



CVP

NT Community Visitor Program

ANNUAL REPORT

2018 - 2019



30 September 2019

The Hon Michael Gunner
Acting Minister for Health
Parliament House
State Square
DARWIN NT 0800

Dear Minister,

Re: Community Visitor Program Annual Report 2018-19

I present to you the Annual Report on the activities of the Community Visitor Program for tabling in the Legislative Assembly.

This Annual Report has been prepared in accordance with section 115 of the *Mental Health and Related Services Act* 1998 and section 66 of the *Disability Services Act* 1993.

I commend the report to you.

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'Sally Sievers', is written over a faint, light blue circular stamp.

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INTRODUCTION

It has been a very full and challenging year for the Community Visitor Program.

Our skilled and dedicated staff are our key strength. They enable us to provide a service that meets the needs of the community's most vulnerable, namely, those detained against their will to receive support and treatment.



One of the challenges of the year was changes to the staffing team. Our highly valued and regarded Coordinator for Central Australia, Sophie Staughton, finished at the end of May 2019. For various reasons, a number of Community Visitors and Panel members were no longer able to continue with the CVP. We said goodbye to these staff, honouring their excellent work.

On a positive note, these staffing changes provide an opportunity for the CVP to revitalise its work with newly appointed members. Due to the small size and uniqueness of the program, however, it has also temporarily affected our capacity to respond to our program's demands and meet our own high standards for quality advocacy and resolution of matters.

Over the past few years, changes to the program funding have affected the capacity of the service to employ permanent staff and use 'sessional' (casual) Community Visitors when staff are unavailable or on leave. At times, there has only been one member of the team available to respond to issues within our remit across the whole of the Northern Territory. I would like to thank all of our employed and sessional Community Visitors for pulling together over the past year. Your ongoing dedication and commitment to the goals of the program is inspiring.

As has been noted in many reports, complaints or concerns are mostly raised in person. That is, people receiving care and treatment talk to Community Visitors when they come on-site. Face to face visits are the strength of the program. Unfortunately, these are negatively impacted when the CVP staff capacity is stretched.

Visits are our priority. Visits into residences and facilities provide the greater opportunity for the most vulnerable to raise matters of concern. Visits enable people's human rights in mandatory treatment spaces to be monitored and addressed in a timely way.

While there are many issues to raise, it is incumbent on me to draw attention to the highest priority concern in the Northern Territory. This is the ever present danger to the most vulnerable and unwell members of our community faced by consumers on the Joan Ridley Ward. This mental health in-patient ward in Darwin struggles to provide services with inadequate facilities and the regular presence of forensic patients and prison guards. Children and women on this ward face particularly heightened risk. This requires immediate attention, and a focus on solutions such as those highlighted in the recent Forensic Services Review (released in September 2019).

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OVERVIEW

The Northern Territory Community Visitor Program (CVP) provides a valuable service to the community. It oversees the quality of public services in specialist areas of mental health and disability. Community Visitors meet people receiving these specialist services. They assist people who may be struggling to have their needs met, and help them to have a voice.



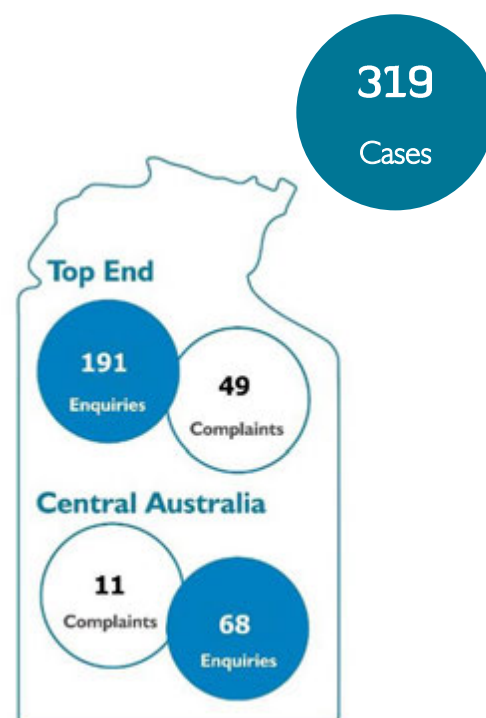
This year the CVP made 157 visits to specialist health facilities, and worked on 319 individual cases raised with Community Visitors. These visits and case matters are provided within a legislative framework, being the *Mental Health and Related Services Act 1998* and the *Disability Services Act 1993*. Visits are conducted by both Community Visitors and specialist multi-disciplinary CV Panels.¹

Our Case Work

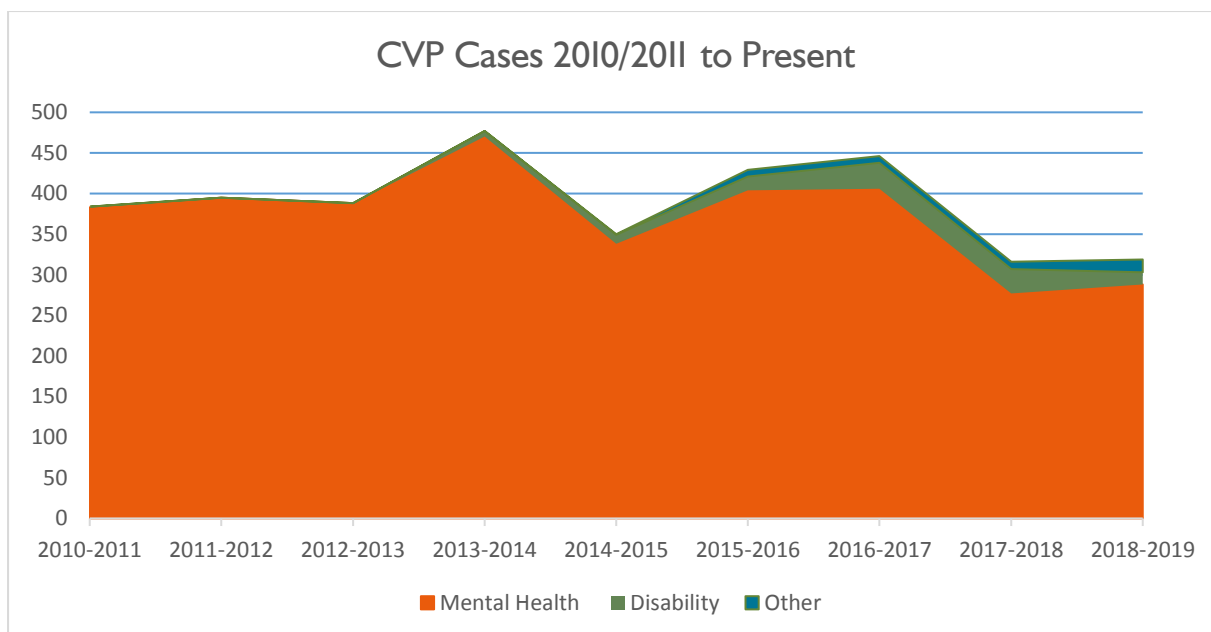
Of the cases raised with the CVP, just over half (51%) were raised in person or on a visit. The majority of the remaining cases were raised by direct phone contact with the CVP. The number of cases raised in person is slightly reduced from last year. This was due to there being less visits made to facilities (for reasons noted in the introduction).

Despite having less visits, the CVP has dealt with the same number of cases over the year. Taking into account that most cases arise from people talking directly to Community Visitors, this means that the CVP has performed well in maintaining its casework focus.

Importantly, the CVP has also met its statutory commitment to responding to requests for assistance within one working day (100% response rate).



¹ CV Panels are a multi-disciplinary panel with a legal, medical/health professional, and community member. The exact composition of a CV Panel is provided for in the relevant legislation. CV Panels visit relevant facilities twice a year. Community Visitors can attend a facility at any time, however visits are usually arranged weekly (for mental health in-patient units), monthly or quarterly (for specialist disability facilities).



While the overall number of cases is useful information, it also does not fully illuminate the challenges of the work.

Within the 319 cases raised, the Community Visitors dealt with 622 different issues. In any one case, a person may raise a number of issues (for example, wanting to be discharged and also being upset by a comment made by a staff member). Some cases may be straightforward, while others may be very complex and take considerable amount of time to resolve between the person and the service.

There are some common themes that arise in the issues raised with Community Visitor. The main areas of concern in the mental health field related to quality of services, legal rights and requests for advocacy support. The matters raised more frequently were those relating to assessment and treatment processes, relationships with staff, and people knowing and having the ability to act on their legal rights.

The main areas of concern in the disability field were in the area of quality of service provision, rights and medication. Specifically, residents raised matters relating to cultural safety, such as having more access to family, overnight visits and to country. Other key areas of attention were health and hygiene, and provision of medication.

Visiting Commitments

The CVP visiting role is unique. Other complaints organisations do not provide this service to the level provided by the CVP.

The visiting role helps the person to get to know the Community Visitor, gain trust, and provide reassurance that they have an independent advocate. Many issues that are raised on visits can be resolved quickly and informally.

Visiting, however, also focuses on systemic issues. This is particularly the case for visits by CV Panel members and the regular inspections of seclusion and restraint records. After the visits

and inspections, the Community Visitors or Panel members reflect on the issues and write to the service about matters of concern.

When the issues are serious or cannot be addressed or resolved quickly, the CVP will open an action item. If required, a formal recommendation may be made to ensure the CVP's concerns are actively addressed. This annual report lists open recommendations that have not been fully addressed by the services.

This year, there were less visits by the Community Visitor in both disability and mental health facilities, mainly in the Top End. This is due to reduced staffing capacity of the CVP. As the CVP team is very small, staffing change or unplanned leave can have a bigger impact on the service.



Although the total number of visits has decreased, the CVP has nevertheless maintained its strong focus on visits to community-based mental health teams. These periodic visits, while time consuming to undertake and report upon, provide confidence that the CVP's commentary on public mental health services in the Northern Territory is comprehensive.

Individual and Systemic Advocacy

Advocacy is at the heart of the CVP's work. The CVP function inherently requires advocacy in order to be effective (both at an individual case or systems-wide level).

Individual advocacy helps people to actively participate in decision-making processes and conversations that impact upon their lives. The Community Visitor listens and acts, helping them to be aware of the different ways they can have a say and supporting them to represent their own interests.

"Sometimes I need you [the CVP] here, so that they listen better."

VIS/2018/00125

"The CV has been so responsive to the rights and views of consumers and their families and it is heartening to me that people have a strong independent advocate."

Mental Health Nurse

Importantly, however, this individual advocacy work also informs the CVP's systemic work that is part of visits and inspections. Each year, the CVP's systemic advocacy is presented in its annual report. This report provides an opportunity to reflect on the significant issues for the Northern Territory services.

Focusing on Safety and Quality

The legislative protections and scope of the CVP means that it has an important role in commenting on the quality and safety of services. Community Visitors and CV Panels are one of the few organisations able to go into a facility and speak to people receiving services

(without the need for an invitation from the service or person in the facility). The CVP also has access to records.

The CVP's open recommendations and action items are part of the broader quality and safety frameworks within both the mental health and specialist disabilities services. As required, the CVP can also request and receive information and reports that are generated internally from the services' own quality and safety reports.

With respect to mental health field, the CVP is a member of the Approved Procedures Quality Assurance Committee (APQAC). It is positive that this past year, there has been renewed energy in constituting APQAC and updating mental health procedures.

The CVP's systemic focus on issues has identified a broader concern with the quality, depth and coverage of policies and procedures. This has been a common area of commentary in all areas of CVP work this year, in mental health and specialist disability fields, Top End and Central Australia.

The CVP has observed that there are structural challenges with how governance in both the mental health and disability services has been established. Governance between the Top End and Central Australia can be fragmented, with inconsistent service approaches and policy.

For specialist disability services, there have been active efforts to streamline processes and systems between both Top End and Central Australia. This has been more successful due to the service being a single entity within the Department of Health. With respect to mental health, however, there is a lack of consistency in service delivery between the two health services. This is despite both services operating under the one piece of legislation.

Clinical Governance Improvements Needed

Public mental health services in the Northern Territory are provided by two different health entities. There are clinical governance processes within each health service (Central Australia Health Service and Top End Health Service).

Given the structural challenges and fragmentation associated to the separate health entities, there is a need to improve the clinical leadership in the public mental health services. The CVP has advocated for the Chief Psychiatrist position to be staffed and this role clearly defined within the legislation. This leadership role could form part of the necessary quality and safety functions in a contemporary mental health service system, as is the case in all other Australian States and Territories.

In line with this, the CVP supports the notion that the Northern Territory should have a Clinical Service Plan as articulated in the recently released Report on the review of Forensic Mental Health and Disability Services within the Northern Territory (Forensic Services Review).²

In the disability field, the CVP has seen marked improvement in the clinical governance of behaviour support. While there is more work to be done in relation to the overall clinical

² Report on the review of Forensic Mental Health and Disability Services within the Northern Territory, January 2019 Recommendation 13, page 14

governance framework for specialist disability services, the CVP recognises that it is a much smaller service than that of the public mental health services.

This work also needs to take account of the changing landscape for disability services related to the roll out of the National Disability Insurance Scheme (NDIS). In particular, it needs to take account of the recent introduction of a Senior Practitioner within the Department of Health to authorise restrictive practices of NDIS providers.

The recommendations of the Forensic Services Review, which affects both public mental health and specialist disability services, provide an opportunity to improve and streamline the clinical governance arrangements for both mental health and specialist disability services. Forensic mental health and disability services are some of the most complex and specialised work in the Northern Territory. It is critical, therefore, that clinical governance and related supports is clarified and implemented consistently across the Northern Territory.

Contributing to Reform

As part of its systemic advocacy role, the CVP actively contributes to broader policy and reforms. This has been particularly important with significant changes in the disability sector related to the NDIS, restrictive practices authorisation, and the announcement of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

This year the CVP has had numerous requests from the different agencies to contribute to reviews or policy reform. The CVP's contributions are valued by its stakeholders, and reflects the specialised knowledge and experience held by the CVP. This past year, the CVP has been involved in the following consultations:

"I want to make a change for others so they don't have to go through the same ordeal"

C/2018/00151

- Office of Disability, Specialist Support and Forensic Disability Unit, consultancy on quality and safety framework;
- Office of Disability, NDIS Implementation, restrictive practices authorisation framework including draft legislation;
- Commonwealth Ombudsman, consultation on the implementation of the Optional Protocol to the Convention against Torture and other Cruel or Degrading Treatment or Punishment (OPCAT);
- Northern Territory Ombudsman, review of the draft report related to Aboriginal interpreter use in the Northern Territory;
- NDIS Quality and Safeguards Commission, meetings and forums;
- Northern Territory Elimination of Abuse and Neglect Working Group;
- Department of Health, Chief Psychiatrist consultation;
- Department of Health, Forensic Services Review;
- Department of Human Services, Review of the National Disability Strategy 2010-2020;
- Northern Territory Regional Area Mental Health AOD and Emergency Service Committee;
- NT Disability Advocacy Collective; and
- Northern Territory Mental Health Coalition, Consumer/Carer Rights Guide update.

While the CVP is pleased to participate in steering groups, forums and policy work, as a small team, it does place pressure on staff capacity for visits and casework. Meeting the CVP's statutory obligations must be a priority for the program.

Official Visitor Reforms for People with Disabilities

The Northern Territory continues to engage with equivalent States and Territory official visitor programs to work together, sharing knowledge about visiting in other jurisdictions and supporting our organisation's continuous improvement.

In the context of NDIS reforms, a national review of official visitor programs has concluded. The CVP understands that the final report is complete and awaiting release. This report will be important in determining the ongoing role for official visiting programs to people with disabilities. At present, it is acknowledged that visiting programs are an essential part of national quality and safety frameworks for people with disabilities.

Prior to and during the NDIS rollout, the CVP has raised that there is a gap in the scope of the *Disability Service Act 1993*. The jurisdiction of the legislation is too narrow, and the CVP role does not extend to all people with disabilities living in supported accommodation.

Concerns about this gap in Northern Territory services are often raised in forums about quality safeguards in the Northern Territory disability sector. Currently the CVP visits just one Secure Care Facility, a facility adjacent to the Darwin Correctional Centre, and five other community-based residences in the Northern Territory.

The Northern Territory, Tasmania and Western Australia are the only jurisdictions to not have a dedicated, legislative mandated, disability visiting service. The CVP has advocated strongly that the Northern Territory's Community Visitor role needs to be expanded in line with most other States and Territories in Australia.

The CVP role needs to cover other people who have disabilities that reside in supported residences. The Northern Territory has high numbers of people under adult guardianship, with limited informal support networks to advocate for their needs, and who are sometimes disconnected from family residing remote where services are not available.



The CVP acknowledges that with the full roll out of the NDIS to the Northern Territory in the past year, improved safeguards are now in place. This includes mandatory worker screening, incident reporting, restrictive practices oversight, and monitoring of quality through the NDIS Commission.

A significant quality safeguard is missing in the Northern Territory. Independent visiting and advocacy for Territorian with disabilities living in supported accommodation is required. A robust visiting service from a professional advocate forms part of the protections for people



with disabilities operating in most other Australian jurisdictions. These safeguards help to prevent violence, abuse and exploitation of people.

The CVP continues to raise that the unique and specialist nature of official visitor functions are required in this rapidly changing service sector. A visitor program must be independent, professional, protected by legislation, report and provide comment on systemic matters, and with free access to people with disabilities in designated places.

Collaboration and Mutual Respect

Some of the challenges for the CVP are in areas not under the program's direct influence. Much of the effectiveness of the CVP role comes from the cooperation and collaboration provided by the services being visited.



When responsiveness of the service declines, and matters are not resolved or attended to in a timely manner, this can affect the reputation of both the service and the CVP. The impact on the integrity of both the CVP's oversight and the quality of services cannot be understated.

In the previous reporting period, the CVP finalised a protocol relating to access to mental health electronic records, stored by the Department of Health in the Community Communication Information System (CCIS). Disappointingly, despite this protocol being signed it has not been implemented in practice. The CVP still do not have access to electronic files. This affects the capacity of the CVP to review all relevant documentation independently of the service.

The CVP has noted that at times the lack of responsiveness to matters relating to the CVP is related to staffing shortages within the service. The CVP considers that a Northern Territory-wide workforce development strategy needs to be revitalised and implemented.

The CVP and services are all working towards quality mental health and specialist disability care and treatment. This work is sometimes difficult. There will be differences of perspective and views. There may be differences of interpretation or priorities.

With a collaborative and respectful working relationship with the CVP, however, the services can build their service quality and continuously improve. Fundamentally, this approach will safeguard the human rights of individuals who may be subject to restrictive practices in a health context, or who have complex needs that require specialist care.

The CVP notes that it is unable to report on some significant cases addressed this year. This is in recognition that the NT is a small jurisdiction and details of some cases may identify the person and/or service.

MENTAL HEALTH

SNAPSHOT

- The safety and wellbeing of consumers in the Joan Ridley Unit, who are the most acutely unwell needs urgent attention.
- Mental health services for children and youth in the Northern Territory need substantial improvements.
- The retrospective recording of seclusion in the Top End, and use of mechanical restraint by Corrections officers in mental health in-patient facilities, is extremely concerning.
- Consumer and carer rights need to be at the forefront of service.
- Mental health assessment and treatment must be provided with the assistance of an accredited interpreter (if required).

A strong mental health system prevents and detects mental illness early, helps consumers recover, and supports people to receive services in the least restrictive way possible.

Northern Territory public mental health services provide for assessment, treatment, care and protection of people with mental illness, whilst protecting their human rights. These services are governed by the *Mental Health Related Services Act 1998* (the Act).

The CVP role forms part of the legislated rights for mental health service consumers and other stakeholders. It is also underpinned by a recovery-oriented approach to services. This approach is about the journey rather than the outcome. It focuses on choice, opportunity and wellbeing during a person's life with an illness and therefore is highly individualised.

There are, however, unique challenges in the delivery of mental health services in the Northern Territory consistent with the person's rights and this approach to services. These challenges includes the vast geographic land mass, small population, and level of disadvantage and trauma experienced by a large number of Aboriginal Territorians.

With this context, it is concerning that the Northern Territory public mental health services is one of the lowest per capita funded services in Australia.³ This is further exacerbated by the current Northern Territory government funding constraints.

³ Australian Institute of Health and Welfare, *Expenditure on mental health services 2016-2017*. Accessed at www.aihw.gov.au.

From the CVP perspective there are obvious and subtle ways in which funding constraints influence the quality and safety of service. This is discussed further below in the section relating to safe facilities and services for children and youth.

The critical elements of a strong mental health system that currently need attention and investment are leadership, clear service planning and workforce development. This is required to ensure capacity and transparency in the provision of a high quality and safe service.

“... A Mental Health system that meets the needs of consumers & carers is accessible, acknowledges a consumers’ dignity, provides care that is relevant to the person’s needs, and achieves the desired outcome for consumers...”

*National Mental Health Commission
National Report 2019*

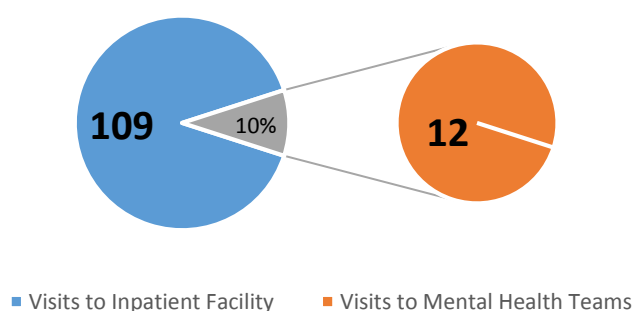
Despite a number of systemic issues needing urgent attention, the CVP acknowledges that there are positive stories for the Northern Territory public mental health services. This includes heartfelt appreciation for the care provided by staff on the in-patient wards and in the community-based teams. The CVP recognises that staff of the service work in a challenging environment.

Regular Visiting and Inspections

Although there are positive experiences in receiving care, the work of the CVP is fundamentally that of a complaint resolution and advocacy service. This is, by its very nature, focused on areas of concern. At times, perspectives on the issues will differ. These challenges and difficulties need to be honoured as much as the achievements of the services.

On a regular basis, usually weekly, Community Visitors enter the mental health in-patient facilities in Darwin and Alice Springs to speak to consumers. This work is important to ensure that consumers in the most restrictive environments are able to access a Community Visitor in person and raise issues of concern. A multi-disciplinary panel visits the in-patient facilities twice a year, and this work provides an additional ‘systemic’ focus to the weekly visiting program.

CVP Visits (Mental Health) 2018-19



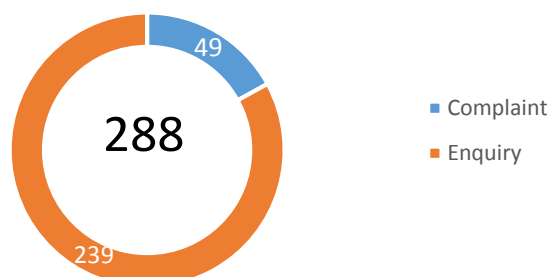
This visiting occurs at the most serious, or acute, spectrum of mental health services provided by the Northern Territory Department of Health. It is important to note, however, that the greater number of people receiving mental health care and treatment reside in the community.

This year, the Community Visitor Program has maintained a strong focus on completing inspections of community-based treatment teams. This work informs the annual report and

enables a broader perspective on the quality and effectiveness of the Northern Territory's publicly funded mental health services.

Some of the issues identified in the weekly in-patient visits are also evident in the community-based teams. Common issues related to culturally safe care and treatment, use of interpreters, services to children and youth, services to vulnerable consumers (such as those with disabilities or trauma histories), and workforce challenges.

CVP cases (Mental Health) 2018 - 19



Together with the visits, inspections and the individual complaint and enquiry data the CVP can see that most of the issues are in the areas of rights (33%), quality of service provision (35%) and advocacy support (15%). This data informs the issues raised in this report.

RIGHTS TO A SAFE FACILITY

Acute mental health care in hospital is challenging. The best care for consumers is usually that which can be provided in the community. At times, however, someone's health may have deteriorated to a point where it is necessary to provide appropriate assessment and care within an in-patient setting.

Joan Ridley Unit (Darwin)

The CVP has repeatedly raised serious concerns regarding the adequacy and safety of consumers who are admitted to the Joan Ridley Unit (JRU). There have been numerous complaints to the CVP this year about safety concerns on JRU. These complaints have come from consumers and their carers.

"I don't feel safe in this ward."

C/2019/00175

The facility is generally overcrowded, has limited functional layout and often accommodates prisoners with a high staff ratio of correctional officers.⁴ This reinforces the impression that the JRU is 'prison-like' and punitive (instead of therapeutic) in nature.

The CVP has noted an increase in the presence of forensic consumers on the JRU in the past twelve months. The assessment and treatment of forensic consumers requires a specialist skillset. The need for custodial supervision adds further complexity to the admission (these issues are discussed in more depth later in this chapter).

⁴ Usually there are 2 correctional officers for one prisoner. This ratio is maintained even if there is more than one prisoner on the ward at any one time, regardless of the individual risk profile of the prisoner.

The CVP commends the Northern Territory government on commissioning the *Review of Forensic Mental Health and Disability Services within the Northern Territory 2019* (the Forensic Services Review). The Forensic Services Review report describes a system and policy review that, if implemented, offers a pathway forward.

"We are 'highly sedated and easily taken advantage of.'"

CV/2019/00146

The findings of the Forensic Services Review support the CVP concerns that the mix of children, youth, woman, men and prisoners within JRU is inappropriate.⁵ The CVP also supports the numerous recommendations for the re-purposing of the Cognitive Behaviour Unit (CBU), in line with contemporary principles of quality care for people with disabilities.

The CVP believes that the re-purposing of the CBU would offer an immediate solution to address and alleviate bed pressure and the overcrowding in JRU.

The CVP is concerned that although the Northern Territory government has endorsed the Forensic Services Review and supported, in principle, the recommendations, there is still more action needed. There is limited concrete commitments or alternative strategies to address the known safety issues for these consumers.

"I've been humiliated and feel completely undignified...the experience isn't helpful, it's has hurt me".

C/2019/00127

Positive Improvements to Facilities

The CVP has positively noted strong efforts by both the Top End and Central Australia mental health services to improve the amenity of the in-patient units. Both CV Panels commented on these improvements in their reports.

"Everyone here is really supportive."

VIS/2018/139

In the Top End, the main ward (Cowdy) in Royal Darwin Hospital has had new carpets and sound proofing. In Central Australia, there are improved spaces for consumers to relax and a wide range of activities for a relatively small ward.

In Cowdy Ward, there is an established activities space, including vegetable and flower gardens, which is a hub for consumers. The Cowdy Ward has introduced a volunteer visiting program that includes former consumers. This has been a positive experience for consumers to see others who are on the road to recovery and volunteering their support as a peer.

The CVP receive significant positive feedback on the quality of the activity centre and acknowledge the dedication of staff in their fundraising and enthusiasm in the care and activities provided to consumers. It is commended and valued.

"Staff are wonderful and kind, very professional."

C/2019/00198

⁵ David McGrath, Report on the review of Forensic Mental Health and Disability Services within the Northern Territory 2019, pg 68: 'The JRU is not an appropriate treatment environment for these consumers with its mix of male and female clients, forensic and civil clients and occasionally young people under the age of 18'.

There has been increased investment in activity equipment in the Darwin 'intensive care' unit (the Joan Ridley Unit). There has been an activity officer for the past year who organises daily activities with the support of the Occupational Therapist. There is a weekly fitness class and consumer group meeting held daily.

Importantly, the Northern Territory public mental health services allow a person to stay on the unit ('boarders') if this is appropriate or necessary for the consumer to feel safe and supported. For Aboriginal consumers, especially those from remote communities, this flexibility is highly valued and is an important part of providing a culturally safe service. This can be reassuring for family and friends, especially when someone is admitted for the first time to acute care facility.

RIGHT TO SPECIALIST CHILD AND YOUTH SERVICES

There are a small number of non-government organisations, most notably *headspace*, that are funded to provide a range of mental health support to children (including *headspace* Youth Early Psychosis Program (hYEPP)⁶.) However, the most complex, high risk or high needs children are referred to government services for specialist support.

The CVP has a specific legislative role in relation to this support offered by the Central Australia and Top End mental health services. In the period covered by this report, the CVP completed inspections of both of the child and adolescent community-based mental health teams.

The inspections noted the positive approaches and high quality care being provided by these teams of specialist psychiatrists and case managers. In the inspection interviews and file reviews, there was evidence of trauma-informed, recovery-oriented and collaborative approaches.

Unfortunately, while the service being offered to child consumers and their families is very good, not enough children and their families are able to access the service. There are serious resourcing issues that limit the provision of services to children in remote areas, those in care of Territory Families, and those in youth detention.

Children in these situations have high need for specialist child and adolescent care and treatment. These children either have the same level of need as their urban-based peers, or (for those in protective care) are facing substantial trauma and stressors affecting their mental health.

For remote children, only the most urgent referrals from remote areas can be accepted. These children then have to be transported to an urban centre to receive specialist care.

The CVP inspection of the child and adolescent teams, and remote teams (held in this and previous years) provides evidence that there are significant unmet needs for remote youth to receive care in their community. In the Northern Territory, there is only one mental health

⁶ *headspace* Youth Early Psychosis Program (hYEPP) an integrated holistic service for young people experiencing early psychosis or at risk of developing psychosis, and their families. Headspace centres in Darwin, Katherine and Alice Springs provide services to eligible young people aged 12 to 25 with their mental health and wellbeing.

team that provides child and youth mental health outreach appropriate to the needs of remote communities (being the Barkly Mental Health Service, based in Tennant Creek).

The gap in youth services for remote and high needs children has been raised repeatedly by the CVP over many years. Staff of the specialist child and adolescent mental health teams acknowledge the need however are not resourced to respond. It is a human right to be able to receive the same level of treatment and care as someone else in a similar situation in the community. There has been limited progress made by the Northern Territory government to address this resourcing gap.

‘Early intervention is key to preventing mental illness later in life. Investing in early intervention and prevention strategies will reduce the likelihood of consumers needing costly supports...including the child protection and justice systems...’

National Mental Health Commission National Report 2019

The lack of early intervention and effective services for remote and specialist needs of youth in the Northern Territory increases the long-term burden of care. This burden will be shouldered by the Northern Territory public mental health services in the future, placing further stress on mental health services.

The lack of mental health services increases the seriousness of child mental health presentations to acute in-patient units. As noted later in this report, there is increasing evidence of very young children being admitted to adult mental health wards and experiencing highly restrictive events that are inevitably traumatising.

The CVP has raised concern with the Top End Mental Health Service (TEMHS) of the impact and relationship between the lack of early intervention and prevention of mental health services for children who have emerging mental health issues and who are prodromal. These children and young people may find themselves dislocated from their families and communities.

Given the protective nature of connection to family, country and culture, this raises serious long term concerns for these children and youth. There are also emerging concerns regarding the joint case management framework of children who are placed in care. As a result, the CVP made a formal recommendation on this issue.

The CVP is aware that, at the time of writing, some additional child and youth resources had been committed. A Children in Care Committee was formed in May 2019, whose membership consists of Northern Territory Primary Health Network, Top End Health Service and Territory Families. The aim of this group is to ensure children with complex needs across the Northern Territory are provided with prompt services and interventions.

As this is in very early stages, the CVP cannot comment on the effectiveness of this to address the systemic issues of concern. It is noted however that regardless of governance arrangements, there needs to be systemic investment in child and youth specialist mental health services to address the current inequities for remote youth.

Children and Youth in Detention

Children in youth detention in the Northern Territory particularly have an urgent, currently unmet need for early intervention services, comprehensive mental health assessments and follow-up case management needs. The lack of appropriate mental health services for children in youth detention is a serious failing in the Northern Territory's support for young people, in particular Aboriginal children.

There are no specialist youth forensic mental health staff in the NT. The Top End mental health service has advised that it is making enquiries as to how to increase service in this area. There is nothing finalised as yet.

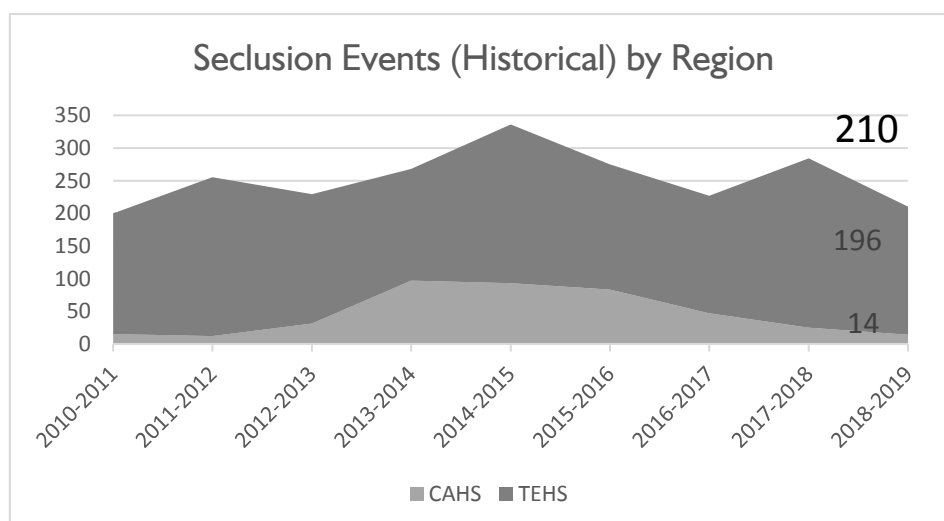
There has been no tangible progress made from the recommendation of the Royal Commission into the Protection and Detention of Children in the Northern Territory 2017. This related to the provision of initial mental health assessment and ongoing mental health treatment for individuals detained in youth detention by Department of Health staff. It is unacceptable that there has been limited progress or plans in this area, two years on from the Royal Commission's recommendation.

There is an urgent need for a whole-of-government approach to expanding youth mental health services in the Northern Territory to youth detainees.

'LEAST RESTRICTIVE' CARE AND TREATMENT

Seclusion Reduction

Both the Top End and Central Australia mental health in-patient facilities have (for many years) been implementing an approach to seclusion reduction called SafeWards. In Central Australia, the program has been very successful. In the Top End, there have been a number of challenges and seclusion events remain at unacceptably high levels.



In Central Australia, the most notable achievement has been maintaining ongoing reductions in seclusion events over the past three years. The smaller size of the in-patient unit, and the different dynamics of a smaller service are relevant considerations in their seclusion reduction

efforts. The achievements of Central Australia, however, rest with the strong leadership and commitment to ongoing improvements.

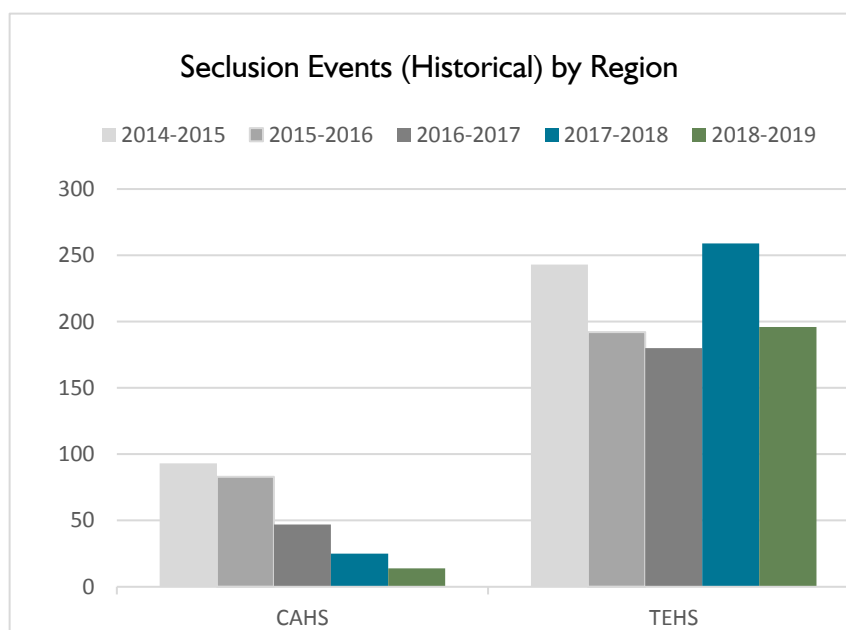
By contrast, the CVP experience of reviewing the seclusion register and analysing seclusion reduction efforts in the Top End is a different story. Over the same time period as Central Australia, the Top End has had a 'rollercoaster' experience with seclusion reduction efforts.

In the first half of 2016, the Top End achieved a very small number of seclusion events in one reporting period (less than 30 events). By the following year, however, seclusion events were again increasing. The service itself has identified management and staffing challenges as contributing to the fluctuations in seclusion reduction efforts.

Top End Trends in Seclusion

This year, there has been a downward turn in the Top End's rate of seclusion. This is potentially a positive development.

The CVP purposefully qualifies this statement. On deeper review, the CVP has identified concerns with the quality of record keeping and documentation relating to seclusion events in the Top End.



It is difficult to have confidence in data when systemic issues related to record keeping have been raised and not addressed. The CVP has noted with the Top End that there are differences between the number of seclusion events on consumer patient files and those in the paper register.

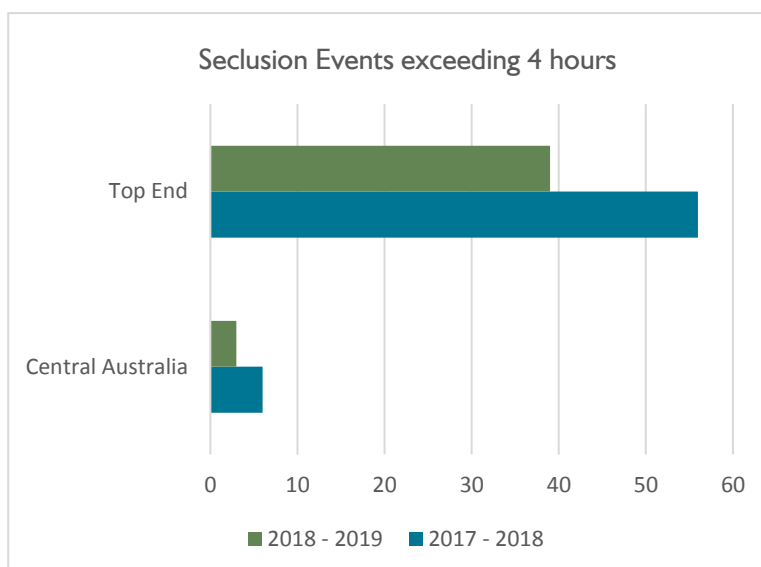
There has been evidence of retrospective completion of documentation. Matters raised with the CVP also give rise to a concern that seclusions are occurring but these events are not recognised as such by staff of the facility.

"I was very scared. I thought I was going to have a heart attack. I couldn't breathe."

C/2019/00056

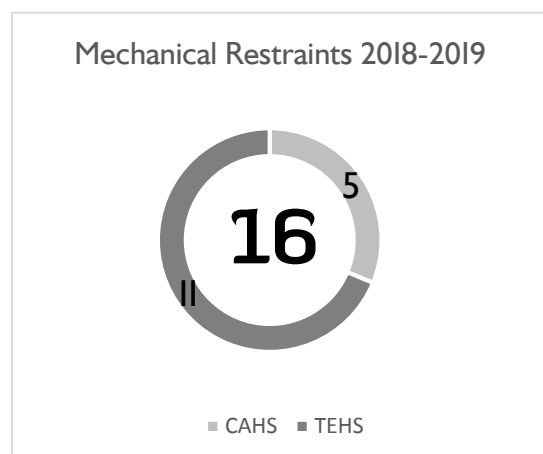
From the CVP's perspective, compliance with the law, the completion of clinical documentation and the storing of this on a consumer's file is a core aspect of professional practice. In the case of a consumer being secluded, it is a matter of professional and legal accountability to ensure complete, contemporaneous records are kept (that is, full records made during the event).

Due to the considerable difficulties in the CVP being able to access a current, complete register at any point in time, there are concerns that the data does not tell the full picture of Top End seclusion events. This means that the data is not a completely reliable tool for quality assurance and continuous improvement. Without a solid foundation of knowing what is happening, it is difficult to put in place the required strategies to avoid or reduce future events.



Mechanical Restraint

For the first time in many years, the CVP reports on the use of mechanical restraint in the Northern Territory public mental health services. This reporting is controversial, from the perspective of the mental health services, as most of the instances are due to restraint applied by Corrections Officers.



The CVP has previously stated that the definition of mechanical restraint is clear in the mental health legislation. The legislation confirms that if a prisoner is admitted as a consumer under the mental health legislation, they have the same rights and protections as other consumers.

The legislation is silent on the rights and protections of people in the custody of police or who are being transported by a third party provider (such as air or road ambulance).

In the absence of any statement to the contrary, the CVP's view is that the rights and protections of the legislation apply to people in transport or in custody. This means that any use of mechanical restraint must be authorised by a psychiatrist and recorded as such by the mental health services consistent with the mental health legislation. Only recently has this begun to occur in the Top End, and as with seclusion events, there remains considerable uncertainty over whether complete records are being kept.

With respect to prisoners who are admitted to hospital for mental health treatment, the CVP has noted a number of instances of mechanical restraint by correctional staff. Unfortunately, many of these have not been entered onto the mechanical restraint register.

Where events of mechanical restraint have been recorded (such as in the Top End), there is insufficient compliance with the documentation required by law. This includes the most basic of data, such as the period of time within which the person was restrained.

At a broader level, the Northern Territory public mental health services have relied upon a narrowly framed legal advice obtained in relation to the use of mechanical restraint by correctional staff. The framing of the advice did not address the majority of instances in which mechanical restraint in mental health facilities has occurred. This is an issue that needs urgent legal clarification and substantially improved reporting by the service in the coming year.

Restrictive Practices on People with Identified Needs

For both services, there remain other concerns about the context within which restrictive practices such as seclusion and restraint are used. Of paramount concern is the seclusion and restraint of children. Of additional concern is the seclusion and restraint of people with cognitive impairments, and those who speak a language other than English.

In this reporting period, there were disturbing incidences of seclusion of very young consumers. That these consumers were on an adult ward is one matter. That these children then experienced seclusion, being locked alone in a room from which free exit is prevented, is highly traumatising.

Similarly, the use of multiple people for prone physical restraint is highly distressing for any person (adult or child) subject to this experience. It is also potentially life threatening.

The CVP has raised with both the Top End and Central Australia mental health services that there are demographic issues to note with the use of seclusion on consumers who are Aboriginal. In the Top End, 70% of people who were secluded were Aboriginal.

It is difficult for the CVP to analyse the data without sufficient information on the number of Aboriginal people admitted for treatment. However, the incidence of seclusion of people who are Aboriginal and who speak a language other than English is concerning.

Furthermore, the CVP found little evidence relating to the use of interpreters for people who spoke a language other than English, and who were subject to one or more seclusion events. Similarly, there was little evidence of systemic, proactive involvement of Aboriginal Mental Health Workers to engage with Aboriginal consumers (either 'pre' or 'post' seclusion events).

Seclusion and restraint are not therapeutic. The use of these practices is highly regulated under mental health legislation as a protection for the fundamental human rights of people who are in locked mental health wards. The use of these practices on children, people from culturally diverse backgrounds, with cognitive impairments and who need an interpreter is very concerning.

Australia is a signatory to international instruments that protect the human rights of children, people with mental health needs, people with disabilities, and First Nations peoples. The CVP has concerns for the human rights of consumers in the Northern Territory who fall within



these international instruments. This statement is indicative of the seriousness with which the current use of restrictive practices must be examined by both Northern Territory public mental health services.

RIGHTS AND LEGISLATIVE COMPLIANCE

Consumer and carer rights are enshrined in legislation. The onus is on the mental health service to provide those rights to the consumer and their carer. Consumers must be supported to know about their legal rights, including the basis of their admission, how to activate their rights, and obligations to be involved in their treatment. This is part of the therapeutic process, which is empowering of the person.

The CVP has raised for many years that there has been poor compliance regarding information about rights and compliance with legislative requirements. This is particularly evident for consumers who are involuntarily detained.

The CVP reviews documentation of involuntary admission ('Form 10') on a quarterly basis. Following that review, individual or systemic concerns arising from reviews are raised with the service to be addressed.

The reviews include whether consumers have been made aware of their legal status, if a consumer requested an early tribunal hearing, that carers and guardians are informed about the admission, and that consumers are receiving information in their preferred language. The CVP is very concerned about the absence, inconsistency or ambiguity of information recorded about consumer rights and language needs in the required documentation.

"Well I said yes but I didn't know I could say no. They told me it was mandatory...I don't know my rights."

C/2019/00092

Procedural Fairness

One of the key rights of a mental health consumer in a locked facility, being involuntarily detained, is that they can raise their case with an independent tribunal, the Mental Health Review Tribunal.

The CVP has received numerous enquiries from consumers that they are not receiving their Tribunal application. Alternatively, they received it, but they did not have adequate time to consider the material being presented as evidence before the Tribunal hearing.

The approved procedures⁷ require that the consumer's psychiatrist must ensure (in advance of the hearing) that the consumer is given an opportunity to read their Tribunal report. It also requires that the psychiatrist explain the information in the Tribunal report.

"Every time I sit down in a room like that [Tribunal], I get scared. I'm like a little kid again and fighting to be with my family and not taken away."

VIS/2018/00125

⁷ MHRSA Approved Procedures 19, Mental Health Review Tribunal

From the CVP's perspective, there are varying levels of compliance with this obligation. Most consumers report that if they receive the application, it is generally on the morning of the hearing or on the day before the Tribunal hearing, late in the afternoon.

This is not consistent with the consumer's right to procedural fairness. The CVP has raised that if the hearing is on a known day of the week, then the consumer should receive the application and/or be relayed the information at least two days before. This is not currently happening.

Rights in Language

The CVP has for many years raised that both voluntary and involuntary consumers can sometimes be very unclear on their rights. Complaints and anecdotal feedback to Community Visitors has highlighted that some consumers have little or no understanding of their basic rights, whether as voluntary or involuntary consumers.

"I didn't know what they were saying."

C/2019/00056

At times, there has been evidence that no or insufficient information was given to consumers or carers about rights while in hospital. In the Top End in particular there has been an open CV Panel recommendation since 2011 relating to involuntary consumer's rights. This year, the CVP has raised concerns about the additional challenge faced by consumers who speak a language other than English to hear and understand their rights.

The services have indicated that they use interpreters, have talking boards, and employ Aboriginal Mental Health Workers to assist with people who do not have English as their first language. In the Top End, the consumer need for an interpreter has been included in shift handover information, the interpreter booking rate has improved, and interpreter use was included in a 'point of care' audit. In Central Australia, there have been active efforts to provide training on the use of audio-visual interpreting options.

While the above initiatives are positive, in the CVP's view, the current efforts are still insufficient to meet the needs of consumers who have been admitted to a locked facility. In the Top End, the CVP has noted that there has been insufficient attention from doctors to ensuring interpreters are used for medical reviews and an over-reliance on a view that the person's English is 'good enough'.

Despite there being talking boards of rights, in Central Australia, the boards have been known to be in need of repair for some time. For those boards in a working state, there was been little evidence that these are routinely used for new admissions. While Central Australia has sought to promote the use of audio-visual interpreting, there has not been sufficient uptake in use of this technology.

Based on the analysis of the involuntary admission paperwork by the CVP, it has highlighted that most people who need an interpreter at Tribunal do not hear their rights in language on admission and/or there is no record of an interpreter being used.

It is inherently contradictory that a person may need an interpreter at a later point in their admission, but not at the time of admission. The lack of interpreter use for the provision of rights on admission is seriously concerning.



With the high turnover of staff, the need to train and support staff to routinely use interpreters is an ongoing task. The CVP considers, however, that both the Top End and Central Australian mental health services can further improve strategies to ensure people hear their rights in language. This work can be done in collaboration with the Aboriginal Interpreter Service.

VOLUNTARY CONSUMERS' RIGHTS

To Be Discharged

A fundamental principle of mental health care and treatment is that it is the 'least restrictive' possible. For acute services, this principle comes into focus from the point at which admission is being considered. The first decision is whether care can be provided in the community. If this is not the best option, the service will consider if a person can be admitted on a 'voluntary' basis (that is, agreeing to the admission with their treating team).

The rights of voluntary consumers are provided for in the mental health legislation. These rights recognise that a person can make an informed choice to admit themselves to hospital for mental health treatment. Part of these rights is that the person can change their mind and discharge themselves 'at any time'. The mental health legislation also provides extensive guidance on the meaning and application of informed consent.

Unfortunately, the CVP has observed during visits and in cases raised that voluntary consumers are not afforded a 'least restrictive' approach to acute in-patient admissions. The CVP is increasingly dissatisfied with the way in which the Northern Territory mental health services disregard the rights of voluntary consumers.

This issue is most strikingly highlighted by cases where a voluntary consumer no longer wants to be admitted to hospital. From a practical perspective, voluntary consumers generally cannot leave a mental health unit without having someone from the service open a locked door. While other consumers in a hospital who decide to refuse can simply walk away, this is not the case for a consumer on a locked ward.

The fact that the doors are locked can be enormously disempowering for consumers. Some consumers express to the Community Visitor that they want to leave, but feel that they do not have the right to leave without permission. In some serious cases, voluntary consumers have even been refused discharge and the 'voluntary' consumer left in a legal limbo, detained on a locked ward.

Although the law is clear that a voluntary consumer can discharge themselves, the reality of how this occurs in practice is much less straightforward. The CVP has noted that some consumers may be verbally persuaded to stay or, in worst case scenarios, even threatened with being made involuntary.

"There's too much red tape for a voluntary patient to access leave. I just wanted to go for a walk, get some fresh air."

C/2018/279

Some consumers may be incorrectly told that they have to wait overnight or until the weekend is over before they are reviewed by their assigned doctor. Matters of how the hospital responds to unplanned discharge requests, including medical review, is not the responsibility of the consumer to resolve.

For many years, there has also been a policy that any person admitted to a mental health in-patient unit 'must' stay in the hospital for the first 48 hours of their admission. While a person may agree to this as part of their admission, if voluntary, they can change their mind even on a matter of policy.

Despite this, the CVP has observed that some people are denied the opportunity to change their mind and discharge themselves from a facility within that 48 hour period. This remains a particular concern for consumers in the Top End facilities. The view of the Top End mental health service is that a person's decision on admission 'holds strong' for the full 48 hour period despite the consumer's legislative right to be able to discharge.

"They say I need to stay here for 24 hours to be observed, and even longer if I am unwell. But I came in voluntary on Friday, and I didn't get leave until Monday. I just wanted a stretch outside."

C/2018/279

Leave While Admitted

A further dimension of the concerns relating to voluntary consumers relates to their ability to be on periods of leave while admitted. In the CVP's view, voluntary consumers have had to jump hurdles associated with leave requests that are the same as those who are admitted involuntarily.

Voluntary consumers report frustration or confusion about their ability to have leave, and to manage their pathway towards recovery while being admitted as a consumer. Sometimes they have to wait for a doctor to give them 'permission' to take leave, even when they are committed to their ongoing admission and treatment.

"It's not fair especially for voluntary clients who should be able to leave when they want."

C/2018/00236

The CVP raised with the service that there are unnecessary procedures and restrictions on voluntary consumers for accessing leave. At present, there have

been blanket rules regarding how leave is administered. These rules are based on the legislation for involuntary consumers but have been applied to voluntary consumers.

Leave decisions are clinically informed. For voluntary consumers, however, these decisions must also be collaborative between the doctor and the consumer. At present, the collaborative and 'informed' nature of these decisions has not been evident for many voluntary consumers.

Informed consent is inherently dynamic. If a person changes their mind, they are withdrawing their informed consent and substituting a new decision. A person cannot be held to a decision made earlier in the day, or in previous days or weeks.

The CVP holds concerns that voluntary consumers are perceived to have given consent and this taken as a 'static' decision that cannot be rescinded. This is despite the legal authority that enables a person to change their mind and leave hospital.

RIGHT TO CULTURALLY SAFE SERVICES

The Northern Territory community is very diverse. In particular, it has a high number of Aboriginal and Torres Strait Islanders compared to other States and Territories. As such, mental health services must be culturally safe and competent, and responsive to the unique cultural diversity of the population.

Aboriginal Staff

One of the foundations of a culturally competent service is effective cross-cultural communication. Aboriginal Mental Health Workers are key partners in ensuring Aboriginal consumers are able to access and use mental health services that meet their needs.

The Top End and Central Australia mental health services have maintained a focus on Aboriginal Mental Health Worker positions being an integral part of the staffing profile (in both the in-patient facilities and in community-based teams). The staff in these positions often face considerable challenges in undertaking their roles, negotiating and supporting cultural dimensions of mental health care.

"It's really good having the Aboriginal worker here, and a woman, that's the right way for us, you know, having both a man and woman."

VIS/2018/139

Inspections of community-based teams, and visits to in-patient facilities, have highlighted the challenges in staffing these positions (both recruitment and retention). Some community-based teams have had long standing vacancies in Aboriginal Mental Health Worker positions. Some teams have been able to staff the positions, but not effectively retain staff or put in place succession plans.

Further to this, the CVP has noted that a number of different teams across the Top End and Central Australia mental health services are seeking to employ, or have employed Aboriginal Health Workers (AHW).

Aboriginal Health Workers differ from Aboriginal Mental Health Workers as their training includes a clinical component that allows them to perform clinical tasks such as physical assessments and medication administration. In particular, AHWs are able to provide intramuscular injections as part of their scope of practice. This can be particularly useful in a mental health context, where many Aboriginal consumers receive regular 'depots' (injections) as part of their treatment plan.

The CVP supports the efforts of the Northern Territory public mental health services to increase the number of AHWs. The CVP encourages further workforce development strategies targeted towards this goal.

The ongoing challenge in recruitment and retention of Aboriginal staff requires systemic focus and support from the Northern Territory public mental health services. This needs to go beyond the individual efforts of team leaders and managers.

Having a stable, well supported Aboriginal workforce is critical to providing a culturally safe and competent public mental health service. The ongoing workforce struggles need to be addressed systemically as a priority.

Use of Interpreters

The inadequate use of interpreters has been an issue raised many times with the service. While interpreter use relates to all languages other than English, it is most evident in the provision of service in Aboriginal languages.

The Northern Territory has 30% of the population identifying as Aboriginal or Torres Strait Islander. Many speak a language other than English at home. As such, this is a priority issue for the Northern Territory public mental health services.

"I don't trust the service, that comes from a long time. That's what they don't understand."

VIS 2018/00125

Too often, Community Visitors will be told reasons why accredited independent interpreters were not used. This can include the time of day the person was admitted, that the person 'speaks English' (despite there being no capacity assessment on their understanding of complex matters), that a family member was used (which raises serious privacy and assessment issues), or there were difficulties in getting an interpreter.

Unfortunately, there are also instances in which Community Visitors or the CV Panel members have identified a lack of awareness of the need for an interpreter, or a lack of knowledge regarding how to book one.

While there is evidence that the in-patient facilities are starting to grapple with these issues, the effective use of interpreters for community-based teams remains largely unaddressed. CVP inspection reports of community-mental health teams have raised these issues and will continue to do so until there is improvements to interpreter use.

It is relevant to note that the Central Australian Mark Sheldon Remote Mental Health Team actively worked over the past 18 months to ensure accredited interpreters were part of the team during visits to remote communities. The positive benefits flowing to consumers, family



members and staff of the mental health service was specifically highlighted by the service in its inspection report.

While this is a positive development, it was only clearly evident in one mental health team. This proactive approach needs to be more widespread across all teams in the Northern Territory public mental health services.

There are challenges to identifying and using interpreters in the Northern Territory. These challenges are known. However, the professional obligation to effective communication requires that strategies are put in place to address identified challenges.

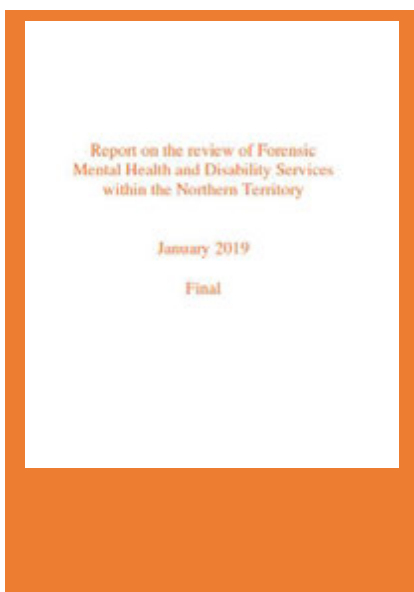
At present, there is not enough evidence that Northern Territory public mental health services are rising to the challenge of using accredited interpreters as a matter of course. This action needs to occur at all levels, from senior leaders addressing systemic issues through to individual staff completing booking requests.

PRISONER'S RIGHTS

Case for Forensic Services Reform

The CVP has advocated for improved mental health services to prisoners for the past few years. This advocacy has particularly been focused on the needs of children in youth detention. This year, however, the CVP draws stronger focus onto the needs of all prisoners to receive an equitable, recovery-oriented and therapeutic service.

The CVP highlights that forensic consumers are the most marginalised and powerless individuals in our society.⁸ As with any consumer, they have a right to mental health treatment and this is provided for under Part 11 of the *Mental Health Related Services Act 1998*. This year the CVP has raised 9 open recommendations regarding the treatment and care of prisoners.



One of the striking aspects of forensic mental health services in the Northern Territory is the complicated governance model in place. All forensic psychiatric care is provided from the Top End mental health service. Over the past few years, there has been difficulties and tensions arising between the forensic services in the Top End and Central Australia.

These difficulties have continued over the past year. Forensic psychiatrists from the Top End no longer provide visits to Central Australia, and instead locums were contracted from interstate. There have been evident difficulties with decisions relating to acute care, which has affected the care provided to prisoners requiring admission to hospital.

⁸ McGrath David Consulting, Report on the Review of Forensic Mental Health and Disability Services within the Northern Territory 2019, p 18.

For forensic consumers released (or needing to be released) from prison on non-custodial supervision orders, there have been substantial difficulties identifying and supporting community placements. In some instances, individuals who are not considered 'fit to plead' as a result of their mental state or cognitive impairments have been held in unnecessarily restrictive environments. This has affected them receiving timely support to transition to the community as a basic human right.

The CVP inspections of both forensic mental health services identified high referrals from prisoners for support, and difficulties in meeting the need for services (including psychological support). As a result, the teams have to prioritise service for the most acute prisoners, being those who are critically unwell or at imminent risk of self-harm.

The problems in the forensic mental health services of the Northern Territory have been known to relevant stakeholder and senior health administrators for a long period of time. Two forensic reviews have been commissioned in the past 3 years. Despite these difficulties, there has been insufficient action to improve governance and service models throughout this time.

In the past year, senior staff have noted that they are awaiting the outcome of the most recent forensic mental health and disability review. The Forensic Services Review report was finalised in March 2019. The Northern Territory government publicly released the report and its response in early September 2019. The delays associated with addressing known, systemic issues in forensic mental health services over many years is concerning.

Prisoners have the right to receive mental health services appropriate to their needs. Children in youth detention in the Northern Territory have an urgent, currently unmet need for early intervention services and comprehensive mental health assessments. Adult prisoners need mental health acute services provided by specialist staff. All prisoners need improved psychological support within detention facilities, avoiding the escalation of mental health crises in order to receive support.

The CVP was pleased that the Forensic Services Review recommended an Implementation Oversight Panel. The Panel is to oversee the implementation of recommendations from the Forensic Services Review, and is proposed to be auspiced by the Office of the Chief Minister. The CVP were included as part of this panel, as there is an urgent need for the improvements to forensic mental health and disability services.

Acute Care for Prisoners

While the issue of mechanical restraint of prisoners in an in-patient facility is a significant one, there are other matters of forensic services care that need highlighting in this report. The CVP considers that there needs to be considerably more clarity in the arrangements for how the 'good order and security' of mental health wards are maintained when prisoners are present on the unit.

At present, there are a number of issues that affect the care, treatment and dignity afforded to prisoners who need acute mental health services. These issues principally occur in the 'Joan Ridley Unit' (JRU). This ward is for the most acutely unwell consumers.

In practice, however, it is also used at any ward where prisoners are held during times that they require admission to hospital. The protocol is that two correctional officers (who are uniformed) will attend and remain on the ward for each prisoner.

If there are a number of prisoners on the ward at any one time, this can be an overwhelming presence of correctional staff. For non-forensic consumers, it contributes substantially to the 'prison-like' environment of JRU. It also substantially affects the therapeutic space for recovery of the most acutely unwell consumers in the Northern Territory.

The CVP noted that these issues were also evident in Central Australia this year, in particular over the Christmas and New Year period. During that time, when there were insufficient forensic psychiatrists available for prisoners in Central Australia, there were a greater number of admissions to the Alice Springs Hospital mental health unit.

There has historically been acknowledged tensions in how the Central Australia and Top End mental health services provide acute care locally for prisoners in Alice Springs. These tensions led to multiple admissions in a short period of time for some prisoners. There was also a lack of clarity regarding procedural and legal matters relating to the rights and care of prisoners.

The Central Australian service struggled to effectively address some issues due to the lack of agreed operational arrangements with Corrections. An agreement is in place with the Top End mental health service, yet despite this being available as a template, it has not been similarly implemented in Central Australia.

In the CVP's view, both the Top End agreement and the prospective Central Australia operational agreement need considerably more clarity. There are broader issues to address such as the operation of the mental health legislation in relation to authorising of all mechanical restraint.

There needs to be more clarity generally in matters related to the therapeutic care and treatment of consumers who are also prisoners. This includes the presence of multiple uniformed correctional staff on the unit at any one time, access to visitors, access to facilities and amenities, and dignity of prisoners. The care that can be provided to prisoners with mental illness or suffering a mental disturbance needs to be substantially improved and their rights as a consumer respected.

CONSUMERS WITH IDENTIFIED NEEDS

The CVP has raised a number of issues in this reporting period for the care and treatment of consumers with identified needs who are admitted to a mental health facility. The different needs and concerns relate to:

- children, including those with behavioural disturbances, on adult facilities;
- the safety of women, in particular in the Joan Ridley Unit;
- people with cognitive impairments; and
- transgender or non-binary consumers.

Receiving care and treatment in a mental health facility is a challenging experience. In most cases, the wards will be locked. With the exception of one ward in Darwin, all consumers will

be adults. The wards will be a mix of consumers at different levels of crisis, from those recently admitted to those at the point of discharge.

Consumers with identified needs face particular challenges in receiving appropriate treatment and care for their needs. While the CVP has observed efforts from the service to respond to individual needs, there are some systemic concerns.

The most concerning is the presence of sometimes young children on adult wards. In general, admissions occur to a paediatric ward or to the Youth Inpatient Program (YIPP). At times, however, there have been admissions of children as young as 12 years to an adult ward. This has occurred when there are serious behaviours of concern. For children of this age, having a trauma-informed lens is essential to providing quality care.

Managing children of this age on an adult ward is very problematic. Although consultation with a specialist child and adolescent psychiatrist is usually sought, the range of issues that can present during an admission inevitably challenge the skills of staff on the ward. In this reporting period, the CVP has provided comment on some disturbing incidents of restrictive practice experienced by child consumers, including restraints and seclusion.

Similarly, consumers who have cognitive impairments often have unique challenges required for effective support and management. In a locked ward, the challenges of delivering quality care that meets their individual needs and responds to their impairment appropriately are heightened. The CVP has seen some consumers with disabilities experience traumatic events such as restrictive practice, in contexts where the appropriateness of a mental health acute admission is also an issue.

An acute mental health in-patient facility is, at its core, meant to be a therapeutic space. If there is insufficient consideration or capacity to respond to consumers individual needs, the space can become traumatic or re-traumatising.

Although the small size of the Northern Territory jurisdiction complicates the provision of specialist services, it nevertheless requires these challenges to be addressed to ensure quality care.

WORKFORCE CHALLENGES

A consistent theme throughout all of the CVP inspection and visit reports this year has been concerns relating to workforce challenges. These challenges are not uncommon in the Northern Territory. The consistency of such issues being identified this year prompts further reflection and analysis in this annual report.

Issues related to staffing a culturally competent workforce have been noted above. Further to this, the CVP considers that the Northern Territory public mental health service needs to substantially improve its response to high turnover of all clinical staff.

Effective mental health care and treatment relies upon continuity of care. Central to this is the establishment of a therapeutic relationship between a consumer and their treating team. The quality of this relationship also extends to that built with the consumer's carers, family

members and support network. It is incredibly challenging for these relationships to support a consumer's recovery when there is high turnover of staff.

Some cases raised with the CVP this year highlighted the challenge for consumers to develop a relationship of trust and confidence in their treating team. Some consumers were distressed by the need to understand or interpret clinical decisions made by different doctors. These doctors were usually on short term contracts to fill in vacant positions.

"I was treated badly and I now have no confidence in the service"

C/2019/00168

Other consumers were given contradictory or incorrect information relating to their rights or the operation of mental health legislation in the Northern Territory. On review, the Community Visitors identified that the underlying systemic issue was one of induction, training and development.

At times, when seeking to resolve cases raised by consumers, the Community Visitors find themselves having to educate professionals on short-term contracts about the specific Northern Territory public mental health legislation and policies. Even if professionals are more established in their roles, there may still be significant gaps in understanding about the operation of mental health legislation, especially for people under adult guardianship.

The CVP considers that these issues are systemic and related also to the need for improved induction, training and support of professional staff. The particular responsibilities placed on psychiatrists in the Northern Territory legislation also comes with an obligation of the service to ensure that all doctors fully understand their powers and concurrent responsibilities.

The open CVP recommendations for both Top End and Central Australia mental health services are summarised below.

FORMAL RECOMMENDATIONS

| Top End Mental Health Service – CVP Open Recommendations | | | | |
|--|--|----------|----------|--------|
| CVP Recommendations | | Made By | Date | Status |
| <i>MH TEHS Approved Treatment Facility</i> | | | | |
| I. | It is recommended that the Mental Health Service ensure that interpreters are present at assessment for all consumers whose first language is not English. It is further recommended that interpreter assistance is then arranged for all further assessments and to assist the consumer at any hearing before the Mental Health Review Tribunal. | CV Panel | May 2007 | Open |

Top End Mental Health Service – CVP Open Recommendations

| | | | | |
|----|---|----------|------------|------|
| 2. | <p>It is recommended that a comprehensive accommodation and support model is developed, adequately resourced and provided in the Top End of the Northern Territory (in addition to the accommodation currently provided through the Manse).</p> <p>It is further recommended that the model takes into account the varied and diverse circumstances of consumers in the NT, and is developed collaboratively with consumer groups and mental health professionals. (Reworded, 2018)</p> | CV Panel | Nov 2006 | Open |
| 3. | That the service provide evidence that in the process of involuntary admission that there is adequate explanation of the rights to consumers, including legal status on admission, offering of interpreters and early access to the Mental health tribunal. | CV Panel | Nov 2011 | Open |
| 4. | To improve the care of acutely unwell consumers in the Joan Ridley Unit and ensure safety for all vulnerable JRU consumers especially women it is recommended that the facility be improved to allow the separation of consumers and that safe practices be documented. (Reworded, 2016) | CV Panel | Mar 2016 | Open |
| 5. | That the Top End Mental Health Service provides evidence of improvement in processes to ensure compliance with the Act in relation to recording information about the seclusion of clients. | CV Panel | April 2018 | Open |
| 6. | TEMHS to revise forms and practices to ensure that they are consistent with the NT Department of Health Intersex, Differences of Sex Development (DSD) and Transgender NT Health Policy. | CV Panel | Mar 2019 | Open |
| 7. | That the teacher vacancy in the Youth Inpatient Program be addressed to help ensure access for youth to support to maintain their education | CV Panel | Aug 2019 | Open |
| 8. | TEMHS, who are responsible for a therapeutic environment, should negotiate access to fresh air for forensic consumers while they are under guard supervision. | CV Panel | Aug 2019 | Open |

Top End Mental Health Service – CVP Open Recommendations

| | | | | |
|-----|--|-------------------|------------|------|
| 9. | The TEMHS review and improve processes related to the service's applications to the Mental Health Review Tribunal, in particular to ensure client access to information consistent with the expectation of natural justice and in line with s132 MHRSA. | Community Visitor | Nov 2016 | Open |
| 10. | That TEMHS raise the need for significant new infrastructure in JRU to address the requirements for all clients but particularly women with high care needs to have a safe and therapeutic hospital environment. | Community Visitor | Nov 2016 | Open |
| 11. | That TEHMS provide advice to the CVP on current trauma informed care work practices that have been implemented across the service and are currently being used by staff to improve trauma-informed care and decrease the potential for retraumatising clients. (Reworded February 2019) | Community Visitor | July 2017 | Open |
| 12. | That a review be conducted to determine the reason for non-completion of each section of the form 10 to determine the rationale for systemic non-completion of certain elements of the form, and that feedback on this review is provided to the CVP. | Community Visitor | April 2018 | Open |
| 13. | TEMHS develop and provide a CCTV policy, procedures and guidelines that comply with Commonwealth and NT Laws in relation to the surveillance and recording of consumers including the storage and use of recordings and access and destruction of historical footage with consideration given to the legal rights of patients. | Community Visitor | Aug 2019 | Open |
| 14. | <p>Seclusions & Mechanical Restraint</p> <p>That TEMHS implement strategies to ensure the cultural safety of clients, with a particular focus on the needs of Aboriginal* clients in line with TEMHS values and objectives.</p> <p>*updated to reflect correct terminology Aug 2019</p> | Community Visitor | May 2013 | Open |
| 15. | That TEMHS provide to the CVP the terms of reference/performance indicators how current seclusion reviews and analysis contribute to seclusion reduction, both for individuals and systemically. | Community Visitor | Aug 2017 | Open |

Top End Mental Health Service – CVP Open Recommendations

| | | | | |
|-----|---|-------------------|-------------|------|
| 16. | That TEMHS strengthen the Approved Procedures and policy suite to ensure that family members and carers are consistently advised of seclusions and, where appropriate, participate in the development of care plans aimed at reducing restrictive practices or the impact thereof. | Community Visitor | August 2018 | Open |
| 17. | That TEHS urgently initiate the recording of mechanical restraint and seclusion of clients under the MHRSA in other areas of the Royal Darwin Hospital 'approved treatment facility' and the Palmerston Regional Hospital. | Community Visitor | August 2018 | Open |
| 18. | That TEMHS Seclusion policy wording urgently be updated to accurately reflect the definition of 'seclusion' as stated in the MHRSA; 'Seclusion of a patient means the confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented'. | Community Visitor | August 2019 | Open |
| 19. | That the PIC ensure that; All instances of mechanical restraint at the ATF are contemporaneously recorded in the register and that a Form 21 and a Mechanical Restraint Observation Form are placed in the register for each event. Where the person has an Adult Guardian the Form 56 should also be in the register. and; All staff are made aware of their legal obligations when applying mechanical restraint and the requirement to fully document the restraint in the client's clinical notes. | Community Visitor | August 2019 | Open |

MH TEHS Approved Treatment Agencies

| | | | | |
|-----|--|-------------------|----------|------|
| 20. | Child & Adolescent Mental Health Team That TEMHS improve access to specialist child and adolescent mental health services for children and young people living in rural and remote locations, including the re-introduction of clinics based in these communities. | Community Visitor | May 2018 | Open |
| 21. | That TEMHS in conjunction with other relevant agencies implements the recommendations made within the Royal Commission into the Protection and Detention of Children in the Northern Territory 2017 regarding the provision of initial mental health assessment and ongoing mental health treatment for individuals detained in youth detention. | Community Visitor | May 2018 | Open |

Top End Mental Health Service – CVP Open Recommendations

| | | | | |
|-----|--|-------------------|----------|------|
| 22. | That TEMHS develop a working protocol with the Department of Territory Families that enhances the outcomes for vulnerable children and young people in the joint care and treatment in line with each agency's statutory obligations their human rights of children to safety and quality therapeutic healthcare. | Community Visitor | May 2019 | Open |
| 23. | That TEMHS finalise in conjunction with other relevant agencies and stakeholders (Working Group) a framework and working agreements for the provision of initial mental health assessment and ongoing mental health treatment for individuals detained in youth detention. | Community Visitor | May 2019 | Open |
| 24. | East Arnhem Community Mental Health Team That TEMHS improves access of psychiatric review in remote locations through providing regular routine review for all consumers accessing mental health services. | Community Visitor | May 2018 | Open |
| 25. | That TEMHS in conjunction with Remote Health Services consider ways to build the capacity of their staff, community members, families and individuals to provide support to those experiencing emotional distress in relation to acute psychosocial issues such as grief and loss, relationship issues and the effects of interpersonal violence and trauma. | Community Visitor | May 2018 | Open |
| 26. | That Top End Health Service conducts a review of its current electronic medical record systems for Remote Health Services and Mental Health Services and consider how to implement an EMR system that can be used for all TEHS. | Community Visitor | May 2018 | Open |
| 27. | That TEMHS improve access to specialist child and adolescent mental health services for children and young people living in remote locations, including the re-introduction of clinics based in these communities. | Community Visitor | May 2018 | Open |
| 28. | Forensic Mental Health Team That TEHS urgently prioritise implementing 'at risk' procedures, comprehensive mental health assessments and integrated models of service delivery for youth detainees supported by child and adolescent psychiatrists or forensic psychiatrists with adolescent experience. | Community Visitor | May 2019 | Open |

Top End Mental Health Service – CVP Open Recommendations

| | | | | |
|-----|--|-------------------|----------|------|
| 29. | Katherine Remote Mental Health Team TEMHS recruit an Aboriginal Mental Health Worker so that it can better provide evidence based, culturally safe, and confidential clinical service delivery to Aboriginal consumers and their families. | Community Visitor | Jan 2019 | Open |
| 30. | TEMHS conduct a risk assessment in relation to the administration of intramuscular medications in the absence of both a resuscitation trolley / equipment and staff knowledge as to the whereabouts of a defibrillator. | Community Visitor | Jan 2019 | Open |

Central Australian Mental Health Service — CVP Open Recommendations

| CVP Recommendations | | Made By | Date | Status |
|--|---|-------------------|-----------|--------|
| MH CAHS Approved Treatment Facility | | | | |
| 1. | That a new policy be developed in accordance with professionally accepted standards and the least restrictive principles as required by the <i>Mental Health and Related Services Act</i> to ensure that adopted practices comply with the fundamental principles of the Act when a prisoner becomes a mental health patient. | CV Panel | Jun 2017 | Open |
| 2. | That the service provides evidence that staff explain rights under the Act to clients on admission or as soon as they are able to understand them and in a manner that they can understand. | CV Panel | June 2019 | Open |
| 3. | That Mental Health CAHS review processes to improve effectiveness of the internal complaints process. (Reworded) | Community Visitor | Jun 2017 | Open |
| 4. | That existing seclusion policies and procedures include detailed strategies to reduce the use and impact of seclusion on minors. | Community Visitor | Jul 2017 | Open |
| 5. | That CAMHS proactively identify strategies to avoid inappropriate in-patient admission for clients with cognitive impairments and/or behaviours of concern presenting for mental health assessment, including through protocols with key agencies such as NDIA, Territory Families, Office of Disability. | Community Visitor | June 2019 | Open |
| 6. | That CAMHS improve the use of interpreters for the provision of information about legal rights on admission to consumers who do not have English as their first language. | Community Visitor | June 2019 | Open |

Central Australian Mental Health Service — CVP Open Recommendations

MH CAHS Approved Treatment Agencies

| | | | | |
|-----|--|-------------------|------------|------|
| 7. | Forensic Mental Health Team That significant efforts are made to recruit to the Aboriginal Mental Health Worker position within the Forensic Mental Health Team, including any development required to upskill a suitable applicant. | Community Visitor | Aug 2014 | Open |
| 8. | That the Central Australia and Top End mental health services urgently resolve resourcing issues affecting inequitable medical support for forensic mental health clients of Central Australia. (Reworded March 2019) | Community Visitor | Dec 2016 | Open |
| 9. | That CAHS and TEHS urgently provide integrated mental health services to youth detainees in the Northern Territory, supported by child and adolescent psychiatrists or forensic psychiatrists with adolescent experience. | Community Visitor | Dec 2016 | Open |
| 10. | That the NT mental health services develop a clear pathway for forensic mental health clients to transition to least restrictive community-based placements with appropriate supervision on transition. | Community Visitor | March 2019 | Open |
| 11. | Child and Youth Team That the service establish with other key stakeholders a case management mechanism to improve coordination and case management of youth clients with complex high needs who are accessing youth mental health services. | Community Visitor | Dec 2017 | Open |
| 12. | Barkly Mental Health Team That the Barkly Mental Health Team work with the CAMHS cultural consultant to develop strategies to improve access to accredited interpreter services and access AIS training for all staff. | Community Visitor | Jun 2019 | Open |
| 13. | Community Mental Health Team That CMHT improve the access and use of accredited interpreters. | Community Visitor | Jun 2019 | Open |
| 14. | Sub-Acute Facility That the Central Australia Mental Health Service address the need for more longer-term supported accommodation and care for consumers requiring sub-acute mental health services. | Community Visitor | Jul 2018 | Open |

DISABILITY

SNAPSHOT

- There are improvements in clinical support and planning within the Office of Disability specialist disability services.
- The quality of day to day management within residential places requires close monitoring.
- The clinical governance framework, in particular for safe medication use and administration, needs to be clear.
- Arrangements for transitioning residents out of the service need to be clear and well established.

Residents of the specialist disability service provided by the Northern Territory government are increasingly transitioning out to mainstream services. Over the past year, there have been very few residents come into the service.

The CVP visits specialist residential facilities operated by the Office of Disability. These places provide support to the most complex clients in the Northern Territory, in particular those who have come into contact with the justice system as a result of their behaviours.

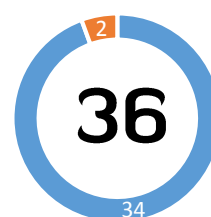
The majority of residents supported by the Office of Disability reside in houses in the community, or in facilities adjacent to the Darwin and Alice Springs Correctional Centres. All are on supervision orders arising from offences for which they have been found 'unfit to plead' or found not guilty on the basis of their disability.

All require clinical support and interventions to address their behaviours of concern. This includes functional behavioural assessments and a positive behaviour support plan with evidence-based interventions. Each assessment and plan is unique to the person and their needs. The majority of residents have behaviour support plans that provide for the use of restrictive practices.

The CVP visits residents in their residence, and engages directly with them to enquire if they have concerns or complaints that need addressing. The CVP also inspects the use of any restrictive practice and related documentation. The overall standard of care and treatment is reviewed.

In the past two years, there has been a marked improvement in the openness and willingness of the Office of Disability to work positively with the CVP's independent complaints and oversight role.

CVP Visits (Disability)
2018-2019



■ Community Visitor ■ Panel

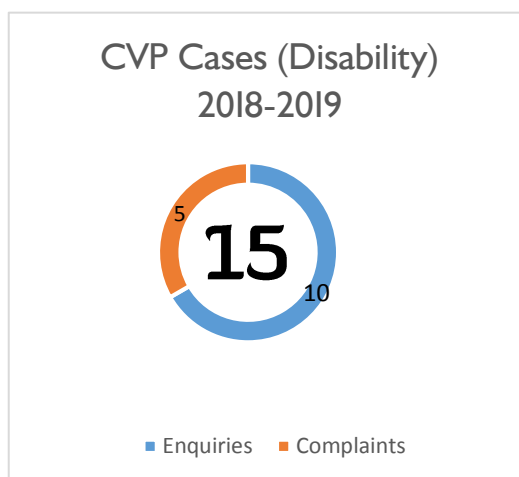
The CVP continues to observe improvements in the senior management's attention to systemic needs across the service. This year there has been evident action to address long standing concerns raised by the CVP. As a result, nine open recommendations have closed. This is a significant achievement and due to the proactive work of the senior management of Office of Disability in addressing these long standing issues.

In the past year, the CVP has particularly noted improvement in the quality of behaviour support interventions. Updated documentation for residents has been individualised, with improved data analysis to support findings, and reflective of good practice in behaviour support.

Structural changes have been made to the staffing of the service to improve oversight of resident care and treatment. This includes clinical, case management and direct support teams. There has been an improved focus on ensuring residents are transitioned to appropriate support in the community, and that interpreters are more often sought for key discussions with residents about their care.

There remain some ongoing areas of concern, including longstanding matters raised by the CVP related to medication and clarity in the clinical governance framework. A new area of concern related to resident basic health and hygiene emerged in this year.

Serious complaints were substantiated in relation to the quality of basic residential needs (such as hygiene and nutrition standards) being provided in community houses in Central Australia. Following the complaints being raised with the CVP, there was evidence of immediate and systemic action taken by management to address these concerns.



In response to the concerns, an increased program of CVP visits (including unannounced visits) was introduced in Central Australia. Ongoing monitoring has been and will be required to ensure standards are maintained over time. The CVP's capacity to substantially increase the frequency of visits, however, is constrained by its limited resources.

CLINICAL SERVICES

Clinical Expertise and Quality

Clinical services provided in residences managed by the Office of Disability principally relate to the field of behaviour support (with residents being supported to access primary and allied health services through mainstream providers).

Positive behaviour support is a holistic, multi-element assessment of a person's environment and individual needs, underpinned by principles of applied behavioural analysis. It focuses on improving a person's quality of life, such as their engagement in the community and reducing their level of restriction.

Behaviour support clinicians, however, are also attuned to services that may be required by a resident which are clinical in nature but outside of the clinician's 'scope of practice'. This might include the need for medical attention, occupational or speech therapy, or other allied health assessments.

The CVP has closed a longstanding recommendation relating to the need for on-site clinical support in the Secure Care Facility, Alice Springs. This year, the service has been successful in recruiting an occupational therapist at the facility. This position has significantly enhanced the clinical services now available on-site in Alice Springs.

At a broader level, the CVP has noted an increase in the quality and depth of clinical services provided to residents in the area of behaviour support. The CVP has expressed concerns in previous annual reports that clinical services provided by the Office of Disability were lacking in this regard.

As part of the National Disability Insurance Scheme (NDIS) implementation, Australia is increasingly moving towards greater regulation in this area. From 1 July 2019, NDIS legislation relating to behaviour support and the use of restrictive practices on NDIS participants has come into effect in the Northern Territory. The Northern Territory has also passed the *NDIS Authorisations (Restrictive Practices) Act 2019*, which provides an additional layer of protection in the use of restrictive practices by a registered NDIS provider.



The CVP has noted with the service the need to consider seeking registration as a NDIS provider (as a safeguard against market failure and, potentially, to support resident transitions). The process of registration also ensures that behaviour support services provided by the Office of Disability meet minimum national requirements for quality. This includes clinical staff having appropriate qualifications and experience at the level required for registration under the NDIS.

The interaction of specialist disability services with transition to NDIS services will become increasingly more important to clarify and resolve. This is an important area to monitor in the coming year, in particular to avoid delays with transitioning residents to community-based services.

Positive Behaviour Support Plans

This year, all residents have a current positive behaviour support plan, underpinned by a functional assessment. This is a long overdue task that has now been completed. Positive behaviour support plans have been progressively reviewed and updated. The CVP has seen marked improvements in the quality of both plan reviews and the development of subsequent plans.

Importantly, the plans are now current for the resident's circumstances and individualised for their needs. The CVP has also noted that as plans reach their due date for review, these are now occurring on time or within a reasonable time of the planned date.

For many years, the CVP has held concerns that there was insufficient evidence that review of positive behaviour support plans were being conducted in a thorough or evidence-based way. Similarly, while the service standard is to work towards a 'least restrictive' approach, it was not evident in plans how this goal was being implemented or achieved.

The CVP is now increasingly seeing evidence that efforts are being made to reduce restrictive interventions that may have been used for a period during transition. For example, transition plans are being developed with shorter timeframes for review; with reviewed plans then phasing out restrictive interventions (as the person's support needs are better understood).

While this is positive, the CVP has noted that there needs to be clearer evidence of engagement by clinicians skilled in behaviour support in debriefing and analysis of behavioural incidents of concern. This is most evident in Alice Springs, as the senior behaviour support clinicians are based in Darwin. Although the team regularly visit Alice Springs, their capacity to provide timely clinical leadership when incidents occur remains an issue of concern.

Implementation of Plans

Despite behaviour support plans now being current, with greater attention to evidence-based interventions, there remain issues with implementation. On visits, the Community Visitors often have not been able to observe that the strategies identified in the plan are linked to daily

Restrictive Practices Within a Behaviour Support Plan

'Must contain:

Strategies that are outcomes-focused, person-centred and proactive.

Strategies that address the participant's individual needs and the functions of the behaviour of concern.

Strategies to reduce or eliminate the use of restrictive practices over time'

NDIS (Restrictive Practices and Behaviour Support) Rules 2018.

activities undertaken with the resident by support workers.

A number of interventions have components that would be observable on a visit. This might include the use of visual sequencing boards, choice opportunities on preferred and non-preferred activities, structured activities related to specific skills, or clocks to indicate the current and future time of planned activities.



The Community Visitors have seen evidence of a general routine or structure for a resident's day or week, which is a very important component of any behaviour support plan. However, there is often no clear link between general plans for the week's activities and specific interventions identified in residents' behaviour support plan.

Similarly, the elements of the behaviour support plan that are often visible in the working spaces of staff are the reactive strategies if escalation occurs. Proactive strategies are the most important elements of a positive behaviour support plan. Proactive strategies reduce the incidence and severity of behaviours (rather than react to a situation that has already started to escalate).

In general, on a daily basis, residents are well supported to engage in the community. There remains a strong focus on community participation. While this is an important component of any plan (namely, meaningful activity and community participation), the emphasis is not primarily on individual skill development and focused support.

The service gathers a considerable body of data on the daily activities of residents. This includes their sleep patterns, detailed logs of daily activities, food and fluid intake, and incidents of concern. Despite the breadth of material collected, it is not clear that this is well utilised or analysed to determine the effectiveness of interventions.

The service has restructured in both the Top End and Central Australia teams to seek to improve the oversight and mentoring of disability support workers. There remains considerable work, however, to build the skills of support workers to understand the individual strategies for residents and be able to effectively implement these.

As disability support workers in the specialist facilities operate in a complex area of direct behaviour support in the Northern Territory, they must be highly trained and skilled to meet the demands of the role.

There remains a considerable body of work for the service to create frameworks and processes to improve implementation of plans. This includes ensuring adherence to plan interventions, review of staff implementation, and support with individualised training being part of everyday management practice.

LEAST RESTRICTIVE CARE

Transition to Community

Over the past year, the CVP has seen a small number of long term residents transition to less restrictive environments. Two residents in the Top End moved to residential accommodation managed by the service. One resident in Central Australia spent a period of time in an aged care residence (supported in the transition by staff from the service). Unfortunately two residents also passed away while in the service's care as a result of health conditions.

Despite these positive steps towards transition, the CVP continues to observe that transition of residents to mainstream support in the community remains very slow. Two residents who recently transitioned to community accommodation in the Top End have had no behavioural

incidents of concern for many years. Despite the absence of behaviours of concern for an extended period of time, the residents have continued on in the direct care of the service.



Where residents' transition needs require engagement with other mainstream providers, such as aged care, the process to effectively transition these residents remains slow and poorly defined. The CVP has consistently advocated for the development of agreements with other agencies to ensure that transition can be streamlined. An agreement with Correctional Services has been commenced, and is in drafting stage, however there are no other agreements with other health services in place.

In the past year, the CVP has noted that there is now increasing involvement of NDIS services, with some residents having approved plans. Despite the complexities in managing the provision of services with NDIS service providers, the service has worked collaboratively to assist residents to transition some of their supports to other providers.

There remain areas of uncertainty, however, in the transition of residents to NDIS or other mainstream services. Having a number of specialists supporting a resident can be beneficial, in particular to ensure quality and review over practice. It can also lead to confusion regarding roles and responsibilities.

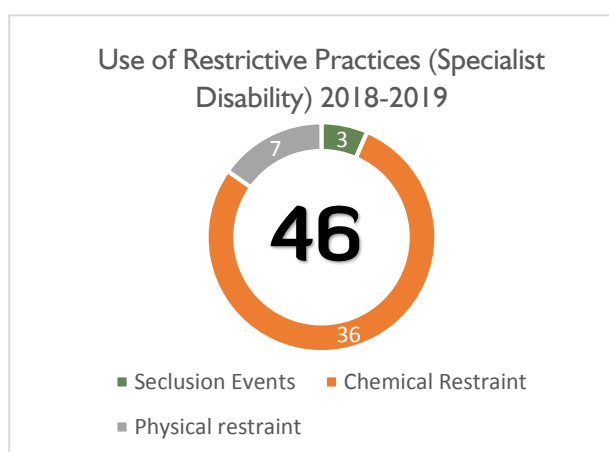
A transdisciplinary practice framework needs to be articulated by the service to ensure clarity in the service environment. It is important that this covers transition of residents to NDIS services, including supported independent living, but also providers such as aged care.

Restrictive Practices

As noted above, the CVP has seen the service seeking to implement a 'least restrictive' approach to the use of restrictive interventions. Some residents have had restrictive practices taken out of their plans on review. There has been low documented use of restrictive practices in general.

The CVP has noted an increasing sophistication in the description and authorisation of restrictive practices that are in place for a resident. There has been most evident in 'restricted access' interventions (known as 'environmental restraint' in other jurisdictions).

While there is recognition at a senior level of working towards 'least restrictive' approaches in all aspects of care, Community Visitors observe that the same understanding of these approaches does not always translate to practices seen on visits. This can range from removing



access to parts of a residence as part of 'morning routine' through to locking of residential gates. This reflects the ongoing challenge of ensuring that staff are well trained and supported.

The service has acknowledged that staff require ongoing training on restrictive practices, in general and those specifically provided for in a resident's plan. The service has begun to explore options to provide training more effectively, including online options for staff.

The Community Visitor is required to review use of restrictive practices on each visit. The summary of data gathered on the use of restrictive practices in this year is noted above. As with previous years, the greatest incidence of restrictive interventions used is 'chemical restraint'.

This year, the service has begun to improve its identification and authorisation processes for 'fixed daily doses' of medication for behavioural reasons. In the past, the authorisations for such restraint only related to 'as needed' use. The legislative definition of chemical restraint covers both instances. As such, the service is demonstrating ongoing improvements in its adherence to legislative requirements.

Restricted Access

'Environmental restraint is associated with loss of freedom and choice, emotional trauma, behaviour escalation, and risk to human rights and personal dignity for a person'.

South Australia Government, Office of the Senior Practitioner (2017), Restrictive Practices Reference Guide for the South Australian Disability Service Sector, Adelaide.

RESIDENT SAFETY & WELLBEING

Medication

The CVP has raised a number of concerns with the service this year relating to quality and safety on the use and administration of medication for residents. Errors in medication administration have been recorded in incident management documents reviewed by the Community Visitor.

While these instances are not frequent, any medication error is a serious 'near miss'. There has been some action within the service to address these concerns, however this has been prompted by serious incidents rather than as a matter of quality governance.

A recent incident earlier in 2019 led to the service conducting its own critical incident review, and development of new procedures and record keeping practices. This incident was taken seriously, however the CVP is concerned that action to systemically address issues are slow. The service has been indicating for an extended period of time that a 'medications policy' is being finalised. The CVP considers the completion of the medications policy to be urgent.

Of concern, PRN medication is able to be authorised by non-medically trained staff. The current service model relies on non-clinical staff to accurately observe, assess and action, or elevate the use of medication for medical or behavioural needs of residents. This presents risks for residents and staff, especially for residents with complex co-morbidities who may be taking extensive amounts of medication on a daily basis.

The CV Panel, which includes a medical practitioner, noted on its first Panel visit this year that the storage of medication and appropriate records management related to medication required improvement. It was positive to note that on its most recent visit, the CV Panel was more reassured that action had taken place and an open recommendation was closed.

The CV Panel has noted the importance of having processes in place to ensure review by a medical practitioner of any medications given for behavioural purposes. While there is evidence that review by a practitioner does occur, the service needs to continue to develop its processes to ensure these are clear and timely.

Day to Day Care

The primary function of the CVP in the legislation is to engage with residents on any matters of concern, and to ensure that documentation on restrictive practices is reviewed. As Community Visitors are the only independent advocates who regularly visit residents in facilities, the CVP considers that it has a broader responsibility in terms of overseeing resident treatment and care.

Complaints from a staff member acting on residents' behalf alerted the CVP to serious concerns in Central Australian residences to basic health and hygiene matters. The staff member concerned was raising these matters internally, however the extent of the concerns raised broader issues about systems and practices that ensure residents live in a hygienic, safe environment.

The CVP substantiated the complaints on the basis of evidence gathered from two unannounced visits. The service immediately accepted the seriousness of the matters, and acted to put in place new processes to avoid the situation re-occurring.

More visits were scheduled by the Community Visitors to ensure that the new processes were being implemented as planned and sustained over a period of months. The complaints were closed following this period of monitoring. However, the CVP has continued to closely review health and hygiene standards after these matters came to light.

The more frequent visits to specialist disability residences, required after these serious events arose in late 2018, have placed extraordinary pressure on the CVP and its limited resources. The CVP's resources for its disability function were provided on the basis of statutory quarterly visits to 'appropriate places'.

The expectation is that the specialist disability service would have appropriate and sufficient procedures in place to scrutinise and monitor the day to day care needs of residents. If ongoing monitoring at this frequency is required, additional funding would be necessary for the CVP to provide that level of oversight of day to day care.

Health Monitoring and Diet

The issues raised relating to day to day care also highlighted gaps in the service's attention to resident's general health. One aspect of the complaint raised above included concerns about the quality of food being consumed by residents and the overall increase in weight of residents.

Ensuring residents consume a healthy diet requires a number of components. The resident's diet needs to respond to their personal preferences, while also being attentive to the quality and quantity of food and fluid consumed over a week.

The CVP noted that residents were meant to be weighed weekly, and this information recorded. When this procedure was looked at in more detail, there was insufficient evidence that this data was consistently being gathered and monitored.

Furthermore, some residents have a preference for food that is of poor nutritional quality ('treat' food). Desire for these foods can and does become a trigger for behaviours of concern, especially when denied by a staff member. The triggers associated with preferred food needs to be managed as part of a positive behaviour support plan.

There was some evidence, however, that disability support workers were trying to manage resident preferences for certain foods or drinks without structured, clinically-informed interventions to assist them. This leads to inconsistencies in approach between different staff and ongoing triggers for behaviours.

In response to concerns regarding health monitoring, the CVP advocated for greater clarity in meal planning and clear attention to overall food consumption across a week. The CVP also reviewed some resident's positive behaviour support plans to ensure these addressed 'treat' related triggers.

There is some evidence that changes to improve resident's health while also respecting their wishes is beginning to occur. Further work needs to be undertaken, however, to ensure that this is well implemented and maintained.

Community and Cultural Access

The service in general has maintained positive attention on ensuring the residents have the opportunity to engage in the community on a daily basis, including with family and members of their community. The service has also responded well to the needs of residents to return to home communities for important events, such as funerals. At times, these events have been difficult or extended events requiring a number of staff.



Having regular contact with family, including visiting family members in their home communities, remains the issues most raised by residents when talking to Community Visitors. While the service has responded well to meet everyday community access needs, it can be resource intensive to organise visits home on a more regular basis.

The CVP had had a number of resident enquiries open for an extended period this year, when the resident's wish to spend more time with family was not acted upon in a timely way. While the CVP understands the difficulties in organising visits, considering the importance of such visits to residents to maintain their connection to family and country, this needs to remain a priority for the service.

SERVICE MANAGEMENT

Leadership and Staffing

As effective service management is a key component of quality standards in disability services, it is essential that the specialist unit supporting residents is well structured and led.

At a more systemic level, the challenges in ensuring health and hygiene standards are maintained have highlighted the inherent difficulties in maintaining consistent staff in the residences and at senior levels. This affected clear lines of accountability from disability staff through to senior staff.

The service identified that it has restructured and improved its team management. The purpose was to provide greater consistency across the specialist services in Top End and Central Australia, and improve accountability for senior support workers. Based on observations of Community Visitors, the effectiveness of new structures and new management in senior positions has yet to be realised and will be monitored in the coming year.

With respect to staff training, the quality and availability of specialist training has improved. The CVP has been provided with evidence of support for workers being provided internally by behaviour support clinicians (such as videos on individual resident needs and skill development). Similarly, experienced staff have been trained to provide de-escalation training to more junior staff. While the CVP would like to see a more structured approach to training and support needs, the service is moving in the right direction.

Contingency planning in the event of critical staff shortages was identified as an issue for close monitored by the CVP this year. The service has advertised for a panel to ensure that appropriately skilled casual workers are available at short notice. The outcome of this process and its effectiveness in ensuring quality staff at short notice will be discussed further with the service.

As staff management, training, retention and turnover remain a constant challenge for service provision in remote Australia, the CVP will maintain its focus on service management as a key safeguard for quality resident care.

Governance and Risk Management

The CVP notes that the Office of Disability has contracted an external consultant to support the development of a robust clinical governance framework for its services. The need for such a framework has been identified by the CVP for many years, and remains an open recommendation for action.

While the outcomes of this consultancy has not yet been finalised, the CVP has provided input to the review on the clinical governance observations and recommendations made as it relates to the specialist services. It nevertheless is positive to see this work beginning to be realised in this year.

A key aspect of effective clinical governance, and service management overall, is robust risk management procedures. The CVP has noted throughout the year that the incident management reporting requires further attention. In particular, the CVP has identified that the

risk ratings did not appropriately reflect the risks in the incidents. This has been addressed by senior management and risk ratings have been corrected as part of risk reviews.

Further training and support to staff in completing risk reports is required. Similarly, the quality of responses by management and clinical staff to incidents, including follow up risk mitigation strategies, needs improvement. It is anticipated that risk management will be a key feature of improvements in the clinical governance framework when finalised.

FORMAL RECOMMENDATIONS

The open CVP recommendations for the specialist disability services are summarised below.

| Specialist Support & Forensic Disability Unit – CVP Open Recommendations | | | | |
|--|---|-------------------|----------|--------|
| CVP Recommendations | | Made By | Date | Status |
| 1. | That the Secure Care Facility ensure accredited interpreters are used to assist in communicating with non-English speaking residents. (Reworded) | CV Panel | Oct 2014 | Open |
| 2. | That a clear individualised transition plan be established for each resident at the facility upon admission, showing steps achieved towards exit. | CV Panel | May 2015 | Open |
| 3. | That to ensure proper consideration of biological and/or psychiatric causes of significant incidents which result from extreme or out of character behaviour, a clear procedure should be developed for notifying the General Practitioner and psychiatrists of such incidents and of subsequent actions taken by both. | CV Panel | Jun 2016 | Open |
| 4. | That the Office of Disability ensure that all disability support workers receive required training to safely monitor and respond to the needs of residents who receive PRN medication (including medical restraint). | CV Panel | Nov 2017 | Open |
| 5. | That the Office of Disability ensure prompt review by a General Practitioner or psychiatrist when a deterioration in behaviour occurs as documented by frequent PRN usage. | CV Panel | Nov 2017 | Open |
| 6. | That the Secure Care Facility establish and implement an effective complaints procedure in accordance with Part 5 of the <i>Disability Services Act</i> . | CV Panel | Nov 2017 | Open |
| 7. | That the Secure Care Facility establish a behaviour support plan review panel as required by the <i>Disability Services Act</i> . | CV Panel | Nov 2017 | Open |
| 8. | That the Secure Care Facility undertake an urgent and major review of its adherents to the basic principles of clinical governance. | CV Panel | Nov 2017 | Open |
| 9. | That adequate duress alarms for staff and visitors are installed at the Secure Care Facility. | Community Visitor | May 2013 | Open |

Specialist Support & Forensic Disability Unit – CVP Open Recommendations

| CVP Recommendations | | Made By | Date | Status |
|---------------------|--|-------------------|-----------|--------|
| 10. | That the service provide the quality assurance framework documentation and process that underpin quality assurance for the Secure Care Facility and appropriate places. | Community Visitor | Aug 2014 | Open |
| 11. | That the Office of Disability implement a quality data analysis and measurement process related to each client's therapeutic program, including improved processes for individual client review. | Community Visitor | Jul 2016 | Open |
| 12. | That the Office of Disability develop a Memorandum of Understanding with the Department of Corrections to ensure a collaborative and 'least restrictive' approach to shared clients. | Community Visitor | Dec 2016 | Open |
| 13. | That the Office of Disability provide evidence of the systematic implementation of the strategies described in the Positive Behaviour Support Plan (PBSP) and evidence-based changes to the PBSPs. | Community Visitor | Dec 2016 | Open |
| 14. | That the service finalise a medication policy that clearly articulates the service's responsibility to ensure that residents are safely administered medications, including PRN medication in response to behavioural incidents. | Community Visitor | July 2019 | Open |

DATA TABLE 2018 - 2019

| | Mental Health | | | Disability | | | | Other | TOTAL |
|-------------------|---------------|------|-------|-------------|-------------------|-------------|-------|-------|-------|
| | CAHS | TEHS | Total | Secure Care | Appropriate Place | Other (DSA) | Total | | |
| VISITS | 56 | 65 | 121 | 31 | 5 | 0 | 36 | | 157 |
| Community Visitor | 52 | 55 | 107 | 29 | 5 | 0 | 34 | | 141 |
| Inspection | 2 | 8 | 10 | | | | | | 10 |
| CV Panel | 2 | 2 | 4 | 2 | | | 2 | | 6 |

| | CAHS | TEHS | Total | Secure Care | Appropriate Place | Other (DSA) | Total | Other | TOTAL |
|----------------------------|------|------|-------|-------------|-------------------|-------------|-------|-------|-------|
| CASES | 60 | 228 | 288 | 7 | 8 | 0 | 15 | 16 | 319 |
| Complaints | 6 | 43 | 49 | 1 | 4 | 0 | 5 | 6 | 60 |
| Enquiries | 54 | 185 | 239 | 6 | 4 | 0 | 10 | 10 | 259 |
| Cases – Raised by | | | | | | | | | |
| Person receiving treatment | 51 | 163 | 214 | 3 | 6 | 0 | 9 | 12 | 235 |
| Carer | 4 | 12 | 16 | 0 | 0 | 0 | 0 | 1 | 17 |
| Case Manager | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 2 |
| Service Provider | 2 | 16 | 18 | 1 | 2 | 0 | 3 | 0 | 21 |
| Nurse | 1 | 19 | 20 | 0 | 0 | 0 | 0 | 1 | 21 |
| Guardian | 0 | 0 | 0 | 3 | 0 | 0 | 3 | 1 | 4 |
| Friend | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Doctor | 1 | 5 | 6 | 0 | 0 | 0 | 0 | 0 | 6 |
| Relative | 0 | 11 | 11 | 0 | 0 | 0 | 0 | 1 | 12 |

| | CAHS | TEHS | Total | Secure Care | Appropriate Place | Other (DSA) | Total | Other | TOTAL |
|-------------------------------|------|------|-------|-------------|-------------------|-------------|-------|-------|-------|
| ISSUES RAISED | 114 | 449 | 563 | 16 | 0 | 21 | 37 | 21 | 622 |
| Quality of Service Provider | 45 | 150 | 195 | 10 | 0 | 14 | 24 | 2 | 221 |
| Assessment & Treatment | 9 | 44 | 43 | 3 | 0 | 0 | 3 | 0 | 46 |
| Cultural Safety | 9 | 1 | 10 | 1 | 0 | 4 | 5 | 0 | 15 |
| Management Plan | 3 | 5 | 8 | 1 | 0 | 1 | 2 | 0 | 10 |
| Activities | 2 | 1 | 3 | 1 | 0 | 1 | 2 | 0 | 5 |
| Discharge Planning | 7 | 25 | 32 | 0 | 0 | 0 | 0 | 0 | 32 |
| Facilities | 1 | 7 | 8 | 0 | 0 | 2 | 2 | 0 | 10 |
| Relationship with Staff | 5 | 35 | 40 | 0 | 0 | 1 | 1 | 0 | 41 |
| Food | 0 | 3 | 3 | 0 | 0 | 0 | 0 | 0 | 3 |
| Health – Physical / Mental | 0 | 8 | 8 | 0 | 0 | 2 | 2 | 0 | 10 |
| Procedures | 8 | 7 | 15 | 2 | 0 | 2 | 4 | 0 | 19 |
| Consultation Carers/Consumers | 1 | 5 | 6 | 0 | 0 | 0 | 0 | 0 | 6 |
| Other | 0 | 2 | 2 | 2 | 0 | 1 | 3 | 0 | 5 |
| Rights | 32 | 155 | 187 | 1 | 0 | 3 | 4 | 2 | 193 |
| Least Restrictive Alternative | 12 | 51 | 63 | 0 | 0 | 0 | 0 | 0 | 63 |
| Legal | 8 | 13 | 22 | 0 | 0 | 0 | 0 | 0 | 22 |

| | | | | | | | | | |
|----------------------------------|----|----|----|---|---|---|---|---|----|
| CV Information on Rights | 4 | 10 | 14 | 0 | 0 | 0 | 0 | 0 | 14 |
| Early Review of Detention | 2 | 15 | 17 | 0 | 0 | 0 | 0 | 0 | 17 |
| Restrictive Practices | 1 | 8 | 9 | 1 | 0 | 0 | 1 | 0 | 10 |
| Respect for Dignity | 1 | 15 | 16 | 0 | 0 | 0 | 0 | 0 | 16 |
| Safety | 2 | 13 | 15 | 0 | 0 | 2 | 2 | 0 | 17 |
| Voluntary/ Involuntary | 1 | 5 | 6 | 0 | 0 | 0 | 0 | 0 | 6 |
| Forensic | 1 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 2 |
| Transport / Transport by Police | 0 | 6 | 6 | 0 | 0 | 0 | 0 | 0 | 6 |
| Location of Admission | 0 | 3 | 3 | 0 | 0 | 0 | 0 | 0 | 3 |
| Electroconvulsive Therapy | 0 | 5 | 5 | 0 | 0 | 0 | 0 | 0 | 5 |
| Detention | 0 | 3 | 3 | 0 | 0 | 0 | 0 | 0 | 3 |
| Community Accommodation | 0 | 3 | 3 | 0 | 0 | 1 | 1 | 0 | 4 |
| Other | 0 | 4 | 4 | 0 | 0 | 0 | 0 | 0 | 4 |
| Information | 13 | 32 | 45 | 1 | 0 | 0 | 1 | 6 | 52 |
| Access to Files | 2 | 5 | 7 | 0 | 0 | 0 | 0 | 0 | 7 |
| Request for information from CVP | 2 | 16 | 18 | 1 | 0 | 0 | 1 | 0 | 19 |
| Information Provided | 8 | 6 | 14 | 0 | 0 | 0 | 0 | 0 | 14 |
| Other | 1 | 5 | 6 | 0 | 0 | 0 | 0 | 6 | 12 |
| Advocacy | 15 | 69 | 84 | 2 | 0 | 3 | 5 | 3 | 93 |
| Enquiry | 11 | 44 | 55 | 1 | 0 | 0 | 1 | 0 | 56 |
| Friend/Family contact | 1 | 0 | 1 | 1 | 0 | 2 | 3 | 0 | 4 |
| Practical Assistance | 3 | 25 | 28 | 0 | 0 | 1 | 1 | 0 | 29 |
| Smoking | 1 | 9 | 10 | 0 | 0 | 0 | 0 | 0 | 10 |
| Visit/Support | 1 | 5 | 6 | 0 | 0 | 0 | 0 | 2 | 8 |
| Other | 0 | 7 | 7 | 0 | 0 | 0 | 0 | 5 | 12 |
| Medication | 7 | 22 | 29 | 2 | 0 | 1 | 3 | 1 | 33 |

| Case Issues - Outcomes | | | | | | | | | |
|----------------------------|----|-----|-----|---|----|---|----|----|------------|
| Resolved | 64 | 258 | 322 | 1 | 5 | 0 | 6 | 3 | 331 |
| Ongoing Monitoring | 32 | 77 | 109 | 8 | 13 | 0 | 21 | 0 | 130 |
| Not Resolved | 4 | 3 | 7 | 0 | 0 | 0 | 0 | 0 | 7 |
| Referred | 1 | 26 | 27 | 0 | 0 | 1 | 1 | 19 | 47 |
| Lapsed | 9 | 5 | 14 | 0 | 0 | 0 | 0 | 0 | 14 |
| Withdrawn | 2 | 35 | 37 | 0 | 1 | 0 | 1 | 0 | 38 |
| Substantiated | 1 | 20 | 21 | 0 | 1 | 0 | 1 | 0 | 22 |
| Other | 0 | 4 | 4 | 2 | 0 | 0 | 2 | 2 | 8 |
| Dismissed | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Not accepted | 0 | 8 | 8 | 0 | 0 | 0 | 0 | 10 | 18 |
| (Open) | 0 | 1 | 1 | 5 | 0 | 0 | 5 | 0 | 6 |
| TOTAL ISSUES RAISED | | | | | | | | | 622 |



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