CVP

NT Community Visitor Program

Annual Report
2017-2018

Respect
Empowerment Courage
Independence
& Integrity

28 September 2018

The Hon Natasha Fyles
Minister for Health
Parliament House
State Square
DARWIN NT 0800

Dear Minister,

Re: Community Visitor Program Annual Report 2017-18

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Services Act*, section 66 of the *Disability Services Act*, and section 101 of the *Alcohol Mandatory Treatment Act* (repealed 1 September 2017).

I commend the report to you.

Yours sincerely,

Sally Sievers
Principal Community Visitor

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INTRODUCTION

SALLY SIEVERS

PRINCIPAL COMMUNITY VISITOR

It has and continues to be a privilege to serve as the Principal Community Visitor for the Northern Territory. The work of independent visiting for people receiving involuntary treatment and care is a significant responsibility.

Independent visiting and complaints resolution protects the rights of individuals. It assists in the provision of quality, person-centred care and services. It places the voice of the person receiving treatment and care at the centre of decisions.

This work relies on the skills, experience and personal qualities of the Community Visitors and Panel members. I would like to extend my thanks and appreciation to all those working for CVP.

Our people are our greatest asset. I would particularly like to thank long term members of the CVP team who have left in the last year, Maya Cifali and Mark O'Reilly in Central Australia, and Hiltrud Kivelitz in Darwin. Their commitment and dedication to the work of the CVP over many years has been exemplary.

The past year has been a significant year of change for the CVP. The program became smaller as the visiting responsibilities in the area of alcohol mandatory treatment ceased at the end of August 2018. There was also a reduction in enquiries and complaints raised in the mental health area due to changes in CVP staff, recording of cases, and improvement in support for consumers in the Top End to raise issues directly with the service.

With these changes, the program re-prioritised other areas of its statutory work, in particular in the mental health field. Community Visitors increased the number of inspections of community-based mental health teams.

For the first time, the CVP included an inspection of the remote mental health team in Groote Eylandt. These inspections have assisted the program to strengthen its reporting on mental health services across the Northern Territory.

One of the main strengths of the CVP is its adaptability. The experience of working in the field of alcohol mandatory treatment demonstrated the CVP's strengths in a number of areas. Its ability to quickly scale up, recruit and retain skilled staff, and implement a strong, credible visiting program.

Although the places being visited may be diverse, the fundamentals of monitoring, advocacy, complaints resolution, inspection and reporting remain. What also remains constant is the program's commitment to the values that underpin the work: our independence and integrity, the courage to raise issues, respect, and empowerment of clients.

We understand that change rarely occurs overnight. This is especially the case when staff move on and corporate knowledge is lost. An effective CVP remains persistent and vigilant in raising what can sometimes be difficult issues.

One of the most important areas of our work is in the area of restrictive practices (restraint and seclusion). As a community, the use of any force or deprivation of liberty by health care professionals is very serious. This is reflected in the legislation, which strictly regulates how restrictive practices are to be authorised, conducted and documented.

The CVP closely monitors and reports on the use of restraint and seclusion. We pay particular attention to any concerns about safety, rights or obligations under the legislation. This work is an essential part in supporting services in their commitment to reduce the use of restraint and seclusion.

Another very important aspect of the CVP's work is maintaining the focus on cultural safety, including the use of interpreters. This is particularly important in the Northern Territory, with high numbers of Aboriginal or Torres Strait Islander people accessing services. It is evident in the high numbers of Aboriginal Territorians visited by the CVP in all fields of our work.

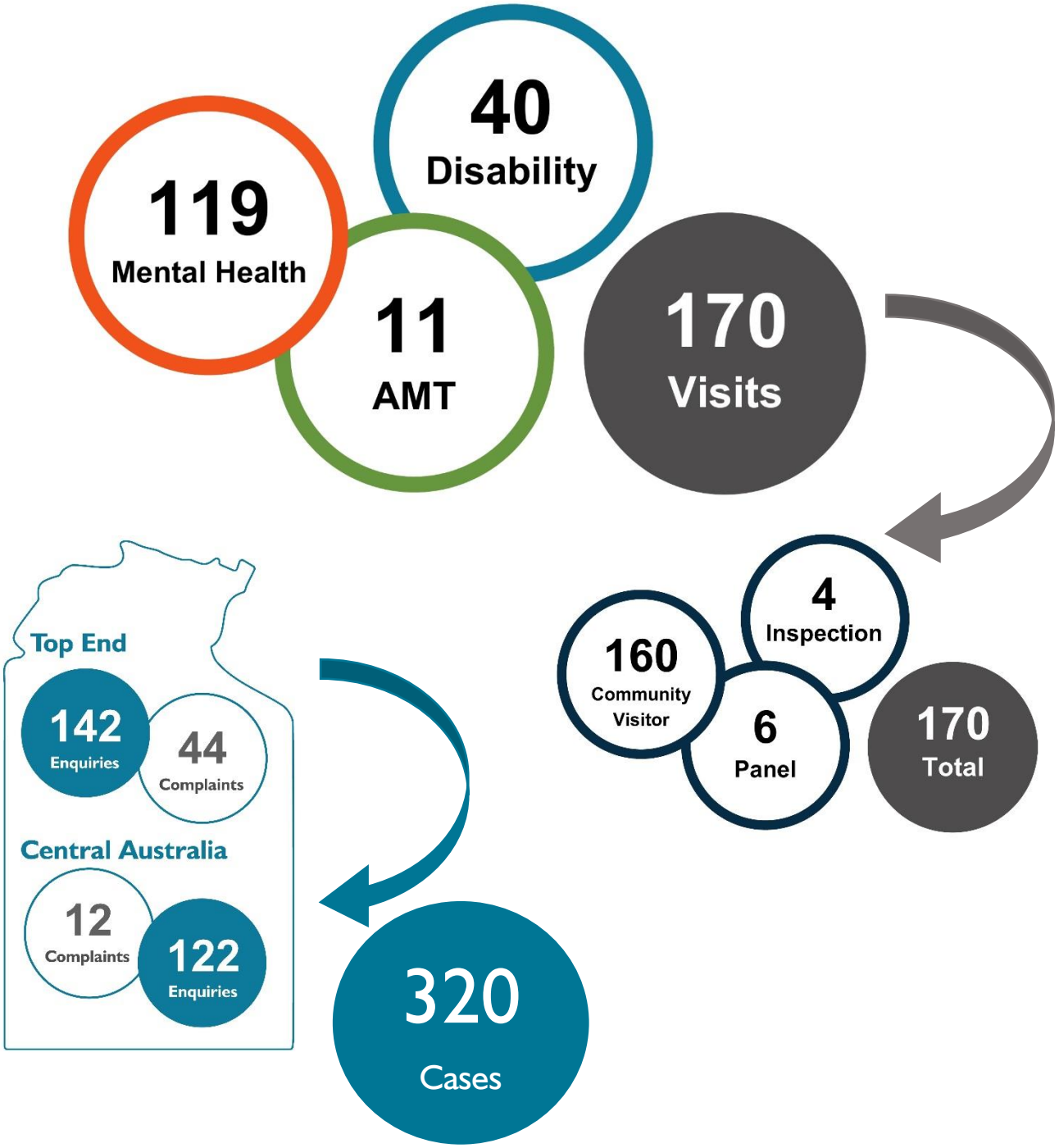
The depth of cultural and linguistic diversity in the Northern Territory is a strength. For some, however, their unique needs and circumstances can affect access to services on an equitable basis. Importantly, professionals have an obligation to use an accredited interpreter when providing services to people who communicate in a language other than English. The CVP will continue to monitor services and advocate strongly in this area.

One of the main barriers to a more culturally safe workforce is the employment of Aboriginal people across all services. This includes the CVP. Our program continues to strive to increase the number of Community Visitors and Panel members who are Aboriginal. It is pleasing to see the progress the CVP has made this year, with a number of Aboriginal people being appointed by the Minister.

The annual report of the CVP records the work of the program over the year. What it cannot capture however is the strength and resilience of the people for whom the CVP advocates and visits in facilities. Our work to support them, however, speaks to our strength as a community to protect their rights to a quality service and 'least restrictive' care.

OVERVIEW

Visits, inspections, resolving complaints, enquiries and advocacy are at the heart of the work of the Northern Territory Community Visitor Program (CVP). This year the CVP made 170 visits, and worked on 320 individual cases.



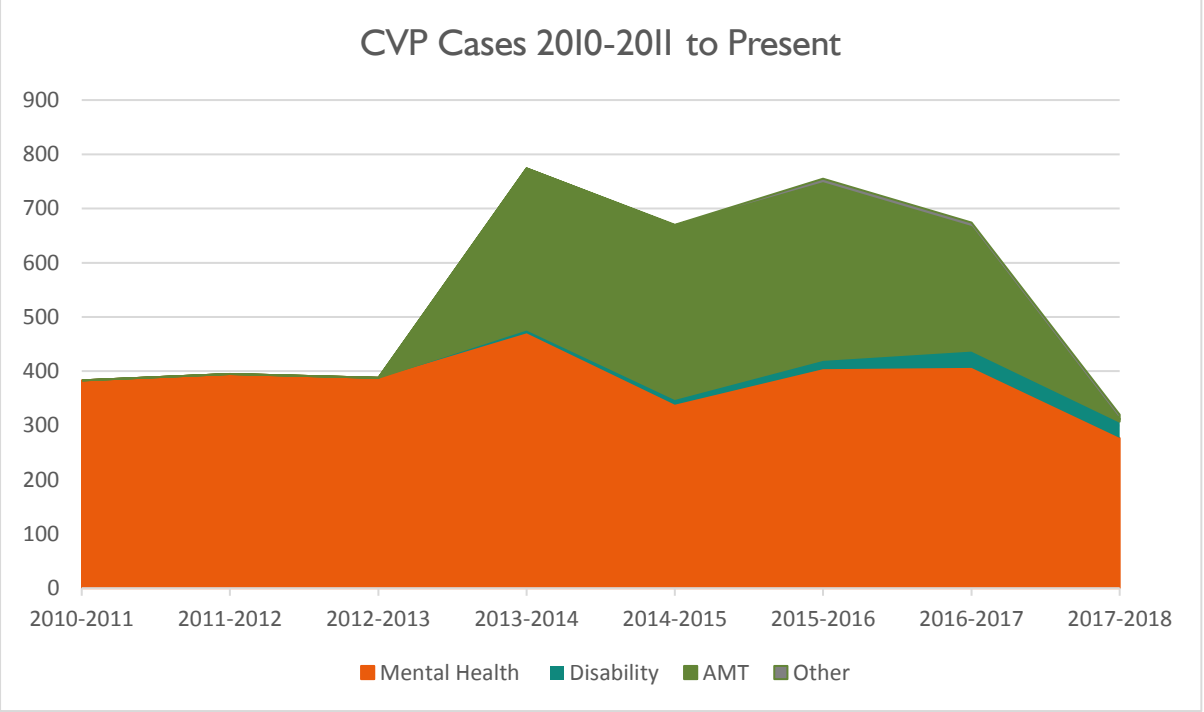
A SMALLER SERVICE

Visits and casework (that is, complaints and enquiries) are the core of the CVP's legislative obligations.[1] The CVP's work under the *Mental Health and Related Services Act* and the *Disability Services Act* continued as usual.

CVP Lessons from AMT Work

On 1 September 2017, the *Alcohol Mandatory Treatment Act* was repealed. Visits and casework in that area stopped from that time. As a result, the CVP became a smaller service with less permanent and sessional staff.

The end of work in the alcohol mandatory treatment field is the main reason that the total number of cases raised with Community Visitors went down compared to 2016-2017. The graph below demonstrates the changes in the CVP caseload over time.



The experience of the alcohol mandatory treatment work demonstrates the agility and flexibility of the CVP to respond to changing needs. As new legislation was introduced, the CVP was able to rapidly respond to new visiting and casework responsibilities.

The program managed well to meet this growth. The additional resources that came with the new area of legislation also assisted the CVP to develop its practice frameworks, improve reporting and data entry, and build a skilled workforce.

[1] Visits are CV Panels are a multi-disciplinary panel of members, comprised of 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.

The CVP now better understands many of the true costs associated with implementing a strong, independent visiting program in the Northern Territory. The reduced budget evident in this year has led the program to step back and re-evaluate its priorities.

The Bigger Picture

Visiting people in facilities and residences, and meeting statutory timeframes, will always be the core of the CVP's work. If the CVP is to fulfil its mandate to be an effective, independent voice on services to the Northern Territory government, then it must also be able to review those services at a more systemic level.

The CVP has an established commitment to visit Darwin and Alice Springs mental health facilities at the hospitals at least once a week. This commitment is nearly always achieved. The weekly visit provides the opportunity for Community Visitors to meet consumers in the facilities, to explain the independent work of the CVP, and to assist in resolving matters at the lowest possible level.

In the past, the CVP often had the time and resources to visit more than once a week. For example, if a consumer requested the CVP, in general the Community Visitor would aim to see them in person.

Due to more limited resources, and changes in staff, the CVP has had to limit the number of visits to the mental health in-patient facilities. The visiting schedule to mental health has reduced to just once weekly, with only occasional extra visits when compelling reasons exist.

Despite reducing the overall number of visits in mental health, the CVP re-prioritised its visiting schedule to increase the number of visits to community-based mental health agencies. These annual visits, while time consuming to complete, are an important part of picture on mental health services in the Northern Territory.

This adjustment in the CVP's visiting schedule in mental health enables the CVP's advocacy to be more informed about the Territory-wide issues. It is also a pragmatic response to the resource constraints on the work of the CVP.

Focusing on Safety and Quality

Even in the face of these resource constraints, the CVP has retained its strong focus on systemic issues that affect safety and quality in facilities. The quality, depth and coverage of policies and procedures has been a common area of commentary in all areas of CVP work.

The CVP has raised with the mental health services that the legislatively required 'Approved Procedures Quality and Assurance Committee' has not met for over a year. This committee monitors and reviews the overarching mental health procedures. It is also set up to assess and evaluate the quality of mental health services. In the absence of a committee being constituted, issues that are best addressed through this forum (as anticipated in the mental health legislation) cannot be resolved. These potentially create risks for consumers and services.

In the disability field, the CVP has raised the importance of updating the policies and procedures in place for the Secure Care Facility and other residential facilities. While some policies and procedures are in the process of being updated by the Office of Disability, it is essential that this work is completed in a timely way.

The safety of residents in facilities, in particular where they are involuntary residents or patients, is paramount. Having clear and consistent policies and procedures, which complement relevant legislation to be implemented, is a cornerstone of a quality service.

The CVP, through its CV Panels and the casework of Community Visitors, will continue to advocate strongly in this area, raising action items and recommendations as required. This is a key area that both areas must improve.

RELATIONSHIPS ARE KEY

Raising Matters Face to Face

In the CVP's experience, raising matters in person is usually the best way to get a 'low level' resolution. It helps prevent worries or concerns becoming more serious. For some people, they may be particularly reluctant to raise matters with someone over the phone, especially if their preferred language is not English.

This year, 55% of all cases were raised in person or on a visit, and 34% by telephone. This is a significant shift from the previous year, when 71% of matters were raised in person or on a visit. This change can mostly be accounted for by the reduction in cases from the alcohol mandatory treatment field.

In general, the majority of cases in the disability field are raised in person or on a visit. The overall number of disability cases is very small, however, being only 9% of the CVP's total caseload this year.

In mental health, there is more diversity in the way that matters are raised. While most people accessing the CVP do so in person, many are also comfortable raising their concerns in the first instance by phone. The people raising issues may be those receiving services or treatment directly ('consumers'), their carers, family members, guardians, nurses or doctors, and even service providers.

It is clear, however, that when it is the consumer who wants to raise an issue, their preferred way of raising matters with the CVP is in person. About 70% of the cases raised by mental health consumers happen during a visit.

This year, there has also been a reduction in the total numbers of cases in the mental health area (down 32% to 277 cases). Some of these changes can be explained by the reduced number of visits to in-patient facilities. There was a 23% reduction in the number of visits to the Alice Springs and Darwin in-patient facilities in this year.

In the Community Visitors experience, sometimes consumers may know and trust them, based on previous contact. Building relationships is an important part of the role, and especially important in the work with Aboriginal Territorians.

The CVP considers that the change in staff within the team in the Top End has impacted on the reduction in mental health cases raised. The introduction of a consumer consultant in the Top End mental health service may also have improved accessibility of the service to consumers wanting to raise issues.[2]

All Voices are Heard

Many people raising matters with the CVP are Aboriginal Territorians. The CVP is proud of its record in supporting Aboriginal people to raise issues of concern. Of the 222 individuals who raised matters (some raising more than one case), 90 were recorded as Aboriginal Territorians.

This means at least 41% of the people using the CVP in the past year are Aboriginal Territorians. When people from other culturally and linguistically diverse backgrounds are included in this picture, this rises to 43%.

Of those people from diverse cultural backgrounds, half required an interpreter. The CVP has been and remains diligent in booking interpreters to ensure that the CVP's professional obligation to clearly understand and communicate is discharged.

It is especially important to use interpreters in this work. Communicating about difficult or sensitive matters is hard. Making a complaint can be a confronting experience. Finding the right words in an emotionally charged environment is both challenging and important.

The CVP will continue to role model the use of interpreters, and enliven the rights of people who communicate in a language other than English to speak, be heard and understood.

Responsive to Requests

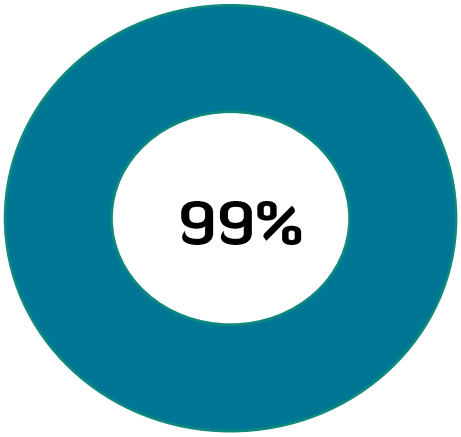
At times, people in facilities will request to see or speak to a Community Visitor. This is their legal right, and the CVP has an obligation to contact the person by the next working day. This safeguards the rights of people in facilities and residences to speak to an independent person.

The CVP continues to strive to meet its 100% target of making contact by the next working. Of the 102 cases this year, nearly all of which were from the mental health area, all but 1 person was contacted by the next working day.

[2] These conclusions have been drawn based on the relatively consistent numbers of cases in Central Australia, which has had a stable CVP staff member and no significant changes within the mental health service.

Each year, the CVP commits anew to the 100% target. With less staff, the challenge to meet this target is higher and does require some re-prioritisation. Just as the CVP has expectations of a quality service from the places visited, so too do those high expectations extend to the CVP's internal management.

CVP Requested & Contacted by Next Working Day, 2017-18



A STRONG VOICE FOR THE TERRITORY

Investing in the Visiting Program

Part of the strength of the CVP is bringing the same critical reflection to quality and improvement internally as with the external work of the program. This year, the CVP developed an agreement with the Office of the Public Guardian, improved orientation for new and sessional members, and streamlined reporting templates.

The CVP maintained a focus on effective recruitment of people to the permanent and sessional roles in the CVP. The program has deepened its professional and consumer expertise, and increased the number of Aboriginal staff.

There is still more work to be done. The Policy and Procedure Manual needs to be finalised and distributed to services. There needs to be an increased focus on 'data fidelity', to ensure that when new staff input data into our reporting system that it is consistent with other staff in the team. More Aboriginal staff, especially sessional Community Visitor and CV Panel members, are needed.

One of the main learnings of the CVP in its own management is that staff are our strength. The CVP is staffed by many long term employees. Staff are experienced, confident and can see change over time in areas where sometimes change is difficult to achieve. Recognising this, the CVP is planning for succession, implementing flexible work practices, and maintaining its focus on professional development.

Some of the work of the CVP comes from long established relationships with consumers, and a depth of knowledge and confidence in the work of visiting. This improves the outcomes for clients and the accessibility of the service more generally.

For this reason, the CVP has continued to invest in support for Community Visitors to maintain professional, external supervision. Even in a limited budget context, the CVP considers that professional supervision is an important investment in staff retention, development and effectiveness.

Connected Nationally

The Northern Territory CVP has also been a leader among other State and Territory visiting services. The CVP Manager has been proactive in supporting States and Territory visiting programs to work together, sharing knowledge about visiting in other jurisdictions, and developing a program for a national meeting in September 2018.

This national focus is essential to ensure that the Northern Territory remains connected to key developments that can impact on the future planning for independent visiting services across Australia. The CVP is staying abreast of developments nationally related to implementation of OPCAT[3] (specifically, the 'national preventative measures' for independent visiting of people deprived of their liberty). The CVP is keeping a close eye on the quality and safeguarding arrangements for people with a disability under the National Disability Insurance Scheme and more broadly.

The CVP is proud of the key role it has in safeguarding the rights of people in facilities, residences and agencies receiving voluntary and involuntary services from the government. It is work that protects individual's human rights, which is work that protects the dignity and humanity of us all.

Case Study – Mental Health

Amelia was struggling with her admission to a mental health in-patient unit. She is 17 years old, so has a nurse with her all the time. Amelia says that she wants her music on her phone, and there is one nurse that she does not get on with. She doesn't want her parents to know what she has told the doctors because they will be upset. The Community Visitor talks with Amelia about her right to confidentiality, and what a 'primary carer' is told on discharge. With Amelia's agreement, the nurse manager is asked to join them so that they can talk about Amelia's preference for her nursing care and how to access her music in the unit.

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[3] UN General Assembly, *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment*, 9 January 2003, A/RES/57/199.

MENTAL HEALTH

CVP SNAPSHOT

- More use of accredited interpreters so that consumers know their rights and can communicate effectively.
- Reducing seclusion requires strong leadership and commitment over time to be effective.
- The safety and wellbeing of consumers in the Joan Ridley Unit needs urgent attention.
- More Aboriginal mental health workers employed in the adult and children's mental health teams.
- More supported accommodation options are needed to avoid people needing hospital admissions.
- Improved access to specialised mental health services for children in remote areas and in youth detention is urgently needed.

The Northern Territory has unique challenges that impact on high quality mental health services. While there have been some improvements this year, there remains a long way to go. This is especially the case for providing services to Aboriginal Territorians, in their community, in their language, in a way that is culturally safe.

Australian governments are committed to supporting people with mental illness to participate fully in the community.[4] 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 (such as with their family and in their community, rather than through hospital admissions).

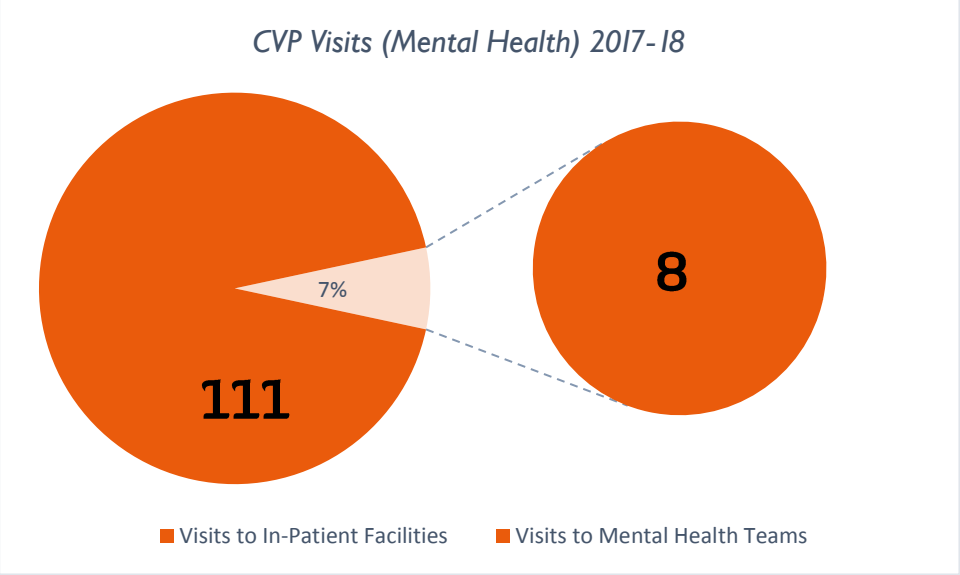
For the Northern Territory, there are significant factors that impact on achieving this goal. The Northern Territory's geographical spread with a small population. The disadvantage and trauma experienced by a large proportion of Aboriginal Territorians.[5] Low levels of funding for mental health services (the Northern Territory has the lowest funding per capita on Medicare-subsidised mental health-specific services in Australia, while also having the highest average cost for mental health hospital admissions per day).[6] These factors have a significant impact and cannot be underestimated and require government attention and advocacy.

Staff of the mental health services in the Northern Territory work in challenging environments, and many with considerable commitment and dedication to consumers and their recovery. At times, they are working with outdated or inappropriate infrastructure, and dealing with workforce capacity and retention issues. This needs urgent attention.

Even with these challenges, some staff have gone above and beyond the call of duty to provide additional resources and activities for consumers. This year, both the Top End and Central Australia mental health services also obtained healthcare accreditation. These positive achievements and efforts are celebrated and acknowledged by the CVP.

Listening to Consumers

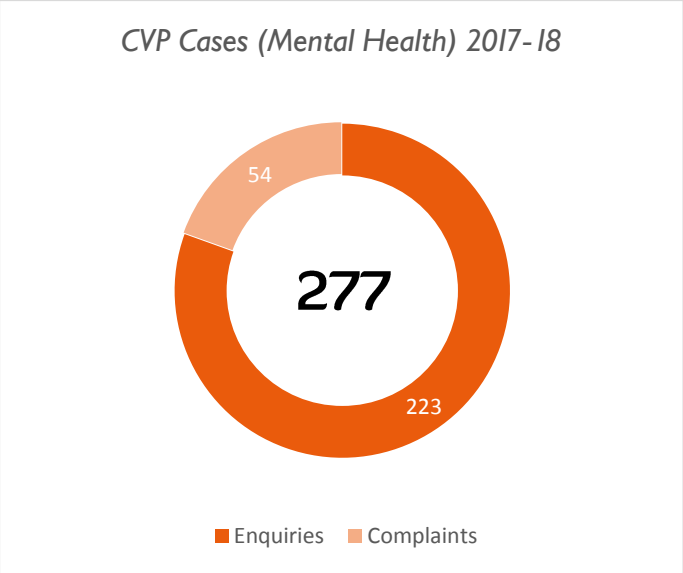
The work of the CVP is to honour the experience of all who come into contact with Northern Territory mental health services. As an independent complaints resolution and advocacy agency, this means that contact with the CVP is more often about raising issues of concern.



[4] Council of Australian Governments (COAG) Health Council (2017), *The Fifth National Mental Health and Suicide Prevention Plan*, p2. Accessed at www.coaghealthcouncil.gov.au.
[5] Northern Territory Mental Health Coalition (2017), *Mental Health and Suicide Prevention Service Preview 2017*, p11. Accessed at www.ntmhc.org.au.
[6] Australian Institute of Health and Welfare, *Expenditure on mental health services 2015-2016*. Accessed at www.aihw.gov.au.

While this may not be the whole picture of services, the light that consumers shine on their experience helps the service to improve.

The majority of the CVP's contact with consumers comes from the regular visits to mental health in-patient facilities. Community Visitors visit each week, assisting consumers and carers to know and understand their rights and, if they wish, support their voice to be heard. About one fifth of the cases raised related to teams supporting consumers in the community or correctional facilities.



The issues raised by people talking to the Community Visitors are the foundation on which the CVP's commentary in this report is built. The mental health case data shows that consumers are concerned about their assessment and treatment, cultural safety, 'least restrictive' decisions, information in general, and their rights.

As in previous years, the Community Visitors often hear from consumers and carers that they are not adequately consulted or involved in their care (which is inconsistent with therapeutic care and treatment principles). Advocating for their needs to be heard, with the assistance of the Community Visitor, is a central part of this work.

"I wanted to ask one question but I was told to come back later and by that time I had forgotton."

C/2018/93

At times, Community Visitors may raise systemic issues that are noticed on visits, from cases raised or from inspection of documents. Community Visitor (CV) Panels, who visit twice a year, have a particular statutory focus on systemic issues. This year the CVP has also dealt with several serious and complex matters in the mental health field. These are not discussed in detail to protect privacy and the cases are not fully representative of the broader issues.

Carer: "I was really alone, really tired you know. He was angry at me for not helping him get out. The staff, they should have helped me a bit more."

VIS/2018/50

In addition to this face-to-face work, the CVP also has a mandate under the mental health legislation to inspect teams of the mental health service that

provide services in the community. This includes teams in both Central Australia and Top End such as crisis assessment, triage, adult mental health, and specialist support provided to remote communities and children. Inspections include random review of files to ensure that information provided to the CVP is validated in documentation. The CVP reports to the service, noting positives and areas for improvement.

RIGHT TO COMMUNITY BASED SERVICE

The CVP has increased the number of visits to community-based mental health treatment agencies. This inspection and reporting has provided a more comprehensive picture of the Northern Territory's mental health system overall to inform the CVP's commentary.

The majority of people using mental health services do so voluntarily and are treated in their own community. This is in line with the purpose of mental health legislation and human rights more broadly, being to provide therapeutic care, treatment and protection for people in the 'least restrictive' way.

Good mental health and recovery takes place best within a person's everyday community life. Therefore maintaining the focus on ensuring 'least restrictive' care and treatment for consumers in the community is essential.

In general, the inspections of the community-based mental health teams noted that there were mental health assessments, reviews, monitoring of medication and psycho-education in place. It was positive to note that the file reviews of community-based teams evidenced that the services are, in general terms, addressing the physical health issues of consumers. This is consistent with a national focus on addressing co-morbidities in mental health care and treatment.

Improved Information Management and Integration

A common theme in the inspection reports, however, was the need to invest in a more integrated and effective information management system. All mental health services rely on good communication to provide effective treatment and care.

The information management systems currently used in the Northern Territory mental health services is flawed. Most of the inspection reports noted the limitations of the electronic medical record, 'CCIS'. Furthermore, if consumers reside in remote areas, clinicians are required to consult another electronic medical record for a complete picture of the consumer's history.

The CVP is aware that there is a Territory-wide patient database and data integration project underway. It is anticipated that this will address limitations in the current system. Until this

project is finalised and successfully implemented, the CVP will continue to raise that there is the potential for communication errors that place consumers at risk. These require interim strategies to address the risks.

Services for Adults in Urban Areas

The CVP completed inspections of teams providing services to adults in Alice Springs, Palmerston and Darwin urban areas. In general, the model of care and standards of service were appropriate. Nevertheless, there was an acknowledged lack of psychological treatment options in the community.

"I'm still using those ideas that they told me about when I was in the hospital. It was a good experience."

VIS/2018/50

The CVP was concerned that in some teams the service needed to improve its focus on recovery-oriented mental health practice. Some adult mental health teams would benefit from broadening their skills and knowledge to provide more evidence-based interventions.

"I have a number of complaints. I was in crisis. What I wanted was a referral to a psychologist when I was discharged."

C/2018/93

The need was most evident for consumers experiencing complex trauma, personality disorders and/or self-harming behaviours. These interventions were not consistently provided to all consumers and were often affected at times of reduced staffing or resources.

Remote Mental Health Services – A Different Model

For teams supporting consumers in remote communities, the Northern Territory mental health services provide a 'consultation and liaison' model. This approach is to work closely with remote primary health clinics, with visiting psychiatrist support for face-to-face consultations.

There are risks in this model, in particular related to the availability of psychiatrists for remote work. These risks relate both to responsibilities that psychiatrists may have to consumers in urban areas (noted in the Top End), and the underpinning funding arrangements that enable the remote visiting service (in Central Australia). It is essential that remote mental health teams have reliable access to visiting psychiatrists to enable regular face-to-face review of consumers in their home communities.

The remote 'consultation and liaison' model is a collaborative, multi-agency approach that requires effective relationships with service providers, especially the primary health care

teams. While relationships are effective at present, the CVP has noted that it is important that these relationships remain a priority for each service.

The inspections noted the strong relational approach of staff in both the East Arnhem and Central Australian remote mental health teams. This approach values the interpersonal relationships of trust that develops between clinicians, consumers and their communities. This approach is particularly important for work with Aboriginal consumers, who comprise the majority of the remote mental health teams' demographic.

There appeared to be effective integration of Aboriginal mental health workers into the remote mental health teams. Aboriginal staff were highly valued in the teams. The CVP noted the importance of strong succession planning for Aboriginal staff. These strategies are essential to safeguard the service's work in remote Aboriginal communities.

Better Support for Children and Young People

Children and young people have a right to equitable access to specialist health services, including mental health services.[7] In the Northern Territory, children and young people aged 15-24 years have high rates of mental illness.[8] Those who are living in rural and remote areas are further disadvantaged by inequitable access to services.

Inspections of both the Top End and Central Australia child and adolescent mental health teams were completed in 2017-18. Both teams provide psychological, medical and social interventions to children and adolescents to support their development, psychological wellbeing and physical health. The CVP saw evidence from both teams of expertise in clinical services and trauma-informed care for children and adolescents.

The model of care differs from adult mental health teams. The focus is on providing psychological therapies, with a significant emphasis on education and social development. The CVP also supports the service's more collaborative and participative approach with children and their families. The CVP noted however the growing need for improved communication and coordination for children with high risk needs, including increasingly younger children.

Both Central Australia and Top End specialist child and adolescent mental health services were operating in a context of high demand and limited resources for their services. In the Top End, the challenge of discharging children from the service was raised. The service noted the limited options for ongoing support services in the community. The services that are available generally provide early intervention yet clients of the service have more complex needs and history.

[7] Council of Australian Governments (COAG) Health Council (2015), *Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health*. Accessed at: www.coaghealthcouncil.gov.au.

[8] Northern Territory Department of Health (2015), *Mental Health Service Strategic Plan 2015-2021*, p9; specifically that young people aged 15-24 years are 15% of the NT population however were one quarter of all community-based mental health clients in the NT. Accessed at: digitallibrary.health.nt.gov.au.

Service Gap for Children in Detention

For many years, the CVP has raised concerns about the lack of specialist child and adolescent in remote communities and youth detention centres. These concerns remain. The lack of appropriate mental health services to children in youth detention is a serious failing in the Northern Territory's support for young people, in particular Aboriginal children.

Staff in the child and adolescent teams are aware of the significant, unaddressed mental health needs of these children. Mental health treatment and care inside youth detention is limited, primarily for 'at risk' assessments. Any specialist assessments requires the child to be transported to the local hospital's emergency department.

While short term, acute needs of children in youth detention are responded to, the long term treatment needs are not effectively met. The CVP strongly supports the recommendations of the Royal Commission into the Protection and Detention of Children in the Northern Territory regarding the need for expanded mental health services to children in youth detention.

Service Gap for Remote Youth

For children and young people living in remote communities, the inspection reports noted the ongoing lack of progress in improving service provision. Staff in the remote teams do not have specialist child and adolescent mental health knowledge and skills to effectively meet the needs of children and young people.

> Carer: "You know, being a 'boarder' there is hard. I didn't know anyone. I didn't know really what was happening, or when we'd go back home."
>
> VIS/2018/50

For children who are referred for assessment to the child and adolescent teams, they and their families are often required to travel to Alice Springs or Darwin. If the child requires ongoing treatment, there are no services available to provide these to the child or family in their home community. The teams will liaise with primary health clinics, non-government agencies or other service providers as available.

With respect to the Top End, the inspection report noted that specialist child and adolescent mental health 'outreach' clinics had operated in several locations, including Tiwi Islands, Wadeye and East Arnhem. The clinics ceased in 2016 due to resource and staffing constraints. The child and adolescent team has a position to provide services to Katherine, however it has not been able to fill the vacancy locally and visiting services are provided from Darwin.

The services have advised that resource constraints are the key reason for the inability to provide equitable access to services for remote youth. The Top End mental health service noted that services had to be scaled back to the 'core client group', with remote teams carrying out triage and screening for mental illness. Telehealth options are used where possible, however in some instances the child and family will need to travel to an urban area to access services.

The lack of specialist services for children and adolescents in the Northern Territory, particularly in rural and remote communities, is a missed opportunity for early intervention. Effective services into the children's home communities at an early age can reduce the effects of mental health problems on their development and later life. It can reduce the severity of symptoms and impact on the social, cognitive and emotional development of the child.

Early intervention enables communities to better manage the mental health needs of their children and young people. It avoids children being dislocated from their extended family networks and communities in order to receive treatment. It reduces the likelihood of them experiencing mental illness during adulthood.

This lack of services impacts on all children and young people in remote locations, however has the most significant impact on Aboriginal children. The CVP made open recommendations for both Top End and Central Australia regarding improved access to specialist child and adolescent mental health services in remote areas. Prioritising and investing in children and young people's mental health in the Northern Territory must be addressed urgently.

A Safe Place to Recover

Since 2007, the CVP has commented annually on the importance of safe, secure, stable accommodation for consumers to recover from mental illness. Housing with appropriate levels of support is the cornerstone of recovery from mental illness.

From a broader perspective, there has been some incremental progress over the years. Both Top End and Central Australian mental health services have expanded the level of supported accommodation available to consumers of their services.

The Top End mental health service has taken over responsibility for a 4 bed supported accommodation service previously run by a non-government provider. The Top End service has also supported initiatives from the non-government sector to increase supported care for mental health consumers. The Central Australia mental health service has established and consolidated a 'sub acute' 8 bed facility in Alice Springs, which includes two places set aside for longer term accommodation and support.

There is still a significant gap, however, in the range of supported accommodations options needed for consumers. This is particularly evident for people who are ready for discharge from in-patient mental health facilities and have complex, high care needs or unstable housing. In Central Australia, the CVP inspection report particularly noted the high demand for longer term supported accommodation beds.

The CVP has noted an emerging issue of serious concern relating to consumers who may have a cognitive impairment. These consumers risk being disadvantaged in circumstances where there is no appropriate provider of services under the National Disability Insurance Scheme (NDIS).

The Northern Territory is acknowledge to be an emerging 'thin' market with respect to disability services. There is a risk that consumers who no longer need treatment in a mental health in-patient facility remain on a locked ward due to lack of a suitable house and supports. The CVP has raised these concerns with both services, namely that it is not appropriate to use mental health legislation to detain consumers with a cognitive impairment who have no ongoing need for mental health treatment.

The CVP has drawn attention to the requirement within the legislation that admissions on a voluntary basis of people under adult guardianship can only occur when the person under guardianship is 'willing to be admitted'. The CVP has and will continue to liaise with the Office of the Public Guardian on individual cases of concern.

The mental health services have a duty of care to consumers on discharge. Discharging a person to homelessness or risk of harm is unacceptable. Nevertheless the detention of anyone in the most restrictive environment because there is not adequate supported accommodation breaches the person's human and legal rights. Appropriate responses to individual discharge needs require support from other teams in the health services, including 'social admissions' to hospital as a last resort.

The CVP's ongoing advocacy in this area ensures that people under adult guardianship have their human rights to civil liberty and 'least restrictive' treatment adhered to and maintained.

Culturally Safe Services for All

Each year, the CVP notes the importance of culturally safe treatment and care for people accessing mental health services. Over the years, there has been some slow progress. In the CVP's view, one of the most important aspects of the program's independent oversight and reporting role is maintaining focus on this area of service improvement.

"I didn't know why I was there, where I was, why I was in hospital in Darwin. I was afraid but I couldn't ask anyone what was happening."

VIS/2018/50

The Central Australian mental health service has made significant steps over the past few years to improve its focus on culturally safe care. A cultural consultant has been recruited and is active within the service, implementing initiatives to improve cultural safety. At the in-patient unit, the service had increased bookings and use of interpreters and improved staffing of Aboriginal Mental Health Workers. The CVP closed a number of recommendations as a result.

The Top End mental health service has four Aboriginal Mental Health Workers employed at the in-patient units. They are actively involved in the care and discharge planning of Aboriginal consumers on the ward and are responsible for the booking of Aboriginal interpreters. The

CVP has encouraged the Top End mental health service to employ Aboriginal Mental Health Workers in the community teams in addition to the in-patient unit.

Aboriginal Mental Health Workers are a valuable resource for consumers and staff. Greater involvement of Aboriginal staff in services increase cultural safety for consumers. The CVP has particularly noted the importance of involving Aboriginal staff with consumers admitted to the in-patient units who may be distressed or angry, and in consumer debriefing after any incidents.

"I don't agree with the treatment. Why was I taken off the anti-depressant I was on? I need it. I was suicidal for the past few months."

C/2018/93

The inspections of community teams in both the Top End and Central Australia indicate that there remain areas to improve. In particular, identifying the need for and documenting use of interpreters, and expanding or recruiting Aboriginal staff in some of the teams. While Aboriginal staff in the remote teams were particularly noted to be well integrated into all aspects of service delivery, this was not as evident in other teams.

In all teams, there were concerns about insufficient use of accredited interpreters. The concerns relating to interpreter use are also evident in the in-patient mental health units, most notably in relation to people understanding their admission and legal rights in their preferred language. These are discussed in more detail in the commentary below.

RIGHT TO 'LEAST RESTRICTIVE' HOSPITAL CARE

Being admitted to an in-patient facility for treatment and care is for consumers with acute needs that cannot be met in the community. The mental health legislation provides for treatment and care to be on a voluntary basis, where the consumer is able to give informed consent. Treatment can be involuntary if the person is not able to consent.

Voluntary Patients Consent to Treatment

The CVP has dealt with a number of serious cases regarding the rights of people who have chosen (with a doctor's agreement) to enter a mental health in-patient facility. Voluntary mental health patients have legally protected rights under mental health legislation; one of these is the right to request discharge and then leave the facility 'at any time'.[9]

Unfortunately, the CVP has observed that when some voluntary patients have sought to exercise this right, they have been re-assessed and admitted as involuntary. While this is a clinical decision, the CVP has raised with the service that the mental health 'Approved

[9] *Mental Health and Related Services Act*, s29.

Procedures' state that a plan to make someone involuntary if they request discharge is not appropriate.

A fundamental aspect of giving consent to treatment is having the right, and capacity, to change one's mind. The difference for patients admitted voluntarily to mental health units, unlike other wards of the hospital, is that they cannot exercise their free will to leave due to the facility being locked. Generally, a consumer would need to be seen by the doctor first, to ensure the service has discharged its duty of care to the patient.

In the CVP's view, a decision to admit someone voluntarily to an in-patient facility is a serious one. It is made based on the assessment that the person has the capacity to understand and consent to the treatment plan.

"They said that if I didn't abide by the rules, then they would section me. I've been bullied the whole time I've been here into doing what they want."

C/2017/532

"I wouldn't have agreed to any of the treatment, but they just ticked the box on the voluntary form that I agreed. I didn't really."

C/2017/532

If the treating team are of the view that the person may be too unwell to give informed consent, in the CVP's view, it follows that the admission must be 'involuntary'. This decision is 'less restrictive' than admitting a person as a voluntary patient and then not allowing them to leave and exercise their rights. This area will be monitored by the CVP in the year ahead.

The Right to a Safe Facility

If a person is required to be admitted to an in-patient facility, whether voluntary or involuntary, it is absolutely essential that the infrastructure provides a safe, therapeutic place for treatment. Across the Northern Territory, there are four dedicated mental health in-patient wards (one in Alice Springs, and three in Royal Darwin Hospital).

While most wards are considered to be appropriate in terms of infrastructure, the CVP has serious concerns relating to the adequacy and safety of one ward. This is the 'high dependency' ward in Darwin known as the Joan Ridley Unit. As a high dependency space, it houses the most acutely unwell mental health consumers.

The Top End mental health service has acknowledged the concerns with the Joan Ridley Unit. In this year, renovations took place to improve the facility. The environment, however, remains 'prison-like'.

"They gave me a needle when I got there. It was like prison. I was really afraid and I got angry. It was not a good place."

VIS/2018/50

The facility is generally overcrowded, has limited functional layout, and often accommodates prisoners (and therefore frequently has correctional officers present on a 2:1 ratio per prisoner). Significantly, women often report to Community Visitors about feeling unsafe. The unit is a highly volatile environment for both consumers and staff.

The CVP continues to advocate for a substantial upgrade to the facilities available for acutely unwell consumers in Darwin, to ensure it is safe, therapeutic and at a standard appropriate for contemporary mental health services.

Understanding Legal Rights

The CVP has noted a range of concerns regarding information about rights and compliance with legislative requirements, in particular when consumers are involuntarily detained.

Under the mental health legislation, when a person is required to receive treatment and care against their wishes, a psychiatric practitioner must affirm that aspects of the law have been complied with during the admission. This documentation is required to be provided to the CVP. It is reviewed at least quarterly by a Community Visitor.

Individual or systemic concerns arising from reviews are raised with the service. The reviews by the CVP pay particular attention to the rights of consumers. These 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.

"They didn't tell me that I had leave, I overheard them. I'm worried I won't be able to get out of here, I am being treated like an idiot, with no respect."

C/2017/520

"They never have enough time to talk to you, they shoo you away and say 'not now'. It doesn't feel like my rights are being respected."

C/2018/93

The CVP has raised for many years that there has been poor compliance with required documentation. This is particularly an ongoing, current issue in the Top End mental health service. The high number of incomplete sections in the Top End means that the service is not able to show clearly that consumers are advised of their rights.

The Central Australian mental health service has made good efforts to provide complete documentation. Their efforts to improve compliance in this area over the past few years is acknowledged. While the total number of forms received in Central Australia is smaller (reflecting the size of the service) the review of documents highlights areas of concern.

The main concern relates to the provision of information about rights to consumers who speak a language other than English. In Central Australia, psychiatric practitioners have accurately recorded their assessment, including that an interpreter was required for the consumer but not used. There have at times been contradictory information, such as an interpreter being required for the consumer at the tribunal hearing but not for the initial advice about rights from the service.

In the Top End, in the limited complete documentation, there is frequently no record of whether an interpreter was required or used in the giving of information about rights or tribunal hearings. The CVP is very concerned about the absence, inconsistency or ambiguity of information recorded about consumer rights and language needs.

There are other areas of poor compliance, in particular whether the person is under adult guardianship and if the guardian was notified. Consistent with the CVP's recently signed protocol with the Office of the Public Guardian, Community Visitors will advocate with the service to ensure that consumers under adult guardianship have their legal rights correctly applied while in an in-patient facility.

REDUCING THE MOST RESTRICTIVE PRACTICES

An End to Seclusion and Restraint

The most restrictive practice that can occur in a mental health facility is the use of seclusion (to be locked in a room with no means of exit) or restraint. [10] This is a serious exercise of power over a person with a mental illness who is receiving treatment and care. With respect to seclusion in particular, there is a lack of evidence to support its use therapeutically.[11]

The CVP promotes and upholds the United Nation's 'principles for the protection of persons with mental illness and the improvement of mental health care'.[12] The principles state, among other things, that physical restraint and seclusion should not be used. The goal of reducing, or

[10] Seclusion is defined in the *Mental Health and Related Services Act* as 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" (s62(16)). Restraint is defined as "the restriction of an individual's freedom of movement by physical or mechanical means" (Australian Institute of Health and Welfare).

[11] National Mental Health Consumer and Carer Forum (2009), *Ending Seclusion and Restraint in Australian Mental Health Services – Position Statement*. Accessed at: nmhccf.org.au.

[12] UN General Assembly, *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, 17 December 1991, A/RES/46/119.

eliminating the use of restraint and seclusion is also a national priority that the Northern Territory has committed to along with all other Australian States and Territories.[13]

The United Nations principles note that the only circumstances in which seclusion or restraint could be used is to prevent imminent harm to the person or others, and only strictly according to official procedures. The official procedures for the lawful use of restraint and seclusion are set out in the Northern Territory's mental health legislation.

The CVP takes very seriously the use of seclusion and restraint under the mental health legislation, and the requirement to strictly observe the conditions set out for its lawful use. Twice a year, the CVP inspects the seclusion and restraint registers and reviews each episode closely. Additional file reviews are completed when questions arise.

Keeping Accurate Records of Restrictive Practice

Keeping accurate records of restrictive practice is not only required by law (for mechanical restraint and seclusion) but also is an essential part of monitoring the provision of a quality, safe service to consumers. This year, the CVP has noted serious concerns related to record keeping and documentation.

The Northern Territory mental health services have a strict policy of not using mechanical restraint. It has been many years since any instances were reported. However, the CVP is concerned that while there are no instances of mechanical restraints in a register, this may not be the true figure for the whole hospital.

The CVP considers it likely that mechanical restraint has happened in other parts of the hospital when a person is under the mental health legislation (such as in the emergency department). There is a lack of consistency and record keeping outside of the acute in-patient units, noted in particular with the Top End Health Service. This means the CVP cannot be sure that the seclusion and restraint register is comprehensively maintained.

The law requires the approved treatment facility (in this case, the Royal Darwin Hospital) to establish a register and documents relating to the use of seclusion and restraint on mental health consumers. A formal recommendation to the service has been made about the need to improve seclusion and mechanical restraint registers in all wards of the Royal Darwin Hospital.

The CVP has noted that with the Top End Health Service that the opening of the Palmerston Regional Hospital adds a further complication to accurate record keeping and appropriate oversight. The Palmerston Regional Hospital is not a gazetted facility under the mental health legislation. This means that there is currently no provision in place for the CVP to monitor the use of any seclusion or restraint in that facility were it to occur.

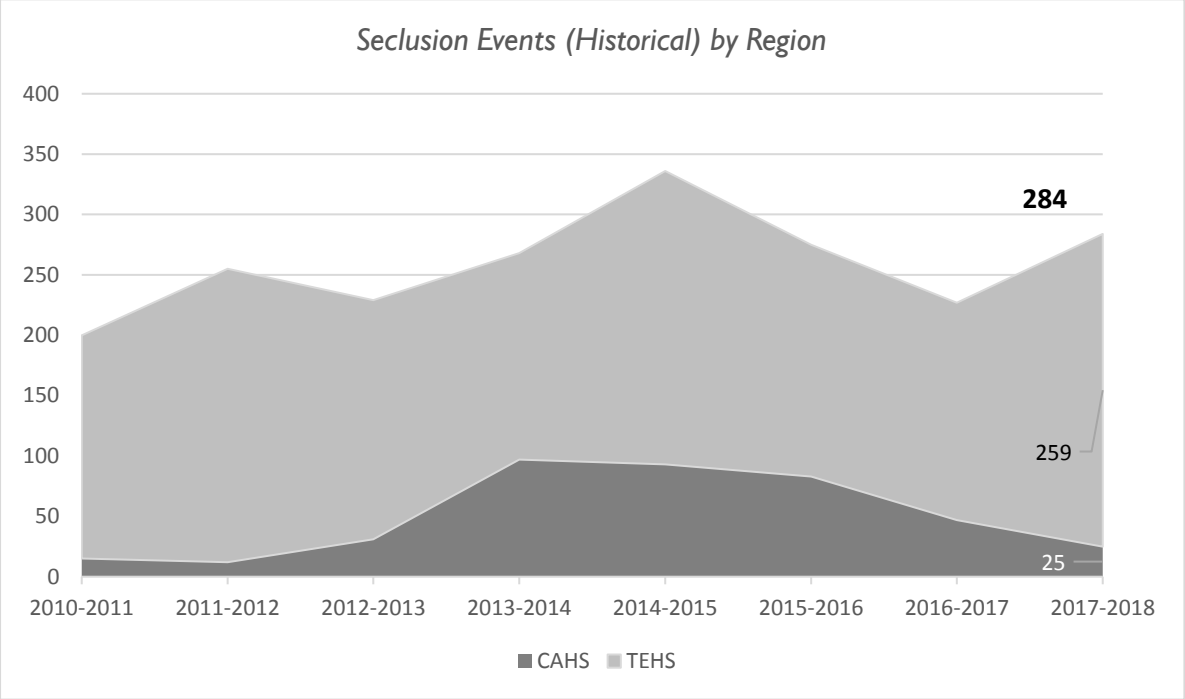
[13] Australian Government Department of Health and Ageing (2005), *National Safety Priorities in Mental Health: A National Plan for Reducing Harm*, National Mental Health Working Group.

Furthermore, in the Top End, the CVP has observed that the seclusion register was not readily accessible, not complete or not consistent with requirements set out in the mental health legislation or healthcare standards for clinical documentation.

The CVP is not confident that the information on the seclusion register is an accurate picture of seclusion events. There was a serious concern that the records were completed retrospectively. As a result of these concerns, the CV Panel for the Top End raised a new recommendation requiring evidence of improvement in documenting compliance with seclusion provisions at the time of the event occurring.

Trends in Seclusion

Nationally, in 2016-2017 the Northern Territory had the highest rate of seclusion in public sector acute mental health hospital services. Nearly 12% of admissions in Northern Territory mental health units included a seclusion event.[14]



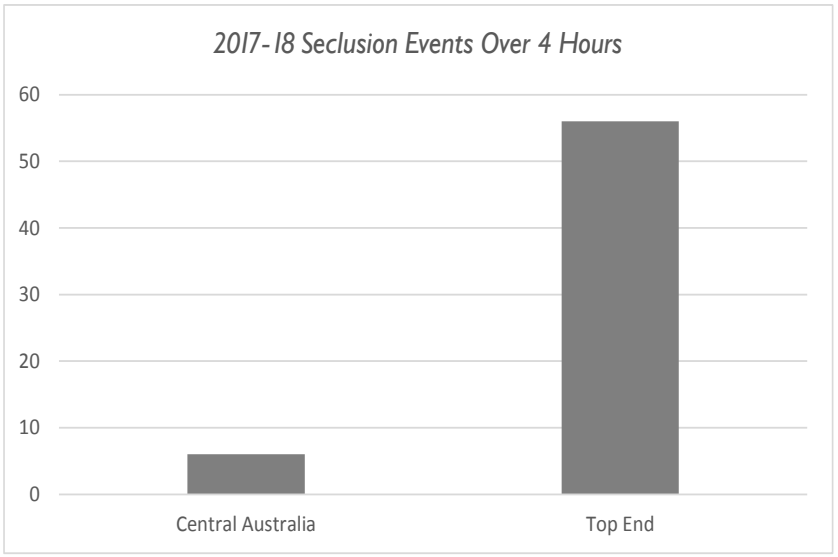
There were a total of 284 seclusion events reported this year, involving 99 individual consumers. In the last two annual reports, the CVP has noted the efforts of both the Top End and Central Australia Health Service to reduce seclusion in their service. The trends have varied across each region over the past two years. This year, the Central Australian Health Service has consolidated and maintained its efforts to reduce seclusion. Seclusion events continue to fall at a slow but steady rate.

Unfortunately, the Top End Health Service has moved in the opposite direction. The initial trend of reducing seclusion evident in 2016 has not continued. The number of seclusion events

[14] Australian Institute of Health and Welfare (2018), *Mental Health Services in Australia*.

in the Top End is now close to returning to its peak levels in 2014-2015. As a result, the CVP has asked the Top End Health Service to undertake an evaluation of its seclusion reduction strategy ('SafeCare) implementation.

Another disturbing trend, particularly evident in the Top End, is that seclusion duration is being anticipated by doctors in the medical review notes. In some cases doctors are indicating that seclusion should continue until the next review. This decision can have the effect of extending a seclusion by at least three hours without consideration to how the person in seclusion is presenting at any given time.



This type of direction from a medical practitioner gives rise to a perception that the senior nurse on duty no longer has the authority to cease seclusion. Under the Northern Territory's mental health legislation, a senior nurse must end seclusion without delay when the conditions that warranted it no longer apply.[15] This might occur, for example, when a consumer is calm and co-operative, there is no longer threat to the consumer or others or the person has gone to sleep.

The CVP has spoken to many consumers who have experienced seclusion in the Northern Territory. Overwhelmingly they speak of being left with a fear of being secluded and a distrust of staff involved. The CVP is concerned that the distrust of staff following seclusion, and the fear of seclusion itself, may deter consumers from seeking treatment in future episodes of illness. It also affects the development of a strong therapeutic alliance between consumers and mental health clinicians.

The use of seclusion puts consumers and staff at risk of serious injury. It can result in severe trauma and emotional distress that remains long after seclusion has ceased. This is particularly the case when a consumer has a history of being abused or has experienced other trauma.[16]

[15] *Mental Health and Related Services Act*, s62(3).

[16] National Technical Assistance Center for State Mental Health Planning (2006), *National Association of State Mental Health Program Directors: Curriculum for the Reduction of Seclusion and Restraint*, Virginia, USA.

Disturbing Trends for Aboriginal Consumers

The CVP has noticed a disturbing trend in who is secluded. There are increasing concerns about the use of restrictive practices for Aboriginal Territorians. Of those consumers secluded in 2017-2018, 66% identified as Aboriginal or Torres Strait Islander. This compares with approximately 52% of people admitted to acute mental health in-patient facilities in the Northern Territory being Aboriginal or Torres Strait Islander.[17] The disproportionate incidence of Aboriginal consumers being involved in seclusion events is occurring in both Central Australia and the Top End.

The CVP has stressed the importance of using interpreters for consumers who are acutely unwell, distressed and/or angry and who prefer to communicate in a language other than English. Unfortunately, in the context of seclusion events, there is insufficient evidence that the professional obligation of the service to communicate effectively with Aboriginal consumers who speak another language is properly discharged.

Interventions to reduce the use of seclusion for Aboriginal Territorians need to be developed and implemented that respond to the specific cultural and language needs of the Northern Territory. These need to be done in partnership with Aboriginal and Torres Strait Islander consumers, families and their communities.[18] Evidence shows that interventions are more effective if they are culturally responsive and inclusive of Aboriginal families and communities.[19]

In the meantime, the CVP strongly encourages the use of interpreters and Aboriginal Mental Health Workers throughout admission and, in particular, if people's behaviour is escalating or if they have experienced seclusion. This trend in seclusion of Aboriginal Territorians will be closely monitored in the year ahead.

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[17] Northern Territory Department of Health (2015), *Mental Health Service Strategic Plan 2015-2021*, p9. This reference is from 2014 data. The CVP requested information from the Department of Health on the 2017-2018 data on Aboriginal mental health consumers being admitted to acute in-patient treatment facility, however complete data from both services was not provided. The data from one service was that 54% of admissions to the acute in-patient facility were Aboriginal consumers; this suggests the 2014 data remains broadly comparable.

[18] Australian Government (2013), *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*. Accessed at: www.health.gov.au

[19] Closing the Gap Clearinghouse (2014), Pat Dudgeon, Roz Walker, Clair Scrine, Carrington Shepherd, Tom Calma and Ian Ring, *Effective Strategies to Strengthen the Mental Health and Wellbeing of Aboriginal and Torres Strait Islander People,* Issues Paper 12.

Children in Seclusion

This year, no child was secluded in the Central Australia mental health service. In the Top End, however, five children experienced a total of 25 seclusion events. These events were 9% of the total number of all seclusion events in the Northern Territory.

International research shows that implementing trauma-informed strategies have promising results in reducing the seclusion rates for children in mental health in-patient units.[20] The CVP continues to encourage TEMHS to implement trauma-informed care training to all staff so that their practice is contemporary and safe for children.

The CVP has also requested that the Top End mental health service review all incidents of seclusion of children to develop more effective strategies and interventions to reduce its use. It is noted that even though children may be admitted to the Youth In-Patient Program (the dedicated ward for children needing mental health treatment in Darwin), they may be taken across to the Joan Ridley Unit in order to be secluded. The CVP is concerned about the conditions in the seclusion room.

The CVP considers that a cultural shift in organisational culture is required to reduce seclusion of children and adults in mental health facilities in the Northern Territory. Strong leadership is required to achieve reductions in seclusion and restraints.[21] This has been shown in Central Australia. The same shift needs to occur again in the Top End.

[20] Azeem MW, Aujla A, Rammerth M, Binsfeld G, Jones RB (2011), Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital, *Journal of Child and Adolescent Psychiatric Nursing*, 2011, 24(1). doi: 10.1111/j.1744-6171.2010.00262.x.

[21] Goulet M, Larue C & Dumais A 2017, Evaluation of seclusion and restraint reduction programs in mental health: A systematic review, *Journal of Aggression and Violent Behaviour*, 34, https://doi.org/10.1016/j.avb.2017.01.019

CVP RECOMMENDATIONS (Mental Health)

Top End Mental Health Service

Themes in Recommendations

- 1 Community Visitor recommendation closed.
- 2 new CV Panel recommendations, 3 new Community Visitor recommendations and 7 new approved treatment agency (community teams) recommendations made.
- Need for improved services for youth, in both in-patient unit and community.
- Priority needs to be given to the redesign of infrastructure to ensure the safety of consumers on the wards, in particular women and youth.
- Need for a greater focus on interpreter use and Aboriginal Mental Health Worker involvement in patient-centred care.
- Community based supported accommodation needs are critical.
- An organisational culture shift and strong leadership is required to decrease the incidence of seclusion and restraint.

CVP Recommendations		Made By	Date	Status
Approved Treatment Facility (Royal Darwin Hospital)				
1.	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). It is further recommended that the model takes into account the varied and diverse circumstances of consumers in the Northern Territory, and is developed collaboratively with consumer groups and mental health professionals. (Reworded)	CV Panel	Nov 2006	Open
2.	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
3.	That the service provide evidence that in the process of involuntary admissions that there is adequate explanation of rights to consumers, including legal status on admission, offering of interpreters and early access to the Mental Health Review Tribunal.	CV Panel	Nov 2011	Open

Top End Mental Health Service				
4.	That management request a report from the director of ECT on evidence of quality activities, demographics of clients receiving ECT, the nature of consent and key clinical indicators for ECT across the patient population.	CV Panel	Apr 2013	Open
5.	That the Top End Mental Health Service (TEMHS) implement strategies to ensure the cultural safety of clients, with a particular focus on the needs of Indigenous clients in line with TEMHS values and objectives.	Community Visitor	May 2013	Open
6.	To improve the care of acutely unwell consumers in the Joan Ridley Unit (JRU) 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.	CV Panel	Mar 2016	Open
7.	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 section 132 of the *Mental Health and Related Services Act* (MHRSA).	Community Visitor	Nov 2016	Open
8.	That TEMHS raise the need for significant new infrastructure in the Joan Ridley Unit (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
9.	That TEHMS establish and advise the service's targets to improve trauma-informed care.	Community Visitor	Jul 2017	Open
10.	That TEMHS provide to the CVP the terms of reference/performance indicators how current seclusion reviews and analyses contribute to seclusion reduction, both for individuals and systemically.	Community Visitor	Aug 2017	Open
11.	That TEMHS address the water heating and pressure to ensure clients have access to hot showers.	CV Panel	Apr 2018	Open

Top End Mental Health Service				
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	Apr 2018	Open
13.	That TEMHS provides evidence of improvement in processes to ensure compliance with the Act in relation to recording information about the seclusion of clients.	CV Panel	Apr 2018	Open
14.	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	Aug 2018	Open
15.	That the Top End Health Service 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	Aug 2018	Open
Approved Treatment Agencies (Top End)				
16.	*Child & Adolescent Mental Health Team* That TEMHS conducts a review of its current electronic medical record systems and considers how it can improve its capacity to record clinical information including consistent assessment and triage documentation and recording of carer/ family contact details and language spoken.	Community Visitor	May 2018	Open
17.	*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

Top End Mental Health Service				
18.	*Child & Adolescent Mental Health Team* 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
19.	*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
20.	*East Arnhem Community Mental Health Team* 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
21.	*East Arnhem Community Mental Health Team* That Top End Health Service (TEHS) conducts a review of its current electronic medical record (EMR) 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
22.	*East Arnhem Community Mental Health Team* 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

Central Australian Mental Health Service

Themes in Recommendations

- 3 Community Visitor recommendations closed as resolved, with improvements noted in relation to recording of restraints and cultural safety in the in-patient unit (use of interpreters and employment of Aboriginal Mental Health Workers).
- 6 new recommendations made, in particular from inspections of community teams.
- Need for improved services for youth, in both in-patient unit and community.
- Forensic mental health team recommendations are included, however there was no inspection in this year. The forensic recommendations remain current.

	CVP Recommendations	Made By	Date	Status
Approved Treatment Facility (Alice Springs Hospital)				
1.	That Mental Health CAHS review processes to improve effectiveness of the internal complaints process. (Reworded)	Community Visitor	Jun 2017	Open
2.	That a new policy be developed in accordance with professionally accepted standards and the least restrictive principles as required by the *Mental Health and Related Services Act* to ensure that adopted practices comply with the fundamental principles of the Act when a prisoner becomes a mental health patient. (Reworded)	CV Panel	Jun 2017	Open
3.	That existing seclusion policies and procedures include detailed strategies to reduce the use and impact of seclusion on minors.	Community Visitor	Jul 2017	Open
4.	That the Mental Health Unit develop a protocol for the delivery of youth-friendly mental health services for inpatient adolescents.	CV Panel	Jul 2018	Open
Approved Treatment Agencies (Central Australia)				
5.	*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
6.	*Forensic Mental Health Team* That the CAHS and TEHS Boards formalise arrangements for responsibility for forensic mental health services in the Central Australian region, including the provision of appropriate and accessible mental health support to Central Australian youth and adult detainees.	Community Visitor	Dec 2016	Open

Central Australian Mental Health Service				
7.	*Forensic Mental Health Team* 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
8.	*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
9.	*Mark Sheldon Remote Mental Health Team* That the service provide information on the actions and avenues taken to address the lack of remote service for children and young people with mental health needs.	Community Visitor	Feb 2018	Open
10.	*Mark Sheldon Remote Mental Health Team* That the service provide the complaints policy and reviewed consumer and carer satisfaction survey process. (Reworded)	Community Visitor	Feb 2018	Open
11.	*Community Mental Health Team* That the innovative inclusion of a child and youth specialist clinician in the Mental Health CAHS Crisis Assessment and Triage Team (CATT) be a permanent position in the CATT staffing profile.	Community Visitor	Jun 2018	Open
12.	*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

CVP SNAPSHOT

- Lack of action on CVP's concerns
- Systemic issues related to clinical governance and oversight, including medication provision
- Resident plans not properly updated or reviewed
- Transition to community accommodation has stalled
- Poor or no interpreter use for significant discussions
- No internal complaints management processes
- Improved leadership and commitment to change
- Significant reduction in the use of chemical restraint

There has been a positive change in leadership and management of the Office of Disability specialist disability services. Despite this, a range of concerns about quality and safety remain.

Time for Change

The CVP has for many years commented on areas for improvement in the NT specialist disability services provided by the Office of Disability. In the past year, senior leadership has changed. The need for change is now acknowledged by the service and work is underway to address concerns. Staffing has been prioritised.

Throughout this period of change, the service maintained its focus on resident needs. Regular activities and community access for residents was maintained. There was very low use of restraints. Most incidents of concern were managed without restraint. Some residents moved to less restrictive orders.

Despite these positive achievements, the CVP remains concerned that there is limited evidence of change on the ground. While the CVP understands that any organisational change process takes time, there is increasing urgency to address issues that have been raised.

The lack of action over time is concerning as it brings into question the capacity and willingness of the service to provide contemporary forensic disability services. It also raises concerns about the responsiveness of the service to the CVP's statutory monitoring and reporting role.

RIGHT TO QUALITY MANAGEMENT

The Office of Disability has responsibility for the direct delivery of specialist therapeutic services and residential care to a small number of people with disabilities. This continues alongside the rollout of the National Disability Insurance Scheme (NDIS).

Residents in places under the responsibility of the Office of Disability have been found to have a mental impairment or not fit to plead under the *Criminal Code*, and are on supervision orders of the Supreme Court. The Office of Disability is responsible for ensuring that these residents are cared for safely and have an individual plan to develop their skills to reduce behaviours of concern.

The CVP is responsible under the *Disability Services Act* to ensure that all residential facilities are regularly visited. Under the legislation, residential facilities include a secure care facility, houses in the community if a supervised person resides there, or anyone receiving direct services from the Office of Disability. Residents have the opportunity to raise any concerns, and facilities and documents are inspected.

While the number of places visited by the CVP is small, the responsibility for quality management of these places is high. Residents have a right to quality services that are safe and meet their needs.

Clinical Governance

Residents in specialist disability places require high quality therapeutic support and interventions to address challenging behaviours. Residents' needs and behaviour may be affected by their disability, medical conditions or situational issues. Good clinical judgment and oversight is required to understand, analyse, interpret and respond appropriately to the person's behaviour.

While the overall structure and clinical staffing is improving, the CVP has for many years raised concerns about the service's clinical governance framework. An open CVP recommendation

requesting the Office of Disability's quality assurance framework has been in place for 4 years. Inadequate or insufficient information has been provided to close this recommendation.

This year, in its November 2017 visit, the CV Panel made a recommendation that the Secure Care Facility undertake an 'urgent and major review' of the service's adherence to basic principles of clinical governance. At the CV Panel's next visit in June 2018 there was no update from the service on any review.

The CVP's level of concern about clinical governance extends into a range of areas, including therapeutic behaviour support, medication use, resident safety and care. The CVP is not established to provide clinical oversight. Instead, the Community Visitors and CV Panel members make general inquiries and inspect documents.

Even though CVP inquiries are informed by critical analysis and common sense, the service needs a functioning, robust clinical governance framework. If concerns remain in the year ahead, the CVP will seriously consider what steps to take to further escalate issues as this ongoing situation is unacceptable.

> "… good behaviour support requires a governance framework that encompasses oversight and accountability…"
>
> University of New South Wales (2017), *Intellectual Disability Behaviour Support Program, Discussion Paper: Responding to Behaviour Support Needs in the Disability Services Future*.

Safe Medication Use

A small number of medication errors have been noted in the incident reports provided to the CVP in the past year. The potential seriousness of these errors was not well understood by staff. At a service-wide level, there was insufficient evidence of clear procedures to involve or consult medical practitioners after such errors.

Medications given in residential places include both regular and 'as required' prescriptions. Non-clinical staff usually administer medication, including the use of medication when serious behaviours of concern arise. At times, non-clinically trained staff have approved the administration of 'as required' medication to control a resident's behaviour. Non-clinical staff monitor the resident after its use.

The CVP is concerned that there is inadequate training and skills required for administration, storage, approval and monitoring of resident medication use. This is particularly the case for 'prescribed' medications that have special handling and approval requirements in other health facilities.

The Department of Health has advised the CVP that these legal requirements do not apply in specialist disability facilities. In the CVP's view, this position does not take account of the context for the specialist disability places, especially the needs and capacities of residents. It also does not discharge the service's duty of care to residents.

The CV Panel for the Secure Care Facility, which is a multidisciplinary panel including a psychiatrist, community member and lawyer, made a recommendation about staff training and medication use. In its second visit for the year, the CV Panel made a further recommendation that there be an immediate review of medication storage and administration.

Effective Staffing

Effective 'service management' is one of the national disability standards. It emphasises the need for good governance, management, and planning. It notes the importance of compliance with work health and safety, human resource and financial management laws and regulations.

The CVP has not commented extensively on 'service management' previously, as there are a range of other priority issues of concern. The importance of having a stable workforce for quality care of residents has been noted with the service by the CVP for many years, especially when periodic fluctuations in staffing have occurred.

At one point this year, however, there were critical staff shortages and turnover in both Top End and Central Australia (including in senior clinical positions). A serious shortage of staff affected the capacity of the Secure Care Facility in Central Australia to accommodate the individual needs of residents. Emergency contingency plans were put in place, in part arising from the CVP's advocacy and concerns for proper processes.

The CVP considers that it is helpful for residents to have a 'key worker' model, so that they have familiar staff working with them. Turnover of staff affects residents, sometimes deeply. In both the Top End and Central Australia, the majority of staff had been on six month contracts with no certainty of ongoing employment. The CVP is pleased to see that the service is moving to longer term contracts to limit the risk of high staff turnover.

Effective attraction and retention strategies remain a risk for resident care and treatment. As this current period of staff instability settles, the CVP will closely monitor service management to ensure that the disability standards are met.

Effective Behaviour Support

Another important aspect of quality in the service's management of the specialist disability facilities is the oversight, planning and review of behaviour supports for residents. This year, the Office of Disability has changed its senior clinical staffing. The change in staff, including some vacant positions, has had an impact on the availability of clinical care and oversight to residents.

Throughout this period, as has been the case for many years, the specialist residential facilities in Central Australia have not had an on-site clinician. External behaviour support from a consultant was contracted for some periods of time when clinical positions in Darwin were vacant.

The service has advised that clinical staff from Darwin will continue to visit Central Australia regularly. At the time of writing, the service has not been able to recruit to a senior clinician

role in Central Australia; recruitment to a more junior clinical positon is ongoing. The effectiveness of the clinical outreach model will be closely monitored in the year ahead.

The CVP has had longstanding concerns about the arrangements for ensuring clinical judgements inform resident care and planning, and assist non-clinical staff to better manage resident's behaviour. One of the key areas in which clinical support is essential is developing and regularly reviewing individual resident plans to reduce behaviours of concern.

Positive Behaviour Support Plans (PBSP) are the guiding document for staff on how to support each person individually with their needs. The plan states the ways in which staff will proactively support the person, building on their strengths and increasing their life skills.

The CVP has raised throughout this year that the *Disability Services Act* requires that a PBSP be developed before a person enters a secure care facility. In some cases, residents who have been in a facility for over a year still do not have a PBSP. The CVP is pleased to hear that urgent work is underway to address this concern.

RIGHT TO REVIEW

The CVP has raised concerns for many years relating to the processes for clinical review of behaviours of concern, including data measurement, recording and analysis. There has been evidence of improvements in debriefing after incidents and some new forms have been introduced. Unfortunately, at this stage, the CVP has not seen evidence of systematic improvements in data analysis or documented, regular clinical reviews.

This lack of review in plan achievements is one aspect of poor review processes overall. The legislation requires that positive behaviour support plans must be reviewed at least once a year with key stakeholders including the resident. With a few exceptions, there was no evidence that people required under the *Disability Services Act* were routinely consulted in plan reviews.

> "Behaviour support may be especially important at times of transition, when stress can be high resulting in challenging behaviours."
>
> University of New South Wales (2017), *Intellectual Disability Behaviour Support Program, Discussion Paper: Responding to Behaviour Support Needs in the Disability Services Future.*

Very few of the plans that were reviewed were updated to reflect the person's current situation. This meant some residents had plans with irrelevant information or strategies. For example, if they transitioned to less restrictive accommodation, their plan did not account for greater freedoms in their new place and how to manage behaviours to ensure safety for all.

A current plan is an essential part of any strategy to support residents effectively. In some cases, residents returned to more restrictive facilities when behaviours arose in the new environment.

Of further concern, if restraints are included in a person's plan, these can only be independently reviewed if the person themselves, or anyone consulted in the development of the plan, requests this review. For the entire period that the *Disability Services Act* has been in place, to the CVP's knowledge, no resident or anyone consulted in a plan has made an application to have restraints reviewed by the independent panel.

Noting the comments above regarding the clinical governance framework, the CVP has raised for many years that the independent review panel could be established by the Office of Disability as its own quality assurance mechanism for reviewing plans. This has been a recommendation for many years, and has now been affirmed by the CV Panel.

RIGHT TO LEAST RESTRICTIVE CARE

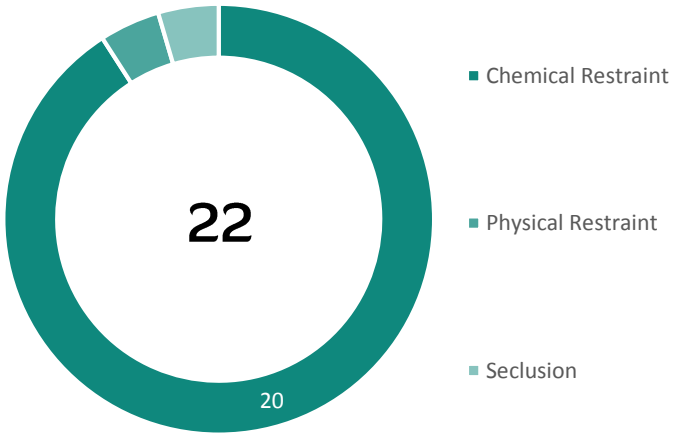
Use of Restraints

The Office of Disability's specialist disability staff have worked hard to avoid the use of restraints on residents. There were 22 instances of restraint recorded and reported to the CVP this year.[22] This is a particularly good outcome in 'least restrictive' care, especially in a time of staffing changes.

As with many other jurisdictions, the main form of restraint in the specialist disability facilities is chemical restraint. 'Chemical restraint' is the use of medication, prescribed by a doctor, to assist the person to calm down when she or he is very upset and displaying behaviours of concern. As noted earlier, in the CVP's view, more attention needs to be paid to processes and practices relating to approval of chemical restraint and medical reviews after its use.

Despite the service having a strong policy and practice of reducing the use of restraint, in this year there were two restraints made using the 'emergency' restraint powers of the *Disability Services Act*. These powers were used for the single instance of physical restraint and seclusion.

Use of Restraints (Specialist Disability) 2017-2018



[22] It is possible that this figure may be higher however the CVP's figure is based on information provided to the Community Visitors from inspections on visits.

The service acted promptly to avoid future use of these emergency powers. Afterwards, the CVP advocated for greater clarity in the safe use of emergency restraints (especially seclusion). While the CVP strongly supports the 'least restrictive' approach of the service, the safety of residents, staff and facility infrastructure are paramount considerations.

> "Eliminating the use of restrictive practices requires a sufficiently skilled workforce with capacity to implement positive behaviour support."
>
> University of New South Wales (2017), *Intellectual Disability Behaviour Support Program, Discussion Paper: Responding to Behaviour Support Needs in the Disability Services Future*.

The use of emergency restraint indicates the dynamic and unpredictable environment of specialist disability residences. In addition to being able to use strategies to avoid behaviours of concerning occurring or increasing, staff need to be trained in the safe use of all four types of restraint allowed for under the *Disability Services Act*. This is the case even if the use of that restraint is not part of the person's plan. Furthermore, facilities must be safe if restraint or seclusion is used.

The service has recognised the need for more staff training, improvements in safety, improved debriefing and clinical review of restraint, and the need for improved documentation on the use of restraint. The CVP will closely monitor progress in these areas in the year ahead.

Self-Determination and Participation

For many years, the CVP has commented positively on the service's commitment to helping residents access the community. Nearly all residents are required to be supervised while in the community (most with one staff member, but some with two staff).

It is important that, even with this supervision, residents have opportunities to exercise choice and control over some aspects of their lives. This 'least restrictive' approach to the resident's everyday daily life is consistent with residents' right to self-determination and to participate meaningfully in the community.

A key aspect of enabling greater self-determination and participation is the gradual reduction in restrictions on residents' liberty. The final decision on what supervision orders are made rests with the Supreme Court. Nevertheless, the court is informed by reports provided by the Office of Disability. These reports are a critical part of the decision-making process for the courts.

The quality of support provided to residents, and the preparation for and identification of 'less restrictive' options (from less supervision to alternative community-based accommodation) rests with the service. It is these supports and options that are essential before residents can move to less restriction with the approval of the court.

This year, the CVP has noted that very few people have moved to less restrictive accommodation. No residents on supervision orders in the Top End were transitioned out of the service. This is despite it being acknowledged that most residents were not showing behaviours of concern. In Central Australia, a few residents moved to 'non-custodial' supervision orders. From the residents' viewpoint, however, there is no change to their supervision, residence or support.

The CVP has also noted an emerging concern relating to the quality of support for people moving to less supervision. At times it is unclear what therapeutic interventions are occurring and, if any, what benefits these have for the person on the supervision order. If the person breaches the terms of the order, including while unsupervised, the response of the service to this is unclear.

The person who holds the greatest risk of having their right to self-determination and participation limited is the person with disabilities. It is therefore essential that the support provided to them as they move to less restriction is carefully planned, of high quality, responsive to their unique situation, and helps them manage risks in the best possible way.

Service Access – Agreements with Others

A significant risk that residents can face in their care and treatment is that related to accessing other services. When residents with specialist needs, who are known to have behaviours of concern in stressful or new situations, need to access other services there has to be clear pathways for streamlined access.

If a resident needs to attend hospital or a health clinic, for example, at present there are no special pathways agreed for them to access these services. The resident must attend in the same way as any other member of the community. Some residents are unable, due to the nature of their disability, to wait. Some experiences in accessing health services can lead to behaviours of concern, both at the time or afterwards.

Some residents may need to be returned to more restrictive environments, such as a correctional centre, or the service may need urgent assistance to safely manage a situation. A number of residents in disability residences require support from specialist services, such as

aged care or mental health. It is concerning that despite these needs being known for long periods of time, no agreements have been made to better support service access.

For many years, the CVP has advocated for formal agreements to be made with key agencies such as health, corrections, mental health and aged care. The Office of Disability has acknowledged the importance of these tasks, but has indicated it is not a priority at present.

The CVP has also advocated for an agreement to be made with the Office of Public Guardian. All residents are under guardianship. Notification of matters of concern to guardians, and involvement of guardians in decisions, has been inconsistent. There is some evidence that communication with guardians is improving. Nevertheless, an agreement would clarify procedures and expectations.

> "… things go wrong when providers fail to take responsibility for issues, when information is not shared, where there is no lead agency that takes responsibility for the collaboration…"
>
> University of New South Wales (2017), *Intellectual Disability Behaviour Support Program, Discussion Paper: Responding to Behaviour Support Needs in the Disability Services Future*.

The same challenge in agreement making faces the CVP. The CVP has been seeking a revised agreement with the Office of Disability for years. Despite the CVP agreement being nearly finalised for most of the year, the Office of Disability has not prioritised this document.

In the CVP's view, agreements assist residents to access services in a safe and equitable way to meet their needs. It provides clarity in processes for all concerned. It resolves issues at a system-wide level. It avoids individual agreements being worked out for each resident, each time. It aids communication and provides a pathway to raise concerns. Agreements do not need to be formal, lengthy documents. They do, however, need to be in place and prioritised for this reason.

RIGHT TO SPEAK UP AND BE HEARD

There is an inherent power imbalance in the provision of government services to people, which is even greater when the person has a disability. All government and government-funded services need to provide ways for people to be heard, included, provide feedback and, if necessary, complain. This is a standard expectation of services. It is a right of people with disabilities. It is part of the national disability standards. It is a right in healthcare standards.

The Right to Complain

The *Disability Services Act* requires the Office of Disability to have an internal complaints system within its residential facilities. The CVP provides an additional protection for residents as an external complaints body.

The CVP has repeatedly raised with the Office of Disability that it has not established a functioning internal complaints process, in either the Top End or Central Australia residential facilities. One facility has no internal complaints register. One facility has an empty register. As a result, there is a heavy reliance on the CVP as the external body to be the only complaints agency for residents.

The legislation in this area is clear. Residents have a legislated right to complain to the service, to have their complaint recorded and dealt with directly by the service. The failure to take action on a fundamental service standard is very concerning. It is a failure to safeguard the rights of people with a disability receiving an involuntary government service.

Interpreters Enable Rights

This lack of focus on residents being heard and properly understood extends into other areas of the service.

Most residents in specialist disability facilities speak a language other than English as their first or preferred language. In some facilities, Aboriginal staff assist residents to communicate their day to day needs. However, these staff are not always available. This means most residents have to communicate in English.

While many aspects of this communication is straightforward, such as activities of daily living or preferred community activities, this is not always the case. It is the professional obligation of the service to ensure that residents are given the best opportunity to understand what is being communicated to them and to communicate in turn.

> "This (visiting) is good for them. (Residents) got to know what's happening… You got to get their trust and get to know them. See them for a couple of weeks. Then they open up… That's the first thing, understanding and trust."
>
> AIS Interpreter with Community Visitor after visiting specialist disability place.

This professional obligation can only be discharged with the use of accredited, independent interpreters. As a minimum, the CVP has advocated for the use of accredited, independent interpreters when residents are being consulted on important matters.

As a step towards evidencing the service's use of interpreters, the CVP advocated for an interpreter register to be established. In this year, a register was established in one facility. Only two instances of recorded interpreter use were noted in one month over the year.

The ongoing failure of the service to use interpreters is a breach of the resident's human, healthcare and disability rights. It remains a serious concern to the CVP.

CVP Enquiries and Complaints

The Community Visitors see residents in the Secure Care Facility next to the Alice Springs prison once a month. Residents in other facilities are seen at least four times each year.

Most of the Community Visitors who see residents are long serving staff. This means that a relationship has developed over time. The Community Visitors are welcomed by residents.

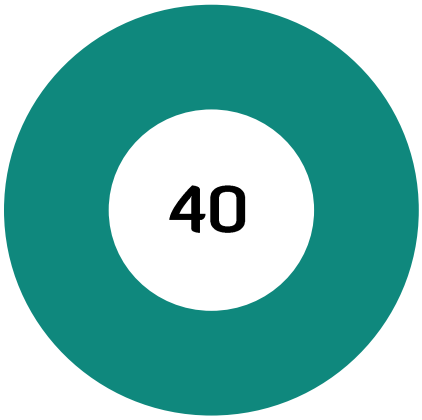
The number of individual cases (enquiries and complaints) raised with Community Visitors this year is similar to last year. The resident population has been relatively stable over the two periods.

The issues raised by residents have many similar themes: wanting to see family more, wanting to visit a nearby community, seeking greater freedoms, being upset about a particular event or staff member.

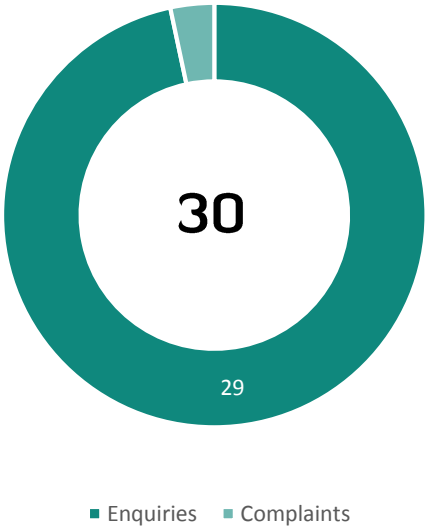
As all residents are Aboriginal Territorians, freedom to make choices on their participation in daily life is an essential aspect of maintaining cultural connectedness.

In the majority of instances, the Community Visitor has assisted the person to raise their issue with the service. Sometimes matters can be dealt with relatively easily. Feedback is provided, or a request passed on.

CVP Visits (Disability) 2017-18



CVP Cases (Disability) 2017-18



In general, the service works hard to help residents stay connected with their family and meet their cultural obligations, such as attending funerals. In some cases, there have been delays in closing cases, as it has taken time to facilitate contact with family. The frequency of the same issues being raised, and the delays in closing cases, suggests that more work can be done to support resident's cultural needs.

Some cases this year remain open, as residents have raised issues related to their transition from the facility back to their communities. The CVP has been assured that this planning is underway, however there is no evidence on the ground for the resident that this is occurring.

The CVP takes a 'person-centred' view on all its enquiries and complaints. If the matter is unresolved from the person's perspective, the outcome is unresolved. If the matter is still not addressed, the case remains open until the outcome for the person is clear.

Case Study

Joshua was moved between disability residences for reasons out of his control.

He is homesick, for his country, his family, his community. When talking with the Community Visitor, using an interpreter, he said that he wanted to go back to his first residence. 'Please help me', he asked.

The Community Visitor raised his request with the service. A number of difficulties in returning Joshua were raised.

Although he may soon move to a house in the community, he still lives far away from his country.

The CVP is keeping his case open until he finally returns home. His wishes are raised at each visit and in each meeting.

CVP RECOMMENDATIONS (Disability)

Secure Care Facility

Themes in Recommendations

- 2 Community Visitor recommendations closed as resolved.
- 8 new recommendations made by the CV Panel, relating to issues identified by the Community Visitor previously and new issues (some recommendations were closed to avoid duplication with the CV Panel recommendations).
- Sustained lack of action on recommendations made by the CVP over many years.
- Need for improved focus on cultural safety, in particular the use of accredited interpreters and gender considerations in residential facilities.
- Need for individualised plans for support and transition
- Greater focus on quality assurance and clinical governance, especially in the areas of medications, training, safety and complaints management.

CVP Recommendations		Made By	Date	Status
1.	That adequate duress alarms for staff and visitors are installed.	Community Visitor	May 2013	Open
2.	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
3.	That Secure Care Facility management and the Aboriginal Interpreter Service meet to organise an orientation session for interpreters called to have language and cultural assistance with the Secure Care Facility residents.	CV Panel	Oct 2014	Open
4.	That Secure Care Facility management explore options for accommodating women within the facility separate from men.	CV Panel	Oct 2014	Open
5.	That information available about early childhood of residents is taken into consideration when Positive Behaviour Support Plans (PBSP) are established.	CV Panel	May 2015	Open
6.	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
7.	That on-site clinical support be readily available at the Secure Care Facility and, as required, appropriate places in Central Australia. (Reworded)	Community Visitor	Jul 2015	Open

Secure Care Facility				
8.	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. (Reworded)	CV Panel	Jun 2016	Open
9.	That the Secure Care Facility 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
10.	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
11.	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
12.	That the Secure Care Facility establish and implement an effective complaints procedure in accordance with Part 5 of the *Disability Services Act*.	CV Panel	Nov 2017	Open
13.	That the Secure Care Facility manager ensure the presence of a female staff member at all times in a residential facility with a resident female client.	CV Panel	Nov 2017	Open
14.	That the Secure Care Facility establish a behaviour support plan review panel as required by the *Disability Services Act*.	CV Panel	Nov 2017	Open
15.	That the Secure Care Facility ensure that individualised Positive Behaviour Support Plans are created for each client of the facility.	CV Panel	Nov 2017	Open
16.	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
17.	That a risk management plan is developed that details strategies and contingency plans to ensure appropriate resident care and treatment including in the event of critical staff shortages and the need for emergency accommodation.	Community Visitor	May 2018	Open

Secure Care Facility				
18.	That Secure Care Facility management undertake an immediate review of storage and administering practices of medication, ensuring the involvement of an appropriately qualified health practitioner.	CV Panel	Jul 2018	Open
19.	That the Office of Disability, in discussion and agreement with the CVP, finalise the revised Protocol for CVP visits to residential facilities.	Community Visitor	Aug 2018	Open

Appropriate Places (Criminal Code)

Note: Information is very general to protect people's privacy. In the Top End, there is a facility near the Darwin Correctional Centre ('the Cottages') and a house in the community. In Central Australia, there are three houses in the community.

Themes in Recommendations

- Improved behaviour support plans and related processes, including currency of plans, implementation and review
- Working relationship and agreements with the Darwin Correctional Centre

CVP Recommendations		Made By	Date	Status
1.	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
2.	That the Office of Disability improve the review processes of Positive Behaviour Support Plans in line with section 39 of the *Disability Services Act* and best practice guidelines.	Community Visitor	Dec 2016	Open
3.	That the Office of Disability provide evidence of the systematic implementation of strategies described in the Positive Behaviour Support Plans (PBSP) and evidence-based changes to the PBSPs.	Community Visitor	Dec 2016	Open
4.	That the Office of Disability has current Positive Behaviour Support Plans for all Top End disability residents that are available for review by the CVP during visits.	Community Visitor	May 2018	Open

Note: The one person living in a residential facility supervised by the Office of Disability ('other premises' under the *Disability Services Act*) successfully transferred across to care under the National Disability Insurance Scheme.

DATA TABLE 2017-2018

	Mental Health			Disability				Alcohol Mandatory Treatment					Other	
	CAHS	TEHS	Total	Secure Care	Appropriate Place	Other (DSA)	Total	Assessment (CAHS)	Assessment (TEHS)	Treatment (CAAAPU)	Treatment (Saltbush Mob)	Total		TOTAL
VISITS	58	61	**119**	19	20	1	**40**	4	0	3	4	**11**		**170**
Community Visitor	54	57	111	17	20	1	38	4	0	3	4	11		**160**
Inspection	2	2	4											**4**
CV Panel	2	2	4	2			2							**6**

	CAHS	TEHS	Total	Secure Care	Appropriate Place	Other (DSA)	Total	Assessment (CAHS)	Assessment (TEHS)	Treatment (CAAAPU)	Treatment (Saltbush Mob)	Total	Other	TOTAL
CASES	103	174	**277**	20	10	0	**30**	3	0	0	1	**4**	9	**320**
Complaints	12	42	54	0	1	0	1	0	0	0	1	0	0	**56**
Enquiries	91	132	223	20	9	0	29	3	0	0	0	0	9	**264**
Cases – 'Raised By'														
People/Consumer	89	116	205	14	8	0	22	3	0	0	1	4	4	**235**
Carer/Relative	2	19	21	0	0	0	0	0	0	0	0	0	2	**23**
Service Provider/Case Manager	7	23	30	1	2	0	3	0	0	0	0	0	2	**35**
Nurse/Doctor	5	11	16	0	0	0	0	0	0	0	0	0	1	**17**
Guardian	0	3	3	5	0	0	5	0	0	0	0	0	0	**8**
Friend	0	2	2	0	0	0	0	0	0	0	0	0	0	**2**
Cases – Issue Outcomes														
Resolved	105	215	320	14	7	0	21	5	0	0	1	6	3	**350**
Ongoing Monitoring	48	60	108	11	11	0	22	1	0	0	0	1	0	**131**
Not Resolved	10	6	16	0	0	0	0	0	0	0	0	0	0	**16**
Referred	10	42	52	0	3	0	3	1	0	0	0	1	6	**62**
Lapsed	9	24	33	0	0	0	0	0	0	0	0	0	0	**33**
Withdrawn	4	3	7	0	0	0	0	0	0	0	0	0	0	**7**
Other	4	13	17	2	0	0	2	0	0	0	0	0	2	**21**
(Open)	4	4	8	0	0	0	0	0	0	0	0	0	0	**8**

Case Issues	CAHS	TEHS	Total	Secure Care	Appropriate Place	Other (DSA)	Total	Assessment (CAHS)	Assessment (TEHS)	Treatment (CAAAPU)	Treatment (Saltbush Mob)	Total	Other	TOTAL
ISSUES RAISED	**194**	**367**	**561**	**27**	**21**	**0**	**48**	**7**	**0**	**0**	**1**	**8**	**11**	**628**
Quality of Service Provider	75	102	**177**	12	7	0	**19**	3	0	0	1	**4**	0	**200**
Assessment & Treatment	19	22	41	1	2	0	3	0	0	0	0	0	0	44
Cultural Safety	11	17	28	2	1	0	3	3	0	0	1	4	0	35
Management Plan	0	6	6	0	0	0	0	0	0	0	0	0	0	6
Activities	5	2	7	0	0	0	0	0	0	0	0	0	0	7
Discharge Planning	14	9	23	0	3	0	3	0	0	0	0	0	0	26
Facilities	1	10	11	0	0	0	0	0	0	0	0	0	0	11
Relationship with Staff	10	9	19	4	0	0	4	0	0	0	0	0	0	23
Health – Physical / Mental	1	3	4	0	0	0	0	0	0	0	0	0	0	4
Procedures	8	8	16	4	1	0	5	0	0	0	0	0	0	21
Consultation Carers/Consumers	4	10	14	0	0	0	0	0	0	0	0	0	0	14
Other	2	6	8	1	0	0	1	0	0	0	0	0	0	9
Rights	48	89	**137**	5	4	0	**9**	2	0	0	0	**2**	**1**	**149**
Least Restrictive Alternative	15	28	43	1	2	0	3	0	0	0	0	0	0	46
Legal	2	7	9	0	0	0	0	0	0	0	0	0	1	10
CV Information on Rights	8	18	26	0	0	0	0	1	0	0	0	1	0	27
Detention/Early Review Detention	1	14	15	0	0	0	0	0	0	0	0	0	0	15
Community Accommodation	5	1	6	1	1	0	2	0	0	0	0	0	0	8
Respect for Dignity	1	1	2	0	1	0	1	0	0	0	0	0	0	3
Safety	4	5	9	2	0	0	2	1	0	0	0	1	0	12
Voluntary/ Involuntary	8	7	15	0	0	0	0	0	0	0	0	0	0	15
Other	4	8	12	1	0	0	1	0	0	0	0	0	0	13
Information	26	55	**81**	2	3	0	**5**	1	0	0	0	**1**	**4**	**91**
Advocacy	33	80	**113**	7	7	0	**14**	1	0	0	0	**1**	**3**	**131**
Smoking	6	12	**18**	0	0	0	0	0	0	0	0	0	0	**18**
Visit/Support	0	6	**6**	0	0	0	0	0	0	0	0	0	0	**6**
Other	1	3	**4**	0	0	0	0	0	0	0	0	0	**3**	**7**
Medication	5	20	**25**	1	0	0	**1**	0	0	0	0	0	0	**26**

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