SUBMISSION TO THE NATIONAL DISABILITY INSURANCE SCHEME (NDIS) ON THE QUALITY AND SAFEGUARDING FRAMEWORK CONSULTATION PAPER

by

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BACKGROUND

The Council of Official Visitors is a statutory body established under Part 9 of the Mental Health Act 1996 (WA) (the 1996 Act). The functions of Official Visitors include:

1. inspecting authorized mental health wards where people may be detained involuntarily every month, and private psychiatric hostels every second month to ensure that they are kept in a safe and suitable condition; and
2. ensuring that the rights of "affected persons" (defined to include involuntary patients and people who are socially dependent because of mental illness and who reside, and are cared for or treated, at a private psychiatric hostel[1]) are observed as well as seeking to resolve complaints by them, their guardians or relatives.

In 2013-2014 Official Visitors assisted 1602 people who requested assistance. Many of the people assisted by Official Visitors are severely disabled by the severity and chronic nature of their mental illness and are likely to come within the NDIS. Many of these people live in private psychiatric hostels (hereafter referred to as hostels). Approximately 500 beds in such hostels are in older institutional style settings, many of which are licensed to "for-profit" entities. Many of the residents in these hostels also have significant cognitive impairment. Some, though not many, residents are also registered with the WA Disability Services Commission. A significant number have lived in the hostels for 10 or 20 years or more, getting little more than bed and board. Many seem to be estranged from family and have guardianship and administration orders over them.

In 2013-2014 Official Visitors assisted 175 hostel residents who raised complaints with them. Nearly all complaints by hostel residents were raised while the Official Visitor was conducting a bimonthly visit of the hostel as required by the Act.

These submissions are based on Council's reported experience over the past 17 years working with hostel residents and other people with severe and chronic mental illness and my own experience as Head of Council.

COUNCIL'S EXPERIENCE RELEVANT TO ISSUES RAISED IN THE CONSULTATION PAPER

Council's Annual Reports, which I have authored over the past 7 years as Head of Council, set out Official Visitors' concerns and advocacy for hostel residents. The reports can all be viewed at: www.coov.org.

Both I, and my predecessor Heads of Council, have repeatedly raised concerns about the vulnerability of the hostel residents and poor oversight of these hostels. The relevance of this is that I understand a number of hostel residents will in future come within the NDIS and that, from our experience, it is essential to have an independent body visiting supported accommodation facilities to protect the rights of, and empower, the residents. It is the single most effective way of limiting the prospect of abuse and ensuring that the needs of this very vulnerable and disempowered group of people are met.

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[1] Private psychiatric hostels are defined under the 1996 Act as "private premises in which 3 or more persons who – (a) are socially dependent because of mental illness; and (b) are not members of the family of the proprietor of the premises; reside and are treated or cared for (see s175 of the 1996 Act).

Experience at Council is that hostel residents (and indeed mental health patients generally) are often too afraid to speak up and raise an issue. They are often bullied, may not be articulate enough to express their concerns and/or believe that they have nowhere else to go or will be separated from other hostel residents who are, in effect, the only family and friends they have. It requires regular visitors who can engage with, and build up the trust of, the residents and who have keen observation skills.

I am also concerned by the increasing number of people being housed individually in the community supported by an inreach service which is usually provided by a non-government organization (NGO). It would be very difficult for people in these circumstances to speak up if they were being abused by a rogue NGO staff member. In WA the only oversight of these types of facilities is via evaluations of the NGO every 3 or 4 years.

One could easily imagine that a person might be reluctant to complain in case they lose their funding. Council is also aware that, to complain more than once is to get a reputation; Official Visitors spend a lot of time trying to persuade service providers to assist people who have been rejected by other service providers and is aware of "cherry picking" by some service providers, so such concerns by residents are not unfounded.

In my time as the Head of the Council, we have had only a couple of cases involving violence and abuse but neither was resolved satisfactorily other than eventually having the offender removed from the hostel. We have numerous and ongoing examples of poor care and living conditions. As fast as we get an issue addressed, another arises. Our motto is that we keep chip, chip, chipping away.

I have attached as annexures A and B, respectively pages 30-40 and 30-38 of Council's 2010-11 and 2011-12 Annual Reports, which set out examples.

In one of the main cases referred to in these two reports a hostel night supervisor was drunk almost every night and bullying residents. On one occasion the police had been called and there were concerns about medication processes. In WA, hostel supervisors are "approved" by the licensing division of the Department of Health but that process involves little more than a police check. It turned out that this supervisor had in fact been sacked by another hostel for being drunk on duty. The second hostel licensee said she was never told this and the licensing division had also not been told. The licensing division were concerned that, even if they removed the person's supervisor status, he would still be employed at the hostel in a lesser position in which case they would have no control over him. They therefore settled on a 6 month supervision period. Council was very unhappy with the process and outcome. As can be seen from the Annual Reports, eventually the hostel was sold to a new owner who very quickly dismissed the person for drunken behaviour....... only to re-employ him later as a cleaner. One outcome of the issue was the drafting of a Code of Conduct for supervisors by the licensing body.

NDIA PROVIDER REGISTRATION

Based on Council's experiences as outlined above, I choose option 4 for accommodation services in particular as the providers have almost absolute control over a person's life.

Other services could be assessed as to risk and the registration level based on that assessment.

I would also be in favour of the providers of some types of lower risk services choosing their level of registration and leaving it up to the participant to decide whether they feel a need for a provider at the higher level of registration or not. That is, the participant gets to decide the level of risk they feel with that type of service.

COMPLAINTS HANDLING SYSTEMS

The Council of Official Visitors is required under the *Mental Health Act 1996*[2] to seek to resolve complaints by mental health consumers who are involuntary patients, on community treatment orders, and/or living in private psychiatric hostels. As such we are an independent body that takes complaints but we have no power to enforce a resolution or provide a remedy for the complainant. The main role we play is in being an advocate for the complainant – taking the person's side and articulating their case ... but always in accordance with the person's wishes. The key to this is being independent and being regularly on site and accessible.

In WA the various psychiatric hostel providers have wide ranging practices in relation to complaints handling ranging from non-existent to reasonably sophisticated. One of the main issues though is the complexity and trying to navigate system. The final complaints body is the Health and Disability Services Complaints Office (HADSCO) but the process is slow and cumbersome and in the main requires the provider to agree to take part in conciliation.

As an absolute minimum:

1. providers should be required to have an effective and transparent complaints process as per option 2;
2. there must be a complaints system independent of providers and the purchaser i.e. NDIA – perception is everything in this regard;
3. advocacy must be freely and readily available to assist people to articulate and present their complaints (and therefore funded); and
4. the advocates should be visiting some sites on a regular basis to make themselves accessible – this can be done via community visitor schemes which ideally would be legislated but otherwise it could be a condition of providers' funding that they promote and facilitate visits by advocacy bodies.

ENSURING STAFF ARE SAFE TO WORK WITH PARTICIPANTS

As noted above, this issue is not well handled in WA's psychiatric hostels. I am in favour of a working with vulnerable people clearance but, as with the level of provider registration, the providers of some types of lower risk services could choose their level of registration so that the participant decides the level of clearance they feel is necessary to ensure their safety and well-being.

Based on the experience related above in one hostel, creating a "barred persons list" and requiring providers to advise NDIA of staff removed for misconduct is also an excellent idea.

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[2] From 30 November 2015 the Council will be replaced by a Mental Health Advocacy Service which will have a similar role under the *Mental Health Act 2014* though bimonthly visits will no longer be legislated. The new role includes representing people in complaints to the Health and Disability Services Complaints Office (HADSCO).

SAFEGUARDS FOR PARTICIPANTS WHO MANAGE THEIR OWN PLANS

I am in favour of people who manage their own plans being able to choose unregistered providers for lower risk supports but the NDIS has a duty of care to ensure that there is sufficient and easily accessible information and support available to ensure that the decision by the person is well informed. The right to the "dignity of risk" should be maintained.

REDUCING AND ELIMINATING RESTRICTIVE PRACTICES IN NDIS FUNDED SUPPORTS

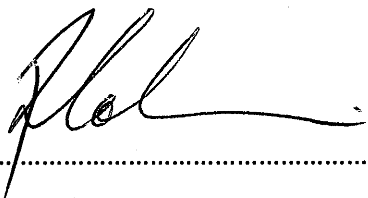
Official Visitors regularly liaise and negotiate with hospital staff in particular in relation to behavioural management plans. The concept of having an independent person who can articulate the wishes and concerns of the person being managed is an excellent idea.

In Council's experience, though, many hostel residents do not have family or friends outside the hostel and in some cases I would be very concerned about family members taking the role proposed as I do not think they would be independent.

In WA the Public Advocate's office is also not resourced sufficiently to play the role of an independent person or even an advocate. Primarily their role is limited to legal decision making.

An independent advocate or visitor scheme should be used in such cases or at the very least made available with the person allowed to choose.

The Mental Health Act 1996 sets up minimum practice and reporting requirements for seclusion, bodily restraint and restriction of visitors and phone access. These are being enhanced under the 2014 Act. Similar provisions should be made wherever restrictive practices are used. It should include mandatory reporting, regular and independent review and access to independent advocacy. Ideally a second opinion confirming the restrictive practice prior to implementation should be required as well.



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In 2009-2010 Official Visitors assisted 26 children and young people in the BAU, attending 11 MHRB hearings. Eleven of the 26 children and young people assisted by Official Visitors were Aboriginal or Torres Strait Islanders. Nine of the 26 consumers assisted by Official Visitors had been in the BAU previously (what Council refers to as "revolving door patients").

Official Visitors assisted 34 children and young people in the BAU during 2010-2011 and were involved in 7 of the 28 MHRB reviews held. Eight of those consumers had previously been in the BAU. Three were Indigenous.

As well as raising concerns about the BAU and young people on a supervised bail order, Council's submissions called for:

- better mental health services for indigenous children and young people
- more services in regional areas to avoid the need to bring children and young people to Perth for treatment
- better follow-up mental health services
- services for 18-24 year old people on the basis that they have different needs and respond differently to ward environments than older people.

As a result of discussing the issues with the 14 BAU consumers, Council also suggested the following:

- trying to communicate differently - for example, the BAU young people told Official Visitors that they weren't interested in talking on the phone to Lifeline. A number of them didn't want to talk at all about why they were in the BAU or what had gone on before. Although literacy is a problem for many, other avenues of talking to young people need to be explored such as through phone text (most if not all have mobile phones on the BAU) and perhaps via media similar to Facebook
- research in, and better training of staff working with children and young people in how to communicate with them at a face to face level
- ensuring support services, especially in schools, are discrete so students can attend unseen by fellow students.

ISSUE 7: LICENSED PSYCHIATRIC HOSTELS

The licensed psychiatric hostels covered by Council comprises 36 facilities, some of which are run by non-government organisations (NGOs) and some by private "for profit" entities. They include private hostels, community supported residential units (CSRUs), community options houses and group homes. There were 58 new beds opened up in the sector this year resulting in a total of 831 beds licensed and funded for people with a severe and chronic mental illness. A list of the facilities, their address and their operators is provided in appendix 2.

The Act requires Official Visitors to:

- ensure that these facilities are "safe and otherwise suitable", although it has no power to demand changes
- ensure that residents' rights are observed
- seek to resolve residents' complaints.

By Ministerial Direction they are visited every 2 months.

As previously reported by Council, the facilities range widely in style and standard of accommodation and care. While Council has been calling for a wider range of supported accommodation facilities, it also has concerns about a number of the existing facilities, some of which are illustrated below.

It is of great concern to Council that this group of very vulnerable people is, or will be, passed by in the reforms currently under way by the MHC and at a national level.

Illustration 1 – Complaints about a supervisor

Council received a complaint about the activities of a supervisor from a caller who was only prepared to identify themself to Council on a confidential basis. Anonymous calls had previously been received by Council from a different caller who refused to say who they were.

The anonymous caller had raised a number of other allegations and Official Visitors had attended the facility following those calls. The issues raised in the earlier anonymous calls included a number of "red herring" allegations, which were investigated and dismissed by the Official Visitors, and they were unable to confirm any of the other allegations with residents. Council monitored the facility monthly during this period (rather than every 2 months).

Following the call from the person who wanted their name to remain confidential, Official Visitors again attended the facility. On this occasion 9 residents were prepared to talk to the Official Visitors about the supervisor. Residents indicated that they were willing to allow the Official Visitors to raise the complaints as long as they were not identified.

Whilst at the facility Official Visitors also received a number of general complaints by the residents about the facility including allegations by the residents that they were threatened with eviction if they complained.

Action and Outcome

Head of Council and an Official Visitor immediately made arrangements to meet with the licensee to inform them of the allegations and to ensure that the supervisor was not allowed back in the facility, pending the outcome of an investigation.

Council also advised the other 3 bodies involved in the oversight of supported accommodation facilities, that is, the Licensing Standards Review Unit (LSRU), the OCP and the MHC, and called for an urgent meeting with them.

LSRU promptly appointed an experienced investigator from within the DOH to conduct an inquiry into the allegations against the supervisor and met with Council to discuss the process. The LSRU approves supervisors pursuant to regulation 7 of the *Hospital (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997*.

Documentation relating to and leading up to the 9 complaints was also provided to LSRU and the investigator.

The investigator made a number of visits to the hostel to meet with residents. The Official Visitors who received the allegations also met with the investigator as did the supervisor and other facility staff.

Council was told that the OCP would be looking into the other allegations. Council requested that the Chief Psychiatrist inform the relevant mental health service community team of the allegations and investigation so that they could check on the mental health of the residents.

Throughout the process, Official Visitors attended the facility to ensure that the residents were kept fully informed and supported.

Council was not provided with a copy of the investigator's report but a meeting was held by LSRU involving representatives of Council, the OCP and MHC. At the meeting LSRU advised that a number of the allegations had been substantiated.

LSRU also advised that it was of the view that its jurisdiction was limited to whether the person could be approved (or removed) as a supervisor pursuant to regulation 7 of the *Hospital (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997*. It was subsequently confirmed that the person wanted to continue working in the facility as a supervisor, and that the licensee of the facility was prepared to have them back on conditions (having initially terminated the supervisor's employment).

LSRU then advised that they would appoint the person as a supervisor again on multiple conditions that included that the person would be:

- supervised by the license holder or another approved supervisor whilst on duty
- monitored for a period of 6 months.

LSRU further required the licence holder to provide a report to LSRU at the end of the fourth month advising of the person's compliance with the above. A stipulation was made that, if during the 6 months there was a demonstrable breach of any of the above conditions, as determined by LSRU, it would result in an immediate withdrawal of the approved supervisor status.

Council then wrote to LSRU, the Chief Psychiatrist and the MHC, thanking LSRU for its prompt attention to the complaints and noting the difficulties that existed in dealing with the issues but asking LSRU to take legal advice regarding the extent of their jurisdiction and raising a number of concerns including that the supervisor had been reappointed.

The OCP subsequently conducted a review of the facility. Council was told that the findings from that review included that:

- the facility's complaint procedures required attention and in particular that residents knew what the procedures were and that they were entitled to access support from a third party such as an Official Visitor
- the facility's management needed to ensure staff were compliant with policies and procedures
- observations suggested that the model of care/service delivery could be less custodial.

Official Visitors are continuing to closely monitor the facility and make themselves accessible to residents.

Comment

This case highlighted a number of issues as set out below.

1. **The difficulty of a sector that has overlapping oversight by four bodies:** Council, LSRU, the Chief Psychiatrist and the MHC all have responsibilities for the oversight of supported accommodation facilities. As a result, there is no one body and no single set of adequate standards to deal fully with an issue like this. For example:
    - Questions were raised as to whether one of the allegations could be considered to be misconduct given there was no standard prohibiting the behaviour. Although everyone agreed that such behaviour was inappropriate, there was no written rule against it – the LSRU is now in the process of drafting a code of conduct for approved supervisors to cover such issues with a view to it being adopted by the sector.
    - The LSRU said it was of the view that it only had authority to control the employment of the person as a supervisor. Council was told that this meant that the person could have continued to work at the facility, or another facility, in a non-supervisory role without any conditions being imposed.

- LSRU's apparent limited jurisdiction also meant that some of the residents' complaints were investigated by the LSRU and the remaining complaints were considered by the Chief Psychiatrist. Different styles of investigation were used by each and neither would provide Council with a copy of their report.
- The Chief Psychiatrist has a set of standards applicable to NGOs managing licensed psychiatric hostels but the standards are not very detailed and largely require the facilities to develop their own policies and procedures. It can be difficult to measure compliance because the NGO may have a policy but it may not be an appropriate policy or may be loosely worded.
- The Chief Psychiatrist's standards and the standards issued by LSRU overlap and it is difficult to know which body to refer complaints to.
- Council was told that not all supported accommodation facilities have signed MHC contracts requiring the Chief Psychiatrist's standards to be observed so that Council does not know what standards it can expect to be observed by facilities.
- The MHC seemed to take only the role of a watching brief yet it is the body which funds and contracts with the facilities.
- A positive outcome of the case was the development of a code of conduct for supervisors by LSRU, but the Chief Psychiatrist's standards already call for a code of conduct to be in place (without specifying the terms of the code of conduct).
- Council visits such facilities every second month whereas the LSRU and Chief Psychiatrist generally only visit once a year. However, Council has no power to enforce standards and it is extremely difficult to ascertain what standards are to be met.

Council has been calling for a review of the way the sector is monitored and governed, including new standards, for many years. It is hoped that a review of the quality assurance framework for mental health in WA will lead to some improvement.

2. **Vulnerability of residents - perceived and actual:** Whilst the residents were clearly very unhappy with the treatment they were receiving from the supervisor, they were equally concerned about being evicted or the facility closing down. The fear was that they had nowhere else to go. In the case of many residents, the facility had been their home for years and they considered the other residents to be their family - eviction or closure would have significant consequences for residents.

   The supervisor worked alone so that no other staff witnessed the supervisor's behaviour. The reaction of some other members of staff initially was that they did not believe the residents' allegations.

   When Official Visitors spoke to residents, many were concerned about being seen by staff talking to an Official Visitor in case it was thought that they were complaining.

3. **Difficulty of handling anonymous calls:** Due to the perceived/actual vulnerability of mental health consumers, Council regularly receives anonymous complaints. The very nature of Council means that all complaints must be investigated, even those that appear quite implausible. However Official Visitors are advocates rather than trained investigators and it is sometimes difficult to ascertain when or if a third party should be notified. A debriefing session was held with the investigator to discuss how Council could have better handled this case.

4. **Communication issues:** A post-issue analysis by Council indicated some internal communication issues. Council's practice of generally rotating Official Visitors around facilities means that good communication is essential, particularly given the increasing number of facilities and consumers. Council has tried various means to improve the flow of information but currently it remains dependent on meetings, email and manually prepared reports. A new database and access system is required.
5. **Lack of suitable alternatives for residents if a facility is found unsuitable:** There are very limited remedies available where a facility is found to be deficient because of the difficulty in finding other accommodation. It is not currently possible to move residents en mass. Splitting up residents who have lived together for years is a punishment not a solution. The lack of alternatives is disabling for all bodies involved in the oversight of this sector and makes it extremely difficult to encourage improvement in the sector.

Illustration 2 - Food issues

Council regularly receives complaints about the quality and variety of food in licensed psychiatric hostels where the food is provided to residents. The *Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations* 1997 and LSRU Licensing Standards set out a number of requirements which include that a 4 week menu is developed and posted in the facility. Following ongoing complaints from one facility, Council sent an Official Visitor out for 3 consecutive days to review the lunch and evening meals and provided a detailed report on what they observed which included:

- the meals rarely matched what the posted menu stated would be served
- residents were only allowed powdered milk
- residents were not provided with juice but given cordial
- the only fruit provided was apples which looked very old and there was little evidence of fresh fruit and vegetables
- the meals largely consisted of processed food which was generally high in sugar, salt and unhealthy fats (eg chips, pizza, crumbed fish cakes).

Action and Outcome

Council wrote to the facility and copied in the LSRU, Chief Psychiatrist and MHC providing them with a copy of the Official Visitor's observations. The licensee was asked to explain how the food provided complied with regulation 10 of the *Hospitals (Licensing and Conduct of Private Hostels) Regulations* 1997. It was pointed out that one purpose of the LSRU standards requiring an advertised menu was so that bodies responsible for ensuring consumer rights were being observed (Council, the LSRU and the Chief Psychiatrist) could check to see if the food preparation and diet was in accordance with regulation 10. If the menu was regularly not followed, this obviously raised concerns for Official Visitors.

The LSRU also sent a letter to the licensee following receipt of Council's letter requiring the licensee to do a number of things including employ a dietician to review the menu, to adhere to the menu and provide fresh milk.

The licensee responded fairly promptly advising of new menus and further stated that:

- menus would be fully adhered to by all staff and that the licensee would be meeting with staff and telling them that there was to be no change without the licensee's personal approval
- the licensee would in future visit the premises more frequently at meal times
- shopping for food would now take place twice weekly in order to serve fresh fruit and vegetables
- fresh milk would be served in future.

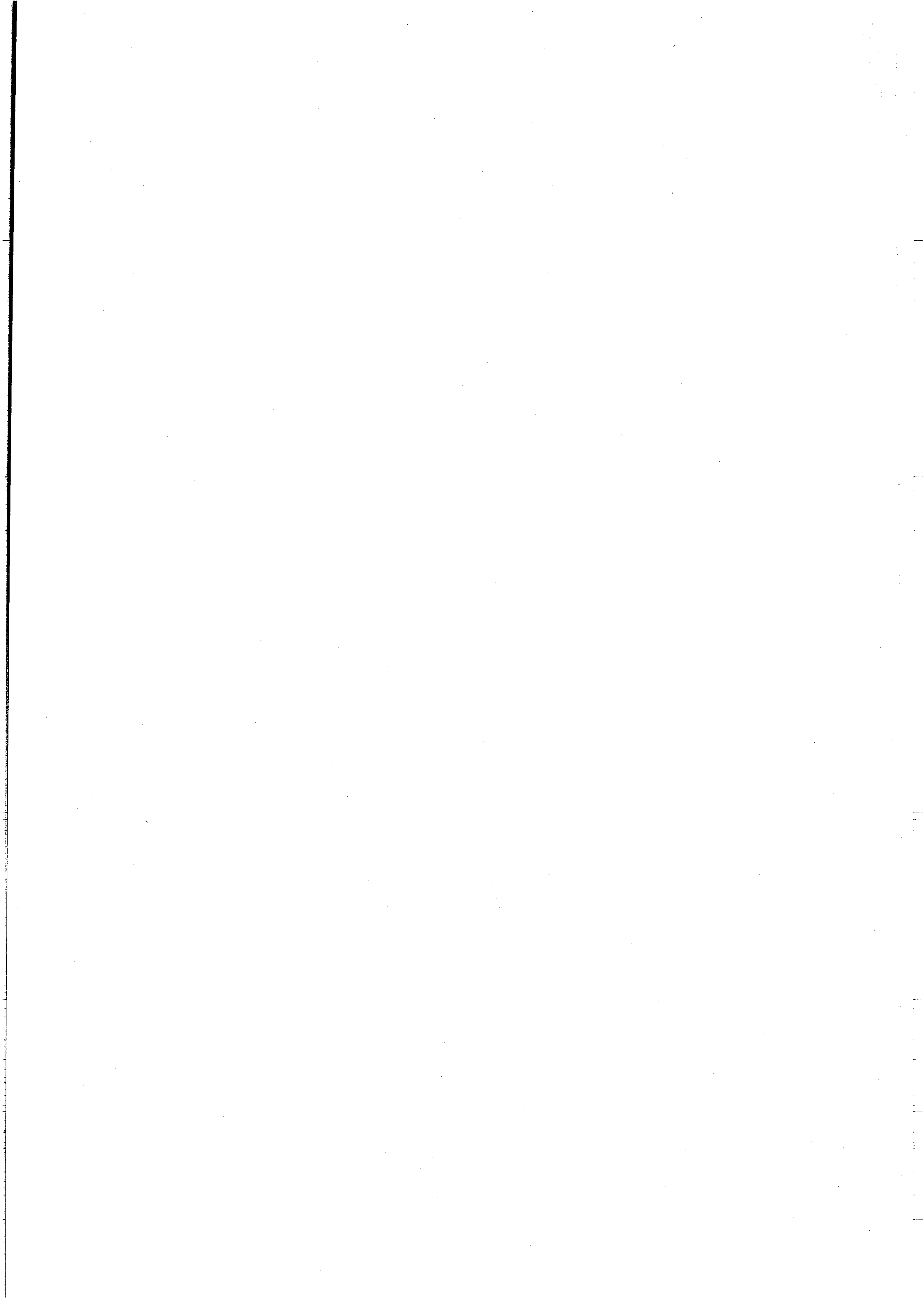

Illustration 3 – Complaint about care in the community and access to a hospital bed

Council received a complaint from the guardian of a resident in a licensed psychiatric hostel about the difficulties he had experienced trying to get the resident into hospital. According to the guardian, the resident had been obviously very unwell for two weeks. The behaviour included screaming and throwing possessions out of windows and threatening behaviour to other residents. The manager of the licensed psychiatric hostel said he had been trying to get the resident into hospital but had been told there were no beds.

After making various calls to the local mental health service, the guardian staged a "sit in" at the hospital and refused to leave until someone from the mental health community service went out to assess the resident.

Whilst the guardian was waiting at the hospital, and without telling the guardian, someone from the mental health service went to assess the resident. On learning of this, the guardian rushed back to the licensed psychiatric hostel. When he got there the person who had gone to assess the resident told him that he agreed the resident needed to be admitted to hospital, but the resident had refused to go so there was nothing he could do. The guardian said he would get the resident to the hospital if the mental health service staff member would meet him there. This was agreed to and as a result the resident was admitted to hospital.

Coincidentally Official Visitors had been present at the hostel 2 days earlier and were so concerned about the resident that they also had contacted both the Chief Psychiatrist and the mental health service to urge them to send someone to assess the resident.

Action and Outcome

Due to the extreme efforts of the guardian the resident was admitted to hospital but the guardian, who is also the father of the resident, is elderly and is very concerned about the care that the resident will get when he is no longer around.

Council wrote to the responsible hospital and community mental health service, the Area Executive Director, the MHC and the Chief Psychiatrist asking the following questions:

1. Why was the very obvious ill health of this resident not detected by visiting clinic staff or any of the 3 visiting GPs who Council had been told serviced the residents at this facility?
2. Why were the requests for help by the support accommodation facility not properly responded to?
3. Why did no-one suggest to the manager of the licensed psychiatric hostel when he called that any one of the 3 visiting GPs could prepare a form 1 referral for the resident to be assessed?
4. Why did it take a father refusing to leave the hospital to get someone to actually go and see this resident?
5. Who was the person who went to see the resident after the guardian refused to leave the mental health service, were they qualified to decide whether or not to make a form 1 referral and if so did they turn their minds to that process, and why did that person advise the guardian that there was nothing they could do?

The mental health service responded saying that:

1. there were no formal liaison arrangements with this licensed psychiatric hostel
2. the service had no formal role in governance at the licensed psychiatric hostel despite a repeatedly stated willingness to become involved
3. there were no beds available at the time anywhere in the state
4. residents who resided in licensed psychiatric hostels were supposed to have access to carers who could provide care to a certain level which included liaising with the mental health service to report deterioration and who should have been aware that they had the option of sending the resident to a hospital emergency department by ambulance
5. they acknowledged the guardian had legitimate cause for concern
6. the governance of the licensed psychiatric hostel should be reformed to make the mental health service more involved in the running of the facility and provide a closer liaison between the service and visiting GPs.

The Chief Psychiatrist responded:

1. referring to the mental health service file entries indicating that the staff were aware of and attended to requests by the licensed psychiatric facility for review of the resident and that the hostel staff had agreed to keep the resident
2. saying a form 1 referral for psychiatric assessment was not completed by mental health staff because there were no available beds and they were attempting to manage the resident in the community until a bed was available
3. concluding that the mental health service had been responsive to the requests of staff of the licensed psychiatric hostel and that the two services had effectively managed the resident within the community until a bed became available.

The licensee of the licensed psychiatric hostel responded complaining about the "erratic treatment regime which contributed to the negative outcome in this case" and noted that the mental health service had only taken affirmative action after being contacted by Council and the action taken by the resident's guardian.

The MHC responded saying that they had asked the Chief Psychiatrist to investigate.

Illustration 4 - Standards of accommodation and care

A number of licensed psychiatric hostels provide accommodation in buildings that fall well short of meeting modern standards as will be seen in Illustration 5 below. Some residents have their own bedrooms, others (often happily) share bedrooms, still others share rooms with up to 3 or 4 other residents.

The MHC funding and correspondingly the care provided in licensed psychiatric hostels also varies widely. The majority of the 831 licensed psychiatric hostel residents live in older, for profit private hostels. Many of these are institutional in structure and style and there is little or no suitable rehabilitation or recovery support available in-house or in the community to residents. Some hostels provide little more than food and board. Many of the residents in these hostels are ageing and have multiple health issues. Such hostels do not feature in plans for change or improvement at either state or Commonwealth level.

In all facilities (even including the new villa style), residents are not allowed to have friends stay overnight and friends cannot share a celebratory drink with them on special occasions so, although reference is often made to these facilities being people's homes, they are far from "home-like".

Action and Outcome

Council provided the MHC with a list of 10 suggestions for licensed psychiatric hostels, to be funded by the Commission, that would make an immediate difference, initiate a key reform and/or would be a non-recurrent funding proposal:

1. A review of the governance, accountability and transparency of the licensed psychiatric hostel sector generally.
2. A person to research and organise the provision of on site services and other non-government organisation (NGO) provided services which are paid for by Medicare or other commonwealth funding and to encourage and/or require selected hostels to provide such services and/or to make them accessible to residents.
3. Smoking – a one-off but substantial quit program specifically designed for this cohort. This could be a collaborative project and the MHC could possibly offset some of the costs via other parties.

   (Note: The MHC has allocated $187,000 per annum for 2 years to the Mental Illness Fellowship of WA (MIFWA) to encourage and help mental health hostel residents to quit smoking. It will fund 8, 10 week programs delivered by people with the lived experience of mental illness who are also former smokers and is based on a South Australian program.)
4. Provide small buses on loan to licensed psychiatric hostels to allow them to transport residents to programs and services.
5. A holiday house possibly combined with some type of rehabilitation/recovery activities run by an NGO – most hostel residents never get to go on holiday and many rarely leave the hostel.
6. Staff training courses and setting minimum requirements for staff – preferably provided onsite, perhaps by an NGO for groups of hostels or perhaps by offering scholarships to do the Certificate IV course in mental health.
7. A fund for one-off contributions to capital improvements that can be applied for by licensed psychiatric hostels on the basis that if the owner/manager sells or shuts down the facility within, say, 10 years, the money must be paid back, and it must have a direct benefit to the consumers.
8. Development of care plans and social worker review of every private hostel resident.
9. An Eden Alternative project - the Eden Alternative proposes, amongst other things, that the right type of environment can substantially reduce the loneliness, boredom and helplessness experienced by many aged care residents. It is equally applicable in mental health residential facilities. The MHC could facilitate a collaborative project in both the hostel sector and hospital wards to create water-wise sensory gardens.
10. A physical health check of all hostel residents to assess their needs.

Illustration 5 – Environmental audit of licensed psychiatric hostels

As with hospital wards, Official Visitors conducted an annual audit of the condition of hostel facilities (in May and June 2011). Below is a summary of what they observed and reported. The facilities are not named in the annual report but this information has been provided to the MHC that funds them.

Facility 1 – Units inspected were generally in very good condition. The only issues noted were a few minor cases of paint peeling in the bathrooms, one shower in poor condition and the poor state of outdoor furniture. Several light bulbs required replacement in carports and courtyards. Indoor and undercover facilities were exemplary and gardens were very impressive.

Facility 2 – Appeared clean and well maintained providing a homely environment.

Facility 3 – Presented as clean, however the carpet in the lounge area was worn and stained. The dining room furniture appeared quite old and the legs of both chairs and tables were rusty. In one bedroom, paint had lifted off almost the entire ceiling and in another bedroom paint was bubbling on one wall, which may have been water damage from heavy rains. The living areas were homely and tastefully decorated. Bedrooms had good disability access.

Facility 4 – Was clean throughout with only a few minor maintenance issues.

Facility 5 – Shared bathrooms had various cleaning and maintenance issues including mouldy tiles, unpleasant smells, rising damp and dirty ventilation fans. Other areas in the hostel that required thorough cleaning included carpet and flooring in 5 bedrooms, kitchen vents, a roller shutter, and the area around the food access hatch. Many furnishings needed replacing and cobwebs removed in the dining area.

Facility 6 – Bathrooms required attention, as doors could not close properly, the shower heads required maintenance, and paint was peeling on the ceiling. Male toilets on one floor did not flush, and glass was missing in a window. Furnishings and carpets in lounge/TV rooms were in poor condition with numerous cigarette burns.

Facility 7 – There were a few minor maintenance issues including the peeling of paint in three units and vinyl floor tiles lifting in one unit. Lounges and beds required replacement.

Facility 8 – The facility was considered to be in excellent condition in terms of overall cleanliness, suitability, provision of equipment, bedroom layouts, furniture and security for residents.

Facility 9 – Some pillows and blankets in bedrooms appeared worn and in need of replacement. There was not enough seating in the lounge or outdoor area to accommodate all residents.

Facility 10 – Lounge room furniture was quite worn and some of the cushions were ripped. The unit had a homelike appearance.

Facility 11 – Considering the age of the buildings it was generally in good repair. Yet much of the interior woodwork required painting, there were missing tiles in some bathrooms, and exhaust fans needed cleaning. There were missing louvres in windows facing hallways in some bedrooms and the skirting boards had been removed in some rooms. The hostel was very clean and homely.

Facility 12 – Official Visitors were very concerned about the safety of the outdoor power supply. A power board which was used for music and lighting was hanging from an outlet exposed to the elements. Floor coverings were in a poor condition with holes and marks. There was mould on the ceiling of one bedroom, and residents' pillows required replacing. A number of pipeline style beds were rusty, few rooms had bedside lamps, one mattress required replacement, and some bedside tables required replacement. Some toilets smelt badly and had rotting door jams. One bathroom had peeling paint. Furnishings in the lounge rooms were tatty and stained.

Facility 13 – The carpets were stained, lifting and showing signs of wear and tear. Toilets and air-vents were in need of a thorough clean. There was no air-conditioning in the upstairs area.

Facility 14 – This facility was generally in good condition. However it was noted that the ceramic tiles in the bathrooms and vinyl tiles in the living areas (not fitted by the licensee) were of a low standard. This made it difficult for residents to keep them clean and well presented.

Facility 15 – This facility presented well with no major maintenance issues.

Facility 16 – Cleaning was the main issue of concern. In the kitchen the fridge, oven and dishwasher all appeared grotty. The grout in bathrooms required a thorough clean. The dining room required dusting and the floor was dirty. Other areas that required thorough cleaning included the lounge, laundry and the front door.

Facility 17 – All units inspected required maintenance. There was prominent chipped and peeling paint in communal living areas, which required repainting. Exhaust fans in all units needed cleaning. Re-grouting around kitchen sinks was required. Flooring needed repair in two units and in one the skirting board was missing. All curtains were sun damaged and needed replacing, as they no longer provided adequate 'block-out'.

Facility 18 – This is a relatively new facility and at the time of inspection there were no items that were regarded as unsatisfactory. However a number of rooms already had paint chips and wall marks.

Facility 19 – There was a query as to whether a gas heater in one unit complied with standards, as it did not have an automatic shutoff. There was some water damage in another bathroom. Bathrooms required more towel rails.

Facility 20 – Painting was required in all bedrooms, the dining room and hallway due to dirty walls, flaking and peeling paint, and plasterwork being exposed in some areas. The grout in bathrooms was dirty and required steam cleaning. Several beds were very low due to the casters being taken off. One mattress was extremely soiled and others smelt bad. The courtyard furniture consisted of cinder blocks and cement seating, which was uncomfortable and did not provide back support. Tabletops were filthy with cigarette residue despite cleaning. The lawn was dying and gardens were shabby. There were patches of uneven paving on the patio that posed a safety risk.

Facility 21 – There was no air-conditioning in the bedrooms and although there was air-conditioning units in the dining/lounge areas, residents could not operate them. In the bedrooms of most units the carpets were very dirty, the walls were marked, particularly around the light switches, some walls also had old food spills on them. Fridge/freezers in all units needed cleaning. Stoves and microwaves did not work in all units. In the main building, paint was peeling on the bathroom ceiling and on the walls. Cupboards and floors in the main kitchen required cleaning at the time of inspection.

Facility 22 – Most bedroom doors were not lockable and most bedrooms did not have lockable storage facilities either. In most bedrooms the curtains required cleaning or replacement and the skirting boards were dirty, damaged and/or rotting. A considerable amount of dust and cobwebs were noted throughout the facility. Bathroom and toilet facilities were dirty and very run down, this included loose, rusty and broken fittings and a number of broken door handles/locks, many parts were dysfunctional and required urgent attention. Many flyscreens were either damaged or broken.

Facility 23 – This is a new facility. A full environmental audit was not carried out. It was noted however that the facility had a light, airy, homelike environment.

Facility 24 – The houses appeared clean, tidy and homely. The only issues noted were 3 blown light globes and the dining room light in one house was dull.

Facility 25 – The cleanliness of the residences was high. However there were a number of maintenance issues noted. One bedroom power point was loose and coming off the wall, posing a safety risk. The female side corridor had floor tiles lifting due to moisture damage from both bathrooms. The men's bathroom door did not stay closed. There was a ceiling vent dropping at one side that looked as though it may fall.

Facility 26 – Two units were inspected and they appeared in good condition with a homely atmosphere.

Facility 27 – Residents at this facility were responsible for their own cleaning and most rooms were of an acceptable standard. However 1 en-suite was filthy and the resident needed assistance with cleaning this bathroom.

Facility 28 – The cleanliness and condition of the residences were generally of a high standard. There was a problem with the disabled bathroom in one unit, as water did not run off towards the drain hole, resulting in water pooling after showers. Some drains in the units blocked up, because large lumps of concrete were in the drainage system, apparently a result of the building process.

Facility 29 – The units were well maintained, however a number of units had issues of minor cracking around the sliding doors. There were no clothes dryers or undercover areas available for drying clothes.

Facility 30 – The house was clean and tidy, furnishings were in good condition and no maintenance issues were noted. Suitable facilities were provided for one resident who is hearing impaired.

Facility 31 – No clothes dryers were available. No heating available in bedrooms. Air-conditioner vents in bedrooms needed cleaning. Shared male bathrooms had leaking showerheads.

Facility 32 – Paint touch ups were required in a number of areas including in the kitchen where a light fitting had been replaced, in bedrooms where curtain tracks had been replaced, in the lounge above sliding doors and in the bathroom near the light switch. In the bathrooms grouting around the basins was in need of repair and the mirrors were losing their reflective surface. A light outside the laundry appeared to be in danger of failing from the ceiling.

Facility 33 – Found to be in satisfactory condition in regards to cleanliness and maintenance.

Facility 34 – The house was clean and maintained in good a condition. At the time of the environmental audit renovations were being carried out in dining room.

Facility 35 – There were no issues of concern noted during the environment audit. All units were well presented.

Facility 36 – The kitchen, lounge, hallway and bedrooms needed painting. Fans in 2 of the bedrooms oscillated strongly and needed to be checked for any deterioration or safety risks. The bathroom cabinet mirror was losing its silver backing and beginning to rust. An area of roofing at the back of the house needed cementing to prevent the possibility of water leaks.

B.

Clearly, an added cost would be involved. However, involuntary patients are seriously ill, the diagnosis and treatment is usually complex, the medications often have serious side effects and, unlike any other serious illness, the process involves taking away fundamental human rights.

ISSUE 5: SUPPORTED ACCOMMODATION - LICENSED PSYCHIATRIC HOSTELS

The licensed psychiatric hostels visited every 2 months by Council comprise 41 facilities, some of which are run by NGOs and some by private "for profit" entities. The facilities range widely in style, size, standard of accommodation and care, and level of funding. In this Report they will all be referred to as hostels.

Council was advised of 38 new beds being licensed in the sector this year (and a reduction of 5 beds at one facility) resulting in a total of 868 beds licensed and funded by government for people with a severe and chronic mental illness. Appendix 2 contains a list of hostels, licensees and addresses. This figure does not include the "100 Houses program" by the MHC. Council's jurisdiction does not cover these homes though consumers living under these arrangements may need advocacy, particularly in relation to any complaints they have with the NGO providing them with support and any issues relating to maintenance of the home.

There was a 43.3% increase in the number of hostel residents seeking visits from Official Visitors this year rising from 97 to 139, possibly supporting the concerns Council has about this sector. The concerns include the following:

1. The ongoing lack of comprehensive oversight and quality assurance because of gaps and overlaps. Until earlier this year 4 agencies were involved in the oversight of hostels - Council, the OCP, LARU and the MHC. In August 2011, Council was advised that the OCP was withdrawing from its monitoring role which was to be taken over by the MHC. (Council is waiting to hear how the MHC plans to conduct the monitoring).
2. The discrimination of "private hostel" residents who have little or no access to appropriate rehabilitation and recovery services which limits their potential for recovery and an improved quality of life. Council is concerned that these residents are being forgotten about and in many cases are also living in large institutional facilities, sharing bedrooms and facilities which are funded less than other newly built villa style hostels run by NGOs which are able to offer in-house services. The private hostels also tend to have the more chronic and severely impaired consumers because they do not fit the criteria of the NGO-run facilities.
3. Issues related to ageing of hostel residents and other disabilities (and see also Issue 2, illustration 7).

Illustration 1 – Complaints about inappropriate behaviour by hostel staff

Last year Council reported on complaints by hostel residents about a supervisor. The issues relating to that supervisor continued this year. Two other cases involving allegations about staff are also illustrated below to show:

1. the vulnerability of hostel residents - with many residents too scared to speak out because they are concerned they will be evicted or don't know who to complain to particularly when a staff member is involved
2. the very different approaches taken by the 3 hostel licensees in dealing with allegations - while one licensee had no difficulty in being transparent about the way the investigation was conducted and the outcome, another refused to provide information requested saying it was confidential, and another left it up to LARU

3. the lack of clear oversight and regulation of this sector – the licensing body, LARU, can only deal with issues if an approved supervisor is involved; assumptions seem to be made that if an NGO is involved they can be allowed to handle the investigation themselves; and MHC, which provides funding to the hostels, currently appears to only maintain a "watching brief" when serious complaints or allegations are made. It is difficult for Official Visitors to know who to approach when there are concerns.

Case 1 – Supervisor drunk on duty

Last year Council reported on allegations made about a hostel supervisor which resulted in LARU sending in an investigator. The allegations included being drunk at work and bullying residents. A number of the allegations were substantiated. The supervisor was reappointed as a supervisor on multiple conditions that included that the person would be supervised by the license holder or another approved supervisor whilst on duty and monitored for a period of 6 months.

At the end of the 6 months the supervisor was allowed to work again unsupervised and was the sole staff member on night duty. Shortly after, hostel residents raised complaints again with Official Visitors. An anonymous call was also received about another staff member yelling at residents.

Action and outcome

Council notified LARU, the MHC and the licensee. The concerns were dismissed by the licensee but sometime later Council was advised that the supervisor had been dismissed after being found drunk during their work shift. The supervisor was then re-employed as a cleaner at the hostel under supervision and with conditions. Official Visitors are maintaining a watching brief.

Case 2 – Allegation that supervisor bullied residents

On a bimonthly visit a resident complained to an Official Visitor that a supervisor had "gone off at me" for going to hospital and not wearing shoes. The resident was clearly upset. The Official Visitor spoke to another resident asking if they were being treated well by staff. They said they were *'too scared to say anything*". A third resident who was asked if they were being treated with respect by hostel staff replied "*not all of them*". Further inquiries of staff supported the resident's complaint with one staff member who was prepared to be named saying they had heard the supervisor yelling and swearing at residents and that residents tended to try to avoid the supervisor. Further inquiries were also made of the Community Mental Health Service (CMHS) nurse who visited the facility. He confirmed that he had heard the supervisor yelling at a resident for making coffee. Other concerns were raised by the CMHS nurse as well.

Action and outcome

In accordance with Council's Serious Issues Policy, Head of Council telephoned the CEO of the licensee and letters were then sent to the licensee, LARU and MHC. A meeting was also held with the AMHS.

Council acknowledged that the supervisor deserved a full right of reply but in such cases Council usually asks that the staff member be moved from the facility and/or contact with residents pending the outcome of the inquiry. This is for the safety and protection of the residents and to avoid contamination of the inquiry. From experience in other cases, residents are often very concerned that by speaking out there will be unfavourable consequences and this is emphasised if the staff member remains on duty. Given the comments by staff and the CMHS nurse, Council also noted that it would expect the licensee to interview all staff, all residents, the Official Visitor and the CMHS nurse.

It was suggested that Official Visitors would like to be present at the facility when residents were interviewed in case residents wanted an Official Visitor to be with them during the interview.

Six days later the CEO of the licensee wrote to Council advising that the investigation had been concluded and that they were satisfied that the *"resident care and the safety and suitability of the facility had not been compromised"*. Some opportunities for improvement had been identified which would be addressed. They would not tell Council anything more, citing issues of confidentiality. The licensee also said they had concerns with the approach taken by Official Visitors during the initial and a subsequent visit to the facility[16].

Separately Council was told that the supervisor's behaviour would be monitored more closely. Official Visitors also attended with a senior manager of the facility when she spoke to residents telling them that the supervisor had done the "wrong thing" but now knew the behaviour was wrong. Council took this to mean that the complaints had been substantiated. The Licensee later advised that this assumption was not correct and that the complaint was not substantiated but it did "identify further opportunities for improvement" with the staff member.

Council remained concerned about the quality of the investigation and the outcome and wrote again to the licensee asking for more details including the action taken to ensure the supervisor's inappropriate behaviour would not happen again. The licensee was reminded that Official Visitors are required under the Act to ensure that residents' rights are observed and that the facility is in a condition that is safe and suitable.

There were also some new concerns about another allegation raised by a resident about bullying by the supervisor (the second allegation) and instructions allegedly given to staff and residents about who they should, and shouldn't speak to about complaints.

While Council is usually prepared to rely on LARU's advice (as LARU is responsible for the approving hostel supervisors and will conduct its own investigations), in this case LARU had advised that they also wanted more information from the licensee.

A meeting was then held with the CEO of the licensee followed by further correspondence. The eventual outcome was that the licensee appointed an independent person to investigate the second allegation.

Four months after the initial letter of complaint was sent, Council was advised by the licensee that the second allegation was unable to be substantiated and the supervisor would remain a supervisor without any conditions. Recommendations made by the independent investigator would be implemented including ensuring that residents were provided with information regarding the avenues for complaints on a regular basis.

LARU also wrote to Council advising that they had now seen the final report. They required the licensee to implement all the recommendations from the report and advised that the licensee would be maintaining a "watching brief" on the supervisor.

Council accepts that LARU has seen the final report and is now apparently satisfied about the investigation of the complaints. Official Visitors will also maintain a watching brief.

16 These concerns were discussed later but agreement was not reached on the issues raised by the licensee. The "concerns" have been included in the statistics on complaints received by Council referred to in Part 4 of this report.

Case 3 – Anonymous complaint about hostel staff behaviour

Council received an anonymous letter alleging that:

1. a hostel staff member had been drunk and behaved inappropriately with 2 residents at a hotel by breaching expected boundaries of behaviour
2. a hostel supervisor who was present at the hotel had asked the residents not to say anything about the incident
3. another hostel staff member was *"often intoxicated at work"*.

Action and outcome

In accordance with Council's Serious Issues Policy, Head of Council telephoned the CEO of the licensee and letters were then sent to the licensee, LARU and MHC. The licensee was asked to advise Council how they intended conducting the investigation, as well as the outcome in due course. It was suggested that Official Visitors could attend at interviews with residents if the residents wanted support.

The licensee quickly arranged for an investigation of the complaint. Staff were given a copy of the complaint and asked to provide written responses. One investigator was appointed to interview staff. A second investigator reviewed the written responses by staff and the report from the first investigator of the resident interviews and then interviewed each of the staff members and further written statements were taken. Council was invited to have an Official Visitor present at the facility for the residents' interviews and advised of the approach which would be taken with the residents in the interview. Both residents asked for the Official Visitor to be present in the interviews when given the option.

Council was provided with a copy of the final investigation report 2 months later. The allegations were unsubstantiated although some mentoring and training about maintaining boundaries was recommended for one staff member. It should be noted that the residents interviewed did not send the anonymous complaint and said they were not upset by the staff member's behaviour.

Illustration 2 - Review of hostel sector – oversight, regulation and licensing

Council has been calling for a review of the oversight and standards applied in the hostel sector for some years. This includes a review of the relevant legislation, standards, licensing, and quality assurance:

1. The combination of legislation, various standards and individual contractual arrangements with hostel licensees, coupled with different types of hostels, means that it is difficult to determine the rights of hostel residents and how to enforce those rights. Official Visitors have to refer to the following:
   1.1. the *Hospitals and Health Services Act 1927*
   1.2. the *Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997*
   1.3. the *"Licensing Standards for the Arrangements for Management, Staffing and Equipment of Private Psychiatric Hostels"* (last issued in 2006 and in need of a review)
   1.4. *"Service Standards for Non-Government Providers of Community Mental Health Services"* (Service Standards)
   1.5. the various policies of the licensees (which vary widely in content and detail)
   1.6. the agreements between the resident and licensees
   1.7. the terms of the licence granted by LARU
   1.8. the general/generic information we have been provided with about the contractual arrangements between the licensee and the MHC – Council does not know precisely what services the hostels are contracted to provide.

2. A number of the regulations are almost impossible to interpret and/or enforce. These include regulations to do with the standard of food to be provided to residents and clothing. There are also questions about regulation 14 regarding the amount that hostels are allowed to charge residents.
3. A number of the hostels do not fully comply with the Service Standards.
4. A number of the *Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations* 1997 are being exempted on a regular basis as part of the licensing arrangements; further reflecting a need to review the Regulations.
5. There is limited quality assurance around the staffing of hostels yet there is a high potential for abuse. The approval and oversight of hostel staff is currently limited to LARU which can only approve (or remove approval for) staff who are employed as supervisors. There is also the question of who conducts investigations when serious allegations are made and the quality and transparency of those investigations (as illustrated in last year's Annual Report and in Illustration 1 above).
6. There are concerns about the level of training and/or qualifications of both supervisors and other hostel staff.
7. This year LARU has had to issue a number of interim licenses. In the case of one hostel, conditions placed on the license were not complied with and several deadlines for compliance came and went. In another case LARU was given very little notice about significant changes at a hostel.

Action and outcome:

Council has written to the MHC and raised the issues in various meetings. In particular Council has asked:

1. whether and what plans there are for a review of the oversight and regulation of the hostel sector
2. whether there are plans to amend the *Hospitals and Health Services Act* and regulations
3. how serious issues and allegations are to be dealt with in future, including who Council is to go to when reporting such allegations, who conducts the investigation and what guidelines there are for such investigations
4. whether the MHC intends to get more involved in the approval and training of hostel supervisors either directly or by contractual/funding arrangements
5. what standards are currently applicable in hostels either by legislation or contractually
6. how the MHC is taking over the monitoring previously done by the OCP and whether any changes are anticipated in that regard?

Council is aware that the Henderson Report[17] made a number of recommendations relevant to the oversight of hostels which included removing the current hospital and hostel inspection function from Council (which would become a new advocacy body). Henderson recommended that this inspection responsibility pass to the MHC which was to contract with an "independent evaluation and monitoring agency".[18] The MHC is also to develop an "integrated quality management framework built on existing Commonwealth processes using a Joint Collaborative Partnership approach between the MHC and DOH". [19]

17 "Developing a Quality Assurance Framework for Mental Health In Western Australia - Final Report" 10 October 2011. http://www.mentalhealth.wa.gov.au/Libraries/pdf_docs/WA_QA_Framework_Final_Report_11_October_2011_FINAL_2.sflb.ashx
18 Ibid pp24-25..
19 Ibid p20.

While work is underway for the planning of the new advocacy body, we wait to hear further from the MHC about its plan for taking over and developing this quality assurance role.

Council also met with Sankey Associates who were retained by the MHC to conduct an evaluation of components of the supported accommodation program funded by the MHC. A sample of 18 sites was selected by the MHC for more in-depth evaluation. Council awaits the outcome of that report.

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Illustration 3 – Lack of access by private hostel residents to programs which promote rehabilitation and recovery

Official Visitors have been concerned for some time about the lack of rehabilitation, recovery and psychosocial community programs available for the 400+ private hostel residents. This concern was exacerbated when the North Metro Day Centre was closed.

The private hostels receive less funding than the NGO run hostels and most do not have the expertise to run inhouse programs so these residents, who tend to be the most chronically unwell, are particularly disadvantaged.

Inquiries revealed that most private hostel residents are not readily able to access DOH programs either, because they are not being case managed by the local CMHS. For example, only 25 of the 171 licensed hostel residents in 1 CMHS catchment area were case managed by the CMHS. Despite having a chronic and severe mental illness, the residents are usually cared for by GPs. There are some local NGO run activities, but the nature of the illness and resulting cognitive impairment suffered by many of these residents, means that most of these programs are not suitable.

The result is that many of the residents of the private hostels are being denied the prospect of recovery. Residents do not tend to improve and leave these hostels, they are not eligible for the MHC "100 Houses program", attempts to get access to Commonwealth programs such as Home and Community Care (HACC) services are denied them because the hostel is State funded (by the MHC); and it has been Council's experience that NGOs which are funded to run the Personal Helpers and Mentors programs are reluctant to provide services in such private hostels.

Action and outcome

Council made numerous inquiries through the year as outlined above and then wrote to the MHC and followed up the issue with them in 2 meetings. Council pointed out that it is the role of the MHC to organise the care co-ordination and future planning for the needs of private psychiatric hostel residents. The MHC funds the hostels and the DOH does not appear to consider hostel residents to be its responsibility unless they are case managed by the CMHS.

Council would like to see the MHC provide funding for in reach services to the hostels (many of which have over 50 residents); or for suitable services to be provided including transport for residents from the hostels; alternatively individualised care packages to be made available as a matter of priority.

Council was told by the MHC that "some discussions about the possibility of a trial with one or two hostels to move them towards psycho-social support" were being held. However we have not been made aware of any further plans and we understand that individualised care packages will not be given to hostel residents at least in the near future.

Council also requested that it be provided with a list of all community programs and activities funded by the MHC that would be suitable for psychiatric hostel residents to attend in Western Australia. This was with a view to Official Visitors promoting the programs to hostel residents and licensees whenever a complaint was received about the lack of programs and activities. A list of 12 providers was given but none were operating in the areas where the bulk of the private hostels are located, and most were unsuitable.

Council has also been liaising with the DSC (see Illustration 4 below) with a view to some hostel residents possibly accessing their programs.

Council also made inquiries of private hostel owners to establish what activities they offer residents. It was suggested that they consider inviting the author of a book published by former consumer, Jenny Middlemiss, titled *"Secret Squirrel Business – A Guide to Mental Health Recovery"* to present her story to residents. The MHC and others helped fund the publication of the book which is being distributed free. Copies of the book were sent to hostel licensees. One licensee of several private hostels replied that they were making inquiries about getting the author to speak to residents. Four private hostels provided a list of activities on offer to residents. The activities in the main included things like church visits, art activities, walking, board games, TV and similar.

Council will continue to advocate on behalf of this very disadvantaged group of people.

Illustration 4 – Hostel residents with ABI, mental impairment and other disabilities

Many private hostel residents have intellectual and physical disabilities as well as their mental illness. Some have DSC Local Area Co-ordinators (LACs) but many do not and, of those that do, the LACs may not have been overly involved in the resident's life. This may be at the resident's request or because they have fallen between the gap between DSC and MHC. For example Council was advised that some of the hostel residents who had been accessing the North Metro Day Centre before it was closed down had an acquired brain injury (ABI) or primary intellectual disabilities and so did not qualify for DOH programs in any event.

In one "good news story" the Official Visitor successfully assisted a hostel resident with an ABI with their application for "Accommodation Support and Alternative to Employment Funding". In the short term, this hostel resident will be able to access DADAA (an alternative to work program) and, once an "Individual Needs Assessment" has been conducted to determine their level of funding, a service provider will be identified for their individual accommodation needs. As the Official Visitor put it: *"Now there's only another couple of hundred to go"*.

Council's interest in accessing DSC funding is aimed at finding more support for such residents, both financially and in terms of access to more relevant programs and housing (given the issues identified about lack of programs for hostel residents, many of whom have significant cognitive impairment). However the DSC has both strict criteria for acceptance as a DSC client and limited funding.

Action and outcome

Apart from dealing with individual cases as they arose, Council wrote to both the MHC and DSC about the issues. It was suggested to the MHC that they should find out how many hostel residents were already DSC clients or who might be eligible.

The MHC has said they would consider Council's suggestion. Council continues to press the MHC to do more for hostel residents in this category.

The Director General of DSC and the Minister for Mental Health attended a meeting with Head of Council and there are ongoing discussions regarding Official Visitor access to LACs so that Official Visitors may advocate better for hostel residents.

Illustration 5 - Elderly hostel residents

Council has been raising concerns about the ageing population in hostels since the 2005-2006 Annual Report. It recommended then that Aged Care Assessment Team (ACAT) assessments be carried out for any hostel residents over 65 to ensure that they are getting the proper level of care and not being left languishing in psychiatric hostels which are not funded to be able to provide this level of care.

This year some hostel licensees obtained ACAT assessments for residents with the result that the resident was assessed as needing high level care. Getting an ACAT assessment done, however, does not necessarily mean improved care will follow. Most psychiatric hostels are not approved for elderly care funding and so the person either stays where they are, or has to move to an aged care facility. It is not always easy to find a suitable place in an aged care facility and there are difficulties trying to take advantage of the various Commonwealth funded programs which are designed to assist elderly people to stay in their homes - though Council argues that for many hostel residents, the hostel has been their home for 10 and sometimes 20 years.

Case 1 - Resident moved from one hostel to another

The resident was simply moved from one private psychiatric hostel to another. The resident told the Official Visitor they felt they were given no choice about the move and believed it was because they had suffered some falls. The Official Visitor sighted the resident's ACAT assessment confirming that they were eligible for permanent residential care at a high level.

Case 2 - Resident bounced back and forth between hostel and aged care facility

The hostel resident was transferred to an aged care facility by the hostel licensee and then transferred back to the hostel almost immediately because there was no ACAT assessment. On arrival by ambulance at the hostel, staff refused to allow the former resident to be removed from the ambulance trolley so the resident was carted back to the aged care facility. There was a dispute between the licensee and the aged care facility as to whether an ACAT was requested.

Action and outcome

Council continues to raise the broader systemic issues with the MHC.

In relation to the second case noted above, Council wrote to the licensee of the hostel, MHC, LARU and the Chief Psychiatrist. The licensee and LARU responded. LARU noted that it investigates only complaints specifically related to their Standards (highlighting the gaps in oversight of the sector). However they had requested a statement about the case from the hostel licensee. LARU then reviewed the matter and noted that the hostel licensee would be contacting the aged care facility to "determine strategies to prevent reoccurrence" of the issue.

The licensee said it was an "*oversight*" by themselves, the CMHS, and the aged care facility. The licensee said this hostel like the other private hostels was *"desperately in need of psychiatric and adequate case worker support"* which would have alleviated this situation.

Illustration 6 - Residents "stuck" in hostels

Official Visitors are often told by residents that they do not like living at a particular hostel but have nowhere else to go. Such residents are likely to have some cognitive impairment, are being treated by a GP rather than the local CMHS and so cannot access any social worker assistance. They may not have any family members or a guardian who is interested enough to assist them. Trying to access and negotiate the various hostel referral pathways can be very difficult in such cases where most referrals are made through the CMHS and require a lot of medical background information.

The case below illustrates the difficulties (and the value of an advocate).

Case 1 - Good news story - success helping a resident move hostels

An application for a regional consumer to move into an NGO-run hostel in the metropolitan area had been started by a regional CMHS some months earlier. Before it was completed, the consumer was admitted to a metropolitan hospital. The consumer was then discharged into a large hostel in the metropolitan area (not the hostel which was the subject of the original application). They were very unhappy at the hostel and asked the Official Visitor to help them reactivate the original application to the hostel of their choice. The Official Visitor contacted the regional CMHS but was told that they could not help because the consumer was not in their area any more. As the consumer was not being case managed by the local CMHS in the metropolitan area either, they would have to make their own application.

The Official Visitor helped the consumer draft up the application. Eventually the Official Visitor also managed to persuade the local CMHS to track down some of the necessary medical information. This process took many weeks and many phone calls.

The Official Visitor also assisted the consumer in making a Centrelink application for work (which involved more assessments and supply of medical information which had to be tracked down). When the consumer told a staff member at the hostel that they were hoping to get a job, the staff member said that this was good because it meant they could charge the consumer more and that the cheap cigarettes and pharmaceuticals they provided the consumer would also cost more.

The consumer became very frustrated at this point in the process as there seemed to be hurdle after hurdle to overcome, both in getting a job and finding alternative accommodation. The consumer expressed that there was no point in working if the hostel was going to take all the money anyway. They commented that they would be better off making an attempt on their life and going to hospital as a means to save money. The consumer also expressed frustration that they had not been able to do a reading course and complained of being bored and uninvolved and needing interaction with other people.

Eventually the application was able to be submitted but by this time the vacancy at the hostel where the consumer had hoped to live had been taken. There was a vacancy at another hostel but it had a 1 year maximum stay time limit and required the consumer to be more independent. More information had to be collected and the consumer had to decide if the new hostel would suit them but they did move into the hostel and have been happy with the move.

Council has also written to the MHC asking if they can provide any assistance or support for these cases or whether it has any other suggestions on how Official Visitors might assist hostel residents who want to move. No suggestions have been made in meetings with the MHC about this issue as at 30 June 2012.

ISSUE 6: FORENSIC ISSUES

Forensic mental health issues relate to people who are put on a Custody Order or prisoners made involuntary and treated in the Frankland Centre.

Illustration 1 - Lack of procedural fairness or natural justice for Custody Order patients and lack of a declared place

People who have been found not guilty of a crime by reason of unsound mind or because they were not fit to stand trial because of their mental illness are usually put on a Custody Order by the Court. There is no expiry date or set term of the Custody Order and it may last many more years than the sentence for the crime and even for "life". The Mentally Impaired Accused Review Board (MIARB) reviews the terms of the Custody Order at least annually and makes recommendations to the Governor on where the person must reside. The only options are prison, the Frankland Centre which is a maximum secured forensic hospital, a ward at Graylands Hospital, or in the community, but usually on strict conditions. Official Visitors may respond to requests for help from those people on a Custody Order who are admitted to the Frankland Centre or Graylands Hospital.

The number of people on Custody Orders who Official Visitors can help is small but there are two major concerns:

1. the lack of transparency, natural justice and procedural fairness in the review process
2. the lack of a declared place (as provided for in the legislation) where people on a Custody Order with a mental illness can be sent as an alternative to prison or a hospital ward.

In relation to the first issue, Official Visitors have prepared written submissions to, and liaised with, MIARB for consumers on a Custody Order at the time of their review by MIARB. However MIARB's review deliberations are closed and there is no right of personal appearance or legal representation (other than by written submission). MIARB does not have to give written reasons for their decisions unlike other tribunal bodies.

Even when MIARB recommends release into the community, its decision can be rejected by the Governor and no reasons are required to be given. It has been Council's experience that the Attorney General's office sometimes goes back to MIARB asking for further information before eventually agreeing to pass the recommendation on to the Governor for decision. The difficulty for the Custody Order patient is that this can take many months and even years in the process and they are given little or no information in the meantime. They usually know that MIARB has recommended conditional release but do not know why there are delays or about the process back and forth between the Attorney General's office and the MIARB, nor why a year or more later they are still awaiting release.

Apart from the immense frustration for the Custody Order person who has been declared mentally well but who has to stay living in a hospital, it means they are taking up scarce forensic hospital beds. Leaving the decision at the Governor's discretion is also arguably inconsistent with Principle 17(1) of the *"Principles for the Protection of Persons with Mental Illness & the Improvement of Mental Health Care"* adopted by the UN General Assembly in 1991[20]. The *Criminal Law (Mentally Impaired Accused) Act* 1996 (the CLMIA Act) needs to be amended.

20 It provides: *"The review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. It shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account."*