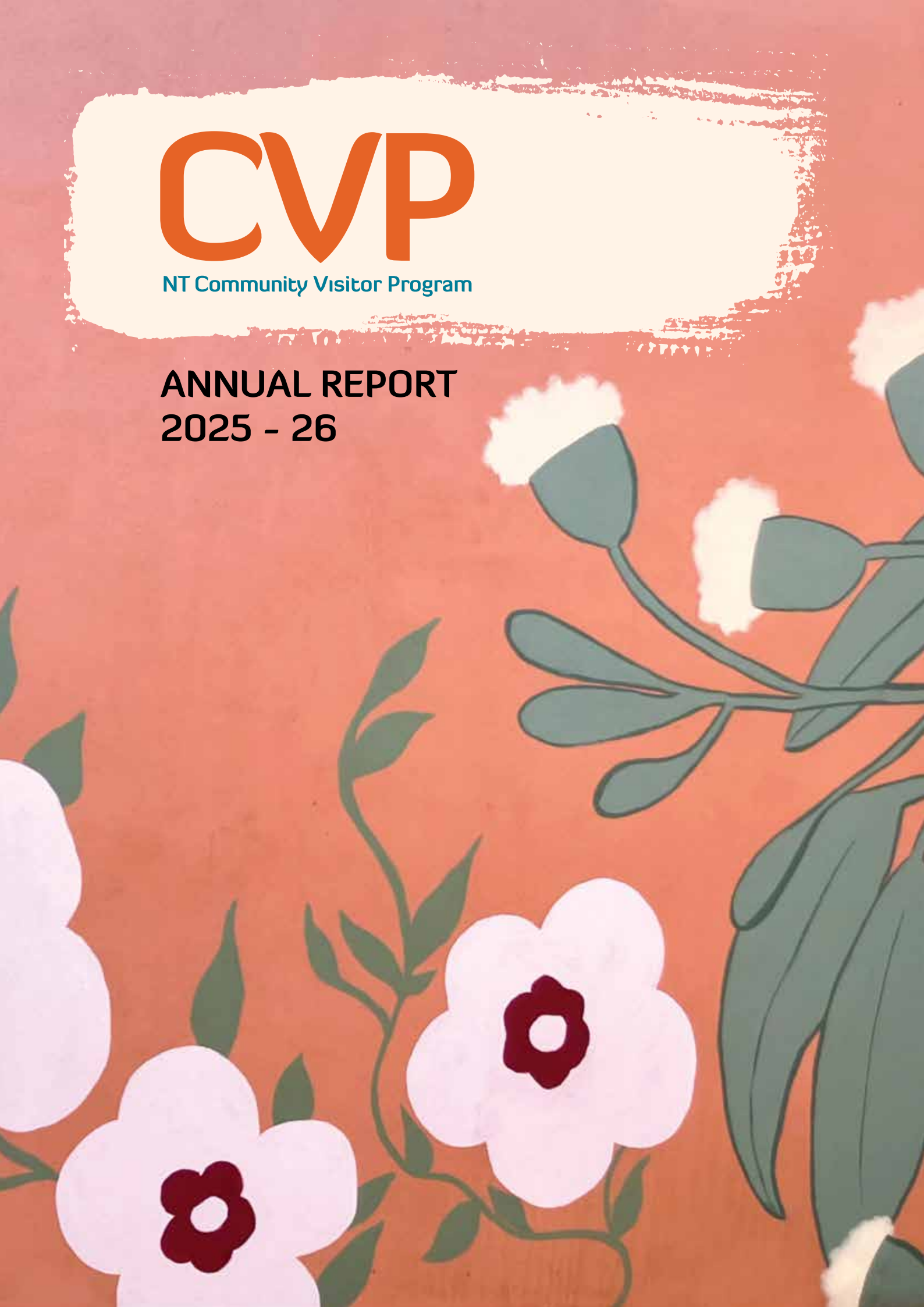
CVP

NT Community Visitor Program

ANNUAL REPORT 2025 - 26



Acknowledgement of Country

The Community Visitor Program (CVP) acknowledges the traditional owners and custodians of the country on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present, and rising and we acknowledge the continuing connection of Aboriginal and Torres Strait Islander people to land, sea and community.

Acknowledgments

The CVP would like to acknowledge and thank all persons who have engaged with the CVP and generously shared their experiences and concerns. The active engagement with, and input from persons with lived experience is essential to improve outcomes for all people. The CVP has the privilege to be placed in a position of trust by the persons, their families and carers who engage with us – thank you.

Additionally, we recognise the work of all staff and clinicians who work in these services, which are often resource poor and regularly at, or over capacity. We acknowledge and appreciate the work you do. We continue to emphasise the importance of the respectful relationships we have maintained with service providers – these have regularly assisted us to achieve lowest level resolutions for our clients.

September 2026

The Hon Steven Edgington MLA,

Minister for Health, Minister for Mental Health

Parliament House

State Square

Darwin, 0800

Dear Minister Edgington,

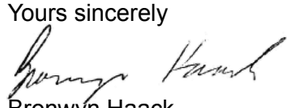
I am pleased to present the Annual Report on the activities of the Community Visitor Program (CVP) for the period 1 July 2025 to 30 June 2026. This report has been prepared in accordance with the requirements of section 115 of the *Mental Health and Related Services Act* 1998 and section 66 of the *Disability Services Act* 1993. The Principal Community Visitor for the reporting period was Mr Jeswynn Yogaratnam.

The contents of this report reflect nationally consistent trends across the mental health sector, including concerning increases in acute presentations to mental health services, particularly among younger people. These trends continue to present significant challenges for government and non-government service providers across Australia, as well as for consumers and their families during times of acute need. As mental health and disability service systems across Australia, including in the Northern Territory, face increasing pressure and complexity of support, the importance of independent oversight in safeguarding the rights of vulnerable individuals and identifying high-risk issues at the earliest opportunity becomes ever more critical.

As the incoming Principal Community Visitor, I acknowledge the significant contribution of my predecessor, Mr Jeswynn Yogaratnam, and thank him for his leadership of the program. Looking to the future, I am pleased to report that I have inherited a high-performing and dedicated team of professionals who are deeply committed to improving outcomes for Territorians. I am also encouraged by reports from the team regarding the responsiveness of the Department of Health's Mental Health Services when concerns are raised by the CVP, and by the collaborative approach consistently demonstrated in addressing those concerns.

The CVP and I remain committed to working constructively with your department to improve outcomes for Territorians receiving mental health and disability services. We look forward to continuing discussions regarding the need for greater investment in community-based services and the modernisation of the legislative framework, particularly the *Mental Health and Related Services Act* 1998 and the *Disability Services Act* 1993, to ensure these Acts better reflect the contemporary service environment and emerging needs of the Northern Territory community.

Yours sincerely

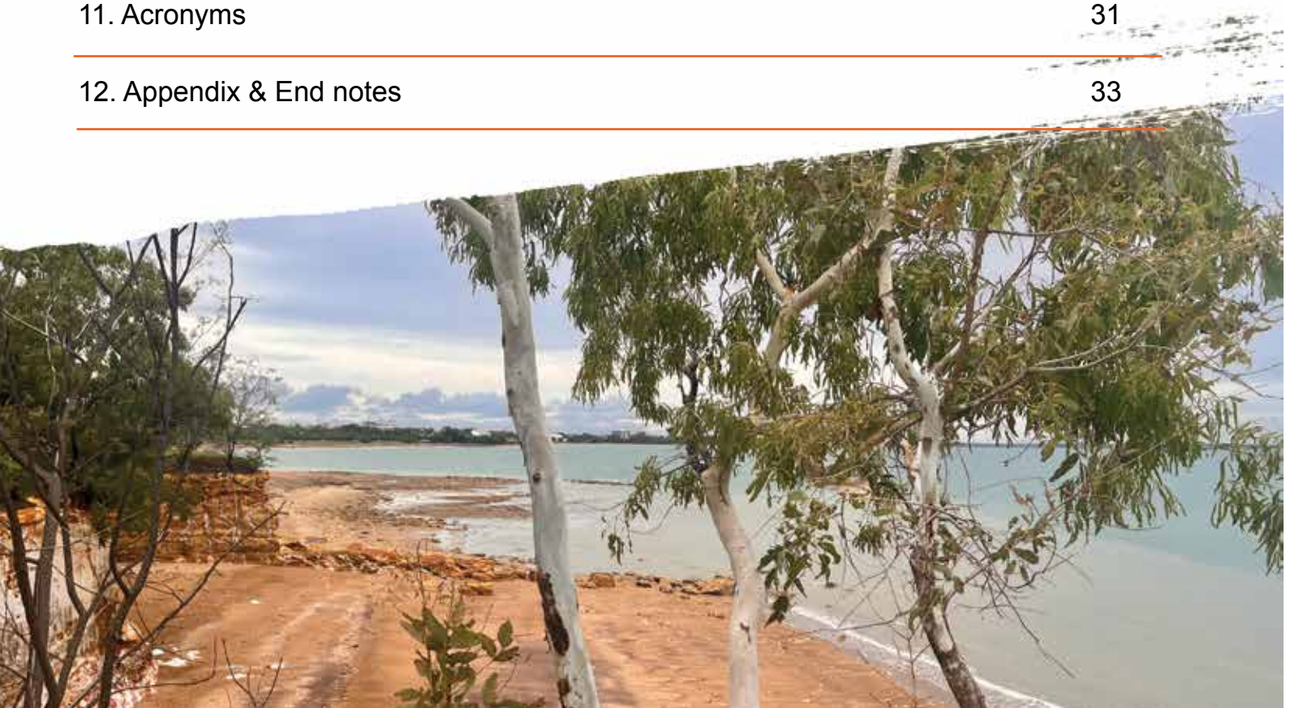


Bronwyn Haack

Acting Principal Community Visitor

Contents

1.	Message from the Outgoing Principal Community Visitor	3
2.	Annual Snapshot Report 2025/26	6
3.	2025-2028 CVP Strategic Action Plan Review	7
4.	What is the Community Visitor Program?	8
5.	2025 - 2026: Our Year in Review	10
6.	In Focus 6.1 Youth Mental Health 6.2 Community Visitor Scheme Project 6.3 Seclusion	15
7.	NT Mental Health Inpatient Settings: CVP's 2025/26 Reflections	23
8.	CVP Impact	28
9.	Financials	29
10.	Wishlist – A CVP Tracking Tool	30
11.	Acronyms	31
12.	Appendix & End notes	33



1. Message from the Outgoing Principal Community Visitor – A Year in Reflection



Jeswynn Yogaratnam

Strengthening the Community Visitor Program

This year has seen the continued implementation of the CVP's 2025–2028 Strategic Action Plan, reinforcing our commitment to strengthening governance, improving operational efficiency, enhancing stakeholder engagement and ensuring the long-term sustainability of the CVP. Throughout my appointment, I have encouraged the CVP to remain curious, adaptable and committed to continuous improvement. While our legislated responsibilities remain unchanged, the environments in which we operate continue to evolve. The CVP has responded by strengthening its reporting, refining its visiting practices, expanding stakeholder engagement and contributing to national discussions regarding Community Visitor Schemes and disability safeguarding reform.

The Program also continued its engagement with the Australian National Preventive Mechanism (NPM) under the Optional Protocol to the Convention against Torture (OPCAT). Through participation in national meetings, joint-training, collaborative submissions and cross-jurisdictional engagement, the CVP contributed to the development of nationally consistent approaches to preventive monitoring and independent oversight. This work strengthened the CVP's understanding of contemporary human rights standards while reinforcing the importance of preventing harm before it occurs through independent, proactive oversight. It also demonstrated the value of collaboration between oversight bodies in strengthening safeguards for people deprived of their liberty across Australia.

During the year, I also met with representatives of the United Nations Working Group on Arbitrary Detention (WGAD) during its official visit to Australia, including the Chair, Dr Ganna Yudkivska. Our discussions focused on the experiences of people subject to Custodial Supervision Orders residing in the Complex Behaviour Unit and the impact that increasing incarceration rates have had on service

Independent Oversight in Practice

As I conclude my appointment as the Northern Territory's (NT) Principal Community Visitor, I do so with a deep sense of gratitude, humility and optimism. Serving in this role has been both a privilege and a profound responsibility. It has provided a unique opportunity to engage with people receiving compulsory mental health treatment and forensic disability services, to listen to their experiences, and to advocate for improvements that uphold their rights, dignity and wellbeing.

Over the past three years, I have come to appreciate that the most effective oversight combines respectful relationships with robust independence. The Community Visitor Program (CVP) has consistently sought to engage constructively with service providers, clinicians, government agencies, people with lived experience, families and carers. While our role is to identify areas requiring improvement, it is equally important to recognise good practice and encourage innovation that enhances the quality of care.

delivery. I highlighted the CVP's concerns that correctional operational pressures can reduce access to therapeutic programs and meaningful recreational activities, creating conditions that may give rise to concerns regarding arbitrary deprivation of liberty where restrictions extend beyond what is necessary for therapeutic care. The discussion reinforced the importance of ensuring that forensic disability services remain rights-based, therapeutic and proportionate, with any deprivation of liberty limited to that which is lawful, necessary and consistent with Australia's international human rights obligations.

These improvements have not altered the CVP's purpose. Rather, they have strengthened our ability to advocate for people, identify systemic issues and contribute to better mental health and disability services across the Northern Territory.

Reflections from the Year

During the reporting year, Community Visitors continued to observe many examples of compassionate, person-centred care across the Northern Territory. The professionalism, resilience and commitment of staff to supporting people experiencing mental ill health, often within complex and resource constrained environments, deserve recognition. This was particularly evident in remote and regional communities, where Community Visitors observed dedicated teams delivering culturally responsive care across vast geographical areas. The CVP specifically acknowledges the East Arnhem Mental Health, Alcohol and Other Drugs, Social and Emotional Wellbeing (EA MHAOD SEWB) team, whose collaborative outreach model, commitment to care on Country and determination to maximise limited resources exemplify the very best of remote mental health practice. Despite significant workforce pressures, the absence of community-based step up/step down facilities and increasing demand, they continue to deliver compassionate, recovery-oriented care for some of the Northern Territory's most geographically isolated communities. Their dedication is a credit to the Northern Territory's mental health workforce.

A continued area of focus has been the Youth Inpatient Program (YIP) at Royal Darwin Hospital. Throughout the year, Community Visitors consistently heard from young people, families and clinicians about the need for a more therapeutic, culturally responsive environment that promotes recovery, meaningful activity and continuity of care. These observations align with the independent Youth Inpatient Program Model of Care Review, which concluded that the current model is unsustainable and requires significant reform to meet contemporary standards of child and adolescent mental health care. The review recommends investment in a purpose designed therapeutic environment, restoration of multidisciplinary allied health services, dedicated Aboriginal mental health support, strengthened clinical governance and leadership, greater family involvement, and stronger integration between inpatient and community-based services. The CVP welcomes these recommendations and looks forward to their implementation to improve outcomes for young people and their families across the Northern Territory.

The CVP also continued to monitor the experiences of people receiving treatment within forensic disability settings. During the year, we observed the impact that broader system pressures can have on therapeutic care, particularly where operational demands reduced opportunities for meaningful engagement, rehabilitation and community participation. These observations reinforce the importance of maintaining a strong focus on human rights, proportionality and individualised care.

Throughout the year, we also continued to monitor restrictive practices, including seclusion, recognising that these practices represent significant restrictions on individual rights. While seclusion may be lawful in limited circumstances, the CVP continues to support approaches that reduce reliance on restrictive practices through improved therapeutic environments, workforce capability and trauma informed care.

The People Behind the Program

No Principal Community Visitor succeeds alone.

This year also marked the conclusion of an extraordinary chapter in the history of the CVP with the retirement of Dr Sarah Giles as Chair and Medical Member of the Top End and Central Community Visitor Panels after more than 22 years of distinguished service.

Since her appointment in 2004, Sarah has been a steadfast advocate for the rights, dignity and wellbeing of people receiving mental health care across the Northern Territory. She has generously shared her extensive clinical expertise, deep understanding of mental health systems and unwavering commitment to person centred, rights-based care. Her leadership has been characterised by wisdom, integrity and quiet compassion, and her contribution has helped shape the CVP into the respected independent oversight body it is today. On behalf of the CVP, I extend my sincere gratitude to Sarah for her remarkable contribution and wish her every success and happiness in the next chapter of her life.

I would like to acknowledge Toni Amiet, CVP Manager, whose exceptional leadership has continued to strengthen the CVP through governance reforms, strategic vision, sound judgement and an unwavering commitment to continuous improvement. Toni has been instrumental in implementing the Strategic Action Plan and fostering a culture that values innovation, accountability and collaboration.

My sincere thanks also go to Nicki McAloon, Senior Coordinator, whose commitment to person-centred, empathy-led and outcome-focused practice has become synonymous with the way she approaches her work.

I am also delighted to welcome Ryan Wakeling back to the CVP following the successful completion of his social work placement with the CVP in 2024. Ryan has returned with renewed confidence, valuable experience and a strong commitment to human rights and independent oversight.

I also extend my sincere appreciation to the Office of Chief Psychiatrist, all our Community Visitors and our dedicated Community Visitor Panel members, whose expertise, independence and commitment continue to strengthen the integrity of the CVP. My thanks extend to every person with lived- experience, their families and carers, together with the many clinicians, service providers and partner organisations who have engaged constructively with the CVP throughout the year. Your willingness to work together has contributed to meaningful improvements across the Territory's mental health and disability service systems.

Looking Ahead

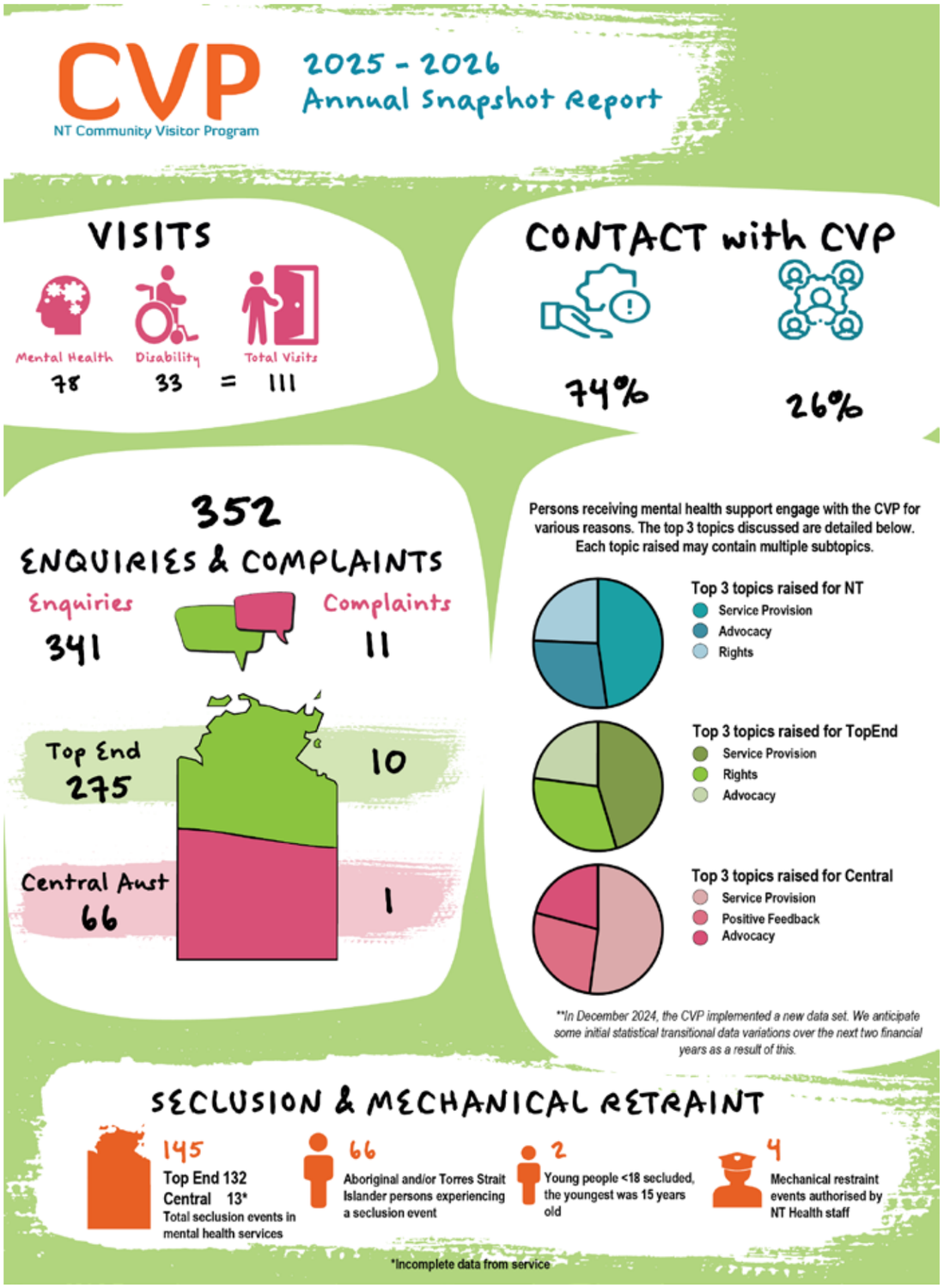
The CVP has continued to evolve over recent years, yet there remains considerable opportunity to strengthen independent oversight across the Northern Territory.

I look forward to the long-awaited reforms to the *Mental Health and Related Services Act* 1998 *(MHRSA)* that Territorians have responded to in extensive Department of Health consultation processes. I also call for the modernisation of the *Disability Services Act* 1993 (DSA), implementation of nationally consistent Community Visitor Scheme principles, ongoing engagement with the Australian National Preventive Mechanism, strengthened safeguarding arrangements and sustained investment in community based mental health services. As Australia's implementation of OPCAT continues to mature, the CVP is well placed to contribute its experience to the development of nationally consistent, preventative oversight that strengthens the protection of human rights in places of deprivation of liberty.

It has been an honour to serve as Principal Community Visitor. I leave with confidence in the future of the CVP and with sincere hope that it will continue to strengthen the rights, dignity and wellbeing of some of the Northern Territory's most vulnerable people.



2. Annual Snapshot Report 2025/26



3. 2025-2028 CVP Strategic Action Plan Review

The CVP team held their annual planning day in December 2025. Aside from discussions and reflections regarding changes the program has undergone over the past 12 months, the team also reviewed and tracked CVP's 2025-2028 Strategic Action Plan alongside our strategic objectives.

In line with the objective of working effectively within the allocated budget while also promoting sustainability, the team further reviewed our legislated responsibilities. Given CVP's active involvement in the CVS project (discussed in section 6), it was agreed that a formal legal review of CVP responsibilities under the DSA be undertaken. At the time of finalising this Annual Report, the CVP was awaiting the legal team's advice and recommendation, which will determine whether further changes are required.



CVP Planning day with Nicki and Toni

Overall, the Action Plan continues to progress well, with several objectives underway. However, some actions have been delayed due to financial constraints. Aside from revisiting the program's purpose and planning for 2026, the annual planning day reaffirmed the program's strategic direction whilst identifying opportunities for ongoing improvement.

CHANGE AREA/ OBJECTIVE	ACTION	REVIEW	STATUS / UPDATE
SUSTAINABILITY	Realign FTE	Annual to Dec 2028	In Progress - new FTE structure trial in 2026
MONITORING IMPROVEMENT	Policy & Procedure Review	Review Jul 2026 Final Jul 2027	In Progress
STAKEHOLDER ENGAGEMENT	Improve awareness of CVP	Annual to Dec 2028	In Progress - info sessions to continue in 2026; database to capture engagements
REPORTING/SCHEDULE EFFICIENCY	Align visit/report schedules with legislation and resources	Annual to Dec 2028	In Progress - additional changes recommended Dec 2025
DATABASE OPTIMISATION	Finalise functionality changes	Annual to Dec 2028	In Progress - additional changes recommended Dec 2025

4. What is the Community Visitor Program?

The Community Visitor Program



Jeswynn
Principal Community Visitor
(Anti-discrimination Commissioner)

Toni
Manager

Nicki
Senior Coordinator

Ryan
Coordinator

We are an independent statutory program under the MHRSA and DSA and located within the Anti-Discrimination Commission.

WHAT WE DO

ADVOCACY
Support people to:
Understand their rights
Raise concerns
Share their worries
Have their voices heard

MONITOR
Conduct regular visits
Monitor restrictive practices
Monitor compliance with the Acts
Identify emerging issues

INSPECT
Inspect and report on Seclusion & Mechanical Restraint registers
Inspect and report on ATA Community Mental Health Teams

COMPLAINTS
Support persons to raise informal & formal complaints to the service.
Raise Own Motion enquiries where appropriate

WHERE WE GO

Facilities and services legislated under the MHRSA

- Approved Treatment Facilities (ATF):
- Royal Darwin Hospital: Inpatient Unit (IPU)
- Alice Springs Hospital: Mental Health Unit (MHU)
- Complex Behaviour Unit (CBU)

Approved Treatment Agencies (ATA):

- Top End Mental Health & Other Drugs (TEMHAODS).
- Mental Health & Other Drugs - Central Australia Region (MHAOD CAR).

Residences legislated under the DSA

- **Secure Care:** Repurposed by Corrections in 2024.
- **Appropriate place:** outlined in the *Criminal Code*.
- **Residential facility:** NT Health run premises for treatment and care of people with a disability.

Additional role:

Anticipated NPM under OPCAT

Whilst the NT CVP is recognised as an anticipated NPM, it does not have any associated legislative powers or dedicated funding to undertake this function.

WHO DO WE PROVIDE SUPPORT TO

Persons receiving treatment under the MHRSA or DSA from one of these teams or at one of the facilities below:



Top End:

Darwin Remote Team

Greater Darwin Region:

Inpatient Unit at Royal Darwin Hospital
Mental Health Access Team
Child and Adolescent Mental Health Team
Adult Community Mental Health Team
Forensic Mental Health Team
Forensic Disability Unit

Palmerston:

Adult Community Mental Health Team
Perinatal Mental Health Team

East Arnhem:

East Arnhem MHAODS SEWB

Big Rivers:

Katherine Mental Health Alcohol and Other Drugs Service

Barkly:

Barkly Mental Health Team

Central:

Mental Health Unit at Alice Springs Hospital
Subacute Facility
Adult Community Mental Health Team
Crisis Assessment Treating Team
Child and Youth Mental Health Service
Forensic Mental Health Team
Mark Sheldon Remote Mental Health team



L>R Ryan, Nicki, Jeswynn, Toni

5. 2025-2026: Our Year in Review

5.1 Special Thanks – Dr Sarah Giles



L>R Toni, Sarah, Nicki

In April 2026, our longest serving Community Visitor Panel member, Dr Sarah Giles, resigned as Chair and Medical Member of the Top End and Central Mental Health Panels. Dr Giles has been a valued Panel member since 2004, where she has graciously shared her extensive experience and knowledge of mental health and service systems.

Dr Giles's commitment to promoting rights in service delivery, together with her person-centred approach to care, has been evident throughout her 22 years on the Panel.

We thank Dr Giles for her dedication and commitment and wish her the very best with her next chapter.

5.2 Behind the Scenes



L>R Nicki, Toni, Jeswynn, Ryan



Ryan with Hannah from Good Dog Therapy Services at the IPU



L>R Nicki, Jane, Toni



Nicki and Marg (CVP/ADC Admin support)



Enjoying an NT sunset after a long day of statutory inspections in Alice Springs.

5.3 Stakeholder Engagements



CVP and Neami National Lived Experience Advisory Group



CVP and TEMHCO staff at Mental Illness Fellowship Australia (MIFA) event



Darwin Disability Expo. Wendy and Nicki



Nicki and Ryan



Taryn, Jeswynn and Nicki

5.4 Legislated Inspections

5.4.1 Panel Inspection:

The Central Australia Community Visitor Panel conducted an inspection of the Mental Health Unit in July 2025. We thank the service for their assistance to the Panel during their visit.



Alice Springs Panel L>R Alex, Sarah and Mathews

5.4.2 Approved Treatment Agency Inspections:

NT Government's community-based mental health services are provided by the NT's two ATA's: TEMHAODS and MHAOD CAR. These two agencies are comprised of several community-based mental health teams.

During this financial year, legislated inspections were carried out on TEMHAODS Palmerston Community Mental Health team and East Arnhem MHAOD SEWB service.

a. Palmerston Adult Community Mental Health Team

Whilst the CVP inspected the Darwin Adult Community Mental Health Team (AMHT) in May 2025, difficulties obtaining information, data and limited engagement from the service led to a decision to combine the CVP's final report with the Palmerston Adult Community Mental Health Team (PMHT) inspection conducted in September 2025. The CVP experienced similar challenges engaging with the PMHT. This impacted the content of the final joint report, which was sent to the service in March 2026.

Based on the limited information available, the CVP understands that despite significant population growth in the Palmerston region, there has been no increase in full-time equivalent (FTE) staffing over the past decade. Additionally, whilst staffing allocations are reportedly shared across the AMHT and PMHT, only one Aboriginal Mental Health Worker (AMHW) position is allocated across both teams.

Whilst the CVP is regularly informed of challenges accessing interpreter services, no data relating to interpreter requests was made available to the CVP, despite numerous requests. This limits the CVP's ability to assess the extent of interpreter use along with access issues.

b. Groote Eylandt and Nhulunbuy October 2025

The East Arnhem Mental Health Alcohol and Other Drugs Social Emotional Wellbeing Service

The CVP visited Groote Eylandt and Nhulunbuy in October 2025 to conduct an inspection of the EA MHAOD SEWB service. As limited funding restricts the CVP's ability for regular travel to all regions of the Northern Territory, the opportunity to visit these areas was particularly valuable.

The visit enabled the CVP to engage with service providers and staff across the region and provided a valuable opportunity to meet persons and families who had accessed support through the Groote Eylandt mental health team and/or Royal Darwin Hospital's (RDH) IPU. These conversations provided a well-rounded perspective on the mental health services available in the East Arnhem region, as well as the challenges experienced by both service users and providers.

Whilst service users on the island spoke positively about their engagement and support from the EA MHAOD SEWB team, common themes from all parties related to:

- **No available Step-Up/Step-Down facilities in the East Arnhem region to support care on Country,** limiting opportunities to prevent admissions to RDH's IPU and to provide an alternative transition pathway back into the community following hospital admission.
- The disconnect and distress that people experienced when sent to Darwin for an admission to IPU with one father sharing his daughters experience **"she is lonely, and her removal from country and culture is making her more distressed".**
- Concern over the impact of IPU admissions and the challenges associated with returning to community. This was referred to as **'people becoming lost in transition to and from Darwin'.**
- **Limited youth specific mental health support in the region.** Access to child and youth mental health expertise in the East Arnhem region is supported through periodic specialist psychiatric consultation. It is acknowledged that further development of structured clinical governance and multidisciplinary support arrangements would enhance local service capability and strengthen care pathways for children and young people.
- Reflecting on the positive outcomes associated with the Anindilyakwa Healing Centre, a 32-bed alternative-to-custody program for men at risk of entering the criminal justice system or transitioning from prison a father stated, **"Why can't we have a healing centre for everyone, not just people in corrections?"**


Rock Art in garden at Angurugu Health Centre


Artwork by person in MHU

At the time of the CVP visit the Groote Eylandt team were involved in a pilot ‘Grow Your Own’ initiative that supports local Aboriginal Health Practitioner students on the island. The team advised that two students were expected to join the EA MHAOD SEWB service, increasing workforce capacity while enhancing the delivery of culturally responsive care.













6. In Focus

6.1 Youth Mental Health

Why this Matters

Research shows half of all adult mental ill health is evident before the age of 14, while 7 of the 10 most common paediatric presentations relate to mental health[1,2]. This highlights the importance of early intervention and accessibility to therapeutic mental health care for young people.

The Australasian Health Facility Guidelines recommend that young people receive care in the least restrictive setting possible, preferably in the community. Where inpatient admission is required, the guidelines describe the importance of environments which promote recovery through natural light, outdoor access, day programs with meaningful activity, sensory spaces and family involvement[3].

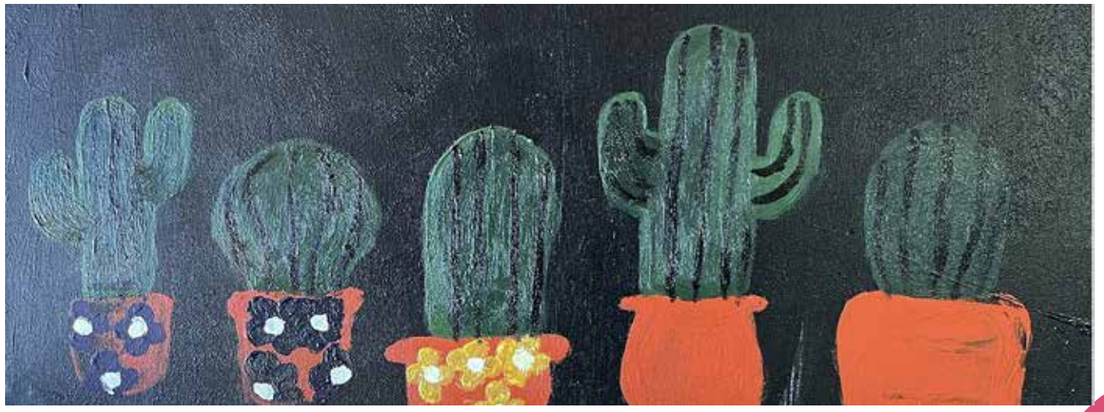
Consistent Themes

In 2026, the CVP received a copy of NT Health’s 2024 review of YIP, obtained through the Freedom of Information process by the Australian Broadcasting Corporation. The document emphasised that Royal Darwin Hospital’s YIP service delivery plan could not be implemented and that its physical environments did not meet the standards of Australian Health Facilities Guidelines[4].Furthermore, it highlighted the challenges of accessing community-based youth mental health supports for young people across the Northern Territory, particularly those living in remote locations.

This review supported the CVP’s ongoing concerns about the YIP environment, aligning with feedback from young people, families, carers and clinicians. Additionally, it highlighted the increase in youth mental health presentations and subsequent workload of the YIP, whilst noting a decrease in staffing.

Issues identified in the report and those commonly raised by young people and/or their families/carers include:

- ward environment does not promote wellbeing
- limited access to outdoor spaces
- no fit for purpose sensory room
- isolation (particularly young people with no family/carer support in Darwin)
- limited access to therapeutic activities
- no dedicated psychologists, aboriginal mental health workers or youth workers.



‘Cacti’ by person in MHU

YIP and Youth Justice

Unlike all other states and territories in Australia, the NT has no dedicated Forensic Mental Health Unit for persons with mental ill health or disability who are engaged in the criminal justice system[5]. As such any person, including youth, who require an inpatient mental health admission are admitted to an ATF.

In June 2026, the CVP raised concerns about the conditions experienced by three young people admitted to YIP, two of whom had been transferred from Holtze Youth Detention Centre to YIP[6]. Following an escape attempt, YIP was divided into three separate sections. This resulted in the two youth from HYDC being confined to an internal passageway area with no windows, natural light, fresh air, or outdoor access for 10 days.



YIP Indoor basketball court area

The third person, a 16-year-old female with no involvement in the youth justice system, was restricted to another section of the ward and experienced reduced access to outdoor areas due to staffing limitations. Unfortunately, the division of the small YIP area into smaller sections, due to acute presentations and/or the admission of young people from Youth Justice, continues to impact the environment and care for young people on this ward. Whilst the CVP acknowledges the additional challenges the service faces when Corrections or Youth Justice are involved, the impact of this non-therapeutic environment on young people, needs urgent attention.

Challenges Beyond the Greater Darwin Region

The CVP continues to observe, and are informed of, significant barriers to accessing mental health support for young people living outside the Greater Darwin region, especially those in remote communities.

During a legislated visit to East Arnhem, the EA MHAOD SEWB team acknowledged the limited youth specific service delivery across the region. Whilst it was evident that the EA MHAOD SEWB team, who provide support to adults, have worked hard to be flexible in their service delivery, the team acknowledged that they do not have capacity to provide this support on a full-time basis.

East Arnhem families described the distress their children experienced when they are admitted to YIP. Boredom, disconnect from family, isolation and limited access to outdoor spaces were some of the concerns raised. At the time of the visit, the CVP were informed that NT Health's plan to establish the *Youth Strength & Healing Service"* (YSHS), for young people in the EA region had not come to fruition.

It is unclear whether this will be a component of NT Health's broader *Roadmap to Reform* for NT infant, child and adolescent mental health service systems. Furthermore, it is unclear what implementation plans for the 2025 *Roadmap to Reform*[7], which identified staged reform opportunities to improve young people's access to mental health and wellbeing support across the NT, have been developed or actioned.

Opportunities for Reform

The challenges facing youth mental health service delivery in the NT have been consistently identified by young people, families, clinicians, the CVP, NT Health and independent reviews.

The CVP encourages NT Health's commitment to reform, which will require continued investment in:

- strengthening community-based youth mental health services
- improving therapeutic inpatient environments that align with national standards
- expanding culturally safe services that enable young people to receive care closer to home
- progressing implementation of the Roadmap to Reform and other existing review recommendations.

Improving therapeutic environments and accessibility is more than an infrastructure issue. It is fundamental to supporting recovery, reducing distress and ensuring young Territorians receive safe, developmentally appropriate and culturally responsive mental health care.



YIP communal area



YIP nursing station

6.2 Community Visitor Scheme (CVS) Project

Over the past year, the NT CVP has actively contributed to a national initiative to develop and implement consistent approaches to Community Visitor Schemes (CVS), as recommended by the Disability Royal Commission (Recommendation 11.12 and 11.13)[8].

CVS were established prior to the National Disability Insurance Scheme (NDIS) and vary significantly in their legislative frameworks and operational structures. This was identified by all jurisdictions as one of the main challenges of the project. The outcome was to develop CVS National Principles alongside an evidence base which supports jurisdictional flexibility on CVP-related reform implementation across Australia. An Ernst and Young review on the costs associated with potential reform scenarios was included in the project.

Underinvestment in CVS was noted in a 2023 research report by Melbourne Disability Institute, highlighting underfunding and under-resourcing, along with lack of access to relevant information as issues impacting the capacity of CVS[9]. This same report acknowledged the impact of the NDIS on CVS which resulted in the 'privatisation' of the disability service sector, whereas most CVS had historically been established for oversight of government run facilities and services.

The 2023 Melbourne Disability Institute report noted the potential benefits of utilising CVS in Australia's obligations under OPCAT, which it ratified in 2017. Under OPCAT, the Commonwealth Ombudsman has established a multi-body Australian NPM comprising of independent national visiting bodies. In the NT, the Office of the Children's Commission (OCC) and the NT CVP are recognised as anticipated NPMs, while the NT Ombudsman serves as the interim coordinating NPM[10]. As such, whilst the NT CVP contributes to the NPM's annual report, it does not have the legislative powers or dedicated funding to undertake OPCAT monitoring visits.

In comparison to other CVS in Australia (aside from Tasmania and West Australia who are in the process of implementing CVS), the NT CVP's scope of responsibilities under the DSA is small and confined to forensic settings. The NT CVP supports increasing the scope of the disability arm of its program, however, to do this the DSA needs to be reviewed and modernised, noting that:

- The DSA was developed before the implementation of the NDIS and does not adequately reflect the current disability service environment, leaving significant gaps in safeguarding and independent oversight arrangements.
- Modernising the DSA would support improved accountability and stronger safeguarding practices in the NT.
- Expanding the NT CVP coverage to a broader range of NDIS funded services, such as Supported Independent Living (SIL), will help ensure there are stronger protections in place for people living with a disability, and would also align with recommendations from the Royal Commission.
- Any future legislative reform should preserve the CVP's independence within the Anti-Discrimination Commission (ADC) to maintain independent oversight and prevent conflicts of interest with agencies that support people with disability.

Reform of the DSA, along with a significant financial investment to strengthen and expand the NT CVP is essential to achieving implementation of the CVS National Principles and improving safeguarding for people with disability across the NT.

6.2.1 Improved Information Sharing

In early 2026, the NT CVP agreed to participate in the NDIS Quality and Safeguards Commission's (Q&S) Strengthening Information Sharing with Community Visitors Project, which is aimed at informing a national approach to information sharing between CVS's and the NDIS Q&S.

While the NT CVP acknowledges the information-sharing project is in its early stages, it is hopeful the initiative will strengthen information sharing with the NDIS Q&S and, in turn, improve safeguarding for people with disability.

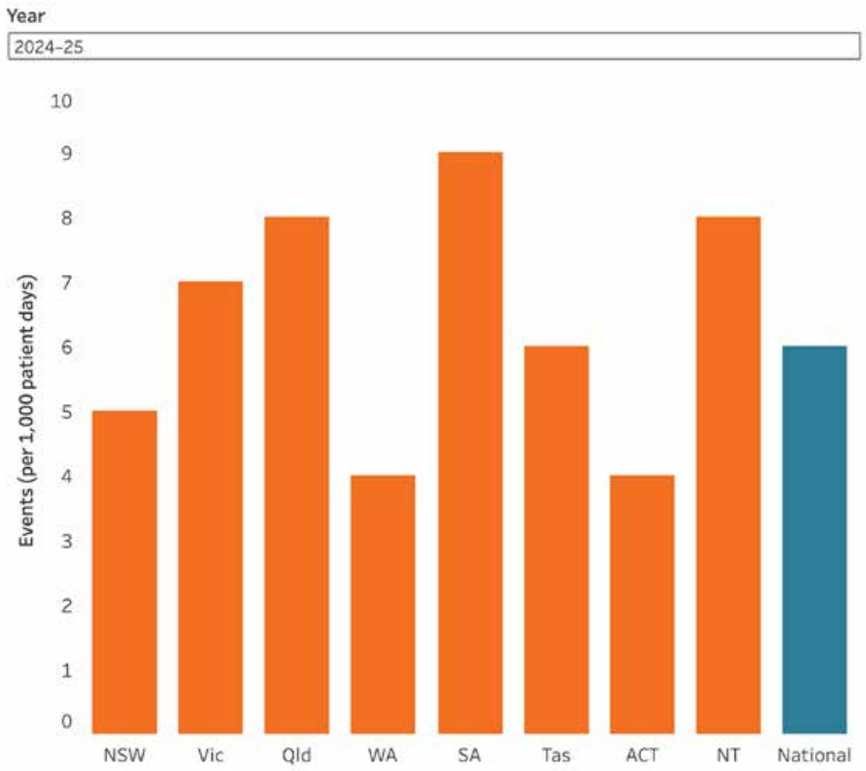
6.3 Seclusion

Seclusion is defined in NT Health's Approved Procedure 11 and section 62(16) of the MHRSA as 'the confinement of a patient at any time of the day or night alone in a room or area from which free exit is prevented'[11].

The Australian Government National Mental Health Commission's (NMHC) April 2025 Position Statement on Seclusion and Restraint acknowledges the international view that seclusion and restraint is a human rights issue which has no therapeutic value and can cause harm to the person who is secluded[12]. The Position Statement also notes that the level of seclusions and restraint in a facility can be an indicator that a system is under stress.

Key Performance Indicators (KPI's) on seclusion and restraint for Australian Public Mental Health Services are provided by the Australian Institute of Health and Welfare (AIHW), with the purpose to monitor whether a system/service is performing at the nationally agreed standard[13]. These KPI's can also show how a service is progressing or changing in "a way that supported quality improvement activities for mental health services".

In the 2024-25 period, the national seclusion rate, calculated as events per 1000 bed days, was 6. A comparison of the national seclusion rates is available from the AIHW[14] and depicted in the diagram below, demonstrating that NT and Queensland recorded the second highest seclusion rate of 8 after South Australia's 9.



Graph obtained from Seclusion and restraint indicators - Mental health - AIHW



Behind every episode of seclusion is a person's experience. The CVP regularly speaks with persons who have experienced seclusion. The comments below highlight some of these:



Under the MHRSA, the CVP is legislated to inspect seclusion registers for NT's two ATF's.

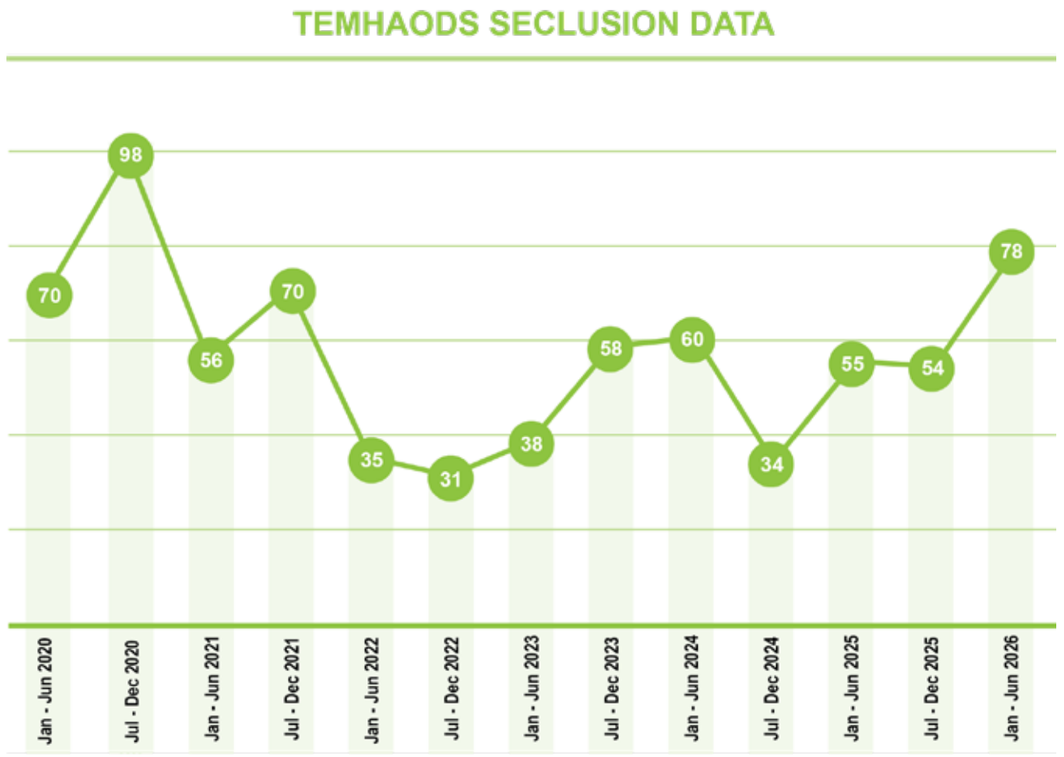
Recent CVP inspections raised concern regarding:

- Clinical records relating to the 3-hour and 45-minute seclusion of a deaf, non-verbal woman contained no evidence that communication supports, or assistance were provided or attempted during a seclusion episode.
- Clinical notes which referred to the seclusion room as a "low stimulus environment".
- Incomplete seclusion authorisation documentation.
- A seclusion authorisation form which stated "can come out of seclusion as accepting of treatment plan".
- Seclusion Registers which had not been updated and were missing documentation.

6.3.1. Top End IPU Seclusions:

The CVP notes the following trends in seclusion data:

- Upward trend in number of seclusions (highest since 2020).
- Over-representation of First Nations people impacted.
- Upward trend in seclusion of people aged 18-24 years.
- Increase in women experiencing seclusion.
- Regular non-compliance with legislated requirements and Approved Procedure 11 for seclusion documentation, indicating ongoing deficiencies in recording and reporting.

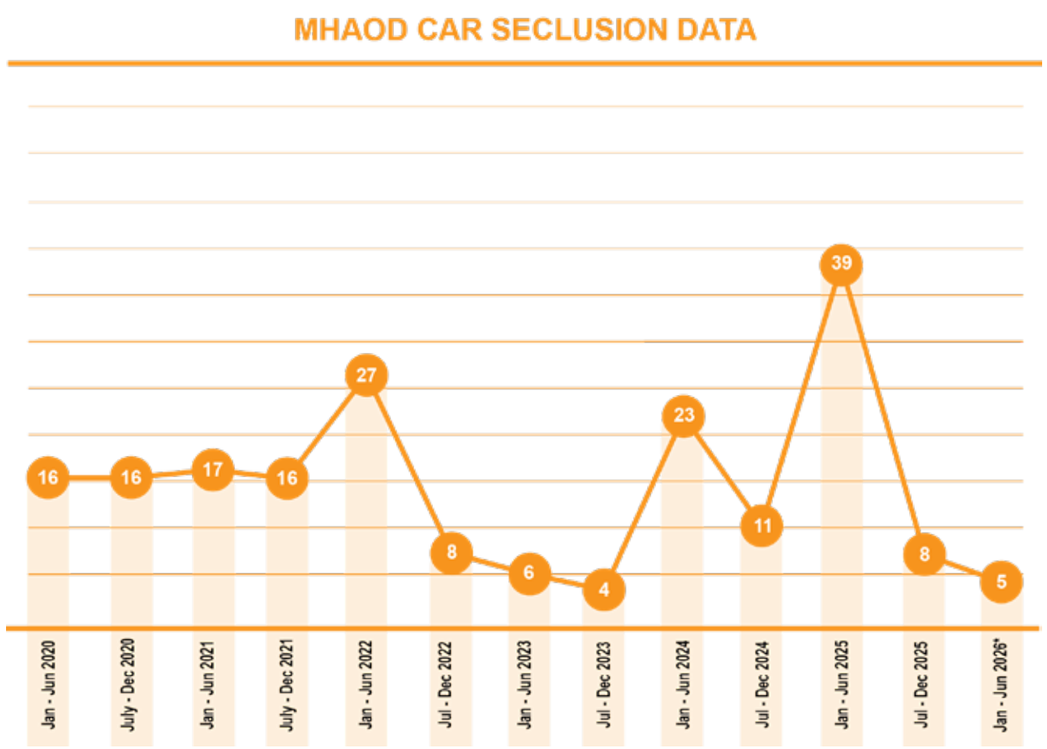


IPU Seclusion data since 2020



6.3.2 Central MHU seclusions:

- Non-compliance with legislated requirements and Approved Procedure 11 for seclusion documentation, indicating ongoing deficiencies in recording and reporting.
- Concern over MHU's seclusion data collation for the January – July 2026 period, with the Seclusion Register missing documentation for seclusion events during this time.



MHU Seclusion data since2020 (*Jan – June 2026 data incomplete)



7. NT Mental Health Inpatient Settings: CVP's 2025/26 Reflections

Under the MHRSA, psychiatric admissions can only occur in an ATF. In the NT, there are two ATF's with inpatient mental health unit's which fall under CVP's remit, namely:

Royal Darwin Hospital's IPU, comprising of:

- Cowdy Ward
- Joan Ridley Unit (JRU), which has a seclusion room.
- YIP

Alice Springs Hospital's MHU, comprising of:

- Low Dependency Unit (LDU)
- High Dependency Unit (HDU), which has a seclusion room.

The following reflections have been gathered by the CVP through communication with persons accessing the services and/or staff in addition to CVP observations made during visits to these facilities.







New Mental Health Unit being built at RDH

7.1 Inpatient Unit – Royal Darwin Hospital

Top End Inpatient Unit - Service Delivery Highlights

- Introduction of weekly therapy dog visits in Cowdy.
- Installation of a basketball ring and additional blackboard walls in JRU indoor courtyard.
- JRU's new outdoor shade sail providing opportunity to restore year-round access to JRU outdoor garden.
- IPU's community partnerships supporting group work, including commencement of a gardening group, donations of gardening equipment and clothing.
- Ongoing collaboration between the CVP, IPU treating teams, management and staff which supports timely responses to enquiries and effective advocacy for persons receiving care.
- Allied Health's structured morning meetings and activity schedules across the IPU, including in JRU.
- The casual attire worn by G4S staff in JRU, contributes to a less authoritative and carceral security presence.
- Ongoing access to the Recovery Hub for persons in Cowdy ward.









IPU Cowdy ward, clockwise from top left: communal area, Recovery Hub, garden, courtyard

Top End Inpatient Unit – Areas for improvement

- No functioning outdoor fans in Cowdy since October 2024, significantly limiting access to fresh air and outdoor spaces.
- Upward trend in seclusions during 2025–26.
- Despite designated mandatory outdoor hours and upgrades to the JRU garden, feedback indicates that access to these spaces is not consistently facilitated.
- Significant delays in complaint responses, with some individuals waiting up to 12 weeks, highlighting the need for additional complaints resourcing.
- The IPU lacks fit-for-purpose sensory rooms to support sensory regulation, therapeutic de-escalation and wellbeing.
- Greater awareness of, and earlier collaboration with, the NDIS Hospital Liaison Officer would improve access to NDIS services and support sustainable discharge planning for people with disability.
- Regular feedback from involuntarily IPU patients indicate inadequate orientation with limited available information on ward rules and rights under the MHRSA.







Clockwise from top left: JRU indoor courtyard , JRU dining area and JRU indoor courtyard

7.2 Mental Health Unit – Alice Springs Hospital

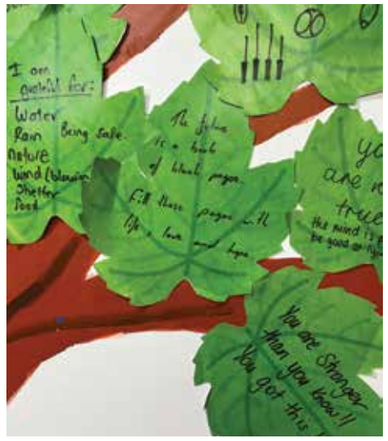
Mental Health Unit - Service Delivery Highlights

- Collaborative mural projects involving church volunteers, staff and patients have enhanced the MHU's environment in LDU and HDU.
- Well-established and well-integrated Allied Health team across the MHU with regular positive feedback about Allied Health led activities from persons on the ward.
- Weekly BBQs shared between staff and persons receiving care.
- The installation of CCTV throughout the MHU.
- Access to Ngangkari healers on the ward facilitated by designated Aboriginal staff. The MHU is the only service in Australia where this is available to Aboriginal persons on the ward.
- The new Peer Worker position marks an important step in embedding lived experience workforce within the service.
- Recognition of MHU staff for their continued support in facilitating CVP online visits and their ongoing assistance during in person visits, often during times when there are staff shortages.







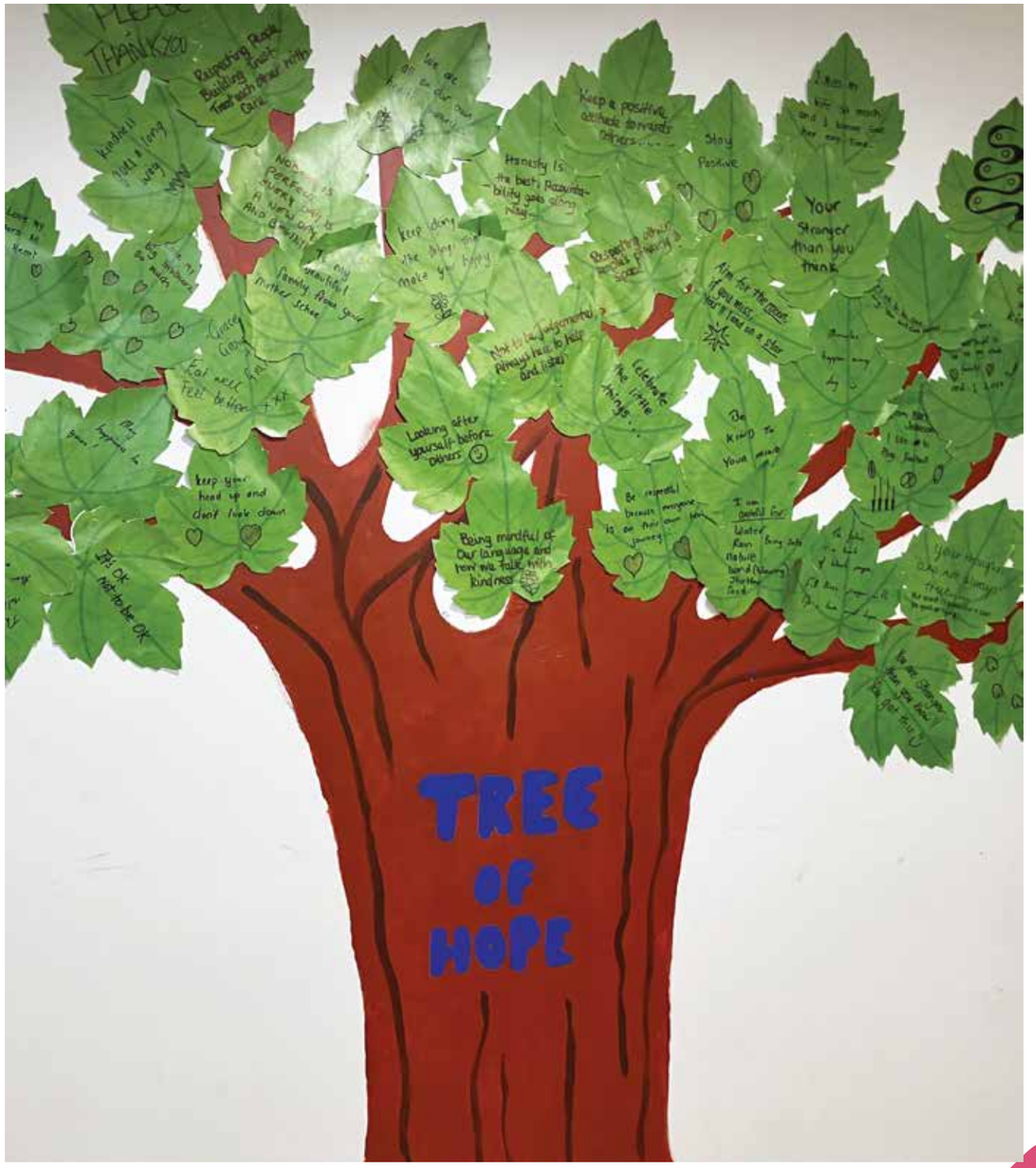




Clockwise from top left: L>R Kendall, Margo, Nicole and Ronald in MHU's HDU outdoor courtyard, MHU entrance , Tree of Hope in LDU, New mural in HDU, Communal TV area

Mental Health Unit – Areas for improvement

- Ensuring legislated documentation for all seclusion events are completed in accordance with the MHRSA and Approved Procedure 11.
- Seclusion Register is kept updated and reflects the total number of seclusion events.
- Environmental modifications to enable persons on the ward to have independent access to outdoor spaces.
- Staffing shortages impacting access to outdoor areas for persons in the MHU.
- Improved communications and responses from the Treating Team in relation to enquiries raised by persons on the MHU.



Tree of Hope, LDU

8. CVP Impact

Over the years, the CVP has played a role in improving the experiences of people receiving care under the MHRSA and DSA. Whilst, at times, our advocacy has led to meaningful change, we acknowledge that we are not always able to deliver the outcomes requested from the persons we engage with.

Over the course of 2025 – 2026, the CVP engaged with many people in involuntary settings. The following reflections were shared by people with lived experience, their families and support persons, offering insight into their interactions with the CVP and the difference advocacy and independent support can make.



9. Financials

The CVP's allocated budget of $530,000 per annum is provided by the Department of Health, with no increase since 2014.

BUDGET	ALLOCATION	DETAILS
1. Personnel	**$438,464 (83%)**	• 2.6 FTE • 0.2 Principal Community Visitor
2. Operational	**$91,536 (17%)**	Divided into non-discretionary and discretionary costs

a) Non-discretionary	***$ 37,656*** *(41% of operational budget)*	This includes:
		• Electricity
		• Rental of NTG IT equipment
		• Fees to draft ministerial appointment instruments
		• PCV vehicle costs
		• Panel and Sessional CV sitting fees:
		  • The CVP Panel and Sessional CV's (casual CV's) are established as Board members of the CVP (as per NTG requirement). Their remuneration follows the NTG guidelines for Board Members.
		  • The two legislated CVP Panels are independent to the CVP permanent staff and are responsible for undertaking the legislated Panel inspections of ATF's.
		  • The cost of these inspections vary from $8k - $12k per inspection, which is paid for from the CVP budget.
		  • Approximately $20k - $24k per year is paid to the CVP Panel for it to conduct legislated activities.
		  • In 2026 the CVP amended its use of the Panel due to the associated costs.

b) Discretionary	***$53,880*** *(59% of operational budget)*	80% is utilised for travel, however CVP is mandated to only use NTG supported suppliers

10. Wishlist – A CVP Tracking Tool

Small change noted Almost completed Completed

24/25	25/26	Wishlist
☐	☐	NT's 2024 Mental Health Bill is passed.
☐	☐	Improved access to interpreters across the services.
☐	☐	Increased resources improving availability and access to community mental health services, including youth mental health supports.
☐	☐	Increased resourcing and availability for services to implement full allied health in mental health services.
☐	☐	The staffing profiles for Aboriginal Mental Health Workers (AMHW) and Aboriginal Health Practitioners (AHP) is reflective of the number of First Nations persons accessing the services.
☐	◔	Lived Experience teams are included in community and Inpatient mental health settings.
☐	☐	Improved access to NDIS supports for persons on the ward via the inpatient NDIS Health Liaison Officers.
☐	☐	Increased services providing Step up- Step down residential facilities across the NT.
☐	☐	A dedicated Forensic Mental Health facility in the NT which is fully staffed and operated by NT Health delivering therapeutic, trauma informed care.
☐	◔	A focus on 'Grow Your Own' initiatives for upskilling and training people in remote areas that is appropriately funded, thus improving and growing staffing pools of mental health and disability support workers in remote regions.
☐	☐	Overall improvement of patient journeys through the mental health system due to a reduction in gaps in service delivery.
☐	☐	Sensory rooms are revamped resulting in a fit for purpose space in the IPU and MHU.
☐	☐	Full CVS Scheme is implemented and appropriately funded in line with DRC recommendations.
☐	☐	The DSA is reviewed and modernised.
☐	☐	The NT CVP funding aligns with its legislated responsibilities.
☐	☐	OPCAT funding delegated to all NPM's.

11. Acronyms

AHP	Aboriginal Health Practitioner
AMHW	Aboriginal Mental Health Worker
AP	Appropriate Place
APP	Approved Psychiatric Practitioner
ASH	Alice Springs Hospital
ATA	Approved Treatment Agency
ATF	Approved Treatment Facility
CBU	Complex Behaviour Unit
CV	Community Visitor
CVP	Community Visitor Program
DCP	Darwin Correctional Precinct
DRC	Disability Royal Commission
DSA	Disability Services Act 1993
EA MHAOD SEWB	East Arnhem Mental Health Alcohol and Other Drugs, Social and Emotional Wellbeing Service.
FDU	Forensic Disability Unit
IPU	In-Patient Unit (the Mental Health Unit at Royal Darwin Hospital)
JRU	Joan Ridley Unit, IPU, Royal Darwin Hospital
MHAOD-CAR	Mental Health Alcohol and Other Drugs – Central Australian Region
MHRSA	Mental Health and Related Services Act 1998
MHU	Mental Health Unit (Alice Springs Hospital)
NDIS	National Disability Insurance Scheme
NGANGKARI	Traditional healers of the Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara (NPY) lands in the remote western desert of Central Australia.

NGO	**Non-Government Organisation**
NPM	**National Preventative Mechanism**
NT	**Northern Territory**
NTG	**Northern Territory Government**
NTCS	**Northern Territory Correctional Services**
OPCAT	**Optional Protocol to the Convention against Torture**
OPG	**Office of the Public Guardian**
PCV	**Principal Community Visitor**
RDH	**Royal Darwin Hospital**
SIL	**Supported Independent Living**
TEMHAODS	**Top End Mental Health Alcohol and Other Drugs Service**
YIP	**Youth Inpatient Program (in the IPU at Royal Darwin Hospital)**



12. Appendix

Please visit the CVP Website at Home I Comunity Visitor Program Northern Territory to view:

i. Additional raw data.

ii. Recommendations.

13. End Notes

1 https://www.mentalhealthcommission.gov.au/projects/childrens-strategy

2 Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR & Walters EE. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593–602.

3 Australasian Health Infrastructure Alliance, 2015 – 2025, Australasian Health Facility Guidelines (AusHFG). Child and Adolescent.

Mental Health Unit (CAMHU), https://healthfacilityguidelines.com.au/sites/default/files/HPU_B.132_8_2.pdf

4 Northern Territory Department of Health. (2024). Youth Inpatient Program Review (prepared by the Chief Psychiatrist and Consultant Child and Adolescent Psychiatrist; obtained through the Freedom of Information process by the Australian Broadcasting Corporation, 2026).

5 Ogloff, J. R. P., Doherty, A., Eason, M., & Shields, R. (2021). Complex Behavioural Unit Feasibility Study: Final Report. Report prepared for the Northern Territory Department of Health.

6 C/2026/0177

7 Nous Group. (2025). Roadmap to Reform for the Northern Territory Infant, Child and Adolescent Mental Health Service System

8 https://www.health.gov.au/resources/publications/disability-royal-commission-progress-report-2025/volume-11-independent-oversight-and-complaint-mechanisms/recommendation-1112-nationally-consistent-community-visitor-schemes

9 https://disability.unimelb.edu.au/research/seed-funding/seed-funding-2022/community-visitor- schemes

10 Australian National Preventive Mechanism (NPM) | Commonwealth Ombudsman.

11 http://internal.health.nt.gov.au/clinical/chief-psychiatrist/approved-procedures/Pages/default.aspx

12 position-statement-on-seclusion-and-restraint-in-mental-health.pdf

13 Performance indicators - Mental health - AIHW

14 Seclusion and restraint indicators - Mental health - AIHW

FRONT AND BACK COVER DESCRIPTION;

Sturt’s Desert Pea wall mural in the Mental Health Unit, Alice Springs Hospital.

Created and painted by volunteers, staff and persons receiving care.



‘Barramundi’ by G.Campion

The artworks throughout this Annual Report have been generously shared by;

Persons who have engaged with the CVP within the Inpatient Unit at the Royal Darwin Hospital, the Mental Health Unit at the Alice Springs Hospital and the Forensic Disability Unit.

The CVP thanks all artists for allowing their beautiful artworks to be featured in this year’s Annual Report.

