectively, a Project Officer and training Advocates.

Payments to Official Visitors were $492,796 which was 54.2% of Council's total expenditure (although final payments to Official Visitors were made in December 2015 and not included in these expenses). The remainder of Council's expenditure was for administration costs (45.8% or $416,812) which included remunerations for the Chief, Senior Advocates and Project Officers assisting with the transition to the new service.

There continued to be extra administration costs associated with the duplication of work created by a 16 year old computer system (a system that has not met Council's operational needs for many years). Despite years of development work on a new computer system the implementation of a new computer system in July 2015 was postponed for a fourth time. This impacted not just on Council's ability to monitor trends and effectively deploy its resources but also to transition to the new MHAS. The delays in implementing the new ICMS resulted in very limited testing of the new system and a number of compromises had to be made in order to have it ready for commencement of the 2014 Act. It had a short pilot with four Official Visitors learning and then using the system and, from their work, improvements were made prior to full implementation. During November all advocates appointed to the new MHAS were trained. The new system will have the ability to report on the types of complaints and issues raised by consumers.

Remuneration of Official Visitors

Official Visitors were entitled to remuneration as determined by the Minister (s180 of the Act) and the last increase in remuneration was effective from 1 July 2014. The rates were as follows:

- Head of Council: full day $504; half day $336
- Official Visitors: full day $336; half day $231.

Premier's Circular 2010/02 requires the remuneration of individual board and committee members to be reported in the MHC annual report.

The remuneration structure of half and full day sittings was based on payments for government board members, but did not reflect the way Official Visitors work which is highly operational. Council had Official Visitors who worked almost full time hours which was more cost effective for Council. Their hours, however, included weekends and evenings and they did not get sick leave, over-time rates or holiday leave. Official Visitors had to supply their own phones, computers and transport. Their work load was erratic, not guaranteed and they were not paid for travel time (except when travelling between facilities). Many did not claim the costs of phone calls, parking fees or things like printing documents from their home computers and Executive Group members could not be paid for additional work they undertook to fulfil their role nor could they be paid at a higher rate, despite taking on increased responsibility.

The MHAS, which replaced the Council, under the 2014 Act, has more flexibility than is currently available including the ability to retain senior Mental Health Advocates who can take on, and be paid for, supervisory and administrative work.

Administrative Support

Council's support staff continues to struggle to keep up with the administrative workload of supporting Official Visitors as the consumer numbers continue to increase.

An independent report produced in September 2010 said Council needed two extra FTE and this was prior to the major increases in consumer numbers. In 2011 Council settled for one new staff member (taking it to four FTE) while calling for a new database which it expected would reduce some of the administrative handling of reports. In the meantime Council has used temporary additional staff to handle the workload over recent years and, as already noted, complaints coding was stopped during 2013–2014 as another cost cutting measure.

Electoral Act Requirements

As required under the *Electoral Act 1907* s175ZE(1), from 1 July to 29 November 2015 the Council expended the following in relation to the designated organisation types:

a) advertising agencies: nil

b) media advertising organisations: $6,144

c) market research organisations: nil

d) polling organisations: nil

e) direct mail organisations: nil.

STRATEGIC PLAN 2013–2015

The Strategic Plan has been used over the years to guide Council's priorities, especially in relation to the monthly and bimonthly visits which were required under the Act. Due to the replacement of Council by the MHAS, the previous two year plan for 2013-2015 was continued for the last five months of Council's operation. A copy of the Plan is provided in Appendix 8. The Strategic Plan was complemented by an annual operational plan.

The goals which continued until 29 November 2015 reflected the issues of greatest concern to Official Visitors, which were:

1. to improve the MHRB process for consumers
2. to improve the variety, and standards, safety and suitability, of supported accommodation facilities inspected by Council (i.e., licensed hostels, CSRUs and Community Options housing) and the quality of care and recovery oriented services provided to residents of these facilities
3. to improve the quality of life and care on authorised hospital wards in accordance with consumers having the best care and treatment with the least restriction of their freedom and least interference with their rights and dignity (as per s5, Objects of the Act)
4. to improve Council's processes and procedures
5. to ensure, protect and improve the observance of consumers' human rights and quality of care in any relevant proposed legislative or other change.

OTHER ACTIVITIES

Liaison with Services and Other Agencies

Head of Council continued to hold regular meetings during the five months and after she was appointed the Chief Mental Health Advocate, the Deputy Head of Council also attended meetings. These included various stakeholders including the Minister, the Chief Psychiatrist, the President of the MHRB, the executive directors of North Metropolitan Mental Health Services and various South Metropolitan authorised hospitals, the clinical and nursing directors of metropolitan authorised hospitals, staff of the MHC, LARU, Mental Health Law Centre and HADSCO, the NDIS Manager, and other agencies and people including Consumers of Mental Health WA and some hostel licensees. At these meetings, Head of Council gathers and shares information and raises issues of concern and/or advocates for specific changes both on behalf of individual consumers and at a systemic level.

Mental Health Bill Implementation Committees and Consultations

Head of Council continued as a member of the Mental Health Bill Implementation Reference Group and the Mental Health Advocacy Services Working Group during the five months leading up 29 November 2015. Her nominated representatives from Council also continued to participate on the Mental Health Bill Education Steering Committee and the Chief Psychiatrist's Approved Forms Working Group.

Presentations on Council's Role and Consumer Rights

Head of Council and various Official Visitors gave presentations on the role of Council and consumers' rights under the Act during this period to:

- Alma St Centre nursing staff on 22 September 2015
- Midland Hospital staff - eight sessions between 29 October and 5 November 2015
- the Mental Health Advisory Council on implementation of the 2014 Act.

Training for the Mental Health Advocacy Service (MHAS)

There was a variety of training undertaken in preparation for the launch of the MHAS:

- the COV Manager and an Official Visitor attended a 2 day "Mental Health Act 2014 Train-the-Trainer Program" in September 2015 which was used to develop the training program for Advocates
- the Chief Mental Health Advocate, Manger, Senior Advocates and all other Advocates completed the MHC's "Clinicians' eLearning package" prior to the six days in house training in November 2015
- the Chief Mental Health Advocate and several Official Visitors appointed as Advocates attended the Mental Health Tribunal "Professional Development Day" regarding capacity and the 2014 Act on 5 November 2015
- all Advocates took part in Induction Training from 18 to 25 November 2015. Training covered the 2014 Act in detail, the role of MHAS, the Chief and Advocates, pure and uninstructed advocacy, the rights of involuntary patients, the Charter, assessment of capacity, Mental Health Tribunal hearings, the roles of various parties in the system, and internal policies and procedures. The training was augmented by various guest presenters.

Other Training

Other training for Official Visitors included:

- Four hours training on the new Integrated Case Management System (ICMS), a database for the management of consumer requests for assistance, follow up and noting issues and complaints raised. Training was given to Official Visitors (who had been appointed as Mental Health Advocates).
- Mental Health Law Centre presentation by David Kernohan, Chief Executive Officer, at a team meeting in 20 August 2015
- Anglicare's "Responding to Challenging Behaviours" on 28 October 2015 (course paid for by the Official Visitor).

RECORDS MANAGEMENT

In accordance with the *State Records Act 2000*, s19, the Council has a Record Keeping Plan governing the management of all its records. Refer to Appendix 4 for the statement of compliance with s19 of this Act and State Records Commission, Standard 2, Principle 6.

QUALITY ASSURANCE

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

Code of Conduct and Conflict of Interest Policy

The Council has a Code of Conduct and Conflict of Interest Policy that bind all its members. Copies of the Code and Policy are available from the Council's office or on the website. Official Visitors are also required to declare any disqualifying interests (see s178 and Schedule 3 of the Act). No disqualifying interests were disclosed for 1 July to 29 November 2015.

Complaints Regarding Official Visitors and Council Operations

There were two formal complaints and two informal complaints received during the year: three of the complaints were from mental health services staff and one from a consumer. An apology was issued to the consumer for a failure to follow up on an issue by an Official Visitor. Mental health services staff complained in one case that the Official Visitor had not announced themselves when they came on the ward which is unsafe practice and against Council policy. The Official Visitor acknowledged the error. Two other outcomes were mediated with the parties. Although Council has a Complaints Policy (a copy of which can be found on the website under 'Other Publications') and an official complaints form, most complaints are not made formally but by telephone or by email.

"It is a goal of Council to "promote and protect the rights of consumers to natural justice and procedural fairness in hearings and endeavour to improve the observance of that right".

Appendix 1: Authorised Hospitals

Hospital name, mental health ward and address	No of beds [2]
Albany Regional Hospital, Albany Mental Health Unit Hardie Road, Albany	**16**[3]
Armadale Health Service Leschen Unit Albany Highway, Armadale	**41**[4]
Bentley Adolescent Unit Mills Street, Bentley	**12**
Bentley Hospital and Health Service, Mills Street Centre Mills Street, Bentley	**76**
Broome Health Campus, Mabu Liyan Unit Robinson Street, Broome	**13**[5]
Bunbury Regional Hospital **Acute Psychiatric Unit (APU) and Psychiatric Intensive Care Unit (PICU)** Bussell Highway, Bunbury	**27**
Fiona Stanley Hospital Mental Health Unit Murdoch Drive, Murdoch	**23**[6]
Frankland Centre, State Forensic Mental Health Services Brockway Road, Mount Claremont	**37**[7]
Fremantle Hospital and Health Service, Alma Street Centre Alma Street, Fremantle	**64**
Graylands Hospital, Adult Mental Health Services Brockway Road, Mount Claremont	**121**[8]
Joondalup Health Campus, Joondalup Mental Health Unit Shenton Avenue, Joondalup	**47**
Kalgoorlie Regional Hospital, Mental Health Inpatient Service Piccadilly Street, Kalgoorlie	**6**[9]
King Edward Memorial Hospital, Mother and Baby Unit Loretto Street, Subiaco	**8**
Rockingham Hospital, Mimidi Park Elanora Drive, Rockingham	**30**[10]
Selby Older Adult Mental Health Service Lemnos Street, Shenton Park	**32**
St John of God Midland Public Hospital, Mental Health Clayton Street, Midland	**56**[11]
St John of God Mt Lawley Hospital, Ursula Frayne Unit Thirlmere Road, Mount Lawley	**12**
Sir Charles Gairdner Hospital, Mental Health Unit[12] Verdun Street, Nedlands	**30**
TOTAL BED NUMBERS	**651**

2 As at 29 November 2015.
3 Albany Mental Health Unit opened with 12 beds on 26 July 2013 and an additional 4 beds were opened on 23 February 2015.
4 One bed was closed on Moodjar ward on 29 November 2015.
5 Mabu Liyan Unit is a 14 bed unit, however, one bedroom is used as a seclusion room.
6 Fiona Stanley Hospital Mental Health Unit opened on 3 February 2015. As at 29 November 23 beds had been opened in the 30 bed unit.
7 Includes seven beds (previously eight beds as at 30 June 2015 on Hutchison ward at Graylands Hospital) that are funded by the Frankland Centre.
8 In addition there were 16 Hospital in the Home (HiTH) beds in the "bed configuration" of Graylands Hospital which are not included in the numbers of authorised beds.
9 Kalgoorlie Regional Hospital, Mental Health Inpatient Service is a 7 bed unit, however one bedroom is used as a seclusion room.
10 Eight beds were closed on the adult open ward.
11 St John of God Midland opened 24 November 2015. Swan Health Service, Swan Valley Centre and Boronia Inpatient Units which had 44 beds closed at the same time.
12 Sir Charles Gairdner Hospital, Mental Health Unit was authorised on 29 May 2015 and opened on 19 August 2015. It is a 30 bed unit and includes 2 swing beds.

Appendix 2: Private Psychiatric Hostels[13]

Licensee, hostel name, and address	Bed Nos
Albany	**11**
Albany Halfway House Association Inc. (Licensee)	
Ballard Heights, Spencer Park, Albany	
Burswood Care	**31**
Burswood Care Pty Ltd atf Roshana Family Trust (Licensee)	
16 Duncan Street, Burswood	
Casson Homes Inc. (Licensee)	
Casson House	**92**
2-10 Woodville Street, North Perth	
Woodville House	**25**
425 Clayton Road, Helena Valley	
Devenish Lodge	**41**
AJH Nominees Pty Ltd (Licensee)	
54 Devenish Street, East Victoria Park	
Franciscan House	**75**
Meski International Pty Ltd (Licensee)	
16 Hampton Street, Burswood	
Ngatti, Fremantle Supported Accommodation for Homeless Youth	**16**
Life Without Barriers (Licensee)	
5-9 Alma Street, Fremantle	
Joondalup Mental Health Sub-Acute Service	**22**
Neami Limited (Licensee)	
22 Upney Mews, Joondalup	
Ngurra Nganhungu Barndiyigu	**14**
Fusion Australia Ltd (Licensee)	
30 Onslow Street, Geraldton	
Pu-Fam Pty Ltd (Licensee)	
St. Jude's Hostel	**52**
30-34 Swan Street, Guildford	
East St Lodge	**10**
53A and 53B East Street, Guildford	
Romily House[14]	**70**
Mediwest Pty Ltd (Licensee)	
19 Shenton Road, Claremont	
Richmond Wellbeing Incorporated (Licensee)[15]	
Bunbury CSRU	**15**
12 Jury Bend, Carey Park	
Busselton CSRU	**10**
Powell Court, Busselton	
Kelmscott Community Options	**8**
25 Hicks Road, Kelmscott	
Mann Way	**12**
4-6 Mann Way, Bassendean	

13 Private psychiatric hostels include group homes, CSRUs, and Community Options homes. Bed numbers are as at 30 June 2015.

14 Mrs Judith Balfe retired as the licence for Romily House, and Mediwest Pty Ltd became the licensee on 7 September 2015.

15 Richmond Fellowship of Western Australia Incorporated changed their name to Richmond Wellbeing Incorporated in May 2015 and new licenses were issued in the new name as of 1 July 2015.

Ngulla Mia 96 Moore Street, East Perth	34
Queens Park Service 21-23 Walton Street, Queens Park	10
Westminster Service 32A and 32B Ullswater Place, Westminster	6
Roshana Pty Ltd (Licensee)	
BP Luxury Care 22 The Crescent, Maddington	44
Honey Brook Lodge 42 John Street, Midland	35
Salisbury Home Legal Accounting and Medical Syndicate Pty Ltd and Calder Properties Pty Ltd (Licensee) 19-21 James Street, Guildford	35
Southern Cross Care (WA) Inc. (Licensee)	
Bentley House 1182 Albany Highway, Bentley	7
Mount Claremont House 60 Mooro Drive, Claremont	7
Stirling House 4 and 6 Limosa Close, Stirling	8
St Bartholomew's House Inc. (Licensee)	
Arnott Villas 20 Arnott Court, Kelmscott	22
Bentley Villas 1 Channon Street, Bentley	25
Cannington Accommodation Unit 73A & B Mallard Way, Cannington	6
Medina Accommodation Unit 61 Ougden Way, Medina	6
Midland Accommodation Unit 7A & 7 B George Street, Midland	6
Sunflower Villas 15 Limosa Close, Stirling	25
Swan Villas 91 Patterson Drive, Middle Swan	25
St Vincent de Paul Society (WA) Inc. (Licensee)	
Vincentcare Bayswater House 65 Whatley Crescent, Bayswater	6
Vincentcare Duncraig House 270 Warwick Road, Duncraig	4
Vincentcare South Lakes House 9 Plumridge Way, South Lake	3
Vincentcare Swan View House 8 Wilgee Gardens, Swan View	4
VincentcareVincentian Village 2 Bayley Street, Woodbridge	28
Vincentcare Warwick House 39 Glenmere Road, Warwick	4
TOTAL BED NUMBERS	854

Appendix 3: Council of Official Visitors' Membership to 29 November 2015

Head of Council	Commencement	Expiry of Term
Debora Colvin	1 February 2007	2 April 2017 *(HOC from 1 April 2008)*
Official Visitors		
Denise Bayliss	7 March 2006	2 April 2018
Donald Cook	2 February 2010	2 April 2018
Cecily Cropley	16 October 2012	2 April 2018
Alessandra D'Amico	1 February 2007	2 April 2018
Michael Dixon	18 January 2008	4 April 2016
Gerard Doyle	18 January 2008	4 April 2016 *(Leave since 11 September 2015)*
Maxine Drake	1 April 2014	2 April 2017
Mardi Edwards	16 April 2012	2 April 2017
Margaret Fleay	2 May 2011	2 April 2017
Barbara Hewitt	5 December 2011	2 April 2017 *(Extended leave since 13 September 2015)*
Naka Ikeda	7 March 2006	2 April 2018
Norma Josephs	2 May 2011	2 April 2017 *(Extended leave from 13 June to 17 September 2015)*
Kerry Long	17 March 2015	2 April 2018 *(Extended leave since 17 March 2015)*
Shelley McClellan	22 October 2013	4 April 2016
Ann McFadyen	7 April 2002	2 April 2018
Sandra McKnight	1 April 2014	2 April 2017
Melinda Manners	1 April 2007	2 April 2018 *(Extended leave since August 2011)*
Gary Marsh	23 February 2010	2 April 2018
Vlasta Mitchell	1 April 2014	2 April 2017
Bruce Morrison	2 February 2010	2 April 2018
Trinette Murphy	27 May 2014	2 April 2017
Kaylee Oberg	22 October 2013	4 April 2016 *(Extended leave since 15 December 2014)*
Graham Pyke	3 December 2009	2 April 2018
Sheila Rajan	7 April 2009	2 April 2018
Patricia Ryans-Taylor	3 December 2009	2 April 2018
Matthew Scurfield	1 April 2014	2 April 2017 *(Extended leave since 29 June 2015)*
Kathleen Simpson	27 February 2012	2 April 2017
Jeff Solliss	7 April 2009	2 April 2018 *(Extended leave since 24 December 2013)*
Kelly Spouse	1 August 2009	2 April 2018
Jennifer Stacey	22 October 2013	4 April 2016 *(Extended leave since March 2015)*
Helen Taplin	7 March 2006	2 April 2018
Peter Upton-Davis	1 April 2014	2 April 2017
Sally Wheeler	16 October 2012	2 April 2018
Ian Wilson	2 May 2011	2 April 2017

Note: Official Visitors' appointments were for terms that expired on the date specified, or on the day upon which the Council ceased to exist, whichever occurred first.

Appendix 4: State Records Commission Compliance Requirements

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

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

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

   An evaluation of the Record Keeping Plan was completed in 2011–2012.

2. The organisation conducts a recordkeeping training program.

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

   Official Visitors' Operations Manual covers recordkeeping requirements and this is reviewed annually and training is provided on an ongoing basis.

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

   The training program is reviewed annually to ensure its adequacy.

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

   The Code of Conduct Policy includes the roles and responsibilities of employees and Official Visitors regarding laws and policies. Official Visitors' induction training includes their recordkeeping responsibilities.

Appendix 5: Authorised Hospital Inspections Between 1 July and 29 November 2015[16]

AUTHORISED HOSPITAL	TOTAL NUMBER OF INSPECTIONS (INFORMAL INSPECTIONS[17])	TIME OF INSPECTION		
		Weekdays 9am – 5pm	Weekdays 5pm – 9am	Weekends and Public Holidays
Albany Mental Health Unit	5 (11)	5 (9)	(2)	
Alma Street Centre, Fremantle	20 (2)	20 (2)		
Bentley Adolescent Unit	5 (4)	5 (4)		
Bunbury Acute Psychiatric Unit and Psychiatric Intensive Care Unit	5	4		1
Frankland Centre	5	5		
Graylands Hospital	45	43	2	
Fiona Stanley Hospital Mental Health Unit	13 (6)	13 (6)		
Joondalup Mental Health Unit	5	2	1	2
Kalgoorlie Mental Health Inpatient Service	5 (10)	5 (8)	(1)	(1)
Leschen Unit, Armadale	20	18	2	
Mabu Liyan Unit, Broome Hospital	5 (8)	5 (7)	(1)	
Mills Street Centre, Bentley	20 (5)	20 (5)		
Mimidi Park, Rockingham	20	20		
Mother and Baby Unit, KEMH	5			
Selby Lodge	5	5		
Sir Charles Gairdner Hospital	9	9		
Swan Valley Centre and Boronia Unit, Swan District Hospital	10 (2)	10 (2)		
Ursula Frayne Unit, St John of God Mt Lawley Hospital	5	5		
TOTAL	**207 (48)**	**199 (43)**	**5 (4)**	**3 (1)**

16 Note: informal inspections are provided in brackets.
17 Those hospitals with more wards get more visits as not all wards are inspected on the same visit.
18 Fiona Stanley Hospital Mental Health Unit was authorised on 3 December 2014 and opened on 23 February 2015.

Appendix 6: Private Psychiatric Hostel Inspections Between 1 July and 29 November 2015[19]

LICENSED HOSTEL, GROUP HOME, CSRU AND COMMUNITY OPTIONS HOMES	TOTAL NUMBER OF INSPECTIONS
Albany CSRU	2
Burswood Care	2
Casson Homes – Casson House	2
Casson Homes – Woodville House	2
Devenish Lodge	2
East St Lodge	2
Franciscan House	3
Joondalup Mental Health Sub-Acute Service	3
Ngurra Nganhungu Barndiyigu	3
Ngatti Fremantle Supported Accommodation for Youth Homeless	3
Richmond Fellowship – Bunbury CSRU	3
Richmond Fellowship – Busselton CSRU	2
Richmond Fellowship – Kelmscott CSRU	3
Richmond Fellowship – Mann Way	3
Richmond Fellowship – Ngulla Mia	3
Richmond Fellowship – Queens Park Service	2
Richmond Fellowship – Westminster Service	1
Romily House	2
Roshana – Honey Brook Lodge	2
Roshana – BP Luxury Care	3
Salisbury Home	2
Southern Cross – Bentley House	2
Southern Cross – Mt. Claremont	2
Southern Cross – Stirling House	3
St Bartholomew's – Arnott Villas CSRU	3
St Bartholomew's – Bentley Villas CSRU	5

19 Private psychiatric hostels include group homes, CSRUs, and Community Options homes.

St Bartholomew's – Cannington Accommodation Unit	3
St Bartholomew's – Medina Accommodation Unit	2
St Bartholomew's – Midland Accommodation Unit	2
St Bartholomew's – Sunflower Villas	3
St Bartholomew's – Swan Villas	2
St Jude's Hostel	2
Vincentcare – Bayswater House	3
Vincentcare – Duncraig House	2
Vincentcare – South Lakes House	2
Vincentcare – Swan View House	3
Vincentcare – Vincentian Village	2
Vincentcare – Warwick House	2
TOTAL	**93**

Appendix 7: Total Consumers and New Consumers 2003–2004 to 29 November 2015[20]

FINANCIAL YEAR	NUMBER OF CONSUMERS	NUMBER OF NEW CONSUMERS
2003–2004	744	412
2004–2005	800	391
2005–2006	891	386
2006–2007	979	440
2007–2008	1,052	479
2008–2009	850	365
2009–2010	957	446
2010–2011	1,201	532
2011–2012	1,438	580
2012–2013	1,539	598
2013–2014	1,602	656
2014–2015	1,772	774
1 July to 29 November2015	867	362

20 Source: Council's Visitor Tracking System database.

Appendix 8: Strategic Plan
1 July 2013 to 29 November 2015

Vision/Statement of Purpose:

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

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

Strategies to Achieve Goal

1.1 Continue to advocate for improvements to the MHRB process under the current Act and have input into the Mental Health Bill as per the report and recommendations made by HOC in May 2010.

1.2 Improve consumers' access to representation by lawyers and Official Visitors at MHRB hearings.

1.3 Improve the standard and quality of representation at MHRB hearings.

1.4 Promote and protect the right of consumers to natural justice and procedural fairness in hearings and endeavour to improve the observance of that right, in particular their right to:

- be provided with a copy of the medical report in a reasonable amount of time in advance of the hearing (Council's position is a minimum of three days before); and
- be given access to their medical file and any other documents made available to the MHRB as part of its deliberations.

TWO YEAR GOAL 2 - SUPPORTED ACCOMMODATION
To improve the variety and standards, safety and suitability of supported accommodation facilities inspected by Council (i.e., licensed hostels, CSRUs and Community Options housing) and the quality of care and recovery oriented services provided to residents of these facilities.

Strategies to Achieve Goal

2.1 Continue to lobby for a review of the sector including the governance, oversight, and quality assurance of supported accommodation facilities.

2.2 Continue to raise issues and advocate for improved standards and quality of care in facilities including access to community and other services aimed at recovery by residents.

2.3 Maintain, and endeavour to improve, accessibility to Official Visitors by residents of supported accommodation facilities.

2.4 Continue to advocate for a wider variety of, and more, supported accommodation.

GOAL 3 - LIFE AND CARE ON THE WARDS

To improve the quality of life and care on authorised hospital wards in accordance with consumers having the best care and treatment with the least restriction of their freedom and least interference with their rights and dignity (as per s5 Objects of the *Mental Health Act*).

Strategies to Achieve Goal

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

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

3.3 Improve Official Visitor accessibility to, and advocacy for, the most vulnerable consumers on wards:

- people 'stuck on wards'
- the elderly
- children
- regional and remote patients being transferred and treated away from their home and family
- Indigenous and Culturally and Linguistically Diverse consumers
- women and sexually abused and particularly vulnerable consumers on mixed gender wards
- consumers with an intellectual disability or acquired brain injury.

3.4 Continue to lobby for consumers' rights to a truly independent "other opinion".

GOAL 4 – COUNCIL OPERATIONS

To improve Council's processes and procedures.

Strategies to Achieve Goal

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

4.2 Improve the quality and satisfaction of Official Visitors' work.

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

4.4 Put in place strategies to be responsive to an expansion of consumer numbers.

GOAL 5 – NEW LEGISLATION

To ensure, protect and improve the observance of consumers' human rights and quality of care in any relevant proposed legislative or other change.

Strategies to Achieve Goal

5.1 Continue to ensure that Council has input to any reviews and draft legislation.

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

5.3 Continue to raise the need for an independent inspection service as well as an advocacy service.

5.4 Prepare for a new Mental Health Act and the changes it brings.

GLOSSARY OF ACRONYMNS AND TERMS

2014 Act	Mental Health Act 2014
Act	Mental Health Act 1996
Consumer	An 'affected person' as defined by s175 of the Act who can be assisted by an Official Visitor; individuals who do not come within this definition are referred to by various titles including patient, referred patient, voluntary patient or resident
Council	Council of Official Visitors
CSRU	Community Supported Residential Unit
CTO	Community Treatment Order
DOH	Department of Health
ED	Emergency Department
HaDSCO	Health and Disability Services Complaints Office
ICMS	Integrated Case Management System
LARU	Licensing and Accreditation Regulatory Unit
MHAS	Mental Health Advocacy Service
MHC	Mental Health Commission
MHRB	Mental Health Review Board
NDIS	National Disability Insurance Scheme
Minister	Minister for Mental Health