




COUNCIL OF
OFFICIAL VISITORS

ANNUAL REPORT
2004 - 2005



*Artwork produced through the
Creative Expression Unit at Graylands Hospital.
Front Cover and internal border detail painting by Craig Wood.*

The Honourable J A McGinty MLA
Minister for Health
30th Floor Allendale Square
77 St George's Terrace
PERTH WA 6000

Dear Minister

In accordance with section 192(3) of the *Mental Health Act 1996* I submit for your information and presentation to Parliament the Annual Report of the Council of Official Visitors for the financial year ending 30th June 2005.

As well as recording the operations of the Council for the 2004 - 2005 year the report once again reflects on a number and range of issues that continue to affect consumers of mental health services in Western Australia.

Yours sincerely



Dr Judyth Watson
HEAD
COUNCIL OF OFFICIAL VISITORS

October 2005

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INTRODUCTION - YEAR IN REVIEW

As well as fulfilling the requirement to inspect those places as defined in the *Mental Health Act 1996* (the Act), the Council's direct work with consumers continued to grow as in previous years. A total of 1600 requests for contact with the Council were received from 800 consumers during 2004 - 2005. This is an increase of 13.07% in the number of requests received compared to 2003 - 2004. The requests resulted in 1329 visits by Official Visitors to consumers and a total of 2551 telephone calls either to or on behalf of the consumers. The planned goals of increased representations at the Mental Health Review Board and an increase in the number of contacts with consumers treated by Community Treatment Order were not able to be met.

Those matters of concern that the Council outlined in last year's Annual Report remain with the same qualifications: namely that slow, but beneficial changes do continue and the many dedicated professional individuals who care for consumers of mental health services contribute to that change. However many infrastructure, cultural and legislative changes must also be made so that the services in this State reflect vibrant and modern ideas that meet the expectations and ideals of this community in 2005 and beyond. This will take some years to achieve.

Of concern are those services, especially those related to long term living conditions, which resemble those of another age. During the past year the Council has engaged with the conditions for consumers who are resident in Murchison Ward at Graylands Hospital, some aspects of which appear in this Report. The Council urges the Government to ensure that appropriate resources and commitments are made for alternative and modern accommodation for this very disabled population.


The voice of consumers and carers is insistent and it must be heard. Their participation is also having an increasing and beneficial impact both in direct service provisions and in policy development. This year the Annual Report includes a consumer's story in response to a complaint about stigma that the Council has made.

The enduring stigma surrounding mental illness is contributed to by inadequate resources allocated to this field for services and programmes, including for accommodation, as well as by some media coverage.

Substantial concerns remain for Council when consumers' rights are not respected, often by those who are charged with their care.

Matters that were raised as concerns and were the subject of comment in the Annual Report of 2003 - 2004 that persist, include:

- overcrowding in acute psychiatric wards;
- lack of slow stream rehabilitation facilities and step down beds;
- long waits in Emergency Departments;
- extra burdens placed on individuals and their families who live in rural Western Australia;
- inpatient services for children and adolescents;
- no modern and dedicated service for mothers and their babies;
- institutionalised services for people with enduring mental illness and disability; and
- the urgent need for new mental health legislation.



These and other issues affecting acutely ill as well as disabled consumers, consumers of all ages and backgrounds, present ongoing challenges for the brief of Council to ensure that the rights of “*affected persons*” are observed.

However, the State Government’s funding for new initiatives provided in October 2004 means that there is now a concrete plan for beneficial short and medium term strategies to address these and related matters. The Council welcomes this and participates in a number of committees and meetings that engage with policy development as well as the more detailed planning aspects of implementation.

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

The focus of Council is on rights and this report addresses how statutory rights are too often breached, and that too often our community’s expectations of the rights to privacy, dignity and bodily integrity, for instance, are not met.

The Annual Report addresses related issues as well, including the past year’s progress and deficits.

PART ONE

THE LEGISLATIVE AND OPERATIONAL FRAMEWORK

LEGISLATIVE FRAMEWORK

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

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

OPERATIONAL FRAMEWORK

The *Mental Health Act 1996*, sections 175 - 192, prescribes the functions and responsibilities of the Council of Official Visitors.

The major responsibility of the Council's members (Official Visitors) is to ensure that "affected persons", as defined in section 175 of the Act, are aware of their rights and that those rights are respected. This includes monitoring the quality of care provided to ensure that it is of the highest possible standard. The Official Visitors also have a responsibility to undertake a complaint management role for "affected persons".

"Affected person", under the Act (section 175), includes:

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

The Council is required to ensure that an Official Visitor or panel visits each hospital authorised under section 21 of the Act at least once per month and each licensed private psychiatric hostel at the direction of the Minister for Health (currently at least once every 2 months). In practice, with the exceptions of the Richmond Fellowship and Casson Homes shared houses, each hostel is visited every month, alternating formal with informal visits.

The Council has maintained its active visiting programme, visiting eleven authorised hospitals and nineteen licensed private psychiatric hostels, including four sets of group homes, during 2004 - 2005.

In late June 2005 the Minister, in accordance with the Act section 186(b), issued a new direction, "*Functions of the Council of Official Visitors Direction 2005*", identifying those facilities to be visited by the Council under that part and the frequency of those visits.

This direction removed Success Hill Lodge and Sherwood House which ceased operating as licensed private psychiatric hostels in May 2003 and February 2005 respectively. It also added a number of facilities operated by Vincentcare that had recently been licensed as private psychiatric hostels. The programme of visits to the Vincentcare facilities will commence in July/August 2005.

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

The Council continued its commitment to offering its services to more individuals who are treated by Community Treatment Order, with varying success.

An “*affected person*” or another person on their behalf (Act, section 189) can request a visit from an Official Visitor. A visit is then arranged as soon as is practicable (section 186(c)). Requests can be made in writing or via telephone or personal contact. 800 consumers had contact with Official Visitors during 2004 - 2005, compared to 744 in 2003 - 2004, an increase of 7.5% over the previous year. A total of 1600 requests for contact with the Council were received from these consumers during 2004 - 2005. This is an increase of 13.07% in the number of requests received compared to 2003 - 2004. The requests resulted in 1329 visits by Official Visitors to consumers and a further 2551 telephone calls either to or on behalf of the consumers.

REPORTING LINES

Official Visitors

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

Executive Officer & Other Staff

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

COUNCIL COMPOSITION 2004 – 2005

A list of the members of the Council during the 2004 - 2005 financial year and their terms of appointment are contained at Appendix 3. Two individuals whose terms expired on 7 April 2005 did not seek reappointment. Another individual resigned from the Council during this time due to personal commitments. The contributions to the Council of those three people are greatly appreciated.

PANEL APPOINTMENTS

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

- 1 **Expert/Consultant** - appointed when issues arise and direct access to professional or expert advice during a visit or contact is required and members of the Council do not have the required expertise.
- 2 **Interested community members** - appointed when members of the community seek a greater understanding of the role of the Council.

Seventeen individuals were appointed and undertook work as panel members of the Council, as prescribed in section 187 of the Act, during 2004 - 2005. This included a number of members of the Council whose terms expired before the 2005 appointment process had been completed, as well as individuals from other agencies who wished to obtain a greater understanding of the functioning of the Council. Two other individuals were appointed as panel members but these appointments were revoked prior to them visiting as part of a panel as a conflict of interest was identified.

COUNCIL MEETINGS

The Council had Full Council meetings four times throughout 2004 - 2005. All meetings had a professional development focus with one being combined with the orientation and training sessions for newly appointed Official Visitors. The programme of combined meetings for regionally based Official Visitors prior to each Full Council meeting continued during 2004 - 2005.

The Executive Group, comprising representatives from each of the sub-groups of the Council, met five times to act as the decision-making body for the Council between meetings of the Full Council.

A summary of the meetings attended by Council members during 2004 - 2005 is contained at Appendix 4.

BUDGET

The Council was allocated a budget of \$560, 000 for 2004 - 2005. Expenditure for the financial year 2004 - 2005 totalled \$585, 087 at 30 June 2004 (Appendix 5).

A grant of \$7500 was also provided by the Office of Mental Health for the research project that investigated reasons for low levels of representation of persons at Mental Health Review Board hearings. The Department of Health acknowledged that the year's allocation proved to be insufficient and provided an allocation to meet the additional expenditure.

Members of the Council are entitled to remuneration (section 180 of the Act). The remuneration rate for members of the Council remained the same as in 2003 - 2004.

The Council was previously unable to pay panel members for the work they undertook as part of a panel for the Council. In July 2004 the Minister approved the payment of panel members for work undertaken on the provisions that:

- 1 the person is not duplicating the functions of other agents of the Department of Health;
- 2 the panel member does not undertake a function that could be referred under section 180(f) of the Act whereby it would be appropriate for another person or body to deal with the matter; and
- 3 fees are paid in accordance with those paid to appointed Official Visitors.

RECORDS MANAGEMENT

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

PART TWO

THE RIGHTS OF PEOPLE WITH A MENTAL ILLNESS

A FRAMEWORK OF PRINCIPLES TO PROTECT RIGHTS

The Council's functions include the observance of the rights of people defined under the Act (section 175) as "*affected persons*". It has the power, among others, to inspect consumers' records in order to ensure that those rights are observed, including that explanations have been given verbally and in writing to the individual.

Statutory rights provided by the Act to "*affected persons*" include the following:

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

Unfortunately, those non-statutory rights expected to be enjoyed by all Australians, including "*affected persons*", and enshrined in the Universal Declaration of Human Rights are frequently breached. For instance, Article 1 states that "*all human beings are born free and equal in dignity and rights.*"

The U.N. General Assembly adopted principles for the protection of people with mental illness in 1991 with Principle 2 reading: "*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 Council's last two Annual Reports outlined the sources for the derivation of rights for people who have a mental illness. These include:

- "Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care" (UN Principles);
- building on the UN resolution twelve Guiding Principles were adopted in Australia in December 1996 to underline the *National Standards for Mental Health Services*. Each set of guidelines for policy development and service delivery in the States was to be developed against this framework of national and international principles. Mental Health Services continue to be assessed for accreditation against the *National Standards for Mental Health Services*;
- *Mental Health Act 1996* (the Act) accords a set of legal rights to consumers that protect them and mental health professionals; and
- a pamphlet published by the Office of the Chief Psychiatrist sets out, in plain English and in an abbreviated form, some of the rights accorded to consumers treated under the Act, including the right to make a complaint to the hospital authorities, the Council of Official Visitors, the Chief Psychiatrist or the Mental Health Review Board.

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

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

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

It is essential that the practice of mental health clinicians reflect their knowledge of, and commitment to, the above standards and legislation. As we did last year, the Council urges the Minister to ensure that the protection of rights based on both UN Principles and the National Standards is explicit in forthcoming amended legislation.

OBSERVING THE RIGHTS OF PERSONS WITH A MENTAL ILLNESS

The following issues represent a number of matters that have either been brought to the attention of Council by means of complaint, or initiated by the Council because of their potential to impinge on the rights of mental health consumers.

The Head of Council and the Executive Officer meet on a regular basis with a range of stakeholders, including Departmental managers and service providers, taking relevant matters to them, advocating not only on behalf of individual consumers, but also for systemic change.

ISSUE

Low representation of individuals at Mental Health Review Board hearings

Illustration: The Council continues to be concerned that of all individuals whose status is examined by the Mental Health Review Board (MHRB), only 18.4% were represented or supported in 2003 - 2004. The Council assisted 8.4% and the Mental Health Law Centre 10%. There is general agreement in the sector that representation by legal or lay advocates is too low and must be improved.

Official Visitors have the authority to assist individuals before and during their hearings. In 2003 the Council decided that as part of its strategic plan, it would aim to increase by 25% its representation for consumers booked for MHRB hearings in each of three consecutive years. (See also report on progress of the strategic plan in Part Three below)

Action: As reported last year funding was committed to the Council to oversee a small research project that would seek to establish why so few individuals have representation or support when their status is reviewed by the Mental Health Review Board (MHRB). The aim was to use the study's results to assist the relevant agencies to review, and if necessary, revise their procedures for disseminating information about their role and services and to improve representation.

The research had Ethics Committee approval and was started in January 2005. The report was submitted to the Office of Mental Health and the major stakeholders at the end of June 2005.

Representatives of the Council, the MHRB, the Mental Health Law Centre, and Health Consumers' Council formed an advisory group to the researcher Ms Barbara Gatter.

The study sample was forty consumers comprising involuntary patients either being treated in hospital or by Community Treatment Orders. Some of them attended a MHRB hearing and some did not.

Specifically the study set out to establish from the participants:

- factors that led to each having, or not having, representation at a hearing;
- current and past experience with representation at MHRB hearings;
- knowledge of the agencies that could assist them at a hearing; and
- sources of information about hearings, their satisfaction with those sources and other information that would have been helpful for them.

It was found, among other observations, that those consumers who had representation appeared to be less negative about the review process than the group of patients who did not, even when their involuntary status was maintained. A number of consumers regarded the MHRB and the review process negatively, with some measuring the "usefulness" of MHRB by the number of orders that were overturned. These groups were unable to see any intrinsic value in being supported at their hearing if it did not result in a change in their status.

The practical problems of actively assisting people who are too unwell to instruct a legal representative, or to understand their rights, must mean that their rights are not exercised. (This issue is receiving active consideration by legal advocates).

A limited examination of statistics was undertaken and found that, overall, rates of representation at MHRB hearings had increased slightly in recent years, but at less than 20%, were still less than the key agencies considered to be desirable.

An analysis of data from the three month period July to September 2004, indicated that at 62% representation was markedly higher at requested reviews than at initial period reviews and six monthly reviews, at each of which representation was slightly over 6%. Of particular concern to the Advisory Group was the finding that during the snapshot period not one of the 30 involuntary patients in an authorised hospital had representation at their six monthly review.

A number of recommendations were put forward and these will be taken up with all stakeholders, including the Office of the Chief Psychiatrist, with a view to implementation.

Status: Council will pursue strategies to improve the rates of representation and/or support when involuntary status is reviewed by the MHRB.

ISSUE

Seclusion experience and practice as reported from time to time by consumers

The Council receives numerous complaints from consumers or family members about seclusion experiences and/or practices, some of which appear to breach the Act, while many others represent invasions of dignity and privacy as the following two examples illustrate.

Illustration - Case 1: A woman was secluded many times and for extended periods because of her threatening behaviour to self and others. The mattress and blankets were removed from the room and she was nursed naked in seclusion, such was the assessed risk of harm. The woman took her own clothes off under the supervision of a female nurse. The seclusion records documented these facts, but the Council, while acknowledging the challenges and also her distress, was left wondering why measures other than seclusion were not taken for her condition and her risky behaviours. The Hospital does not have a supply of tear proof pyjamas. This was taken up with the Hospital Executive.

Illustration - Case 2: It is also claimed by the Council that a woman at a different hospital had her personal dignity compromised by her seclusion experience. She was apparently physically blocking the seclusion room door. The woman said that she was cold and uncomfortable and wanted to go back to her room because of the cold. The nurse however, told the patient that if she didn't move away from the door by the count of five all her clothes would be taken off.

The nurse did take the woman's night clothes off, leaving her totally naked. The door to the room opening into a side room was not closed. The patient was cold, embarrassed and humiliated. She acknowledged that her behaviour was a challenge to the nursing staff, but said the removal of her clothes was not an acceptable means of improving her behaviour. The Council agrees and remains concerned about the punitive aspects of some seclusion experiences.

On inspection, the seclusion record indicated by one word that she was "naked" but no reason for this was given.

(This same woman and the Council were further concerned when, during another episode of distress a duty doctor suggested she be nursed naked rather than restrained until the medication took effect).

Comment: Official Visitors have a number of statutory powers and functions that enable them to inspect seclusion rooms, inspect seclusion registers and hear and seek to resolve complaints made about practice.

It is the experience of the Council that seclusion practices differ between hospitals and also within hospitals. Guidelines and protocols for seclusion are in place in authorised hospitals but the use of

discretion by individual health professionals can provide potential for inconsistent practice and recording. It is not unusual for patients to think that they were being punished by being secluded.

Action: Despite the legislative framework there is not a sector wide approach to seclusion practice. The Council decided to collect data to illustrate these problems in order to persuade clinicians of the need for a more consistent approach to seclusion.

Limited data was requested from four metropolitan authorised hospitals and demonstrated that:

- times that individuals spend in seclusion differ between hospitals;
- categories of reasons for seclusion differ, are not standardised and cannot be compared; and
- numbers of seclusions reported to the MHRB are considerably less than those recorded at each hospital.

Relevant stakeholders were provided with Council's report of the findings with a request that:

- further data be collected as part of an investigation to establish whether units do comply with statutory requirements;
- consistent reporting and recording protocols for seclusion episodes are implemented across the sector; and
- reports from consumers about seclusion experiences be canvassed.

Status: These and related matters will be followed up with the relevant services in the coming year.

ISSUE

Stigma surrounding mental illness

Illustration: On March 16th and 18th 2005 the West Australian Newspaper published a front page story covering a murder in Margaret River. It was reported that the suspect who was named was known to have a mental illness. The story was illustrated by a photograph of the alleged perpetrator in the street, naked and said to be 'incoherent'.

Action: The Head of the Council wrote to the Editor of the newspaper to complain, to ask for its policies in regard to the reporting of mental illness and to ask for an apology about the breach of privacy, dignity and confidentiality. Council pointed to the fact that the photograph and style of reporting add to, rather than detract from stigma and public pre-conceptions of mental illness. Despite the fact that the man's name was published, the newspaper responded in part by claiming that the man was not identifiable. As a consequence of dissatisfaction with the Editor's response the Council made a formal complaint to the Australian Press Council.

In June the Head of Council attended a meeting to co-mediate the complaint with the Chief Psychiatrist with 2 editorial staff. Both complainants were unconvinced that a satisfactory outcome was achieved.

Comment: The media has generally taken an ethical interest in mental health matters and, as a component of the National Mental Health Strategy, a web based resource www.mindframe-media.info is available as a type of check list for media professionals. It addresses issues that editors and sub-editors will have to decide, including questions of whether or not to run a story, choice of headline, choice of language and use or not of photographs. There are numerous other resources available to inform and guide editorial decision making.

This photograph and story evoked a number of strong responses from people with mental illnesses, their carers and advocates as well as the general public.

Illustration: A young man who has a long standing mental illness wanted to respond to the article by telling his story. Anthony (a pseudonym) has agreed that a summary can be used for the Annual Report in order to illustrate how the constant barrage of prejudice that comes the way of people in his and similar circumstances can impact. His story is of course unique, but it is also typical of those told every day to Official Visitors.

Anthony says that people with a mental illness have to work twice as hard in every aspect of life - work, study, time keeping, socialising and friendships, relationships and housing - but must also face the fact that these substantial efforts are still likely to mean little can be achieved. So, despite working hard at a present course of study, Anthony finds it hard to learn new things and to recall what he thought he had learned. He says this effort/achievement ratio is little understood and that stigma and prejudice play a role in maintaining it.

The medication is powerful and after so long he still needs regular adjustments. In the first place he was bed ridden at home for seven years by the medication and its side effects. He had an average of one hospital admission a year. Medication that makes him sleepy and hungry has meant he has put on more than 50kgs. detracting from his body image and esteem.

This young man was diagnosed with a schizophrenic illness more than a decade ago when he was in his early 20's. He was a keen sportsman and swimmer, a university student and had a part time job. He smoked, drank alcohol and was sociable generally always seeking a good time with many friends and fellow students. He "*took life for granted*".

The first thing that happened after his diagnosis was that his friends, including his then girlfriend, deserted him. They "*couldn't handle it*" and acted, he says, from a fear of the unknown. His family have been steadfast in their support and care; but his mother's grief was exacerbated when, weeks after diagnosis, Anthony's first psychiatrist told her that parents are usually to blame for these illnesses. Anthony has needed to "*learn how to live again*". He is a reflective person who has developed thoughtful insights and looks for a purpose to the illness to explain his suffering.

Anthony claims that the illness becomes who and what one is and knows that many people see him as "*a schizophrenic*". He says that the way that too many people are treated means they can become "*the stereotype schizophrenic*" as others determine, and behave as they believe that label defines.

Behind these observations is the stigma that he and others identify every day. This may take the form of patronising behaviour especially by health professionals or it may be the prejudiced approach of a media report or a landlord or work colleague. The prevailing attitude according to Anthony is formed by "*an established response*", "*a readiness to respond*" to mental illness and means that on the whole the stigma associated with this prejudice means that people "*keep their distance*". They project their fears and ignorance about these illnesses onto the people who have symptoms or a diagnosis of mental illness.

The newspaper report, Anthony said, evokes only negative emotions, including anger at its inherent prejudice, and a helplessness to respond effectively. He says that at the time the article took away the hope that things will improve in his life time. He remains concerned for the impact on the young man and his family.

Anthony reflects that Aboriginal Australians and people with enduring mental illness share similar struggles for recognition and acceptance.

Status: The complaint against the West Australian is to be referred to the Australian Press Council for adjudication.



ISSUE

Use of security guards

Illustration: The practice at Bunbury Hospital for instance has been to place a security guard to watch over any person diagnosed with a mental illness who is admitted to the general ward, regardless of their behaviour.

It is also practice at the Bunbury and Joondalup Emergency Departments for any person with any one of a range of mental illnesses to be allocated a security guard thus marking them out. In other hospitals the policy is to place a hospital orderly with the patient, if required.

Comment: In many ways this matter illustrates the Council's contention that among other adverse effects the participation of security guards in itself is a stigmatised decision with a stigmatised effect.

Action: The Council was sent a copy of the Bunbury Hospital policies regarding the "Use of Security Officers and PCAs for Close Observation of Patients in the Acute Psychiatric Unit"; "Use of Security Guards and Specialling: Acute Psychiatric Unit and Specialling and Close Observation in the Acute Psychiatric Unit for Nursing Staff" and invited to comment. A summary of the Council's concerns follows:

- the emphasis on safety and on potential for violence is the main "driver" of practice and of the policy document;
- there is no reference in any policy to the observance of patient rights accorded by the Act;
- the positions taken augment the Council's concerns about the use of security guards and Patient Care Assistants (PCA). Issues that the Council has continued to raise about patients subject to the Act admitted into the general medical ward with the associated use of security guards remain;
- the policy is silent on the matter of admissions of acutely ill people to the general wards. In our opinion it is inappropriate to attach the term "special" (which implies an appropriate if not expert level of observation and care) to the PCA and the security guard observation forms;
- when a request is made for a 1:1 special the nurse in charge must "take into account existing and projected nursing resources, overall acuity within the unit and the clinical needs of the patient". It has to be asked whether this decision making process differs from that which would be made in wards other than Acute Psychiatric Unit (APU): for example would a person needing a nurse special for post operative care or post stroke care trigger the same issues about nursing resources, acuity and clinical needs? We venture to suggest that difficult and inconvenient as a decision to allocate a nurse special to a patient other than one with an acute mental illness may be, the need would be accommodated. It is hard to imagine that an acutely ill medical or surgical patient would be subject to the observations of a security guard or PCA.

The types of patients admitted to the Bunbury Hospital must be fairly typical or representative of patients in every acute psychiatric unit in the State. In our view acutely ill people deserve to be cared for by a suitably qualified and experienced nurse or other clinician. We claim that any care or observation other than that provided by nursing or clinical staff denies individual patients the care to which they are entitled.

The Council argues that individual risk assessment should be the determinant of how staff is allocated. On this basis if a physical presence is considered essential and constant nursing observation is not required then a Patient Care Assistant would be the preferred choice.

Status: Council concerns remain unresolved and we will continue to monitor the issues through inspection visits and individual consumer complaints.

ISSUE

Right of capable persons to exercise their right to vote

Illustration: An involuntary patient at Graylands Hospital contacted the Council to say he wanted to vote in the forthcoming State election in February. He had been deemed incapable of exercising his right to vote by a psychiatrist (Act sections 201 & 202).

The Council arranged for an urgent MHRB hearing (Act section 203) the day prior to the election and the decision was overturned. On polling day the man was taken with other patients to the local polling booth, a mini-bus ferrying people between it and the hospital.

This example and the transport provisions raised a number of matters about a citizen's right to vote and the organisation of these arrangements for people hospitalised with mental illness.

Comment: Patients admitted from their home for treatment are eligible to vote unless deemed incapable by a psychiatrist as provided by the legislation. Although only two individuals resident at Graylands Hospital are on the Electoral Roll at that address, it is the Council's view that there are more people resident at Graylands who should be enrolled to vote in elections, although there may be individuals who do not have the capacity to exercise a vote.

The current arrangements for transport to a local polling booth in itself must preclude those people whose behaviour could compromise themselves or others when off campus.

Any other hospital of this size would be provided with an appropriate service for its patients.

The Council made inquiries from the Hospital and from the State and Commonwealth Electoral Commissions about the feasibility of enabling Graylands Hospital to host a community polling booth in forthcoming elections. This is not acceptable to the Hospital Executive and postal voting could prove difficult for some individuals.

Status: Council has asked the Electoral Commission to ensure that all long term residents of Graylands who are capable are enrolled and that consideration is given to allocating a mobile polling booth for the week preceding elections.

ISSUE

Criminal Law (Mentally Impaired Defendants) Act 1996: Frankland Centre consumers: provisions for court appearances

Illustration: Official Visitors (and others) noted that individuals subject to Hospital Orders under the *Criminal Law (Mentally Impaired Defendants) Act 1996* and required to appear in person before a magistrate at seven days and intervals thereafter, were often distressed and upset on return from the Court. On occasions they were away from the ward for most of the day.

Action: Many stake holders suggested options for improving the protocols. The Council advocated for change, proposing a number of options that would mean individuals were away from the ward for less time and could be certain of being provided with lunch, drinks and medication in order to reduce the inevitable distress.

Status: Resolved between the State Forensic Mental Health Service, the Chief Magistrate and Department of Justice so that people will appear before the magistrate by video conference facility without leaving the ward. Necessary legislative amendments were made.



ISSUE

Night time consumer experience in authorised hospitals

Illustration: The Council has received complaints from consumers that:

- they were woken to move their beds and/or wards at night; and
- hot drinks and access to tobacco were not always available for them if having a sleepless or distressing night.

Action: The Council decided that one of the regular monthly inspection visits would be done on a night shift. Over a period of 2 months in summer each authorised hospital was visited at night.

It was decided that the focus of these visits would be to introduce the Council and its functions to the night staff and to make observations about the environs and how they might contribute or not to sleep/rest, speaking to patients only if they were awake. The Official Visitors returned next day to speak to consumers from the ward. The visits were unannounced but Hospital Executives had been told of the Council plan and supported it.

On the whole the consumers said they knew the night nurses by name and felt comfortable with them. Nursing staff may be either on permanent night duty or rotate shifts. Few agency nurses were said to be used at night, though a casual pool might provide nurses as needed. Two groups of nurses commented that provisions for available medical staff at night are not satisfactory.

In general most wards in most hospitals were settled and subdued ward lighting and noise were evident, although in older wards creaking floorboards can disturb patients and are a source of complaint.

At one hospital patients who like to read needed to bring in their own lamp to use as long as no-one was disturbed by the light.

Night time access to smoking space is an issue at most units; nurses accompany most smokers outside.

Water is available at most units for the patient to access although some need to ask a nurse for it. Kitchens are usually out of bounds but most staff will make the sleepless or distressed person a hot (non-caffeinated) drink.

New admissions will in any case mean that some noise is inevitable, but nurses spoke of their own and patient distress when patients are moved at night to accommodate new ones.

(See below for comment regarding the Murchison Ward night visit.)

Status: The Council and hospital staff found this a useful exercise. Late evening visits were made later in the year to hostels. An annual night time inspection is under consideration; the decision to be made at a meeting of the Full Council.

ISSUE

Cigarette smoking in authorised hospitals

Illustration 1: The Mills Street Centre decided to restrict patient access to cigarettes by assuming blanket control and rationing but, following Council arguments, reverted to individual autonomy. If for any reason staff thought any person's tobacco should be rationed, this was to be done on a case by case basis. It is understood that this matter was also brought to the notice of the MHRB by an individual patient.

Comment: The matter of who controls cigarette smoking, and for what purpose, is complex. It can adversely affect the decision making rights of individuals. Besides the clear implications for health, there are safety concerns with matches and lighters and some services provide for this with fixed communal lighters. Consideration has to be given to the fact that some consumers will use cigarettes to bargain or to exert power; some cannot ration them to last themselves. Sometimes cigarettes can be used by staff as incentives or likewise withheld. The rationale for nurses or hostel supervisors providing rationed cigarettes is related to these observations.

None of the arrangements is satisfactory but Council claims that individuals should be able and encouraged to manage their own smoking habit. They should also be encouraged and supported to reduce or preferably stop smoking.

Illustration 2: In January 2005 the Council's Official Visitors reported that the prohibition of cigarette smoking within 5 metres of the doors to government buildings and 10 metres of air conditioning units was having a direct and negative impact on consumers in authorised hospitals, especially those confined to secure wards.

Comment: The Council of course supports any educational and related programmes to assist individuals to quit smoking. However, a significant number of consumers are addicted to tobacco and nicotine and it is recognised that they cannot be required or persuaded to stop smoking or vary their habits, especially when in an acute phase of illness.

Those mental health consumers who smoke and who are detained in secure wards are restricted in their movements, including in the secure outdoor areas of these environments. The facilities for smokers usually provide a degree of weather protection. At night consumers are restricted in their ability to access garden areas (to reduce the potential risk of absconding). However it has to be recognised that the provisions for night time smoking may not be the required 5m distance from a doorway or building.

The policy is clear that discretion should be applied by the hospitals when, due to patient security, duty of care or other reasons, compliance is not possible. However, it is the Council's experience that few health services are using discretion – and this causes consumer distress. Further, some interpreted the instruction as based in law rather than as Departmental policy, meaning that there may be restrictions in some secure wards for night time smoking. The kiosk in one metropolitan hospital has discontinued stocking tobacco products, creating extra problems for its inpatients.

Action: The Council conveyed its concerns to the Acting Director General of Health and urged him to make an exemption of the rules for mental health units and in particular for secure units in authorised hospitals. Both he and Departmental officers confirmed that every mental health service is expected to exercise discretion so as not to cause distress to individuals already experiencing high levels of distress. A "Quit" programme for consumers of mental health services is to be implemented in the near future.

Status: The Council continues to advocate on behalf of individual complainants and to point out the discretion that mental health services are able to exercise.



ISSUE

Rights of clients of the Public Trustee

Illustration: Council has been contacted by a number of consumers with chronic and enduring illnesses who are also clients of the Public Trustee.

Action: The Council has urged the Public Trustee to establish how charges and conditions for their clients who live in Licensed Private Psychiatric Hostels can differ, even within the same hostel.

The Public Trustee has developed an agreement as a contract to be provided by the Hostel proprietor to people at the time of their admission. The document complies with and reflects the standards required by the Department of Health's Licensing Standards and Review Unit. The Council commented on drafts.

During 2004 - 2005 the Head of Council visited one Hostel (making a total of three) with Senior Trust Officers to audit the in-house systems for tracking resident income and expenditures.

Status: Continue liaison with the Public Trustee about clientele and issues of mutual concern.

ISSUE

Quality of life for residents of Licensed Private Psychiatric Hostels

Illustration: In previous years the Annual Report has observed that life for many residents of Licensed Private Psychiatric Hostels has been less than 'homelike' in terms of autonomy, privacy and safety. There are few pleasures or community linkages for residents and access to allied health professional services is not assured. Little has changed this year.

Comment: The Council was invited by the Office of Mental Health (OMH) to offer its view on how an extra grant of money to Licensed Private Psychiatric Hostels could be best expended to benefit residents by supporting their personal care.

Our contributions to the consultative process were made from information collected from numerous requests over several years. It included the need by all such residents to feel and be safe, and to have somewhere safe to store belongings (other than in the staff office). This concerns every hostel and is raised by one or more consumers at every visit. The Council argues that every resident should have a lockable cupboard and/or drawer and that a master key infrastructure be incorporated.

Residents in almost every hostel want and need easy access to drinking water, for example installation of a drinking fountain.

Council of its own volition claimed that it would a very supportive gesture to ensure that every resident in every hostel was able to engage in at least one outside/community event for their enjoyment for example picnic, zoo, concert, or movie with transport and carers provided.

Although hostel residents find it difficult to access health care providers such as dieticians and dentists the Head of Council argued that the lack of access to those services is a matter that should be negotiated between the licensee (and/or local Mental Health services) and these providers. Residents have a right of access to these services and it was her view that this money should not be spent in this way.

Status: The project was completed by the Office of Mental Health but will not be reported on until October 2005.

ISSUE

Board & Lodging charges to involuntary patients and mentally impaired defendants

Illustration: From October 2003 numerous long term Graylands patients who are involuntarily detained have contacted the Council to complain that they are charged for Board and Lodging. They also complain to say that not all individuals are charged, identifying another inequity. At June 30th, 54 Graylands patients were charged Board and Lodging, 41 of them being involuntary of whom 34 are in Murchison Ward. The number admitted to the Frankland Centre is not known.

Comment: In the last Annual Report the Council raised this matter by way of an individual complaint that as part of a management plan an involuntary patient was to be charged \$22.05 per day for board. A note in the medical record confirmed that this would be part of a disincentive to discourage him from seeking readmission. It had been confirmed that board is charged to those who “*treat Graylands Hospital as a rest home or the like*” and has been the practice with a number of other consumers.

The Council remains of the view that should a person meet the criteria to be admitted under the Mental Health Act, i.e. as an involuntary patient, then s/he meets the criteria for acute care and there can be no justification for charging board.

A disciplinary component is unacceptable especially as a ‘disincentive’ and when imposed at a time when an individual has no choice about detention. On the other hand, if an individual does not really need acute care then the bed occupied is unavailable for a person who does need it. Discharge with a Community Treatment Order might be one option for some people.

It is acknowledged that this predicament may reflect and accentuate the lack of appropriate accommodation for people disabled by an enduring illness. But the consequences of the lack of accommodation should not be borne by those most in need.

The Council claims that individuals admitted to an authorised hospital as involuntary patients should not be charged for their board and lodging during the time that they are waiting for placement in long term accommodation. There is no choice or other option for this group of consumers, other than detention in a secure unit. The same principle applies to individuals subject to Custody Orders under the *Criminal Law (Mentally Impaired Defendants) Act 1996*.

Despite a legal opinion of 13 February 2001 that does not object, the Council claims the decision to charge detained people lacks inherent logic and is an unjust imposition.

Action: The Council has continued to raise this matter and has urged both Graylands Hospital and the Department of Health to reconsider its policy. (It is adopted from that of charging aged persons awaiting nursing home placement).

A commitment to examine the matters was made in mid 2004 but at the time of writing, the committee in which Council will participate is still to be established.

Status: There is a basic injustice in charging involuntary patients and mentally impaired defendants. Ongoing.



ISSUE

Emergency Departments and lengthy stays of acutely ill psychiatric patients

Illustration: As follow through on the matters raised in last year's Annual Report related to the holding and restraint of persons in Emergency Departments, the Council met with the Departmental Head of the Emergency Department (ED) at Royal Perth Hospital (RPH) in October 2004. Later in the year and following a complaint, a short visit was also made to the Emergency Department at Joondalup Hospital.

It is acknowledged that specialised staffing and new procedures taken to reduce waiting times and to better manage mentally ill people in EDs are slowly starting to have a positive impact. There has been a marked decline in the number of complaints received by Council in the last six months.

Action: At RPH we were provided with a comprehensive introduction as to admission, diagnostic protocols and procedures for individuals with a suspected mental illness that left us feeling very reassured.

The Council shares the concerns of the Departmental Head regarding the flow-on effect of an inadequate number of acute mental health inpatient beds resulting in increased pressure on ED personnel who then have to manage the situation whilst mental health consumers await beds in authorised hospitals. The unrelenting impact on all staff is acknowledged.

It can be said that this vicious circle often results in practices that manage the administrative problems associated with bed shortages rather than the clinical condition of the individual patient.

Status: Ongoing, though recent initiatives are demonstrating some improvement and a consequent decreased number of complaints.

ISSUE

Provision of copies of forms - Mental Health Act 1996, section 159

Section 159 means that the person who is subject to an order of the Act (with possible exclusion of order of referral) must be provided with a copy of that order by the psychiatrist making it. It is Council's observation that adherence to this section is often missed in relation to people treated by Community Treatment Order. The illustrative cases were all receiving treatment through one community mental health service.

Illustration - Case 1: A woman subject to a Community Treatment Order (CTO) contacted the Council and during the course of the discussion with her it became clear that a variation to her CTO had been issued and 13 days later she had still not received a copy of this form. Six days afterwards the Official Visitor established that the variation on the CTO form was still held in the community mental health service office (i.e. after 19 days).

Illustration - Case 2: A man subject to a CTO requested that an Official Visitor ask on his behalf whether his order had been extended after the due date of expiry 2 days previously. He had seen a doctor the day before the expiry date but was not told the decision; neither had he seen his treating psychiatrist.

The Official Visitor spoke to the doctor and the man's acting case manager, neither of whom knew his legal status. Not until 8 days following the expiry of the original order was it confirmed to the Official Visitor that the order was to continue and a copy of the order was received by the consumer that day. It is acknowledged that the acting case manager endeavoured to clarify this for the Official Visitor but was unable to ascertain the information.

The Official Visitor became aware during her phone conversation with this consumer that he had difficulty reading important aspects of the Form 12, including the dates. This is a clear indication of the need for a personal explanation of all forms and rights as generally required by the *Mental Health Act 1996*.

The man's position became rather more tenuous when, the day following the receipt of the order the Official Visitor assisted him to apply for a second opinion, a right accorded by the Act (section 76) when an order is to be extended. The Official Visitor needed to advocate - with some vigour - to the psychiatrist to provide a second opinion for this man.

Illustration - Case 3: Some weeks later another man's situation became apparent when accompanied to a Mental Health Review Board hearing. The same psychiatrist (as treating the man of case 2) had signed a CTO Form 10 in regard to this man with no record of the psychiatrist having seen him. As a consequence the Board determined that the CTO was not valid. The making of an order without examining a person appears to be a breach of the Act (section 67).

Comment: No time frame or limit for providing a copy of the order to the affected person is specified in section 159 of the Act. The Council's view is that delay is unacceptable, especially in these cases, of delays of 8 and 19 days.

When variation to the treatment is made and the person is unaware of the conditions it is not possible to comply and can put the individual in breach of the order. The consequences of a breach of a CTO by consumers can mean that the order is revoked and they are made an involuntary detained patient.

People subject to CTOs are "*affected persons*" for whom the Council has a statutory responsibility. They are in general a challenging population for Council to contact, and as such remain vulnerable to idiosyncratic interpretations of the Act and the practices of some psychiatrists.

Action: The Council referred these matters in cases 2 and 3 to the Chief Psychiatrist for his investigation and resolution.

Status: Council continues to follow up complaints of this nature.

ISSUE

Advising of rights in elderly persons' units

Illustration: Observations by Official Visitors that notice of rights is not always provided to either patients or their next of kin in the Elderly Persons' Units.

Comment: The opportunity was taken in regular liaison meetings to ask service coordinators and providers what procedures and protocols are in place to ensure service based adherence to the Act sections 156 and 157. Authorised units utilise a range of reminders, stickers, labels, signatures and colour codes for staff to record that the person has been informed of their rights under the Act, as has a nominated next of kin or other person. Further relevant information pamphlets about treatments, complaint measures etc are also given to the person at this time. Clearly, because of illness, there can be a delay with completing these tasks and this is also noted. When patient records have been read by Official Visitors, it is of some concern that even when information may be noted as having been provided, a required signature and date may be missing.

Status: The Council will continue to follow up on these records as appropriate and will ask units to audit their system.



ISSUE

Frequency of Reviews by Treating Psychiatrists

A psychiatrist has the authority to order the detention and involuntary treatment of “*affected persons*” and it is therefore incumbent on that authority to review their status on a regular basis and, as thought reasonable/practicable when requested.

Illustration: Three separate complaints from involuntary detained patients in the High Dependency Unit at Armadale were made to Council regarding delays in being reviewed by their treating psychiatrist. In all three instances it was confirmed that their treating psychiatrist had not reviewed the consumers for at least seven days. In one case it was seventeen days. The same psychiatrist treated all 3 patients. In the previous year a similar complaint involving the same psychiatrist had been made.

Other medical staff (medical officers/residents or registrars) had seen the complainants but their psychiatrist had not seen them. At least one of these consumers had repeatedly requested that her psychiatrist see her and this was noted in her medical record.

Comment: The Council raised these complaints with the Regional Director because of the extended periods in which consumers are not reviewed by the psychiatrist responsible for their involuntary treatment and detention. Further it is not acceptable for the psychiatrist to treat consumer requests so lightly.

Action: The Council requested the Regional Director’s response to the complaints and asked for his advice regarding an acceptable minimum frequency of review by the treating psychiatrist of consumers admitted to the High Dependency Unit, as well as the expected response to consumer requests.

Similar illustration: See page 41 for the sequel to Council’s response to similar patient complaints at Joondalup. This action resulted in a complaint about the Council made to the Chief Psychiatrist.

Status: These particular complaints have resolved with staff changes, however it is expected that complaints with a similar basis will continue to be made to Council for investigation and resolution.

ISSUE

Debate Regarding Use of Provisions of the *GUARDIANSHIP AND ADMINISTRATION ACT 1990* rather than the *MENTAL HEALTH ACT 1996*

The Office of the Public Advocate and the Council share some reservations about a number of proposals accepted by Government in response to the review of the *Mental Health Act 1996*¹, especially related to those that have the potential to compromise some crucial rights. Three such proposals are outlined and have been discussed with the Minister. It is considered that they represent the inappropriate use of the *Guardianship and Administration Act 1990* (GAA).

Illustration 1 - Review Rec. 3.9: This recommendation advises the amendment of the Criminal Code in order to protect staff of an authorised hospital who claim to be providing care/treatment through their professional “*duty of care*” to an individual without a diagnosed mental illness but with, for example, brain disease caused by degeneration or injury, who is in an authorised – usually locked – hospital.

Comment: An already vulnerable individual may well have an appointed guardian, but a guardian cannot consent to the detention of a represented person. Mental health legislation provides a

¹ Holman CDJ. *The Way Forward. Recommendations of the Review of the Mental Health Act 1996*. Perth: Government of Western Australia, 2003

framework for the *detention* of individuals meeting section 26 criteria, and as such, an order for detention should be made by a psychiatrist.

The issues are complex but the staff should not be absolved from detaining a person who has no status under the Act because they cannot meet the section 26 criteria. Even if detained in an authorised hospital these individuals with a guardian would have no access to the protections of the Mental Health Act e.g. independent review, second opinion etc. All this review recommendation would achieve is the protection of staff from potential criminal charges. It would not protect the patient.

Illustration 2 - Review Rec. 5.3: This recommendation is inherently contradictory. It advises that a voluntary psychiatric patient must either give informed consent to treatment or have a guardian appointed for this purpose. The guardianship legislation would need amendment to this end.

Comment: It has been established practice that those people with a mental illness who do not or cannot consent to essential treatment are treated under the provisions of the Mental Health Act as involuntary patients.

There appears to be an increasing contemporary readiness to consider guardianship legislation rather than mental health legislation when consents to some psychiatric treatments (e.g. Electroconvulsive Therapy – procedures for which are clear in the Act) are required but may not be forthcoming.

Mental health legislation sets out a regime of protections for people with psychiatric illness and as noted above, sets out a number of rights, one of which is review. Although a guardianship order can be reviewed, the decisions of the guardian can not be reviewed. Section 26 of the Mental Health Act defines who can be protected by it and the criteria that must be met. A number of patient rights and the statutory obligations of psychiatrists and mental health practitioners are established by the Act. The appointment of a guardian to consent to psychiatric treatment does not provide the safeguards of the Mental Health Act.

Victoria and WA have similar mental health and guardianship legislation. The Victorian guardianship legislation however, makes explicit provisions to ensure that consent to psychiatric treatment is that of the person concerned. It is explicit that a substitute decision-maker such as a guardian cannot consent to psychiatric treatment in Victoria. If unable to consent to psychiatric treatment then the involuntary provisions of the mental health legislation are considered.

The purpose of mental health legislation is to provide treatment - and safeguards - to patients who cannot or will not consent and they are then subject to the schedules of the Act. In our view there is no room for the appointment of a guardian, because it would establish a major contradiction in the reason for mental health law and further it would also detract from the rights of the people it is meant to protect.

Illustration 3 - Review Rec 5.10: This recommendation is directed towards empowering a supervising psychiatrist to consent to medical treatment on behalf of an involuntary patient or mentally impaired defendant who is in an authorised hospital.

Comment: The prime purpose of mental health legislation is to provide psychiatric treatment, not other medical treatment. In this instance the provisions of the guardianship legislation should be used because it is inappropriate, if not discriminatory, to legislate in this way for patients of mental health services in authorised hospitals.

It is hard to imagine that in some other field of medicine the prescriber of treatment would also consent to it on behalf of their patient.



AUTHORISED HOSPITALS

ISSUE

Graylands Hospital: Murchison Ward

Illustration: The 42 people for whom Murchison Ward at Graylands Hospital is home are perhaps the most vulnerable population of those in the sector. Because of disability caused from their enduring illness, many have been there for years. A number of these patients have one or more additional physical impairments stemming from, or additional to, their psychiatric disability, as well as those related to ageing.

A particular concern is that although Murchison is deemed to be a slow stream rehabilitation service, Council's inquiries about the provision of individual programmes are rarely satisfactorily answered. The plans to move these residents and others in similar circumstances into community-based supported accommodation are yet to eventuate, leaving them not only in unsatisfactory accommodation, but also without skills to manage their daily lives. Questions about this preparation have been raised by the Council now for over three years to little avail.

Action: Meeting with clinicians

The Head of Council and three Official Visitors met with the psychiatrist and team members at Murchison to discuss these and related matters of concern. The concerns include:

- Meal type, choice and presentation. It was confirmed that improvements for some individuals are needed;
- Socialisation/normalisation/rehabilitation. These include individual care plans, maintenance of life skills, confidence and interests. It was confirmed that the ward and patient routines have been established for the last ten years or so. Apart from the medical record and a nursing care plan, there are no individual care plans which set patient goals for short and long term; and
- Maintenance and refurbishment protocols. These include improvement to day rooms in the locked area. These matters were taken up in a later facilities audit in which the Council participated.

Action: Night time visit

In November 2004, two Official Visitors participated in a late night visit to Murchison. Although the male ward was generally found to be fairly satisfactory at the time, the women's wing reinforced some of the concerns held about the ward as different night time procedures were employed. For instance there was a blanket rule that women are not allowed to smoke after 10pm, whereas the smoking room for the men was not locked until midnight. Within reason, individuals (male) could access a cigarette if needed from time to time after this. Women had no access to drinks at night except via the bathroom tap: men were able to approach nursing staff for a drink. In seeking an equitable remedy, these matters have been taken up with the Hospital Executive.

Action: Facilities Audit

In May 2005 the Council's Executive Officer and an Official Visitor were invited to participate with hospital staff in a facilities audit of Murchison Ward.

Fifty two obvious repair and maintenance matters were noted by the team. These ranged from rust removal and a need for painting to the provision of toilet seats and new shower heads.

Council in particular raised their concern about several matters that impact negatively on an individual's rights to dignity and privacy. It is acknowledged that staff members need to be able to view into bedrooms, however the viewing panes do not provide any privacy from passers by who might look

into the bedrooms. We suggested that this fixture be reviewed in order to ensure privacy. In the female dormitory there was a store of underwear, including underpants, provided for some of the women. The communal underwear is provided to individuals as needed, washed after use and then circulated through the bulk store. It is not assigned to a particular individual. It remains unclear whether the same arrangements take place for male consumers. The Council has no objection to the Hospital undertaking to provide underwear, however it should be purchased for individuals, to fit them and be labelled with their name so to be used only by that person. The Council condemns any practice such as these that institutionalise patient care and detract from the dignity of the individual.

The general ambience at Murchison is dreary and by no means resembles a homelike environment; rather the observer is left with an impression of a mid twentieth century institution.

Status: The Council acknowledges that many of the identified problems are beyond the scope and resources of the ward staff to rectify. But it must be said that for many reasons the patients at Murchison do not always receive the sustained and high quality of care to which the Council thinks they are entitled.

The Council will continue to pursue matters related to the care of people resident at Murchison and also to their environs in order to contribute to improving the quality of life for them. In particular the Council is committed to cooperate with the Department of Health to ensure that appropriate alternate housing options are pursued.

ISSUE

Access to Allied Health Services

The Council has previously addressed the matter of lack of access to allied health services across the sector and which is particularly stark in non metropolitan services.

Illustration: Rural Mental Health Services

At the time of the report:

- *Bunbury Acute Psychiatric Unit* has 15 beds with the following complement of allied health professionals: half time (0.5 FTE) Occupational Therapist; 0.6 FTE Therapist (generic therapy position currently filled by a Social Worker); 0.8 FTE Social Worker; 1.0 FTE Therapy Nurse; and 0.7 FTE Occupational Therapy Assistant.
- *Kalgoorlie Inpatient Unit* has 7 beds and has not been able to fill a half time position for an Occupational Therapist. There is no allocation for a Social Worker but the Unit shares the one employed for the entire hospital. Funding for an Activities Officer was “reabsorbed” as the vacancy was not filled. A business plan is currently being developed in order to fund a weekly activities programme.
- *Albany Hospital, G Ward* has 9 beds and employs: 0.7 FTE Occupational Therapist; 0.6 FTE Counsellor (generic therapy position currently filled by a Social Worker); and 0.8 FTE Occupational Therapy Assistant. Access to the Psychologist/s based in Community Mental Health can occur if required.

Status: The Council will continue to monitor individual complaints. The Government commitment to improving this situation across the sector is welcome, although it is likely to be some time before funding for allied health professionals and country based recruitment are accomplished.

ISSUE

Sector Wide policies - Problems with locally initiated policy

Illustration - Example 1: Mills Street Centre - Phone with camera facility

The Department of Health circulated a position paper addressing the use of mobile phones with a camera facility. A coordinated approach to consider the implications of the new technology and a coordinated response is essential. However several services have interpreted the paper to suit local conditions, with disparate implications for patients and for visitors. For instance, the Mills Street Centre acted on Departmental advice by prohibiting visitors and staff from taking such a phone into any service. Anyone who carried a phone was required to hand it in to staff, but there were no procedures or safeguards to ensure that the phone was collected or taken elsewhere.

Illustration - Example 2: Mills Street Centre - Restricted Items Vs Security Issues

Several matters were brought to Council's notice as a result of a memo circulated at a secure ward at the Mills Street Centre about security issues. The impact of implementation would have been to provide restriction without individual risk assessment. A list of potentially harmful items, including pencils, belts and shoelaces, was circulated, including to the Council.

It was also proposed that searches of all patients were necessary. The aim was to implement a policy to increase security for patients and staff. Council pointed out that the circulated memo breaches both the OMH policy and ours on searches, which state that:

"It is paramount that the least intrusive measure for this procedure is adopted at all times. Unnecessary touching of the patient at any time is not permitted. Admission to an 'Intensive Care (Secure) Environment' is not a reason in itself to conduct a search of a patient's person".

Status: Council will continue to negotiate for risk based assessments of individuals and to monitor progress through discussions with the Mills Street Centre management.

ISSUE

Hospital accommodation - Additional comments regarding accommodation

Comment: Much of the accommodation in acute hospital settings, even the more recent, is open to criticism because the ward environments reflect decision-making processes that did not engage with providers or consumers in the planning stages. Few have separate visiting rooms. It is often impossible to make a private telephone call because of the location of telephones. Few have adequate outside areas, especially the secure facilities.

Additionally many units are shabby and need re-painting, new floor coverings and a thorough clean. Repairs often take an inordinate time to be effected, leading to impressions of drabness and inertia. Areas surrounding units often add to negative impressions with gardens not tended and cleaning neglected. These environs impact adversely on consumers and their families, in the view of Council augmenting the stigma too often associated with mental illness.

Illustration - Authorised hospitals: Design and Furnishing

The outdoor area at Joondalup's secure ward is, and always has been, inadequate as is also the case at Armadale's secure ward. Further, the outdoor area at Armadale has only this year had suitable furniture purchased. After a long period, through which the Council was an advocate, the Frankland Centre consumers were able to use a newly refurbished outdoor area from early this calendar year.

In terms of the aesthetic of outdoor areas it was disappointing that the Kalgoorlie unit has erected a high wire fence round its space that is unfortunately more reminiscent of a prison than a hospital.

The Frankland Centre has been 10 years in operation and whilst general maintenance has been adequate over this time some elements have not been addressed (the carpets have not ever been replaced). The Council is also concerned that there was no seating for consumers in the outside courtyards for many months, due to a garden bench having been used for an escape in 2004. Consumers either had to stand or sit on the grass. Whilst this has been rectified the delay is most unsatisfactory and it is suggested these conditions would not be tolerated in a general hospital.

We understand that a range of matters needing redress were identified in a brief security review of the Centre carried out following an escape from it in 2001 and that none have been rectified. The original courtyard benches mentioned above were identified as a risk as part of that review.

The Council supports an urgent review of security at the Frankland Centre to ensure the safety and security of consumers, their visitors and staff. It has lobbied to that effect and believes that the review should be done in good faith with a view to implementing its recommendations. Until then not only the statutory rights of consumers at the Frankland Centre are at risk, but the potential to compromise individual human rights exists.

Action: The Council continues to make representations about hospital environs which impact on the quality of life in hospital, as well as on the rights of individuals, because they can have a major impact on consumers and on their experience of their illness.

The Council has welcomed the opportunity to participate in a number of committees: some to address current issues needing redress and others to contribute to deliberations about the design and furnishing of new Units such as the planned Mother and Baby Unit as well as a range of community-based housing options.

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

Status: The Council has started to develop an architectural checklist *Translating Legal Rights into Building Design Guidelines* that should assist.

LICENSED PRIVATE PSYCHIATRIC HOSTELS

ISSUE

Quality of life in Licensed Private Psychiatric Hostels

Illustration: Almost exclusive use of powdered milk for licensed private psychiatric hostel residents.

Comment: For some years concern has been recorded by Official Visitors that in most of the hostels only powdered milk is available for residents. People have no choice as to whether they would like to use this or not. The Council sought information and advice from the Nutrition and Physical Activity Branch of the Department of Health as to whether there could be nutritional disadvantage to those residents using the formula.

On this advice the powdered milk may be less expensive. Further it is of equal nutritional value to fresh milk provided it is properly mixed and diluted. Therefore standard procedures for mixing should be practised. Reconstituted powdered milk may not be as palatable as fresh milk, especially if not prepared correctly. This may deter people from drinking milk, with potential nutritional consequences.

Status: The Official Visitors will make inquiries as to whether each hostel uses procedures to ensure that milk is properly reconstituted.



ONGOING ISSUES THAT REQUIRE REMEDY

A number of issues raised in the Council's Annual Reports from 1997 remain unresolved and have continued to give concern during 2004 - 2005. They are again outlined and although a few require amendment to legislation for progress to be made, most are matters to be resolved by committed management decisions. If these issues were to be addressed not only the Official Visitors, but importantly the consumers themselves, believe that the quality of life for people with acute, as well as enduring, illnesses will be improved.

For People Admitted to Authorised Hospitals

1997 - 1998

1 *The outside area at Joondalup Mental Health Unit secure ward has always been inadequate. The outdoor area should be extended to an appropriate size and configured to enable access to the garden.*

2004 - 2005

The Council welcomes plans that have been made to enlarge this space when the unit is extended as part of the extension and upgrade of this facility.

1998 - 1999

1 *The impact of overcrowding in authorised hospitals*

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

2004 - 2005

The new State's Mental Health Plan and initiatives aim to address and rectify some of these problems. However the quantum of need inevitably means that complaints will continue for some years.

2 *Definition of "affected person"*

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

2004 - 2005

Although this recommendation has been provided to the Minister of Health for his consideration in forthcoming legislation, this is a reminder that Council is frequently requested to intervene on behalf of these groups of consumers. We emphasise that the rights of voluntary consumers can also be breached.

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

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

2004 - 2005

OMH has now issued a mobile phone circular but how it is implemented remains dependent on the individual services. Consumers continue to comment that they experience/observe differences between services.

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

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

2004 - 2005

Amendment to the legislation is still required.

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

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

2004 - 2005

There must be a separation between the psychiatrist who is prescribing the medical (non-psychiatric) treatment and the psychiatrist who approves i.e. consents to the giving of non-psychiatric medical treatment (refer page 21).

6 Second opinions

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

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

2004 - 2005

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

1999 - 2000

1 Shortage of age appropriate facilities for children and adolescents

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

2004 - 2005

The State Mental Health Plan addresses the provision of appropriate Child and Adolescent Mental Health Services. Problems are bound to arise during the development and implementation of the plan because the quantum of need is large.



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

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

2004 - 2005

The situation was compounded by additional restrictions due to a security upgrade, but the Council is pleased to report that the work was completed and that consumers have improved access to outdoor areas.

3 *Human relations and need for intimacy*

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

2004 - 2005

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

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

Increase access to on-site gyms and to equipment (bikes, balls etc). Access to physical exercise opportunities varies between hospitals and wards.

2004 - 2005

Little if any change since first reported. In particular consumers complain that weekends are especially difficult because of the lack of scope for any physical activity.

2000 - 2001

1 *Design of facilities*

The Council noted that they, consumers and providers should be invited to participate in planning renovations and new units to ensure a consumer perspective is considered in design. Over the past two years the Council has been asked to comment on proposed renovations for a small number of facilities. Unfortunately with few exceptions, this input still may not be incorporated. Among other matters, the standard and provision of facilities for visitors, outdoor areas and telephone access differ between acute units.

2004 - 2005

Council welcomes the policy of OMH to include consumers, and where appropriate, carers and other advocates (including Council representatives) as members of the many planning groups for the new initiatives.

2002 - 2003

1 Access to Allied Health Professionals/Multi-disciplinary team

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

2004 - 2005

Refer to page 23 above.

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

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

2004 - 2005

There has been no marked change, despite a plan to move very disabled consumers into community-based supported accommodation.

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

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

2004 - 2005

It appears that consumer and advocate membership of planning committees will go some way to ensure that these needs are addressed.

2003 - 2004

1 Bunbury Acute Psychiatric Unit

A number of matters were reported, including those concerning the use of security guards as a substitute for nurses, the failure to inform persons of their rights as involuntary patients and procedures in the Accident and Emergency Unit.

2004 - 2005

Refer to page 12 for the Council's response to the policies issued by the management of the hospital in relation to the use of security guards and also to Emergency Department. From time to time the local Official Visitors and the Council have received complaints and questions from patients regarding their rights and have taken these matters up with the ward staff as appropriate.

2 Hospital Emergency Departments (ED) and the management of people with a mental illness

It was of concern to the Council that practices had developed to manage access to acute beds, not the clinical needs of each patient. Undue lengths of time in the ED and use of mechanical and/or chemical restraints were noted. It was acknowledged that the pressure on beds is a sector wide issue compounded by the lack of intermediate care beds.

2004 - 2005

The Council welcomes the Government funding commitment and the Department of Health's early implementation of steps to resolve this unsatisfactory solution (see above).

3 Indigenous services

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

2004 - 2005

The Council welcomes the range of initiatives planned to meet the needs of indigenous people and will participate in any consultative processes established for this purpose.

4 Charges for Board and Lodging: Graylands Hospital

The Council is of the view that should a person meet the criteria to be admitted under the provisions of the Mental Health Act then s/he meets the criteria for acute care and it is an injustice to charge them for involuntary detention.

2004 - 2005

Refer to page 17 related to Council's ongoing engagement with this matter.

5 People with Acquired Brain Injury

Secure mental health units are being used as a solution to concerns about safety in general medical wards. It is the Council's view that this particular small but growing group of individuals with challenging and aggressive behaviours should be treated in a specialised service. They need skilled and trained staff and appropriate long term accommodation.

2004 - 2005

These matters are to be addressed as part of the twelve new mental health initiatives, although Council understands that costings and priorities are still to be established. It is Council's view that these steps are urgent; because of unmet need, because the care and accommodation uses scarce mental health resources and because individuals are accommodated in secure wards, but without the protections of the Act.

6 Mental Health Review Board hearings: medical staff attendance and/or reports

Two hearings had to be adjourned because medical staff did not attend. When, for whatever reason, medical staff are unable to attend a hearing or do not present a report to the Board, there is a perception by the patient that fairness and justice are compromised.

2004 - 2005

The practice of consumers only receiving access to the reports provided to the MHRB within minutes of the hearing commencing continued during 2004 - 2005. The Council also had contact with a number of consumers where medical staff treating them did not attend their MHRB hearings.

7 Community Treatment Order issues

Instances of breaches and potential breaches of the Act were cited as they related to complaints received from consumers subject to Community Treatment Orders.

2004 - 2005

Refer to page 18 as further illustration of the concerns continuing with this particularly vulnerable group of consumers.

1998 - 1999

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

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

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

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

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

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

2004 - 2005

In general there remain great deficiencies and improvements should be a priority for the sector. Council welcomes the activity of the Office of the Chief Psychiatrist in undertaking a number of reviews of the Care Standards for residents in the last year.

2 Licensing standards in licensed private psychiatric hostels required

2004 - 2005

The Council welcomes the introduction of standards for hostels and a three year process of implementation from 01 January 2004. Council argues that the reports of standards that are monitored and audited by the Licensing Standards and Review Unit should be subject to procedures to facilitate publicly accessible reporting.

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

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

2004 - 2005

These are ongoing issues of concern for residents in a number of hostels and can contribute to a demeaning of dignity and privacy and in some instances a neglect of hygiene.

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

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



2004 - 2005

Complaints from residents continue and the Council also continues to pursue with individual licensees the case for each person to have a safe and secure place to keep belongings and a key for their room door.

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

A resident agreement should, among other requirements, detail the rights and responsibilities of the resident and the owner/licensee. These are a crucial component of the licensing arrangements and Council argues that all hostels should provide this kind of undertaking to residents.

2004 - 2005

The Public Trustee (PT) consulted the Council in the development of a residential agreement for its clients. A trial at one hostel has been instituted and the PT will monitor.

1999 - 2000

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

2004 - 2005

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

While it disturbs the Council to report on the (growing) number of unresolved matters, the Council is pleased to acknowledge the improvements made to the outdoors area of the Frankland Centre.

As recognised above the Council welcomes the Government funding for urgently required improvements to a range of long unmet needs.

PART THREE

ACTIVITIES OF THE COUNCIL

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

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

Mental Health Act 1996, section 186.

PROGRESS ON STRATEGIC ACTIVITIES: STRATEGIC PLAN 2003 - 2006

The plans and change throughout the sector due to Government commitments and funding has overridden some explicit plans the Council had made for these three years. Council is engaging with the change and participates as invited with planning and comment. The Council has continued to address its own strategic plan.

Quantitative Targets

The following priorities are among those set for each of the three years of the plan (i.e. to 30 June 2004, 2005 and 2006):

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

It can be seen (Table 1) that although the first year of the plan exceeded the planned goals in each category, the year ending June 2005 has not resulted in similar achievements. The two years in question, however, do demonstrate an overall increase since the goals were set. The Council is not in a position to identify any trend or reason for the differences over such a short time period, but will monitor this situation over the coming twelve months in an attempt to establish the cause of these variations. The Council continues to aim for the planned increases in each of the three categories of contact.



TABLE 1: PROGRESS TOWARDS REACHING STRATEGIC PLAN GOALS BY YEAR 2006

	01/07/02 - 30/06/03 Base on which goals set	01/07/03 - 30/06/04	01/07/04 - 30/06/05	01/07/04 - 30/06/05 compared to 01/07/03 - 30/06/04	01/07/04 - 30/06/05 compared to 01/07/02 - 30/06/03
Each year increase by 50% the number of consumers on CTO who receive assistance from Council					
Metropolitan	47	63 = 34%	54	- 14.3%	14.9%
Non-Metropolitan	4	9	13	44.4%	225%
TOTAL	51	72 = 41%	67	- 6.9%	31.4%
Each year increase by 25% (both for CTO and hospital based consumers) MHRB attendances by Official Visitor with consumer					
Involuntary Inpatients	54	81 = 50%	60	- 25.9%	11.1%
CTO	23	28 = 21.7%	23	- 17.8%	=
TOTAL	77	109 = 41.5%	83	- 23.8%	7.8%
Each year increase by 25% MHRB attendances by Official Visitor with consumer					
Metropolitan	76	101 = 32.8%	71	- 29.7%	- 6.6%
Non-Metropolitan	1	7	12	71.4%	1100%
TOTAL	77	109 = 41.5%	83	- 23.8%	7.8%
Each year increase by 10% the number of contacts with new consumers					
TOTAL	599	744 = 24.2%	800	7.5%	33.5%

Qualitative Targets

The first key activity area identified for the strategic plan was to address the rights and quality of life of "affected persons" i.e.:

- the rights and quality of life of involuntary patients in hospitals;
- the rights and quality of life of hostel residents; and
- the rights and quality of life of people with a Community Treatment Order.

In relation to these matters, to the end of the year 2004 - 2005:

- 1 The joint project on low levels of representation at Mental Health Review Board hearings was undertaken with the Mental Health Review Board and the Mental Health Law Centre. The report was submitted to the Office of Mental Health and selected stakeholders.
- 2 The development of a Position Statement on a hospital environment that promotes Best Practice, enhances the inspection and reporting processes of Official Visitors and ensures that information is available to facilitate Council follow up, will be completed in the coming year.
- 3 A review of seclusion practices in four authorised hospitals was undertaken (refer page 9), the report circulated and discussed with service providers. Further hospital based research to benefit consumers is acknowledged to be needed.
- 4 A report has been provided to stakeholders following a meeting and detailed inspections of Murchison Ward in which both the Head of Council and the Executive Officer have participated.
- 5 The Council remains committed to ensuring that problems in the hostels sector are addressed. In particular the matter of each resident being able to secure their personal property has been taken up with licensees. The Council has also entered into a partnership with the Public Trustee to ensure that our mutual clients' payments are auditable.
- 6 Council is acutely aware that most consumers treated by CTO throughout the State have no contact with us. Our concern is to ensure that their rights are observed. It remains a challenge for all concerned to establish and maintain contact with this population of consumers. Letters of introduction to the Council continue to be provided to individuals by favour of treating clinicians.

The **second key activity area** involves a commitment to achieve an annual professional development plan for Council members. This is progressing with a learning component structured into each Full Council meeting. In the coming financial year a concerted effort is planned with a focus on the rights of people with mental illness and advocacy skills for Official Visitors.

The **third key activity area**, which aims to raise the profile of the Council needs to be reconsidered, not only because overly ambitious goals were set, but also because of planned sectoral changes. The Head of Council and the Executive Officer meet regularly with a range of service and associated providers and Executives.

INSPECTION VISITS

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

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

Appendices 7 and 8 contain summaries of the inspection visits to authorised hospitals and licensed private psychiatric hostels by the time and day of the week.



The following targets for formal inspection visits occurring outside usual working hours (i.e. other than Monday to Friday, 9.00 am to 5.00 pm) were set:

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

During 2004 - 2005 the Council conducted 44.5% of formal inspection visits to authorised hospitals and 49.5% of such visits to psychiatric hostels outside these hours (Appendix 9). This was an improvement on the performances against these targets during 2003 - 2004.

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

Authorised Hospitals

The focus of the monthly hospital inspections undertaken in 2004 - 2005 has included:

- Explanation of Rights – policy & procedures;
- Seclusion;
- Access to Medical Staff and Second Opinions;
- Access to Occupational Therapy (OT)/Recreation Activities;
- Privacy and Safety;
- Personal Effects/Belongings and Amenities;
- Catering;
- Furnishings and Clothing;
- Finances;
- Provision of Services at Night (after 11.00 pm); and
- Relationships and Intimacy Needs.

The inspection visits also provide an opportunity for consumers to raise questions, concerns or compliments directly with the Official Visitors.

During 2004 - 2005 the Council determined to undertake at least one visit to each authorised hospital after 11.00 pm. This provided the Official Visitors with an opportunity to obtain an understanding of how the wards operate at night and to meet staff working night shifts. These visits were coupled with daytime visits to speak to consumers regarding their experiences at night in the wards.

All authorised hospitals were visited each month with a total of 220 inspection visits. Not all wards of the larger hospitals are necessarily visited each month. Wards are visited on a roster basis, usually once every two or three months. On occasions areas other than the wards that form part of the authorised site were also visited, for example the Creative Expression and Primary Rehabilitation Units on Graylands Campus. In addition to the formal monthly visits, the regional hospitals (Albany, Bunbury and Kalgoorlie) were visited at least one other time each month on an informal basis.

Licensed Private Psychiatric Hostels

All licensed private psychiatric hostels were visited as planned with 111 formal inspection visits. Evening inspection visits were undertaken at the licensed private psychiatric hostels. At various times over the year the following provided a focus for inspections of the hostels:

- Clothing;
- Privacy;
- Access to Services/Staff in Evenings (after 7.00 pm);
- Safety;
- Access to Occupational Therapy (OT)/Recreation Activities;
- Furnishings;
- Management of Finances;
- Catering;
- Relationships and Intimacy Needs; and
- Personal Effects/Belongings and Amenities.

The practice of informal visits on a bi-monthly basis to the licensed private psychiatric hostels, (not the small group homes) was continued. The purpose of these informal visits is to actively seek out and engage the residents of the hostels. These visits occurred in the alternate months to the formal inspection visits. They often occurred on weekends or outside normal working hours.

The Council has never reported on the details of these monthly informal visits to hostels, but will do so from 2005 - 2006 so as to ensure a more complete reporting of its activities.

CONSUMER CONTACTS

Total Individual Contacts

During 2004 - 2005 a total of 1600 requests for contact with the Council were received from 800 consumers (Appendix 10). This is an increase of 13.07% in the number of requests received compared to 2003 - 2004 (Appendices 10, 13A, 13B, 14A and 14B).

These requests resulted in 1329 visits by Official Visitors to consumers and a further 2551 telephone calls either to or on behalf of the consumers as reported by the Official Visitors (Appendix 12)

Authorised Hospitals and Licensed Private Psychiatric Hostels

Three hundred and seventy three (373) consumers receiving treatment at Graylands Hospital comprised the largest number from any one service with whom the Council had contact during 2004 - 2005 (Appendices 10 and 11). This large proportion of contacts from Graylands Hospital has been consistent since the Council was established.

The Council has mailboxes located in the wards of some authorised hospitals. During 2004 - 2005, in addition to correspondence collected from the boxes that resulted in action by Official Visitors, the Council received 42 pieces of correspondence that were either anonymous or the author was unable to be identified. Most of them came from the mailboxes at Graylands Hospital.



The number of consumers requesting contact from a number of metropolitan authorised hospitals decreased during 2004 - 2005 compared to 2003 - 2004. They are Armadale, Joondalup, Mills Street Centre and Swan units (Appendix 13A). The reasons for this are unclear. In June 2005 the Council decided to conduct a trial of informal visits to those metropolitan authorised hospitals which do not have Council mailboxes and are likely to receive only one visit per month. The focus and purpose of these visits is to actively seek out consumers to ensure that they are aware of their rights and to inform them of the availability of Official Visitors. If a facility only receives one visit per month there is a significant likelihood that some involuntary consumers will have been admitted and discharged between visits by the Council. The trial and contact with consumers from the facilities mentioned above will be monitored during 2005 - 2006.

The overall number of consumers contacting the Council from non-metropolitan authorised hospitals continued to be small, with a small decrease at both the Bunbury and Kalgoorlie Units (Appendices 10, 13A and 13B).

There was a continuing increase although smaller than the previous year (18% for 2004 - 2005) in the number of licensed private psychiatric hostel residents requesting assistance from the Council (Appendices 10, 13A and 13B).

Community Mental Health Services

The difficulty for the Council in fulfilling its role of ensuring that the rights of individuals subject to Community Treatment Orders (CTOs), who may never have contact with the Council, are respected, continued during 2004 - 2005.

The Council's strategic plan has set a target increase of 50% per year in the number of consumers on CTOs who receive assistance from the Council. This is to allow the Council to ensure that these consumers' rights are being observed and they are aware of the availability of the Council's service.

The Council almost met its strategic plan target in the non-metropolitan areas with a 44% increase in the number of consumers contacting the Council. But the actual number of consumers contacted (13) remains very low. A number of these individuals are already known to the Official Visitors due to a recent admission to an authorised hospital (Appendices 10, 13A and 13B).

All these consumers were from the regional areas where Official Visitors are present due to the presence of an authorised hospital in the health service area. However, it must be noted that consumers in whole areas of the State do not have ready access to the Council.

In the metropolitan area there was decrease of 15.6% in the number of consumers on CTOs having contact with the Council (Appendices 10, 13A and 13B and Table 1 above).

A number of community mental health services continued to provide letters of introduction from the Council to consumers on CTOs. This strategy will be continued and endeavours made to identify other strategies to improve contact with individuals subject to CTOs, particularly in areas where there is no Official Visitor presence.

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

Mental Health Review Board

During 2004 - 2005 there was an overall decrease by 22.4% in the number of Mental Health Review Board (MHRB) hearings attended by Official Visitors in a support/advocacy role compared to the previous year (83 in 2004 - 2005 and 109 in 2003 - 2004) (Appendices 12 and 14A). These figures only represent a small percentage (less than 10%) of the total hearings conducted. It does appear

however that the total number of MHRB hearings declined overall this year, but it is not possible to attribute the decrease noted in Council data to this fall.

Analysis of consumer contacts

A summary of the issues raised by consumers is contained at Appendices 15A and 15B. Issues are categorised based on the consumer's view of the matter, with the major issue raised being the one categorised and recorded. The Council continued to utilise the same categorisation of complaints and issues as in previous years.

Issues associated with the *Mental Health Act 1996*, including Mental Health Review Board applications (16.3%) and attendance (9.1%), accounted for approximately 33% of contacts with consumers during 2004 - 2005.

As in the previous year eighteen percent (18%) of the issues raised during 2004 - 2005 related to discharge or transfer arrangements, with the majority of these based on the consumer's complaint that they did not require inpatient treatment. A small proportion of these related to delays in transfer to open wards or multiple transfers between wards, or transfer between wards late at night.

Approximately five percent (5%) of complaints related to individuals being given medication against their will, i.e. without their consent. This directly related to the consumer's involuntary status. Complaints related to inadequate treatment accounted for approximately eight percent (8%) with a further two percent (2%) relating to staff said to be inconsiderate or discourteous.

Hostel Closure Management Strategy

On 21 February 2005 Sherwood Hostel was closed by its proprietor. The Division of Mental Health had instituted the Hostel Closure Management Strategy once the intended closure was known. In line with this strategy the Council undertook a role in ensuring that the rights of the residents were observed during this process of relocation.

Official Visitors subsequently sought out residents who had been relocated to other licensed private psychiatric hostels to establish their level of satisfaction with the move. A small number expressed some dissatisfaction with their new location and the Official Visitors referred them to the appropriate local mental health service for follow up regarding their changed accommodation.

OTHER ACTIVITIES

POLICY REVIEW AND DEVELOPMENT

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

Position Statements

On 9 December 2004 the Council adopted a position on "*Electroconvulsive Therapy and Informed Consent*". This arose out of the Council's participation in the Chief Psychiatrist's Advisory Group on Electroconvulsive Therapy.

The Council's previously adopted positions statements which underpin its work, remain in place and include:

- "Access to Telephone, Mental Health Act 1996 (section 167)";
- "Closed Circuit Television (CCTV) Monitoring in Inpatient Units";



- “Access To Second Opinions In Authorised Hospitals, Mental Health Act 1996 (section 111)”; and
- “Access To Second Opinions – Community Treatment Orders, Mental Health Act 1996 (section 76)”.

Copies of all the Council’s position statements are available from its office.

The Council’s position statements related to “Consumer’s Right to Receive Visitors in Reasonable Privacy (Mental Health Act 1996 section 168)” and “Translating Legal Rights into Building Design Guidelines” are to be finalised in the current year.

Submissions

The Council provided comment and submissions in relation to:

- Mental Health Review Board’s powers as per section 145(2)(b) of the *Mental Health Act 1996*;
- The Government response to the Recommendations of the Review of the *Mental Health Act 1996*;
- Implementation Guide and Standards Resource Kit for Service Standards for Non-Government Providers of Community Mental Health Services;
- Implementation of Government’s policy to ban smoking of Cigarettes within close proximity of Government Buildings;
- One-Off Personal Care Grants to the Licensed Private Psychiatric Hostels – examples of acceptable services or items to be purchased;
- South West Health Service’s Policies Relating To Use of Security Guards and Specialising: Acute Psychiatric Unit;
- Design of the proposed Mother and Baby Inpatient Unit to be located at King Edward Memorial Hospital; and
- Designs and plans for community-based supported accommodation.

Participation in Sector Committees

Mail Management and Postal Remittance Policy Review

After raising concerns with the Department of Health regarding its policy of opening all mail delivered to public hospitals and the potential for this to be in breach of the *Mental Health Act 1996*, section 166 the Council accepted an invitation to participate in the above committee. A revised policy was developed by the group.

Mental Health Advisory Group

In response to the Government’s funding of initiatives to improve mental health services, the Acting Director General of Health invited the Head of Council to join the Mental Health Advisory Group, which he chairs. Besides meetings of the group, the Head of Council has also attended a number of consultations, writing groups and working parties.

Subsequent to the development of the Mental Health Strategy 2004 - 2007 and the Mental Health Action Plan 2005 - 2010 the Council has also participated as a member of certain strategy coordination groups for key initiatives including those for the development of:

- The Mother and Baby unit;
- Supported Community Accommodation; and
- Occupational Health and Safety in Mental Health Services.

Open Forum, Licensed Private Psychiatric Hostels

The Head of Council represented the Council at the above forums convened by the Office of Mental Health. The last meeting was held in November 2004.

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

The Council continued its involvement in the CPAG on ECT. The purpose of this group is to provide advice and recommendations to the Chief Psychiatrist on the future developments of best practice and monitoring of ECT in Western Australia.

Additionally, a Council representative participated in the Australian Council on Health Care Standards: In-depth Review of Mental Health Services Surveys for Armadale Health Service.

LIAISON WITH SERVICES

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

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

In addition to the joint visit undertaken with staff from the Public Trustee a member of the staff of the Inspector of Custodial Services was appointed as a panel member and visited the Frankland Centre. A planned visit by a Council representative with the Inspector of Custodial Services to a prison is yet to occur.

QUALITY ASSURANCE

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

Codes of Conduct and Ethics

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

Complaints Regarding Council Operations

During 2004 - 2005 two complaints were received regarding the operation of the Council.

The complaints were investigated and dealt with in line with the Council's complaint management policy, a copy of which is available from the Council's office.

- 1 A formal complaint was received relating to a complex matter going to the core of the powers and functions of Official Visitors.

Because the Council had received numerous complaints over several months in relation to the length of time between doctors' visits at the Joondalup Unit (see above) the Council decided to audit a number of files of patients at that unit and check as to whether these complaints could be verified more generally. The aim was to present our findings to the Unit's Director.

The audit of files was done in good faith under the provisions of section 190 of the Act and as had been the practice of Official Visitors. Nurses provided four files to the Official Visitors for this



purpose. A number of anomalies were found to confirm patient complaints. However the Unit's Director claimed afterwards that the Official Visitors were acting outside their powers and made a complaint to the Chief Psychiatrist. His specific complaint was that patients had not given their consent for Official Visitors to access their records.

The State Solicitor's advice confirmed the view. This has practical implications for the day by day functions of the Official Visitors whose major statutory function is to ensure that the rights of all "affected persons" are observed. In particular our concerns relate to accessing information that is required by the Act to be kept in case notes and relates to the rights outlined above.

Official Visitors are required to ensure that "affected persons" have had their rights explained to them (section 188(a)). The evidence of this explanation is the record made as required by the Act and which is to be placed in the person's "case notes" (section 158(2)). In practice this check usually, but not always, happens during the course of a required monthly inspection in an authorised unit. The practice of Official Visitors has always been consumer focused in an effort to preserve statutory and other individual rights and to identify possible or potential breaches of the legislation. Official Visitors are bound by the confidentiality provisions of the Act (section 206).

Additionally Official Visitors have the statutory authority to check seclusion and restraint records. Although details should be entered into a ward/hospital register, it is also necessary to ensure that a record is contained in the individual's "case notes". Sometimes an individual requests information or complains to an Official Visitor about these events and specific consent is therefore sought and provided.

It must be noted that the statutory obligation of Official Visitors to ensure that an "affected person's" rights are observed is an overarching one (section 188(b)), and not dependent only on receipt of a complaint. If any person refuses access to their medical record then of course the Official Visitor does not check the records. Refusals are rare but not unknown.

Importantly however, there are circumstances where, despite the statutory obligation on Official Visitors to ensure that rights are and have been observed, consumers will lack the ability to both consider and/or exercise their right to deny access to medical records e.g. those individuals treated in authorised units who are elderly with dementias. Similarly other consumers in acute wards may be too unwell to exercise this right so as to enable an Official Visitor to check that their rights have been explained and/or that the correct procedures have been followed for involuntary status. It has always seemed to us that this is the critical time for such a check, in order to safeguard the rights accorded under the Act. It is these categories of patients for whom the concerns are most pertinent.

For the present we especially note with concern the potential difficulties that the State Solicitor's advice raises for that population of "affected persons" unable to exercise their right to deny access to their medical records because they are acutely ill and/or have a cognitive impairment. The implications of that advice are that Official Visitors are prevented from fulfilling their statutory functions. Predictably there will continue to be breaches of the Act that relate to very vulnerable consumers and they are likely to remain unknown and unaddressed.

Outcome: The matter of Official Visitor's access to case notes/medical records (Act section 190(5)) must be clarified. The current advice of the State Solicitor impedes both Official Visitor practice and their statutory function to ensure that the rights of all "affected persons" are observed. We have written to the Minister recently about this impediment urging it be addressed in new legislation.

- 2 An informal verbal complaint was made by a hostel licensee who had been concerned about the information provided by an Official Visitor to a resident in order to assist him. The resident was subject to a CTO and was scheduled for a Mental Health Review Board hearing.

Outcome: The concerns were dealt with by the licensee, the consumer and the Head of Council as best they could be without a written complaint.

Professional Development Activities

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

A two day orientation programme was provided to members of the Council during 2004 - 2005. In addition a number of Official Visitors attended lectures external to the Council.

A report writing workshop was held. Later in conjunction with all Official Visitors the Council developed new consumer reporting and recording documents for initial and ongoing contacts with individuals, with the aim of improving the Council's protocols and of modernising information held in the Council's database.

PRESENTATIONS TO COMMUNITY GROUPS

The Council provided presentations on the Council's role under the Act to the UWA Law School as part of its Mental Health Advocacy Training workshop and to staff at the Public Trustee.

PRIORITIES FOR 2005 - 2006

In day to day activities and in longer term planning, consumer rights will continue to underline the Council's priorities. The Council will continue to address its strategic plan targets during this last year of the plan and will write a further strategic plan for implementation from June 2006.

- 1 In line with the current plan it is aimed to increase:
 - Mental Health Review Board hearing attendances by 25%; and
 - contact with individuals subject to Community Treatment Orders by 50% this year.
- 2 Provide professional development for Official Visitors in relation to the development of advocacy skills and in relation to communication skills for people with challenging behaviours.
- 3 The Council will formulate position statements on:
 - Authorised Hospital environments and practices that promote such rights as privacy for telephone calls and visitors, care of patient property and recreation;
 - Community-based Supported Accommodation (including Licensed Private Psychiatric Hostels) environments and practices that promote best practice relating to rights and improved quality of care/life for residents; and
 - Translating Legal Rights into Building Design Guidelines.
- 4 The Council aims to recruit indigenous Australians as either Official Visitors or panel members to assist the Council with its responsibilities.
- 5 Spot audits will be conducted during two calendar months to quantify the number of requests for assistance made of the Council that must be referred elsewhere.
- 6 A conference on meeting the rights of people with mental illness will be held during the calendar year 2006.



APPENDIX 1: AUTHORISED HOSPITALS

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

**Albany Regional Hospital
Albany Mental Health Unit**
Hardie Road
Albany

**Fremantle Hospital and Health Service
Alma Street Centre**
Alma Street
Fremantle

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

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

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

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

**Kalgoorlie Regional Hospital
Mental Health Inpatient Service**
Piccadilly Street
Kalgoorlie

**Joondalup Health Campus
Joondalup Mental Health Unit**
Shenton Ave
Joondalup

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

**Mercy Hospital
Ursula Frayne Unit**
Thirlmere Road
Mount Lawley

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

APPENDIX 2: LICENSED PRIVATE PSYCHIATRIC HOSTELS

As per

“Functions of the Council of Official Visitors Direction 2003”, May 2003

superseded by

“Functions of the Council of Official Visitors Direction 2005”, 21 June 2005

Casson Homes

Aitken House	55 View Street North Perth
Casson House	2-10 Woodville Street, North Perth
Violet Major House ²	47 View Street, North Perth
Woodville House	425 Clayton Road, Helena Valley

Richmond Fellowship

56 Glyde Street, East Fremantle
58 Glyde Street, East Fremantle
4-6 Mann Way, Bassendean
23 Walton Street, Queens Park

Devenish Lodge

54 Devenish Street, East Victoria Park
--

Dudley House

24 Dudley Street, Midland

Franciscan House

16 Hampton Road, Victoria Park

Glyde Street Hostel

48 Glyde Street, Mosman Park

Honey Brook Lodge

42 John Street, Midland

John Wilson Lodge

38 Hamilton Street, East Fremantle

Maude Armstrong

16 Davies Road, Claremont

Romily House

19 Shenton Road, Claremont

Rosedale Lodge

22 East Street, Guildford

St Jude’s Hostel

26 & 30-34 Swan Street, Guildford

Salisbury Home

19-21 James Street, Guildford

Shannon House

23 Coolgardie Street, Subiaco

Sherwood House ³

5 Kalamunda Road, South Guildford

Success Hill Lodge ⁴

1 River Street, Guildford

Vincentcare ⁵

Bassendean House	1 North Street, Bassendean
Bayswater House	65 Whatley Crescent, Bayswater
Coolbellup House	66 Waverley Road, Coolbellup
Duncraig House	270 Warwick Road, Duncraig
South Lakes House	9 Plumridge Way, South Lake
Swan View House	8 Wilgee Gardens, Swan View
Warwick House	39 Glenmere Road, Warwick

² Vacant as of March 2004

³ Ceased operation February 2005

⁴ Ceased operation effective 5 May 2003 (2003 Direction)

⁵ Effective 2005 Direction



APPENDIX 3: COUNCIL OF OFFICIAL VISITORS 2004 - 2005 MEMBERSHIP

Head of Council	Expiry Date of Term
Dr Judyth WATSON	01 April 2006
Official Visitors	
Mr Bruce AMBROSIUS	07 April 2008 ⁶
Dr Michael ANDERSON	07 April 2008 ⁷
Ms Joyce ARCHIBALD	07 April 2008 ⁶
Mrs Sherril BALL	07 April 2007 ⁶
Mr Scott BARNDON	07 April 2005
Mrs Toni DACEY	07 April 2007
Mr Clive DEVERALL	07 April 2008 ⁶
Mr Adrian GAVRANICH	07 April 2006
Ms Jane GIBSON	07 April 2006
Mr Kevin HOGG	07 April 2006
Mr Darren JONES	07 April 2008 ⁸
Dr Helen LETTE	07 April 2006
Mrs Kerry LONG	07 April 2007 ⁹
Mrs Ann McFADYEN	07 April 2007
Ms Edana McGRATH	07 April 2007
Mr Stewart McMULLIN	07 April 2007
Mrs Maria Luz NOÉ	07 April 2008 ⁹
Mr Sean O'CONNELL	07 April 2007 ⁶
Ms Val O'TOOLE	07 April 2008 ⁶
Ms Leanne PARNHAM	07 April 2006 ¹⁰
Ms Leanne PECH	07 April 2008 ⁶
Mrs Theresa PIPER	07 April 2007 ⁹
Mrs Rosalind SAWYER	07 April 2006
Mrs Maxinne SCLANDERS	07 April 2006
Mrs Sheila STEPHENS	07 April 2008 ⁶
Ms Margaret STOCKTON	07 April 2007
Mrs Judith TAYLOR	07 April 2007 ⁹
Ms Catriona WERE - SPICE	07 April 2007 ⁶
Ms Rachael WILSHER - SAA	07 April 2005
Mrs (Angela) Leonie WILSON	07 April 2007

⁶ Reappointment March 2005

⁷ Appointment May 2005

⁸ Reappointment May 2005

⁹ Appointment March 2005

¹⁰ Resigned effective October 2004

**APPENDIX 4: COUNCIL OF OFFICIAL VISITORS'
MEETINGS ATTENDANCE 2004 - 2005**

OFFICIAL VISITOR	FULL COUNCIL		EXECUTIVE GROUP	
	Present	Apologies	Present	Apologies
Dr Judyth WATSON (Head of Council)	4	0	5	0
Mr Bruce AMBROSIUS	4	0		
Dr Michael ANDERSON ¹²	1	-		
Ms Joyce ARCHIBALD	4	0	4	1
Mrs Sherril BALL	4	0	4	1
Mr Scott BARNDON ^{13,14}	0	2		
Mrs Toni DACEY	3	1		
Mr Clive DEVERALL	1	3		
Mr Adrian GAVRANICH	2	2		
Ms Jane GIBSON	3	1		
Mr Kevin HOGG	4	0		
Mr Darren JONES	4	0		
Dr Helen LETTE	4	0		
Mrs Kerry LONG ¹⁵	1	-		
Mrs Ann McFADYEN	3	1		
Ms Edana McGRATH	3	1	3	2
Mr Stewart McMULLIN	3	1		
Mrs Maria NOÉ ¹⁵	1	-		
Mr Sean O'CONNELL	3	1		
Ms Leanne PARNHAM ¹⁶	-	1		
Ms Leanne PECH	2	2		
Mrs Theresa PIPER ¹⁵	1	-		
Ms Val O'TOOLE	4	0	1 (proxy)	-
Mrs Rosalind SAWYER	3	1	2 (1 as proxy)	-
Mrs Maxinne SCLANDERS	3	1		
Mrs Sheila STEPHENS	2	2	1 (proxy)	-
Ms Margaret STOCKTON ¹⁷	0	4	1	-
Mrs Judith TAYLOR ¹⁵	1	-		
Ms Catriona WERE – SPICE	4	0	4	-
Ms Rachael WILSHER – SAA ¹⁴	2	1	2	2
Mrs Leonie WILSON	4	0	1 (proxy)	-

¹² Appointment May 2005

¹³ Leave of absence 9 August 2004 - 7 April 2005

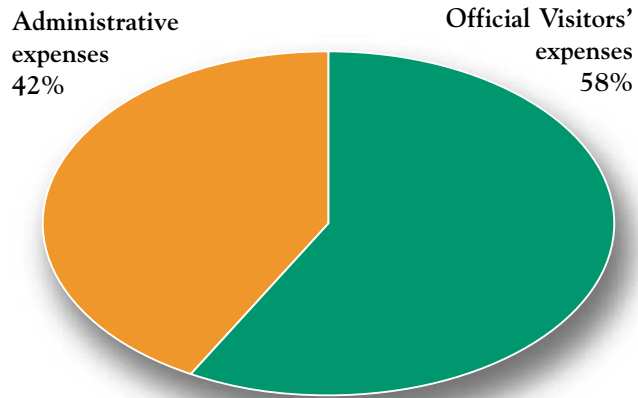
¹⁴ Term expired 7 April 2005

¹⁵ Appointment March 2005

¹⁶ Leave of absence from 13 September 2004 until resignation effective October 2004

¹⁷ Leave of absence August 2004 - 30 June 2005

APPENDIX 5: CHART - SUMMARY OF EXPENDITURE 2004 - 2005



As required under the *Electoral Act 1907* section 175ZE (1), during 2004 - 2005 the Council expended the following in relation to the designated organisation types:

- (a) advertising agencies: nil;
- (b) market research organisations: nil;
- (c) polling organisations: nil;
- (d) direct mail organisations: nil; and
- (e) media advertising organisations: \$2081.41.

APPENDIX 6: STATEMENT OF COMPLIANCE WITH STATE RECORDS COMMISSION - STANDARD 2, PRINCIPLE 6

Question 1: Whether the efficiency and effectiveness of your record keeping systems have been evaluated or alternatively when such an evaluation is proposed?

The efficiency and effectiveness of the Council of Official Visitors' record keeping system was evaluated on 4th July 2005 and submitted to the Director of the State Records. This evaluation will occur at the end of every financial year.

Question 2: The nature and extent of record keeping training programme conducted?

Record keeping training is conducted by Coordinator Records Services, Department of Health directly with Council's administrative assistant on a regular basis and more frequently when specifically requested. On average, information or training is provided once every 2 months.

Question 3: Whether the efficiency and effectiveness of the record keeping training programme have been reviewed or alternatively how this is planned to be done?

The review of training programme is carried out by the Executive Officer on a regular basis following specific training sessions.

Question 4: Assurance that the organisation's induction program addresses employee roles and responsibilities in regard to their compliance with the organisation's record keeping plan?

Council of Official Visitors' induction programme provides one to one training about the record keeping plan and its role and importance relating to employee roles and responsibilities.



APPENDIX 7: LICENSED PRIVATE PSYCHIATRIC HOSTEL INSPECTIONS BY HOSTEL & TIME & DAY OF INSPECTION

2004 - 2005

LICENSED PRIVATE PSYCHIATRIC HOSTEL	TOTAL NUMBER OF INSPECTIONS	TIME OF INSPECTIONS		
		Mon-Fri 9am-5pm	Mon-Fri 5pm-9am ¹⁸	Sat/Sun/ Pub Hol
Casson Homes ¹⁹	6	2	4	0
Casson House	6	2	4	0
Devenish Lodge	6	3	0	3
Dudley House	6	4	2	0
Franciscan House	6	5	1	0
Glyde Street Hostel	6	3	3	0
Honey Brook Lodge	6	1	5	0
John Wilson Lodge	6	4	2	0
Maude Armstrong	6	2	4	0
Richmond Fellowship - 4-6 Mann Way, Bassendean	6	4	1	1
Richmond Fellowship - 56 & 58 Glyde Street, East Fremantle	6	4	2	0
Richmond Fellowship - 23 Walton Street, Queens Park	6	4	0	2
Romily House	6	3	2	1
Rosedale Lodge	6	2	1	3
St Jude's Hostel	6	3	2	1
Salisbury Home	6	2	1	3
Shannon House	6	3	2	1
Sherwood House ²⁰	3	2	1	0
Woodville House	6	3	0	3
TOTAL	111²¹	56	37	18

¹⁸ With the exception of the Casson Homes and Richmond Fellowship shared houses all other private psychiatric hostels received at least one inspection visit commencing after 7.30pm.

¹⁹ 'Casson Homes' includes Aitkin House and Violet Major House.

²⁰ Ceased operation effective 21 February 2005.

²¹ **Note:** The 111 recorded inspections represent the minimum requirement as decreed by the Minister for Health (viz at least every 2 month). However informal inspections in alternate months are also undertaken to seek out residents who may be particularly vulnerable. The actual number of visits is approximately double that recorded above.

**APPENDIX 8: AUTHORISED HOSPITAL
INSPECTIONS BY HOSPITAL & TIME & DAY
OF INSPECTION**

2004 - 2005

AUTHORISED HOSPITAL	TOTAL NUMBER OF INSPECTIONS	TIME OF INSPECTIONS		
		Mon-Fri 9am-5pm	Mon-Fri 5pm-9am ²²	Sat/Sun/ Pub Hol
Albany Regional Hospital - Mental Health Unit	13	11	1	1
Alma Street Centre	26	16	3	7
Armadale Health Service - Adult and Elderly Units	26	17	3	6
Bunbury Acute Psychiatric Residential Unit	13	6	1	6
Graylands & Special Care Health Service	31	20	6	5
Joondalup Mental Health Unit	13	5	3	5
Kalgoorlie Mental Health Unit	13	6	5	2
Mercy Hospital, Ursula Frayne Unit	13	8	5	0
Mills St Centre	33	16	8	9
Selby Lodge	13	6	4	3
Swan Health Service - Boronia Unit & Swan Valley Centre	26	11	6	9
TOTAL	220	122	45	53

²² All authorised hospitals received at least one inspection visit commencing after 11.00pm which was coupled with a day time visit to speak to consumers.

**APPENDIX 9: PERCENTAGE OF FACILITY
INSPECTIONS BY TIME & DAY OF INSPECTION**

2001 - 2002 TO 2004 - 2005

AUTHORISED HOSPITAL	FACILITY TYPE	TIME OF INSPECTIONS (% of total)			
		Mon-Fri 9am-5pm	Mon-Fri 5pm-9am	Sat/Sun/ Pub Hol	Mon-Fri Time not recorded
2001 - 2002	Authorised Hospitals	48.6%	26.2%	23.5%	1.7%
	Licensed Private Psychiatric Hostels	46.6%	24.6%	25.4%	3.4%
2002 - 2003	Authorised Hospitals	54.6%	31.9%	13.5%	-
	Licensed Private Psychiatric Hostels	44.9%	27.1%	28%	-
2003 - 2004	Authorised Hospitals	68.3%	15.1%	16.6%	-
	Licensed Private Psychiatric Hostels	64.9%	19.3%	15.8%	-
2004 - 2005	Authorised Hospitals	55.45%	20.45%	24.1%	-
	Licensed Private Psychiatric Hostels	50.5%	33.3%	16.2%	-

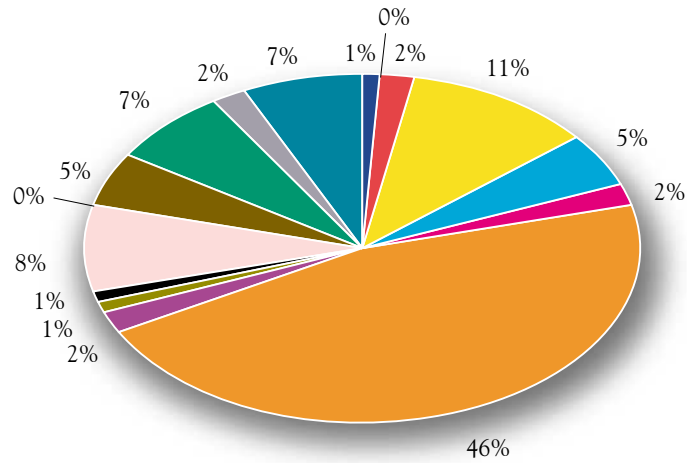
**APPENDIX 10: NUMBER OF CONSUMERS
AND REQUESTS BY FACILITY
2004 - 2005**

FACILITY	NUMBER OF CONSUMERS CONTACTED	NUMBER OF REQUESTS RECEIVED
Albany Mental Health Unit	12	14
Alma Street Centre, Fremantle	88	156
Armada Health Service - Adult & Elderly Units	36	73
Bunbury Acute Psychiatric Residential Unit	19	35
Graylands & Special Care Health Services	373	843
Joondalup Mental Health Unit	19	25
Kalgoorlie Mental Health Unit	7	7
Mercy - Ursula Frayne Unit	6	14
Mills Street Centre, Bentley	60	100
Selby Lodge	2	4
Swan Mental Health - Swan Valley Centre & Boronia	40	87
Metropolitan Clinics	54	101
Non - Metropolitan Clinics	13	28
Psychiatric Hostels	59	98
Other	11	13
Private Practice	1	2
TOTAL	800	1600

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

**APPENDIX 11: CHART - PERCENTAGE²³
OF TOTAL CONSUMERS BY FACILITY**

2004 - 2005



- Albany Mental Health Unit - 1.5%
- Alma Street Centre, Fremantle - 11%
- Armadale Health Service - Adult & Elderly Units - 4.5%
- Bunbury Acute Psychiatric Residential - 2.4%
- Graylands & Special Care Health Services - 46.6%
- Joondalup Mental Health Unit - 2.4%
- Kalgoolie Mental Health Unit - 0.8%
- Ursula Frayne Unit - 0.75%
- Mills Street Centre, Bentley - 7.5%
- Selby Lodge - 0.25%
- Swan Mental Health - Swan Valley Centre & Boronia - 5%
- Metropolitan Clinics - 6.75%
- Non-Metropolitan Clinics - 1.6%
- Psychiatric Hostels - 7.4%
- Other - 1.4%
- Private Practice - 0.15%

²³ Percentages rounded to nearest whole value

APPENDIX 12: CONTACTS WITH CONSUMERS BY FACILITY

2004 - 2005

FACILITY	NUMBER OF CONSUMERS CONTACTED	CONTACT TYPE			MHRB ²⁴ Attendance
		Visit	Telephone call	Letter	
Albany Mental Health Unit	12	13	5	0	0
Alma Street Centre, Fremantle	88	115	263	4	5
Armadale Health Service - Adult & Elderly Units	36	46	154	1	4
Bunbury Acute Psychiatric Residential Unit	19	47	48	3	4
Graylands & Special Care Health Services	373	819	1112	73	34
Joondalup Mental Health Unit	19	18	50	2	1
Kalgoorlie Mental Health Unit	7	7	9	0	0
Mercy - Ursula Frayne Unit	6	17	15	8	2
Mills Street Centre Bentley	60	74	260	1	5
Selby Lodge	2	3	1	0	0
Swan Mental Health - Swan Valley Centre & Boronia	40	38	134	1	3
Metropolitan Clinics	54	31	167	17	15
Non - Metropolitan Clinics	13	4	59	7	8
Psychiatric Hostels	59	97 ²⁵	252	10	10
Other (including Private Practice)	12	0	22	0	2
TOTAL	800	1329	2551	127	83

²⁴ MHRB - Mental Health Review Board

²⁵ Includes one attendance as a support person to a State Administration Tribunal hearing (Guardianship and Administration Act 1990)

APPENDIX 13A: TOTAL CONSUMERS CONTACTED BY FACILITY

2001 - 2002 TO 2004 - 2005

FACILITY	NUMBER OF CONSUMERS			
	2001-2002	2002-2003	2003-2004	2004-2005
Albany Mental Health Unit	8	5	10	12
Alma Street Centre, Fremantle	45	51	69	88
Armadale Health Service - Adult & Elderly Units	17	29	43	36
Bunbury Acute Psychiatric Residential Unit ²⁶	4	2	22	19
Graylands & Special Care Health Services	266	289	298	373
Joondalup Mental Health Unit	15	13	22	19
Kalgoorlie Mental Health Unit ²⁷	-	1	11	7
Mercy Hospital - Ursula Frayne Unit ²⁸	-	0	4	6
Mills Street Centre, Bentley	57	77	90	60
Selby Lodge	4	10	7	2
Swan Health Service - Swan Valley Centre & Boronia	38	35	45	40
Metropolitan Clinics	29	46	64	54
Non - Metropolitan Clinics	2	4	9	13
Psychiatric Hostels	32	36	50	59
Other (including Private Practice)	4	1	0	12
TOTAL	521	599	744	800

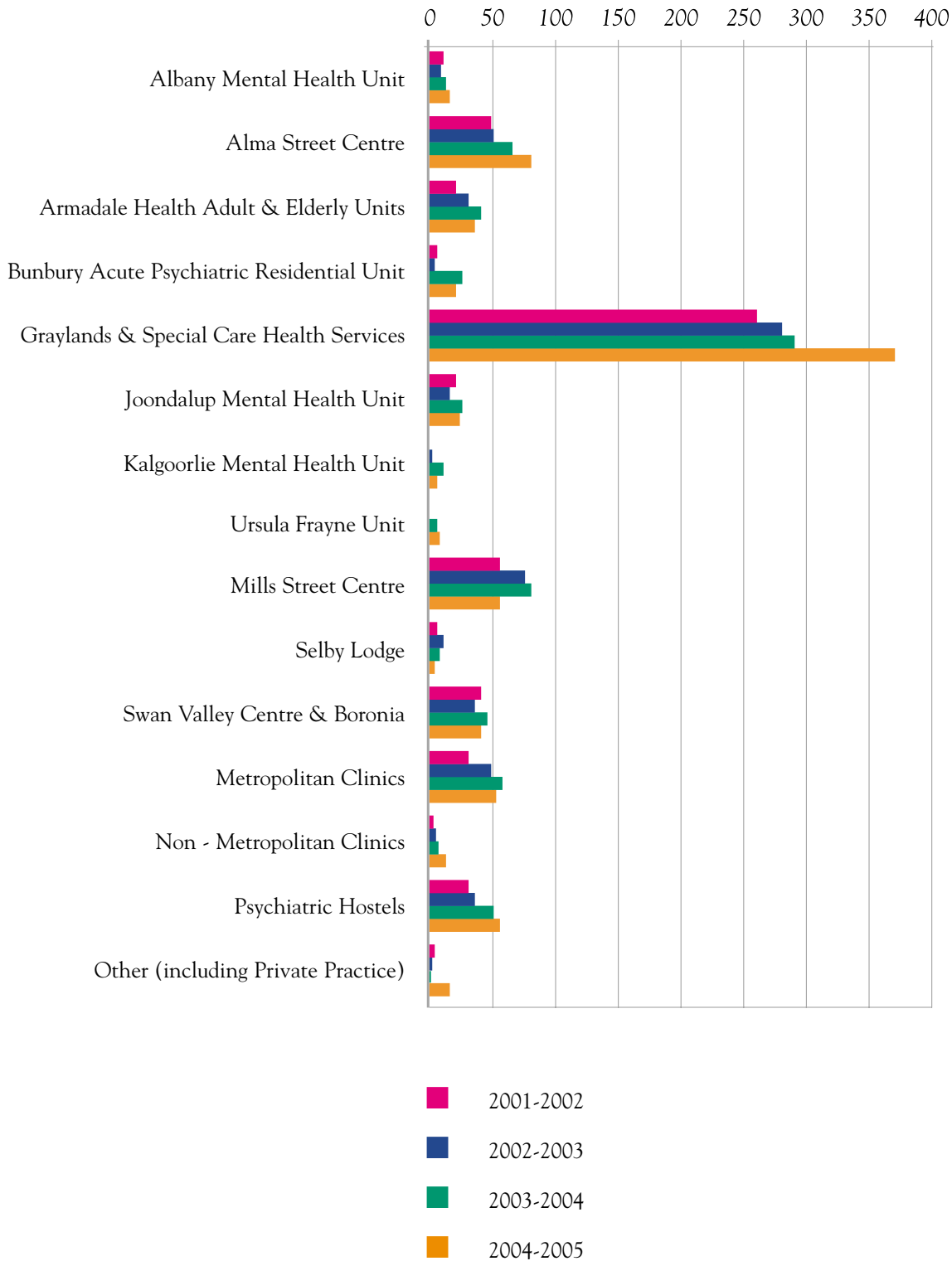
²⁶ Suspended admission of involuntary patients effective 31 August 2001 recommended admitting involuntary patients during August 2003.

²⁷ Commenced admitting patients 26 March 2003.

²⁸ Commenced admitting patients March 2003.

APPENDIX 13B: GRAPH - TOTAL CONSUMERS CONTACTED BY FACILITY

2001 - 2002 TO 2004 - 2005



APPENDIX 14A: TOTAL CONTACTS WITH CONSUMERS

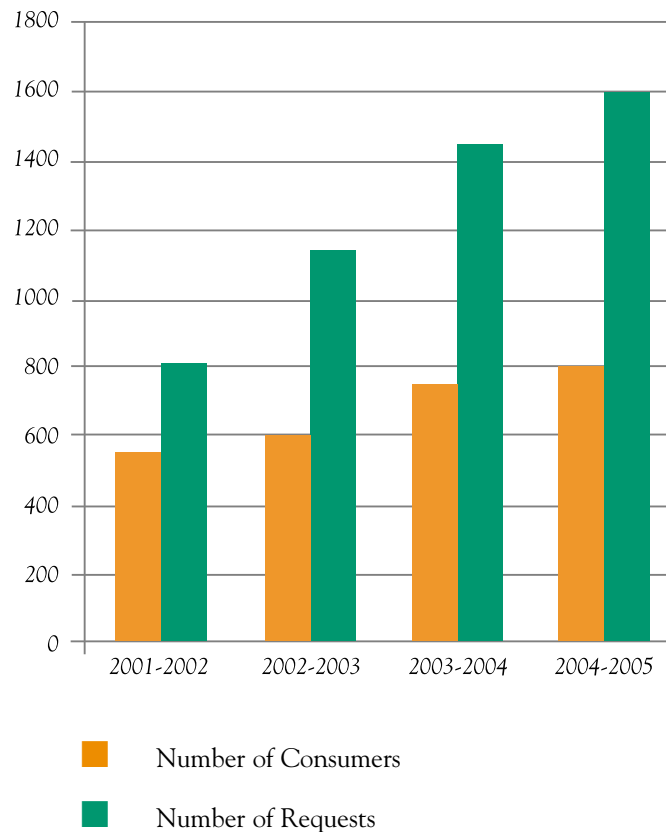
2001 - 2002 TO 2004 - 2005

FINANCIAL YEAR	NUMBER OF CONSUMERS (# Requests)	CONTACT TYPE			
		Visit	Telephone call	Letter	MHRB ²⁹ Attendance
2001 - 2002	521 (807)	722	931	98	43
2002 - 2003	599 (1126)	974	1474	67	77
2003 - 2004	744 (1415)	1234	2149	84	109
2004 - 2005	800 (1600)	1329	2551	127	83
% increase - 2003 - 2004 to 2004 - 2005	7.5 % (13.07%)	7.7%	18.7%	51.2%	- 23.8%

²⁹ MHRB - Mental Health Review Board

APPENDIX 14B: GRAPH - TOTAL CONSUMERS CONTACTED AND REQUESTS RECEIVED

2001 - 2002 TO 2004 - 2005



APPENDIX 15A: TOTAL CONSUMER REQUESTS BY ISSUE CATEGORY - ALL FACILITIES

2004 - 2005

1.	ACCESS	NUMBER
1.1	Delay in Admission or treatment	22
1.2	Waiting list delay	0
1.3	Non-attendance	3
1.4	Inadequate or no service	40
1.5	Refusal to admit or treat	5
1.6	Discharge or transfer arrangements	288
1.7	Access to transport	2
1.8	Physical access/entry	0
1.9	Parking	0
	Subtotal (%³⁰ TOTAL³¹)	360 (22.5%)
2.	COMMUNICATION	NUMBER
2.1	Inadequate information about treatment options	3
2.2	Inadequate information on services available	10
2.3	Misinformation or failure in communication	10
2.4	Failure to fulfil statutory obligations	4
2.5	Access to records	7
2.6	Inadequate or inaccurate records	1
2.7	Failure to provide interpreter	0
2.8	Certificate or report problem	0
	Subtotal (% TOTAL)	35 (2.19%)
3.	DECISION MAKING	NUMBER
3.1	Failure to consult consumer	5
3.2	Consent not informed	2
3.3	Consent not obtained	86
3.4	Private/public election	0
3.5	Refusal to refer or assist to obtain a second opinion	4
	Subtotal (% TOTAL)	97 (6.06%)
4.	QUALITY OF CARE	NUMBER
4.1	Inadequate diagnosis	2
4.2	Inadequate treatment	132
4.3	Rough treatment	29

4.4	Incompetent treatment	0
4.5	Negligent treatment	0
4.6	Wrong treatment	10
	Subtotal (% TOTAL)	173 (10.81%)
5.	COSTS	NUMBER
5.1	Inadequate information about costs	0
5.2	Unsatisfactory billing practice	2
5.3	Amount charged	6
5.4	Overservicing	0
5.5	Private health insurance	0
5.6	Lost property and/or reimbursement	0
	Subtotal (% TOTAL)	8 (0.5%)
6.	PRIVACY/CONSIDERATION/DISOURTESY	NUMBER
6.1	Inconsiderate service/lack of courtesy	33
6.2	Absence of caring	14
6.3	Failure to ensure privacy	5
6.4	Breach of confidentiality	3
6.5	Discrimination	0
6.6	Discrimination of public consumer	0
6.7	Sexual impropriety	4
6.8	Sexual transgression or violation	5
6.9	Assault	16
6.10	Unprofessional conduct	0
	Subtotal (% TOTAL)	80 (5%)
7.	GRIEVANCES	NUMBER
7.1	Inadequate response to a complaint	4
7.2	Reprisal following a complaint	0
	Subtotal (% TOTAL)	4 (0.25%)
8.	OTHER	NUMBER
8.1	Administrative practice	9
8.2	Catering	32
8.3	Facilities	46
8.4	Security	35
8.5	Cleaning	2
8.6	Fraud/illegal practice	0
	Subtotal (% TOTAL)	124 (7.75%)

9.	MENTAL HEALTH ACT 1996 (OTHER)	NUMBER
9.1	Mental Health Review Board Application	261
9.2	Mental Health Review Board Attendance	146
9.3	Second Opinion Request (not 3.5)	58
9.4	<i>Mental Health Act 1996</i> Information	40
9.5	<i>Mental Health Act 1996</i> Non- Compliance (not 2.4)	20
	Subtotal (% TOTAL)	525 (32.8%)
10.	CRIMINAL LAW (MENTALLY IMPAIRED DEFENDANTS) ACT 1996	NUMBER
10.1	Mentally Impaired Defendants Review Board	2
	Subtotal (% TOTAL)	2 (0.12%)
11.	UNABLE TO BE DETERMINED	NUMBER
11.1	Unknown/Undetermined	156
	Subtotal (% TOTAL)	156 (9.75%)
12.	COMPLIMENTS	NUMBER
12.1	Compliments	19
	Subtotal (% TOTAL)	19 (1.19%)
13.	GUARDIANSHIP AND ADMINISTRATION BOARD	NUMBER
13.1	Information on processes	16
13.2	G & A Board attendance	1
	Subtotal (% TOTAL)	17 (1.06%)

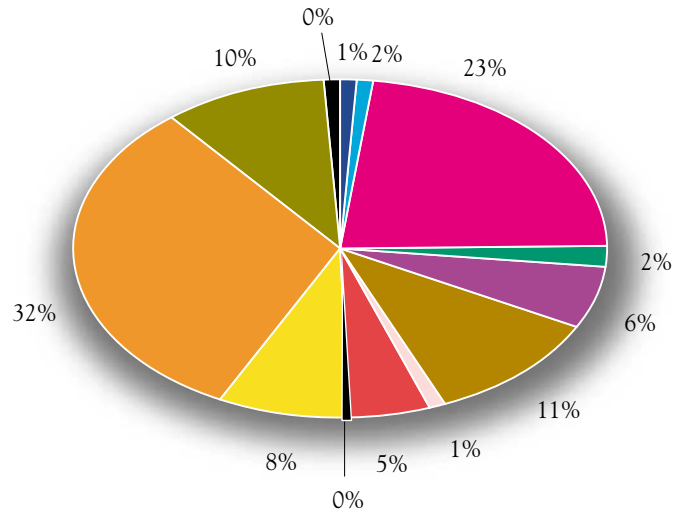
³⁰ Rounded value

³¹ Total Requests = 1600



APPENDIX 15B: CHART - PERCENTAGE³² OF REQUESTS BY ISSUE CATEGORY - ALL FACILITIES

2004 - 2005



- Access - 22.5%
- Communication - 2.2%
- Decision Making - 6%
- Quality of Care - 10.8%
- Costs - 0.5%
- Privacy/Consideration/Discourtesy - 5%
- Grievances - 0.25%
- Other - 7.75%
- Mental Health Act 1996 - 32.8%
- Unable to be determined - 9.75%
- Criminal Law (Mentally Impaired Defendants) Act 1996 - 0.1%
- Compliments - 1.15%
- Guardianship & Administration Board - 1.3%

³² Percentages rounded to nearest whole value

