COMMUNITY VISITOR PROGRAM
NORTHERN TERRITORY

Protecting and Promoting the Rights of Territorians Affected by Mental Illness

Annual Report 2004 - 2005

The Hon Ms Delia Lawrie MLA
Minister for Family and Community Services
Parliament House
State Square
DARWIN NT 0800

Dear Minister

Pursuant to section 115 of the *Mental Health and Related Services Act* 1998, please find attached the Annual Report on the operations of the Community Visitor Program for the financial year ended 30 June 2005.

Yours sincerely

TONY FITZGERALD
PRINCIPAL COMMUNITY VISITOR

30 September 2005

Foreword:
Service Delivery for Territorians affected by Mental Illness

The way we treat those members of our society who are vulnerable for reasons of mental illness is a major issue facing mental health services today. We need to decide whether we value a paternalistic system, one that seeks to protect the person with illness and to keep the person and society 'safe', or whether we strive to promote autonomy, and the right of the individual to live according to his or her own aspirations. Of course, not all cases fit neatly into each category, but it is apparent that at various times in our society one value has been more dominant than the other.

The principle of the least restrictive alternative has emerged as a mechanism for finding a balance between these two opposing values. According to this principle, people should receive the least restrictive or least intrusive treatment in the least restrictive environment possible.

The tension between the two values mentioned above (paternalism and autonomy), and the attempt to resolve this tension through the principle of the least restrictive alternative is reflected in the Northern Territory's mental health policy and legislation, as found in the *Mental Health and Related Services Act (NT) 1998* (the Act). Paternalistic values underlie the practice of detention (by means of enforced hospitalisation) of a person who is mentally ill or mentally disturbed and who is deemed to be a danger to themselves or others. Other forms of coercive treatment outlined in the Act include seclusion and enforced outpatient treatment through a Community Management Order. The value of autonomy, on the other hand, is also present in the Act's protection of the person's human rights. This is achieved through the requirement of independent review of all 7-day detention orders, the requirement for complaints procedures and the establishment of the Community Visitor Program.

The pendulum is swinging towards a system that places more value on 'safety' than on rights or choices, and we need to ask why. Safety refers to the 'safety' of the person who has a mental illness as well as the 'safety' of the community from the perceived threat of people with mental illness being treated in the community. There have recently been a plethora of media articles that focus on the disadvantages of deinstitutionalisation, implying that it has resulted in higher rates of homelessness and imprisonment of people with mental illness. The implication of these articles is that people with mental illness would be "better off" if only they had access to long term hospital beds and if their choices were again restricted.

The headline of a story in the NT News dated 28/8/05 reads: "Coroner calls for security review at hospital ward". In his findings, the Coroner stated that if changes at Cowdy ward do not reduce the number of involuntary patients leaving the ward, "further changes should be made and should be considered expeditiously". Cowdy ward is beginning to look like a prison, with all easy exits from the ward now locked. We need to ask whether the people who are most qualified to determine mental health policy are in fact able to do so.

There is no evidence that locking people away improves access to mental health services or makes either the ill person or the community 'safer'. It is arguable that people are less likely to see our hospitals as a place of sanctuary or asylum as they become more coercive. As a consequence, people will be less likely to seek help from mental health services at the early stages of their illness. This would in turn make it

more likely for them to be admitted to hospital more often. This is the concept of the "revolving door", which existed long before the closing down of institutions.

Furthermore, there is no evidence that higher levels of coercion contribute to greater 'safety' for the person with a mental illness. Throughout the literature, the death rate of people with mental illness from other than natural causes is estimated to be somewhere between 6% and 10%. The actual death rate is determined by the way in which "non natural cause" is defined and by differences in social and economic environment. So, while no definitive statements can be made about the safety of a particular individual at a particular time, there is some evidence to indicate that over time the level of institutionalisation in the system does not significantly affect the rate of non-natural deaths.

In a conference held in Adelaide in August/September 2005, Dr Roberto Mezzina, the Director of the Mental Health Service in Trieste, Italy, a city with a population of 250,000, stated that there has been no compulsory treatment in Trieste for the past two years. That is, there have been no detentions, no seclusions and no Community Management Orders.

The Trieste system is based on legislation that enshrines the right to voluntary treatment, and a system that values citizenship and community integration above all else. Mental health services in Trieste address the needs of the person, ensuring that appropriate accommodation is available, and that the person has access to therapeutic and meaningful work programs. The recovery rate of consumers in Trieste is reported as being well over 80%. This is particularly striking when compared with the 33% recovery rate that has been reported in Australia since the 1940's. Furthermore, the proportion of people with mental illness who end up in prison has not increased since the introduction of this supportive community program 40 years ago and the suicide rate has remained constant (well below that of Australia).

That is, in Trieste, the 'safety' of the mentally ill person has not been threatened any more than in a coercive system and the safety of the public has not been compromised either. Thus the system in Trieste ensures the 'safety' of society, and also protects the mentally ill person's human rights.

In 2004 – 2005 there were no compulsory treatments in Trieste. In 2004 – 2005, in the Northern Territory, the MHRT reports 756 hearings to review detentions, Tribunal Orders and applications/reviews of Community Management Orders, with a further 280 detentions revoked prior to the hearing. In Cowdy Ward alone, there were a minimum 450 separate incidents of seclusion. This means that in the Northern Territory over the past year there were a minimum 1500 compulsory orders and/or treatments.

The Trieste experience has demonstrated that it is possible to successfully work with people with mental illness in a recovery based model that promotes citizenship. At present, the Northern Territory appears to be moving in the opposite direction, without evidence that a more paternalistic framework will in fact provide more "safety" for the consumer or society.

It is time for the community of the Northern Territory to examine the philosophy and values that guide the way mental health services are delivered to Territorians who experience mental illness.

JUDY CLISBY
Manager Community Visitor Program

Agency Access

The Community Visitor Program is located in the offices of the Anti-Discrimination Commission.

Location:

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Chapter 1: Looking Forward, Looking Back

Highlights: 2004 – 2005

During the 2004 – 2005 financial year, the Community Visitor Program (CVP) was able to fully meet its legislative requirements in urban areas with respect to:

- ✓ Response to enquiries and complaints;
- ✓ Community Visitors Panel inspections;
- ✓ Inspection of Seclusion Registers; and
- ✓ Inspection of Complaints Registers.

The CVP continued to respond to enquiries and complaints from people receiving treatment under the *Mental Health and Related Services Act (NT) 1998* (the Act), and visited the approved treatment facility in Darwin (Cowdy Ward) at least once each fortnight in order to ensure that consumers could access the program. This improved access is reflected in the increase in complaints received by the CVP.

For the first time, Community Visitors Panels visited the approved treatment facilities and agencies in Darwin and Alice Springs in accordance with legislative time frames. A Community Visitors Panel has not visited the Approved Treatment Agencies in Nhulunbuy, Katherine and Tennant Creek, and is unlikely to be able to do so due to problems with funding and recruiting the appropriate people to convene expert panels in those areas. It is expected that the Act will be altered to address these difficulties.

Funding is still a major issue for the CVP. Currently, the program is funded at its inception level of $70,000 per annum. With the employment of the Manager of the CVP for 12 months, the cost of the program was $113,000 for the 2004 – 2005 financial year. We thank the Department of Justice (DOJ), which assisted with the provision of an additional $40,000 and the Anti Discrimination Commission (ADC) which contributed an additional $3,000. A cabinet submission for increased funds will be submitted early in the new financial year.

Issues raised by the CVP in the 2004 – 2005 Financial Year

A number of issues have been raised by community visitors and by community visitors panels in their visits to the Approved Treatment Facilities and Agencies. These will be discussed at length in this Annual Report. Some issues go very much to the core of the human rights of consumers of mental health services and the standard of treatment available to them. Matters that require urgent attention include:

- The need to improve the standard of facilities at Cowdy Ward (in particular JRU);
- Changing the culture of transport to Hospital by police such that ambulances are used in the first instance;

- The need for improved discharge planning from all services;
- The need to give a multi-disciplinary focus to services in the Approved Treatment Facilities, and in particular the employment of a Social Worker at Cowdy Ward and an Occupational Therapist at the Mental Health Unit;
- The need to be able to access the Aboriginal Interpreter Service after hours (particularly in Alice Springs);
- The need for increased Aboriginal Mental Health Worker support in urban and remote environments; and
- The need for the approved treatment facility in Darwin to adhere to the Act and Approved Procedures when secluding persons within the facility.

Looking Forward to June 30th 2006

The last Annual Report for the Community Visitor Program included a draft Strategic Plan, a copy of which is included in Appendix 3. Only the additional activities planned for the CVP during the next reporting period are included in this section of the Report. These activities correspond to the objectives outlined in the draft Strategic Plan, however if the submission for increased funding is not successful, the ability of the program to meet these objectives will be severely curtailed. These activities, subject to funding, are as follows:

Objective 1
To operate the CVP in accordance with the requirements of the Mental Health and Related Services Act (NT) 1998 by*:*

- Ensuring a community visitor inspects the approved treatment agencies in Tennant Creek, Katherine and Nhulunbuy at least once every six months; and
- Liaising regularly with the Director, Mental Health Services and the Managers of Top End Mental Health Services (TEMHS) and Central Australian Mental Health Services (CAMHS).

Objective 2
To increase accessibility of the CVP to consumers, carers and service providers by*:*

- Doubling the number of visits to the Mental Health Unit in Alice Springs and Cowdy Ward in Darwin;
- Employing and training an indigenous community visitor in Tennant Creek, Katherine and Nhulunbuy; and
- Developing new material for marketing the CVP.

Objective 3
To develop, maintain and share a comprehensive knowledge of mental health policy and evidence based mental health practice by*:*

- Attending national conferences on mental health and providing opportunities for community visitors and/or panel members to attend;
- Developing a resource library.

Objective 4
To develop and maintain relationships with key players within the Northern Territory – consumers, carers and service providers by:

- Visiting consumer run groups regularly (with their permission); and
- Establishing an advisory structure for the program that would include representatives from consumer organisations in the Territory.

Chapter 2: Community Visitors 2004 – 2005

The CVP achieves its functions through the work of community visitors and community visitors panels. Community visitors are responsible for responding to complaints and inquiries and for carrying out inspections of Seclusion Registers and Complaints Registers. More detailed information is contained in Appendix 2. The activities of community visitors for the past twelve months are detailed in this chapter.

Community Visitors for Top End Mental Health Services (TEMHS)

In the 2004 – 2005 financial year, the CVP responded to 77 complaints and enquiries about Top End Mental Health Services from 58 consumers, carers and service providers. Issues raised by 11 of these complaints were resolved without a follow up visit to either Cowdy Ward or the Tamarind Centre. Community visitors visited Cowdy ward at least once each fortnight, and some complaints were received from consumers during these visits.

Issues Raised in Complaints/Enquiries to the CVP

Complaints have been placed into categories to assist with explanation and analysis. Many are one-off complaints, however they can be indicative of more systemic problems. When this is the case, the Principal Community Visitor will include recommendations in a section 109 report to the person in charge of the Approved Treatment Facility or Agency visited. Alternatively, the Principle Community Visitor may, under section 104 of the Act, refer a matter for investigation by a community visitors panel. Recommendations made by community visitors in response to visits to TEMHS are included in Appendix 1.

Case examples are included throughout this Chapter. Examples have been depersonalised to protect confidentiality.

Complaints About Rights

The CVP has received 17 complaints related to people's rights while inpatients of Cowdy Ward. Issues raised include:

- Consumers being admitted to Cowdy Ward as voluntary patients and being under the impression they will be detained if they try to leave;
- Restricted access to telephones while in the Joan Ridley Unit (JRU) – the secure environment within Cowdy Ward; and
- No property list being kept when a person is detained to JRU and personal items are removed.

Case Example 1 Voluntary Status

Josephine is a middle aged woman admitted to Cowdy Ward as a voluntary patient. She has a long history of contact with mental health services, often resulting in lengthy admissions. Despite being admitted as a voluntary patient, Josephine was under the impression that she would be detained if she tried to leave.

This is typical of several instances where, in an attempt to ensure that treatment is the least restrictive possible, the consumer is admitted as a voluntary patient, even though in reality their status is involuntary. Mental health staff believe that using voluntary admission whenever possible assists them to develop a rapport with the consumer.

The CVP argues that in this situation, the consumer's rights are adversely affected. A person admitted involuntarily has his/her case reviewed by the Mental Health Review Tribunal (MHRT) within 7 days of the detention. A voluntary admission is not subject to review, however, the MHRT must be advised of the admission when the person has been a voluntary patient for a continuous period of three months.

When contacted by a consumer in these circumstances, the community visitor speaks to nursing/medical staff to ensure that the consumer's status is clarified, and that if indeed their status is voluntary they are able to leave. If deemed not well enough to do so, then they may be detained in accordance with the Act.

Case Example 2 Locked in the Dining Room of JRU

Bryan was a middle aged man with a diagnosis of schizophrenia. When he was detained to the secure unit, he was seriously underweight. A special diet was organised in consultation with him. However, when the food was served it was different to what he had agreed to, and he refused to eat. When other consumers had finished eating, he was locked in the dining room until he had finished eating. In addition, one nurse began to withhold cigarettes unless the consumer ate morning and afternoon tea. The consumer contacted the CVP because he felt he was being punished by being locked in the dining room and not being given his cigarettes.

The community visitor noted that technically, being locked alone in the dining room was the same as being secluded, which according to S62 of the Act *means the sole confinement, at any hour of the day or night, of a person – … in a room of which the doors and windows are locked from the outside* …The Act is specific about grounds for seclusion, which do not include the circumstances outlined in this case. When reviewing the case notes, the community visitor also noted that no behaviour management plan was documented in the notes. The community

visitor advised nursing staff that in her opinion, locking the consumer in the dining room contravened the Act, and that unless a management plan agreed to by the Consultant Psychiatrist and nursing staff was in place, the withdrawal of cigarettes was inappropriate and should cease.

On further investigation, the community visitor found that consumers are sometimes locked in the dining room when they eat more slowly and other consumers become agitated waiting for them to finish eating. Cutlery is seen as a potential weapon, and cannot be removed from the dining room. A recommendation was made that alternatives to this practice be found.

The CVP contacted the consumer the following day, and was informed that the practice of locking him the dining room had ceased and cigarettes were no longer being withheld.

Involuntary Detention and Treatment

The CVP has received 14 complaints about involuntary detention and treatment. The CVP does not have a role in questioning either the decision to detain or treatment decisions of Approved Psychiatric Practitioners (APP), however it does have the capacity to act as an independent advocate for the consumer, and to ensure that complaints about the side effects of medication are heard. Community visitors will also ensure that the consumer is aware of the reasons for the involuntary detention and treatment and provide information about their right to appear before the Mental Health Review Tribunal with advocacy from either Northern Territory Legal Aid (NTLAC) or Northern Australian Aboriginal Legal Aid Service (NAALAS).

Standard of Facilities

Twelve complaints from staff, carers, consumers and service providers have been followed up with respect to the standard of facilities in Cowdy Ward. Issues such as curtains falling down, the removal of mirrors from the open section of Cowdy Ward, a lack of facilities specifically for young people and stained canvas mattresses being used in the seclusion rooms in JRU have been raised with the CVP.

The community visitor has expressed concerns about the lack of an alternative to JRU as a closed environment, and the effect of this environment on consumers who are detained to JRU when assessed as a risk to themselves or at risk of absconding. This issue is addressed at length in this Report when discussing the findings of the Darwin community visitors panel.

Case Example 3: Replacement of Stainless Steel Cutlery

The CVP was contacted by several nursing staff at Cowdy Ward who were upset because the stainless steel cutlery had been replaced with plastic cutlery. They felt that this undermined the dignity of patients of Cowdy Ward, and argued that plastic cutlery placed them at risk due to sharp edges when the cutlery was broken. The community visitor broke some cutlery and tested the edges, and found that it was still difficult to cut anything! However, she agreed that the institution of plastic cutlery did undermine the dignity of mental health consumers.

The Clinical Nurse Manager stated that the cutlery had been changed because it was often left in the sun waiting to be picked up from RDH, and that this presented a problem because it smelled. It was generally agreed that the solution to this problem lay in either ensuring used cutlery was collected more quickly, that it was placed in the dishwasher with plates and bowls or stored more appropriately. The Clinical Nurse Manager informed the CVP that a decision to restore the use of stainless steel cutlery had already been made and would be implemented that day.

Systems and Procedures

The nine complaints placed in this category include complaints about problems with accessing mental health services and difficulties related to discharge procedures. A complaint about loss of personal property is of some concern because all personal property is removed when a person is placed in JRU, however a list is kept only of cash and credit cards.

Case Example 4: Complaint from a parent about services for his son

A parent contacted the CVP extremely angry about his inability to access mental health services for his 15 year old son, Darren, who suffered a psychotic illness and had been extremely unwell. Darren had run away from home, and his case manager had an assessment warrant issued because he was concerned for Darren's safety. The family were aware of the case manager's actions.

Darren had returned home briefly, and his father had contacted the police who denied having an assessment warrant. The parent then contacted the After Hours Mental Health Service, who stated that Darren was not a client of the service. Eventually, the police transported Darren to the Emergency Department for assessment, where the Approved Psychiatric Practitioner (APP) determined that he did not need a hospital admission. Darren then left with friends, and no attempt was made to contact his parents to inform them of the decision not to admit him.

In this case just about every system failed. The police system for holding assessment warrants had failed, information about the young man was not

readily available to after hours staff, new staff lacked the skills to operate the computer record system and so were not able to locate his records and the APP was not aware of his obligations with respect to notifying the family.

TEMHS treated this complaint very seriously, and addressed a number of existing systems as a result. The CVP was informed that liaison with police was improved, effort was made to ensure that all staff were trained in operating the electronic records system (and those who weren't were unable to take calls), a procedure for handover from case managers was implemented and medical staff undertook training with respect to their legal obligations when working with young people.

Activities at Cowdy Ward

An Occupational Therapist is currently employed half time at Cowdy Ward to provide inpatient activities. In the open section of the ward, these activities include a morning meeting, relaxation, a session in the gym and some cognitive work. A TV is available for general viewing, there are books available, some games and an area set aside for art. When speaking to a community visitor, six people have stated that they would prefer extra activities, and in particular, older people have stated they would like to have the capacity to engage in more age and gender appropriate activities such as craft.

Other Complaints

The CVP has received five complaints from consumers who were upset with the way they were treated by mental health staff, with one of these complaints related to a doctor in Emergency at the RDH. The CVP has also received two enquiries from consumers concerned that their families had the capacity to "commit" them to Cowdy Ward. Two consumers complained about transport to hospital by police – this issue was referred to the Darwin community visitors panel and their comments are included under the panel's report. The CVP was also contacted by staff at Cowdy Ward to assist with a consumer who suffered multiple disabilities, and who was managed in Cowdy Ward because there were no other available community services.

The case example below is a merger of two such cases that the CVP is aware of, and is indicative of the difficulties experienced when a person is inappropriately managed in Cowdy Ward because there are no other options.

Case Example 5: Lack *of Accommodation for People with Dual Disability*

Staff contacted the CVP about Damien, a young man with a psychotic illness and acquired brain injury who was being managed in JRU because there was no alternative. Damien has severe behavioural difficulties, and while an inpatient of JRU, assaulted several staff. He had to remain separate from other inpatients for

his own safety and for the safety of others, and therefore spent long periods of time either in seclusion, or separated in the courtyard at JRU.

Because no suitable supported accommodation was available, Damien remained in JRU well after his psychosis had resolved. Finally, he was discharged into the care of his family. Liaison with disability services (with advocacy support from the CVP), resulted in dual case management with mental health services. Damien was re-admitted to JRU on two additional occasions to provide respite for the family who, despite strong commitment to Damien's care, had difficulties coping. At this stage, the situation has not resolved, although with formal and informal support systems in place the family are managing better. The situation remains very stressful for them.

Inspection of Seclusion Records, Cowdy Ward

Seclusion Records at Cowdy Ward were inspected in September 2004, January 2005, March 2005 and June 2005. Problems with documentation were raised following the inspection in June 2004, and on the whole these issues were addressed by mental health services. However, other problems raised from reports forwarded to mental health services about seclusion practices in Cowdy Ward were not being addressed, and under S109(3) of the Act a report was forwarded to Mr Griew, CEO Department of Health and Community Services on 10th May 2005. One major issue identified by the community visitor outlined in this report relates to "breaking" seclusion to avoid review by a medical practitioner after 4 hours as required by the Act. The practice has been to seclude a person for 4 hours, "break" the seclusion for 5 – 10 minutes and then place the person in seclusion again. Excerpts from the report to Mr Griew are included below:

S109 Reports on Inspections of the Seclusion Register at Cowdy Ward, forwarded to the Person-in-Charge of the Approved Treatment Facility on 18th August 2004 and 27th January 2005, commented on:

- *Insufficient documentation, and the need to incorporate the time a medical practitioner is notified/makes contact, the name of the medical practitioner, a signature and a date;*
- *The need for medical practitioner oversight of instances where a seclusion period is longer then 4 hours, or where consecutive seclusion periods with a short 5 – 10 minute seclusion break are longer than 4 hours; and*
- *The need to ensure that a client is secluded on grounds that are consistent with those outlined in the Act.*

Given these reports, it is of concern that issues regarding the reasons for seclusion and length of time without review are still arising.

At the same time, the CVP is aware that the Tamarind Centre has recently concluded a comprehensive audit of seclusion records and is planning to implement any recommendations that might arise from the audit. It is the view of the CVP that there needs to be a change in organisational culture such that the restrictiveness of

seclusion and its impact on the consumer is recognised and it is used as a last resort.

In addition to the findings outlined earlier in this report, other issues with seclusion practices are identified as follows:

- *There is no indication that clients and staff are counselled "…as necessary following a seclusion episode" (Northern Territory Approved Procedures p 12).*
- *There is no evidence that each incident of seclusion is reviewed in depth by the Clinical Team as required by the Northern Territory Approved Procedures (p9).*
- *Because the Act requires review by a medical practitioner after 4 hours, it is my impression that this is perceived to mean that seclusion must be "broken" after 4 hours, rather than when the reasons for seclusion no longer apply. This is an example of practice being moulded to meet legislative requirements rather than being responsive to individual circumstances. "Four hours or until settled" is a phrase commonly used on the Form 62A to describe the proposed seclusion period. Notwithstanding this however, the impression gained from reviewing the seclusion register is that there are now fewer instances of seclusion for four hours than there were when I first inspected the seclusion register in June 2004.*

The CVP is aware that training in seclusion procedures has been provided to all staff in Cowdy Ward. When the Seclusion Register was reviewed again in June 2005, considerable changes were noted by the community visitor. It appeared that consumers spent less time in seclusion, and there was only one instance where an Approved Psychiatric Practitioner (APP) had documented that the time without medical review was being increased in contravention of the Act and Approved Procedures.

Central Australian Mental Health Services (CAMHS)

In the period covered by this Annual Report, 18 complaints about services within CAMHS were received from consumers, carers and service providers. Most of these complaints were resolved quickly.

Involuntary Status and Treatment

Seven complaints were received from consumers regarding involuntary detention and treatment. The approach used consistently by community visitors from the CVP is to explain to the consumer that the program is unable to intervene in this area, to explain the consumer's rights and to offer advocacy support.

Case Example 6: Complaint from consumers about medication

During one visit to the Mental Health Unit by the community visitor, one consumer and one carer approached her about changes in medication.

The consumer, who was willing to take medication, stated that he felt that the new medication interfered with his ability to sleep and did not manage his symptoms. With assistance from a nurse, the consumer spoke to the APP and the medication was changed. With time, the carer was happy with the change in medication. The CVP's role in both cases was to offer advocacy support.

Systems and Procedures

The five complaints placed in this category include lack of follow up by case managers (three complaints), inadequate liaison with carers and difficulties contacting the service after hours. The case example used in this section of the Report highlights the difficulties that can arise when the consumer, the carer and mental health services have different perspectives.

Case Example 7: Complaint from parents about services for their daughter

Parents contacted the CVP with concerns about a change in medication for their adolescent daughter Karen, who suffers a bipolar illness. According to the parents, Karen had been managing well on her medication, but rapidly became unwell after it was changed. The treating psychiatrist changed the medication because it was her opinion that Karen had been depressed, and believed that the change in medication would alleviate these symptoms. Further, the psychiatrist assessed that the new medication was successfully managing these symptoms. Karen, although she initially expressed some reservations, was happy with the change.

According to her parents, Karen became so disorganised that she was unable to manage her day to day affairs. The family reported this to mental health services over a period of some months, but felt that their accounts were either not being listened to, or not being believed.

The CVP arranged a meeting between the APP, the case manager and the family. Karen chose not to attend. During this meeting, some systems issues became apparent. For example, the case manager who had met Karen on only one occasion (when the family brought her in for assessment following a crisis at home, during which time her behaviour had settled) reached the conclusion that as Karen could manage her presentation, the issues were behavioural and related to family dynamics and high expressed emotion within the household. It is the role of mental health professionals to assess the consumer's functioning, and advanced practitioners recognise the impact of the family on the consumer. However, practitioners need to be wary of assumptions. In this case, regardless of the level of accuracy of the assessment, it appeared to have been reached on

the basis of a single contact. There had been no systematic review of the case notes, and no handover from the previous case manager. The family experienced strong feelings of frustration and powerlessness because their perception of the situation seemed to be discounted by practitioners who had very limited knowledge of their daughter.

This is an extraordinarily complex case. The CVP has seen its role as ensuring that the family's views are heard. The expertise of mental health practitioners needs to be acknowledged by all involved, as does the expertise the consumer has about herself. At the same time, it is imperative that the expertise held by the family and the contribution they make to the consumer's ability to manage in the community is acknowledged.

Rehabilitation after Discharge

Two carers contacted the CVP with concerns about how their child would spend their time meaningfully after discharge from hospital. One carer in particular felt that her daughter had lost living skills during a long admission. In both cases, the community visitor followed up with information about the proposed Step Down Program to be operated in conjunction with the Mental Health Association of Central Australia (MHACA), and the ability of MHACA to then link the consumer to their rehabilitation service.

Other Issues

Other complaints to the CVP related to a perceived lack of activities on the ward, consumer's perspectives that staff did not relate to them respectfully and uncertainty about voluntary status. This issue is discussed at length in the report from the community visitors panel.

Inspection of Seclusion Records, Mental Health Unit

Ruth Morley, the community visitor in Alice Springs, inspected the Seclusion Register in November 2004 and noted that information contained in the Register was not in accordance with requirements of S62 of the Act. Ms Morley recommended that she meet with Ward 1 staff in the New Year to ensure the register complied with the Act, and to invite staff to consider ways they could amend the register.

Accordingly, the community visitor met with staff in February 2005 to review the newly developed forms. She was satisfied that at that time, the requirements of S62 of the Act were being met.

Community Visitors' Achievements in Darwin and Alice Springs

After each visit to an approved treatment facility or agency, the community visitor is required, pursuant to section 109 of the Act, to report through the Principal Community Visitor to the person in charge of the approved treatment facility or agency visited. These reports will often include recommendations, and those recommendations awaiting action are included in Appendix 1 of this Report. At times, the CVP will negotiate a particular issue with mental health services without conducting a visit.

Actions that have taken place subsequent to complaints and to recommendations from community visitors are included below (it should be noted that this list is not exhaustive):

- ✓ Windows frosted and either curtaining altered or new curtains made to protect the privacy of inpatients of Cowdy Ward, particularly in bedrooms;
- ✓ The retention of salad meals only for consumers arriving in Cowdy Ward after hours. This measure was put in place due to the community visitor identifying risks associated with reheating meals;
- ✓ The cessation of the practice of locking consumers in the dining room at JRU to finish their meals;
- ✓ The purchase of high quality stainless steel mirrors to replace the mirrors removed from Cowdy Ward following an incident at Christmas, 2004;
- ✓ The changeover of plastic cutlery to stainless steel cutlery in Cowdy Ward;
- ✓ A written apology to a consumer whose ring was cut off when admitted to JRU;
- ✓ Transfer of a consumer to a long stay ward in Adelaide after he had been detained to JRU for almost 12 months. The APP contacted the CVP for advocacy assistance in securing a bed;
- ✓ The cleaning of canvas mattresses used in Seclusion Rooms in JRU;
- ✓ Renegotiation of a treatment plan for a consumer who had complained about discharge from case management from the Tamarind Centre;
- ✓ Care being taken to ensure that the appearance of a consumer's bedroom in Cowdy ward was changed following advocacy assistance from the CVP;
- ✓ Joint case management between mental health services and disability services in Darwin for a consumer with dual disability;
- ✓ Follow up of a client in remote NT experiencing extreme side effects from his medication;
- ✓ An immediate service for a consumer of the Tamarind Centre who was unable to access medication due to problems with the way the prescription was written;
- ✓ Plans for a music system to be installed in JRU;
- ✓ A review of CAMHS practices with regard to hand over of case managers; and
- ✓ A review of CAMHS policies and practice working with carers.

Chapter 3: Community Visitors Panels 2004 - 2005

Community visitors panels inspect approved treatment facilities and agencies at least once every six months to comment on the standard of services and the observance of the rights of consumers. When visiting approved treatment agencies and facilities, community visitors panels use the standards contained in the National Standards for Mental Health Services as the basis for their findings and recommendations. Mental health services have commented that this can be helpful for them as they move to accreditation, as the Australian Council of Healthcare Standards uses the National Standard as the basis for the EQuIP standards which need to be met for accreditation.

Not all panel findings are included in this document. Each panel has produced 4 large reports over the past 12 months, and excerpts only can be included in this report.

Community Visitors Panel - TEMHS

Cowdy Ward

The community visitors panel conducted visits to Cowdy Ward, the approved treatment facility in Darwin, in October 2004 and May 2005. The panel raised a number of issues in its reports which are outlined under the following headings:

- Adequacy of Facilities;
- Rights;
- Recreational Activities in JRU; and
- Discharge Planning.

Adequacy of Facilities in Cowdy Ward

Resourcing

When the panel visited Cowdy Ward in October 2004, there were 37 inpatients in a facility which the Clinical Nurse Manager stated was funded for 26 people, but able to accommodate 31. The outcome of such high bed numbers was that consumers were sleeping on mattresses on the floor and some consumers who were not involuntary had to sleep in JRU, the secure unit. The panel recommended that

- *The approved treatment facility be funded at a level consistent with its usage; and*

- *The mental health service make plans to resource an approved treatment facility designed to cater for the growing mental health needs of people living in the Top End of the Northern Territory.*

Prior to their visit in May 2005, the panel were informed that it is unlikely that a new facility will be resourced because the current facility is only 10 years old. However, extensive funds are being put into refurbishing the unit and increasing the number of usable beds.

Standard of Buildings and Facilities in JRU

After visiting JRU, originally designed as a forensic unit, the panel noted that *JRU is not a low stimulus environment given that the environment is hard and harsh with echoing sound, especially at times of high occupancy. After half an hour in the atmosphere, panel members report feeling distressed. Staff expressed similar views.*

The outdoor area comprises a closed in concrete area about the size of a basketball court with a high roof and two high set fans. There is no greenery…One wall has a mural which adds colour and brightens the atmosphere…One consumer in JRU who spoke to a panel member agreed that the courtyard was hot and gave the analogy of the frog in the saucepan of cold water on the stove who suddenly realises he is being cooked. .

The panel recommended that:

- *The roof be opened in the outside area and lawn and plants be planted to ensure that all consumers have access to an outdoor environment; and*

- *A maintenance program be implemented to repair and maintain items in JRU such as the outside toilet.*

The CVP has been informed that a plan is in place to open a section of the outside area of JRU by breaking through a wall and planting grass. **The CVP wholeheartedly supports this initiative.**

Fishbowl in Cowdy Ward

On both visits to Cowdy Ward, the panel observed that when staff are working in the fishbowls (the central glassed-in nursing stations), consumers tend to be ignored. One panel member, when trying to borrow a telephone book, waited outside the glass enclosure for over three minutes waiting for a staff person to look up and notice she was there. She said: *This experience emphasised what the sense of frustration, powerlessness and isolation must be like for patients put in the same situation of waiting on the outside*.

The panel recommended that:

- *A physical upgrade be undertaken in Cowdy Ward to allow for a private, secure area for staff to write notes and make phone calls, and an open counter area for working with consumers.*

The CVP has been informed that a new nurses station without glass is planned as part of the refurbishment of Cowdy Ward.

Services for Young People

There is no separate facility for treatment of young persons, and given the size of the population in the NT, the panel accepts that such a facility is not feasible. However, the panel believes it is possible to look at alternatives to the current policy of transferring young people under the age of 14, who require a long hospital admission, interstate to specialist inpatient facilities. While this happens rarely, it is the panel's view that alternatives, such as use of the paediatric ward in Royal Darwin Hospital should be explored. The panel recommended that:

- *In consultation with the community, the mental health service develop a framework for the delivery of mental health services for young people that is based on evidence of best practice in other similar populations.*

- *As a consequence of this framework, mental health services develop a range of options to be considered for the provision of the inpatient care of young people experiencing acute phase of illness.*

Rights

Cultural Safety

Three issues relating to cultural safety were addressed by the panel in their two visits to Cowdy Ward; the composition of the Aboriginal Mental Health Worker (AMHW) team, the lack of appropriate information for indigenous consumers and poor access to interpreter assistance, particularly after hours.

The panel was informed that approximately 60% consumers of Cowdy ward are indigenous, and of these, the vast majority are male. There are two FTE AMHW's employed in the facility, only one of whom is male. The panel was informed by the AMHW's that it is culturally appropriate for men to work with men and women with women. The panel concluded that additional male AMHW time is needed.

The panel was concerned that despite all indigenous consumers seeing an AMHW soon after admission, there was no evidence of "indigenous friendly" information, identified by the panel such as posters, or a video. Trained interpreters are not always available to assist at the time of admission.

The panel recommended that:

- *The AMHW team is restructured to create another position and that this appointment should reflect the gender ratios of indigenous clients in the approved treatment facility; and*

- *Information services to aboriginal consumers be improved by providing greater access to Aboriginal Health Workers including when admitted out of hours, advocating for improvements to the interpreter service and providing appropriate visual material.*

Information about Rights

It is ward policy to give consumers a booklet that contains information about mental health services and about their rights when they are admitted to Cowdy. Copies of the booklet are placed in bedrooms and around the ward. However, the panel found that not all consumers were aware of the booklet and what it contained. It is the panel's view that every effort needs to be made to ensure that consumers are aware of their rights, and recommended that:

- *Consumers' files show evidence of (1) the provision of information about rights occurring at a time when the consumer is able to understand and (2) the consumer having understood his/her rights; and*

- *Posters giving information about legal rights be prominently displayed in both Cowdy Ward and JRU.*

The CVP offered to work with consumers and staff to develop a poster which details the legal rights of consumers. TEMHS has not contacted the CVP regarding this offer, and the poster has not been developed.

Transport to Hospital

In its first visit to Cowdy Ward, the panel questioned the routine use of police staff and vehicles to convey involuntary consumers to Cowdy Ward, believing that using them as the first option may give the message to consumers and others that the person being conveyed is dangerous. The panel accepts that there are times when conveyance by police is the most appropriate means of transport. Following their second visit to Cowdy Ward, the panel stated:

The panel has been made aware that barriers to transport to hospital by ambulance as the preferred option relate to three issues. Firstly, the ambulance service is perceived to be in financial crisis and not able to deliver a service to mental health consumers. Secondly, mental health services are not funded to provide transport to hospital by ambulance; and finally, the practice of transport by police is entrenched as standard mental health practice in the Northern Territory.

The panel is nevertheless of the opinion that mechanisms to address these barriers need to be instituted, so that, like other members of the population who are too unwell to travel to hospital by private means, mental health clients gain access to hospital by ambulance.

The panel recommended that:

- *Copies of all assessment warrants be lodged on the consumer files;*
- *TEMHS communication systems be improved so that police receive a copy of an assessment warrant prior to apprehending all involuntary consumers;*
- *TEMHS and Police work together to determine, develop and deliver suitable training for police in relation to mental health consumers, including specific training about mental illness; and*
- *Guidelines be negotiated between Ambulance, Police, and Mental Health Services to provide for transport of involuntary patients to the ward in the least restrictive and most appropriate means.*

Recreational Activities in JRU

The Occupational Therapist facilitates a morning program of activities for consumers in the open section of Cowdy Ward. During its first visit to Cowdy Ward, the panel noted the lack of either activities or entertainment in JRU, leading it to comment that *the general atmosphere in JRU was more reminiscent of a prison than a treatment facility.*

Accordingly, the panel recommended that:

- *A DVD and or VCR be provided in JRU to provide alternatives to day time television; and*
- *TEMHS explore and provide some additional low stimulus recreational activities in JRU.*

The CVP is aware that Austar is now available on television in JRU, and ways of providing access to music are being explored. TEMHS management informed the CVP that the Occupational Therapist would soon be introducing a low stimulus activity program in JRU, although this was not in place at the time of the panel's second visit in May 2005.

Discharge Planning

In their visit to Cowdy Ward in October 2004, the panel noted that while there seemed to be a considerable number of activities related to discharge, such as phone calls and contact with relatives, these activities did not appear to be documented. The panel commented that nursing discharge summaries were brief

and relevant, however there was no evidence they were faxed to other agencies and no evidence of identification of the consumer's GP or contact made with GP's. There was also no evidence of consumer involvement in discharge planning.

In its follow up visit in May 2005, the panel noted no improvement from its previous visit. One consumer informed the panel that the treating team were aware she had no accommodation at the time of admission and yet at the time of discharge accommodation had still not been organised. Fortunately, one panel member was able to arrange accommodation for her.

The CVP was informed that a nursing position would be dedicated to discharge planning. There is no evidence that this has occurred.

The panel recommended that discharge planning procedures be improved by:

- *Implementing all criteria of Standard 11.5 of the National Standards for Mental Health – Planning for Exit;*
- *Appointing a full-time Discharge Coordinator to oversee the implementation of the Standards;*
- *Identifying and referring to preferred ongoing General Practitioners; and*
- *Inclusion of the consumer's signature on the plan to show evidence of consumer involvement.*

Employment of a Social Worker

Inpatient units throughout Australia employ Social Workers to assist with discharge planning, work with families and ensure that the day to day issues that can act as stressors for inpatients are resolved. Several non government agencies have contacted the CVP and commented on the need for a social worker at Cowdy Ward.

There are difficulties with staffing at Cowdy related to the number of nursing staff available, particularly when usage is high and/or consumers require one-to-one nursing. The panel felt that one way of reducing the load on nursing staff would be to employ a social worker. The panel recommended that:

- *A Social Worker is appointed to deal with many of the tasks which currently take up the time of medical and nursing staff. This would have the added advantage if the social worker also acted as discharge co-ordinator.*

The Tamarind Centre

The Darwin Community Visitors Panel inspected the Tamarind Centre in December 2004 and June 2005. For the purpose of this report, the panel's comments are divided into two major sections – provision of services and service quality.

Provision of Services

Case Management

The adult community mental health team, comprised of nine case managers, provides a service to approximately 380 – 400 consumers. This means that each case manager has a case load of between 35 and 45 consumers. While some consumers are followed up more intensively, this can only happen at the expense of others.

The panel recommended that:

- *The service use appropriate assessment tools to clearly identify consumers with complex rehabilitation needs and who therefore require active case management, those who can be managed with lower level case management and those who can be discharged from the service.*

The CVP was informed that the service has plans to increase the number of case managers to 12, with the team divided into two sections to correspond to teams in the inpatient unit. It is planned that in this way, transition from hospital to community will be improved. The CVP is of the view that plans currently in place to improve services have met this recommendation.

Rehabilitation

Following an interview with a consumer, the panel recommended that:

- *The Tamarind Centre conduct a review of the recreational and rehabilitation needs of consumers and the feasibility of providing these services from the Tamarind Centre.*

The Manager of TEMHS informed the panel that there is no possibility of space at the Tamarind Centre being used for recreation and rehabilitation of consumers as all space is taken up for offices. The panel were also informed that there is a space adjacent to Cowdy ward, formerly built specifically for mental health services. Apparently, the Physiotherapy Department from Royal Darwin Hospital (RDH) moved in to this space when the new ED was being built, with the intention of moving back to RDH when this was completed. This has not occurred. **The CVP strongly supports the return of this space for use by consumers of mental health services.**

Services for Young People

Following comments from staff of a non government organisation and a school counsellor about the lack of appropriate mental health facilities for young people, the panel was asked to examine services for young people during its visit to the Tamarind Centre in June 2005. The panel made the following comments:

The panel acknowledges that the Tamarind Centre is managing the space available to them as well as possible, and that one recent innovation has been the institution of a separate waiting room for clients of the Child and Adolescent Team.

… The panel agrees that a completely separate facility is necessary to provide an effective service for young people. The existing waiting room is smelly and hot, and the Child and Adolescent Team reports receiving complaints from clients about the room. Young people and their families have to walk through the main waiting room in order to access child and Adolescent Services. The team also reports that offices are used as therapeutic rooms, a situation which the panel agrees is unacceptable.

The Child and Adolescent Team does not work with clients in their own homes for safety reasons and for what they describe as philosophical reasons. They state that working only from Tamarind means that their time can be used most effectively, and that travelling to Tamarind indicates commitment on the part of the client's family.

Staff in the Child and Adolescent Team state that there is no suitable venue in Palmerston. They state that they currently have to carry what they need to Health Precinct House, and that a more suitable, ongoing alternative venue is needed.

The community visitors panel is aware that the mental health service is constrained by its budget, however in the interests of providing a comprehensive and effective service to children and adolescents, it recommends that the service's long term plans incorporate the provision of separate, appropriate facilities for child and adolescent services.

The panel recommended that:

- *The current child and family waiting area is closed in and air conditioned; and*
- *Therapeutic rooms, separate from offices, are designated for child and family use.*

Forensic Services

The panel met with the Forensic Mental Health Team during its last visit to the Tamarind Centre and provided an extensive report. The panel reported as follows:

Need for Forensic Facility

S43R(5) of Criminal Code states that in the case of people with mental health issues who are found to be unfit for trial due to mental impairment, but who are likely to become fit for trial within 12 months, the Judge may make interim orders including
(a) an order for bail of the accused person or
(b) an order that the accused person is remanded in custody (whether in prison or another appropriate place) during the adjournment.

For prisoners with mental illness who mental health staff believe should not be in prison, there is no alternative if they are still regarded as threat or risk to the

community. A person may be acquitted due to mental illness and still remain in prison because there is currently no alternative facility for these clients. Principle 3 of The National Statement of Principles for Forensic Mental Health 2002 states that:

> *A prisoner who requires inpatient mental health care will be transferred from prison to an appropriate mental health facility having regard to the person's mental health needs, the offence leading to the person's detention, their social circumstances and the likelihood of their remaining in treatment. Specialist inpatient forensic mental health services (secure facilities) are to be owned, funded and staffed by mental health services. Specialist inpatient forensic mental health services are to be located beyond the geographic boundary of a prison and run independently from correctional services.*

In the Northern Territory, the Joan Ridley Unit (JRU), formerly used as the specialist inpatient forensic unit, is now used as a secure unit for the management of consumers who are acutely unwell. When a prisoner is acutely unwell now, they are admitted to JRU, however each client must be accompanied by 2 prison officers. The building of a separate Forensic unit, beyond the boundary of the prison, would resolve issues related to appropriate location of prisoners deemed unfit for trial and prisoners suffering an acute episode of mental illness.

The panel recommended that:

- *A separate Forensic Mental Health Unit is built beyond the boundary of the prison; and*

- *Prison staff receive appropriate training to assist them when working with prisoners who experience mental health problems.*

Co-ordination of Service Provision

Four separate teams provide services for prisoners with mental health issues. The forensic team provides counselling (including CBT) for clients in prison. The Prison Rehabilitation team, comprising a Psychologist, counsellor, and prison doctor are responsible for provision of services along with the Corrections Medical Service which operates externally to the prison under contract. Correctional Services Officers make up the fourth team. The Forensic Team is the only team employed by mental health services and the only team to provide services solely for prisoners with mental health problems.

The panel was informed that despite weekly meetings held Fridays, there are issues with data collection and recording and co-ordination of services. The panel was informed that members of the medical service refuse to attend the weekly meeting.

The panel was also informed that maintenance of medication within the system can seem to be impossible. There needs to be careful control of medication to avoid issues associated with hoarding, overdosing and selling. The prescription and dispensing of medication to prisoners with mental health problems is the responsibility of the Corrections Medical Service on advice from the forensic team. Issues arise in relation to the complexities in documenting and implementing a plan due to the number of teams involved, with the example given of a prisoner prescribed

medication on a Monday, and still not receiving it on the following Friday. This is an issue that needs urgent resolution.

The panel recommended that:

- *The mental health system and justice systems work together to provide a single service for prisoners with mental health problems;*
- *That in the interim, the contract with prison medical service is amended to ensure that a member of this team attends the meeting held each Friday; and*
- *TEMHS immediately appoints a staff member to administer and document the administration of medication.*

Services for Indigenous Prisoners

About 70% of forensic clients are indigenous. Team members informed the panel that there is limited specialist support, and that it is difficult to access AMHW.

Draft 4 of the Guidance on Operational Standards for the Provision of Health Services to Aboriginal and Torres Strait Islander People in Custody outlines an operational standard for prisoners with mental health issues as follows:

> *That Aboriginal and Torres Strait Islander prisoners receive assessment, treatment and rehabilitation that is appropriate to their needs and respectful of their culture.*

The panel is of the opinion that employment of AMHW, either by the justice or mental health system is a necessity in order to meet this requirement

Quality of Services

Continuity of Care

The panel reported that at the time of their first visit to the Tamarind Centre, there was *no quality process in place to co-ordinate transfer from the inpatient setting to the community setting. The discharge process from hospital, which is often with short notice, was reported as "a real problem" for those expected to provide ongoing care* - that is, for case managers in the community team.

Staff believe that the following issues are key factors affecting the continuity of care between hospital and community; discharge plans being completed late - particularly when there are changes in medication, differences in orientation procedures between inpatient and community staff and difficulties with the case note systems of which there are three (hospital, community and electronic systems usable across both hospital and community). After its visit in December 2004, the panel recommended that:

- *Consumers, where appropriate, are discharged from Cowdy ward with five days medication and a prescription so that further medication can be accessed if there is a delay in doctors completing the discharge summary;*

- *All staff inducted into mental health services receive orientation across the inpatient and outpatient sectors;*

- *Mental health services implement an effective electronic record keeping system common to hospital and community settings;*

- *All staff are trained in the use of the electronic client record keeping system; and*

- *The efficacy of the electronic client record system is reviewed and monitored regularly.*

The CVP has since been informed that where possible, consumers are discharged with prescriptions for medication in addition to five days medication. The CVP is now aware that the electronic system is being upgraded, and expects that this will be reflected in improved continuity of care across settings. The panel will monitor this during its next inspection of the Tamarind Centre.

Documentation

Use of Formal Assessment Tools

After reviewing case notes, the panel commented on the use of formal assessment tools as follows: *A Risk Assessment Tracking Tool (RATT) has been revamped following an extensive process of consultation and the panel was informed that this tool is now being used more frequently. One staff member commented that it is widely used because it works for them. Plans are in place to extend its use across the inpatient service.*

While the mental health service advocates the use of other formal assessment tools such as Health of the Nation Outcome Scale (HoNOS), this does not seem to translate into clinical practice.

The panel recommended that:

- *TEMHS implement the use of HoNOS during initial assessment, and thereafter at regular intervals to evaluate the effectiveness of clinical interventions; and*

- *In addition to the use of HoNOS, TEMHS review the evidence for the use of other clinician report and consumer self report assessment tools, identify appropriate tools and implement them into everyday practice.*

TEMHS reports that current use of the Health of the Nation Outcome Scale (HoNOS) has been assessed at approximately 1%. Various mechanisms are being put in

place to increase staff use of assessment tools, supported by the Consumer Outcomes Embedding Team (COMET), a centralised team whose charter is to embed the use of assessment tools into everyday clinical practice. The panel will review progress during its next visit to the Tamarind Centre.

Management Plans

When reviewing case notes in December 2004, the panel found that use of management plans is "sporadic at best". Because this practice is integral to sound mental health case management, the panel recommended that:

- *Tamarind Centre place priority on ensuring that individual management plans are developed for each consumer, that they are developed in collaboration with the consumer and signed by the consumer.*

This recommendation will be reviewed during the panel's next visit to the Tamarind Centre.

Discharge Planning

Ron Coleman, a consumer advocate and now mental health professional, stated in a conference in August 2005 that the first two plans that should be made when a consumer enters a service is a crisis plan and a discharge plan, so they can be safe and know that they're going to get their life back.

During their December 2004 visit, the panel stated that: *at the Tamarind Centre, planning for discharge does not begin at entry to the service, or at regular intervals throughout case management. Staff interviewed by the panel stated that it takes a "long time" for discharge to take place, and that at any one time 5 – 10% of consumers could be discharged from the service. There appears to be no standardised discharge format for the service, although a letter is sent to consumers to inform them of their discharge. As there appears to be no documentation system in case notes to identify GP and other service providers, the panel is unclear how they are notified of discharge.*

As a consequence, the panel recommended that:

- *Discharge planning commence on entry into the service and is reviewed regularly throughout the case management process; and*

- *A discharge format be developed and documented to include at a minimum: the relapse prevention plan, interventions and their outcome, medication and referrals to external organisations including GP's*

The panel will review Management Plans and the quality of discharge planning on all visits to the Tamarind Centre.

Community Visitors Panel - CAMHS

As will be seen from the report from the Alice Springs community visitors panel, many of the issues outlined in this report are common to both approved treatment facilities in the Northern Territory.

Mental Health Unit (Inpatient Facility)

The panel in Alice Springs visited the Mental Health Unit in September 2004 and March 2005. During their last visit, the panel identified 3 major issues: lack of appropriate information for consumers and carers, difficulties with voluntary admissions and informed consent, and a lack of meaningful activities on the ward.

Information for Consumers and Carers

The issue of lack of information for consumers and carers was raised during the panel's first visit to the Unit in March 2004, and reported in our previous Annual Report. Following this report, the CVP was informed that an information pack had been developed and the service was filming a video for indigenous consumers. The panel re-examined this issue in the light of the panel's previous report and the response from mental health services. The panel reported as follows:

On admission to the Unit, consumers are given a pamphlet entitled "Welcome to the Mental Health Unit" which we understand was recently redrafted and simplified. This appears to comprise the only actual written information provided to consumers on admission although the panel noted that information booklets about the community visitor program were available in the lounge room area. Staff advised that the "Welcome" pamphlet was usually left with a consumer to consider and that after a day or two, staff ask the consumer whether the pamphlet has been read and understood. It does not appear to be standard procedure for staff to ask a consumer if an interpreter is required or even if the consumer is literate. These questions are sometimes asked in certain cases but not as a matter of course.

There was no evidence of any information available in indigenous languages. A written response by CAMHS dated January 2005 to the panel's two previous reports ("the response") referred to a proposal to develop an information video for indigenous consumers in consultation with aboriginal organisations. Our inquiries into the progress of this project revealed that the video has not progressed much beyond the funding submission stage. We were told by one member of staff that the first funding submission had been knocked back on the basis that the Unit had not asked for enough money. ***The panel feels very strongly that this project should be revisited and progressed.***

As has been previously found by the panel, there was no evidence that interpreters were routinely used, and when asked about the use of interpreters, staff advised us of the difficulties in getting suitable interpreters to attend the ward. The response referred to the development of an interpreters register at the Unit to record requests for interpreters and outcomes of those requests. When asked about this register,

staff were not aware of its existence and were unable to show the register to the panel.

We were advised that information about mental illness and services available is provided on a case by case basis and only to carers on request. There is no standard package of information that can be handed to consumers and their carers on arrival.

The panel formed the view that standard information available to consumers about rights, mental illness and effective introductions to relevant services and supports is fairly scant. Of particular concern to the panel is the apparent lack of standard information made available to carers and the lack of follow up with consumers as to whether they can read and understand any information given or whether they want an interpreter to help them understand the information.

The panel recommended that:

- *Recommendation 1 of the panel's previous report dated 21 March 2004 which stated that "the Mental Health Unit staff work with other stakeholders ……to improve outcomes relevant to NSMHS Standard 1 Rights and 11.4E Inpatient Care in assisting in-patients to gain information about rights, mental illness and effective introductions to relevant services and supports" be revisited. Urgent consideration should be given to the development of an information package in more than one language and to pursue the development of an informative video to be given to consumers and carers on arrival or as soon as possible after admission.*

In response to the panel's report, the Manager of CAMHS has stated that this information is currently being developed in consultation with consumers. The Manager has also stated that the service is seeking funding to translate some materials into "language" with the possibility of a DVD format.

Voluntary Admissions and Informed Consent

The issue of consumers being admitted on a voluntary basis when the intent is in fact to detain if the consumer decides to leave the facility was addressed at length in the panel's report. The panel also analysed whether consumers were giving informed consent to treatment, and what this means in terms of the Act and the National Mental Health Standards. Their excellent analysis is included as follows:

During the course of the interviews with staff the panel became concerned about an apparent blurring of the line between the voluntary admission of consumers and the involuntary detaining of consumers. This seems to arise in situations where consumers are advised by staff that if they refuse admission and treatment, there may be grounds to detain them on an involuntary basis and an order to that effect can be obtained from the Mental Health Tribunal. The panel was informed that when confronted with the choice between signing an informed consent form and submitting to treatment or facing a possible involuntary treatment order, consumers usually agreed to sign a consent.

The Act states that a person gives informed consent "…when the person's consent is freely and voluntarily given without any inducement being offered" (section 7(2)(a)). The panel is of the view that where consent to treatment is only given following an explanation to the consumer that they will be detained involuntarily if they do not agree to treatment, the explanation amounts to an inducement and therefore the consent obtained is not "informed consent" within the meaning of the Act. If a consumer cannot or does not give informed consent to treatment, in order to continue treating that consumer, the requirements of the Act with respect to involuntary admissions must be observed by the Unit. Failure to do so offends both the Act and National Standards for Mental Health Services' Standard 1.1 which states that "Staff of the MHS [are to] comply with relevant legislation…..protecting the rights of people affected by mental disorders and/or mental health problems".

The panel is further of the view that it is not appropriate for staff to raise the possibility of involuntary detention of a consumer during the course of that consumer exercising their right to consent to or refuse treatment. Involuntary detention should only be raised after a consumer has refused treatment and in the context of informing the consumer about a course of action determined by the Unit.

Another issue that arose during the course of interviews related to admitting consumers as voluntary when their judgement is clearly impaired and when they are not really able to give informed consent. The common practice in such cases has been to use [voluntary] admission, to be less intrusive and not raise the "threat" of involuntary admission, but then if the consumer wants to leave to make them involuntary. This practice has a number of implications. One is that they were not really voluntary to start with, as the intention from the beginning is that should they decide to leave, then they would be made involuntary. Such practice contravenes the requirements of the Act. The second is that as it does not give clear guidance to the nursing staff as to the way these patients need to be managed; at least in one case, this led to a patient that should have been detained to leave the ward and end up in ICU after self-harm.

The panel recommended that:

- *Staff be informed of this very concerning issue and be trained in the requirements of the Act with respect to informed consent and what those requirements mean in the context of involuntary admissions;*

- *A protocol for dealing with involuntary admissions be established that takes into account the need to allow a consumer an unfettered ability to exercise their right to refuse or consent to treatment without the threat of involuntary admission being raised in the course of their decision making process; and*

- *The MHS draft clear guidelines as to whether a patient with a clear lack of judgement can actually consent to voluntary admission.*

The Manager of CAMHS has acknowledged the seriousness of the panel's findings, and stated that staff will receive appropriate training when attending orientation, staff in-service and mandatory training days.

Recreational Facilities

The lack of facilities was raised in the first panel report in March 2004, and reviewed in March 2005. At this time, the panel again commented on the need for appropriate activities, and after discussions with staff and consumers concluded that it would be appropriate to employ an Occupational Therapist to work with consumers on the ward. The panel stated:

The Unit has an indoor and an outdoor recreational area as well as a well equipped and nicely maintained dining area and lounge/TV area. In the recreational area, the panel observed that the gym equipment was broken (we were advised that it had been broken "forever") and needed updating. All recreational materials such as painting materials, games, puzzles etc. were kept locked in a cupboard to prevent misuse or damage. There were no outdoor recreational facilities set up for use.

Staff informed us that painting was the preferred activity of most indigenous consumers and it was apparent that someone had been painting shortly before our viewing of the facilities. However we were told that a lot of indigenous clients were disappointed with the materials and environment available for artwork – there is only a single desk set up as a painting station and we understand that for funding reasons, the Unit is unable to provide proper dot painting materials and canvasses (only paper is available).

All staff spoke of the potential therapeutic benefits of enhanced recreational facilities and in particular the appointment of an occupational therapist to supervise and encourage the use of the recreational facilities and to organise group activities and excursions. While the nursing staff do their best to encourage the use of and assist consumers in the use of the available facilities, they feel unable to give that aspect of treatment great focus due to the demands of the clinical workload. Consumers themselves may embrace more positively an external, non-clinical activity person whose presence is independent from that of nursing staff.

The panel recommended that:

- *The Department of Health and Community Services consider providing funding for the employment of an occupational therapist in the Unit and that further funding be allocated to enhance the range of recreational materials and activities available to consumers at the Unit*

In response to this recommendation, the Manager of CAMHS stated that the service is currently seeking to employ an Occupational Therapist who will provide a service to inpatient and community teams.

CAMHS Community Teams

The panel visited the community teams in October 2004 and April 2005. They stated that they were:

… extremely impressed by the energy and dedication of the current manager of the service and all of the staff interviewed. All staff were very enthusiastic about speaking with the panel and we feel that that enthusiasm reflects a real commitment to quality improvement. As the panel noted in the October report, CAMHS is continuing to audit all systems and introduce any changes required to improve the service. Some examples of those quality improvement activities that the panel was advised of are:

a. *the community team is in the process of identifying regular consumers and, with consumers consent, notifying relevant organisations such as the hospital's emergency department and other non government mental health organisations of any management plans in place for a consumer;*
b. *CAMHS is involved in a national plan of clinical studies that aims at ensuring that people with mental illness that present to the emergency department are treated promptly (within 4 hours of presentation) and appropriately;*
c. *working on building up a better collaborative relationship with non government mental health organizations including outstations;*
d. *working on a sub acute program aimed at providing "step down" from inpatient admission as part of a broader rehabilitation program which is aimed at facilitating earlier discharges from hospital and which will potentially play a preventative role in the community;*
e. *developing "promotion, prevention and early intervention" programs;*
f. *formalising a professional development program to up-skill all mental health professionals and workers;*
g. *negotiating to have a bulk billing general medical clinic attached to CAMHS to fill an obvious and alarming gap in mental health services provided in Alice Springs by providing an opportunity for consumers to attend a GP to have any side effects of medication monitored (it was pointed out to the panel that indigenous clients often consult Aboriginal Congress for this however non-indigenous consumers do not have a bulk billing general practice to consult and may well therefore go unmonitored);*
h. *working on the interpretation of mental health information into language and to develop audio tapes for indigenous consumers;*
i. *working on ensuring that all information provided to indigenous consumers is culturally appropriate.*

The panel felt that it would be premature to make recommendations in areas in which CAMHS is trying to improve, and instead focused on the following:

- access to interpreters;
- access to mental health services for remote communities; and
- the provision of the after hours service.

Use of Interpreters

In October 2004, the panel reported on difficulties accessing interpreter assistance, particularly after hours. Six months later, the panel found that the situation had not improved. The panel reported as follows:

All staff reported difficulty in getting interpreters especially quickly and at short notice as the nature of their work often requires. Most consumers present without appointments and often in crisis. Staff reported that family members who attend with consumers are usually relied on to interpret as interpreters are difficult to get hold of. But while staff cope well with the difficulties and they are generally satisfied that communication with consumers via family members is effective, to ensure consumer confidentiality, accuracy of interpretation and where relevant accuracy of diagnosis, the panel feels that use of family members should be avoided where possible and that an qualified impartial interpreter should be the preferred option.

The panel recommended that:

- *The MHS work with interpreter services in Alice Springs, the NTG Aboriginal Interpreter Service, the Hospital interpreter service and other agencies (such as Congress, CAALAS, IAD) to explore ways to improve the availability of interpreters generally but in particular in cases where crisis intervention is required and after hours.*

In her response to the CVP in June 2005, the Manager of CAMHS acknowledged the importance of this issue and stated that it would be a priority of the service over the next few months.

Access to Mental Health Services for Consumers Living in Remote Communities

In October 2004, the panel reported that only two AMHW's are working on remote communities. Staff report that their effectiveness is demonstrated by the infrequency of admissions from the areas in which the AMHW's are based.

On its last visit, the panel noted that the Division of Primary Health Care has obtained funding for the appointment of two more aboriginal mental health workers in remote communities, but that the funding had remained unallocated.

The panel recommended that:

- *CAMHS should liaise with the Division to find out why the funding has not yet been allocated and encourage that allocation as a matter of urgency;*

- *CAMHS should liaise with mental health organisations to explore the possibility of providing some support services (such as education for carers, consumers and community members) to remote communities; and*

- *CAMHS should consider establishing links with community based organisations that have their own health workers that visit communities and work with those organisations to improve access to mental health services.*

After Hours Service

The CVP is aware of complaints from carers and service providers about difficulties accessing the After Hours Service in Alice Springs. The panel commented as follows:

While others were aware of the after hours call out service offered by CAMHS, many carers spoke of a lack of reliable after hours crisis care and complained that on occasions when they have contacted the after hours service to seek intervention, they have just been told to go to the emergency department or in some cases, the police. Carers also spoke of what they perceived to be "chronic" understaffing of CAMHS after hours and at weekends and a great reluctance of CAMHS on call staff to attend the consumer's home to assist at times of crisis. There is, therefore, a widely held view amongst carers that the after hours call service is of little use to them. Many carers expressed a preference for "the old days" when there were two shifts of case managers per day at CAMHS meaning that the clinic was staffed until 7pm.

While the panel acknowledges that the after hours service is an emergency service only, we feel it is important for CAMHS to clarify the role of the after hours service to relieve the apparent frustration of consumers and carers in the community.

The panel recommended that:

- *CAMHS consider ways to raise community awareness of the availability and scope of the after hours service; and*

- *CAMHS liaise with carers and explore ways to make the after hours call out service more effective in accommodating needs of carers and consumers.*

The Manager of CAMHS has reported that new brochures and fact sheets explaining the role and functions of CAMHS are being developed, to be completed at the end of August 2005. The Manager also reports that the CAMHS model of service delivery will be discussed when the new Consumer Advisory Group is implemented.

Chapter 4: Performance

The performance for the CVP during the 2004 – 2005 financial year is measured against the objectives and strategies outlined in the Draft Strategic Plan, included in this document in Appendix 3.

Objective 1: To operate the Community Visitor Program in accordance with requirements of the *Mental Health and Related Services Act 1998.*

Description: This objective refers to the purpose of the CVP and its ability to meet its legislative requirements.

The table below compares the achievements of the program over the past two reporting periods.

		Darwin		Alice Springs		Rural & Remote	
	Legislative Requirements	2003/ 2004	2004/ 2005	2003/ 2004	2004/ 2005	2003/ 2004	2004/ 2005
Complaints & Enquiries Received & Actioned	N/A	17	77	6	18	0	1
Visits	In response to requests/ inspection	9	50	3	7	0	0
Panel Visits Inpatient Facilities	2 (At least once every 6 months)	0	2	1	2	N/A	N/A
Panel Visits Agencies	2 (At least once every 6 months)	0	2	0	2	0	0
Inspection Seclusion Register	2 (At least once every 6 months)	1	3	0	2	N/A	N/A
Inspection Complaints Register	2 (At least once every 6 months)	1	2	0	0	0	0

Notes:

1. The increase in complaints is directly related to the increase in accessibility of the program.
2. The lack of contact in Rural and Remote NT is apparent but may only be addressed with increased funding.

Performance Measures	Unit of Measure	2004 – 2005	Proposed Action 2005 - 2006
Develop a Handbook for the program	N/A	Achieved	Update the Handbook - ongoing
Establish a database for the CVP	N/A	Achieved	Continuous improvement of the database
Timeliness	Visits conducted within 24 hours of notification of a request	100%	100%
New Strategy			Community Visitor to conduct 6 inspections of Approved Treatment Agencies in Remote NT.
New Strategy			Establish regular meetings with the Director, Mental Health Service and Managers of TEMHS & CAMHS

Objective 2: To increase accessibility of the CVP to consumers, carers and service providers.

Description: This objective refers to ensuring that Territorians affected by mental illness are able to access the CVP.

Performance Measures	Unit of Measure	2004 – 2005	Proposed Action 2005 - 2006
Quantity	Number of visits to approved treatment facilities	57	100
Develop a remote area strategy	N/A	Not Achieved	Have strategy in place ready to implement 2006 - 2007
Develop and maintain the CVP website	N/A	Partially achieved	Achieved – to be updated
New Strategy			Employment and Training of 3 indigenous community visitors
New Strategy			New logo developed.

Objective 3: To develop, maintain and share a comprehensive knowledge of mental health policy and evidence based mental health practice.

Description: By meeting this objective, the CVP ensures that its comments and recommendations to mental health services are relevant and useful.

Performance Measures	**Unit of Measure**	**2004 – 2005**	**Proposed Action 2005 - 2006**
Develop a Training program for community visitors and panel members		First 6 hour training program completed	Issue specific training programs developed
Quantity	All program staff receive a minimum 6 hours training each year	100%	100%
Develop resources for personnel of the CVP.		Partially achieved	Ongoing
New Strategy			Community visitors and panel members have the opportunity to attend a National Conference

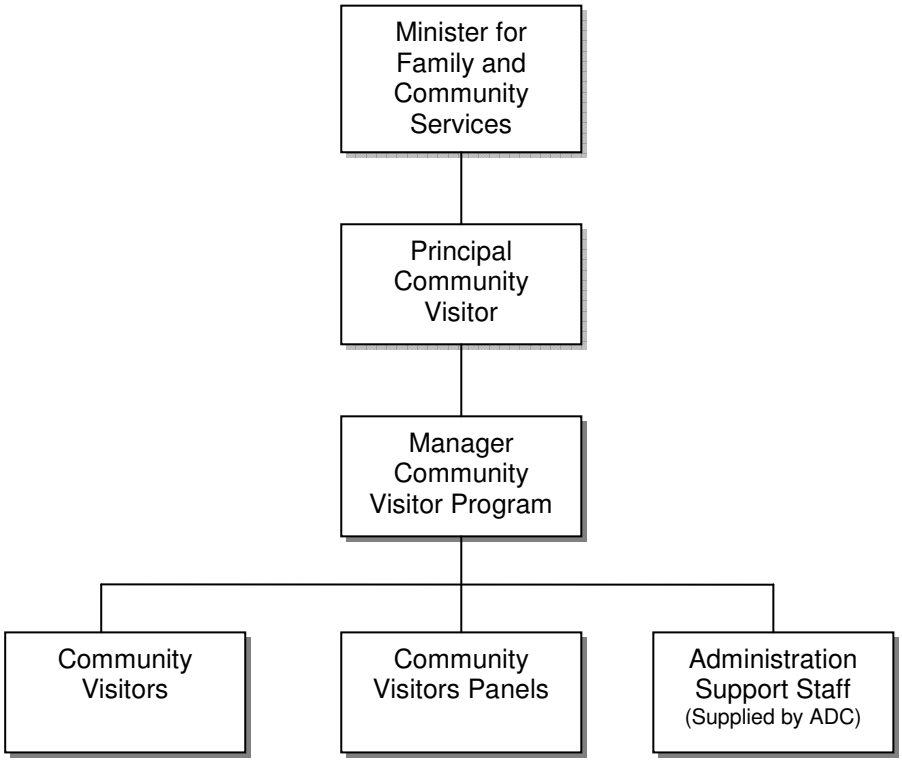
Objective 4: To develop and maintain relationships with key players within the Northern Territory - consumers, carers and service providers.

Description: Government and non-government organisations throughout the Territory become aware of the CVP and referral processes**.**

Performance Measures	**Unit of Measure**	**2004 – 2005**	**Proposed Action 2005 - 2006**
Relations with consumers, service providers and mental health services	Number of meetings	68	80
New Measure	Number of referrals from service providers	N/A	
New Strategy			Establishment of an Advisory Structure

Chapter 5: Administration

Organisational Chart



Staffing

Sections 103(1) and 110(1) of the Act state that the Principal Community Visitor shall appoint Community Visitors and Community Visitors Panel members.

Within this framework, the CVP team is as follows:

1. Staff of the Anti-Discrimination Commission, employed under the Northern Territory Public Sector Employment and Management Act, constitute the three Community Visitors in the Top End.

2. The Community Visitors in Alice Springs, Community Visitors in Darwin who are not employees of the ADC and all Community Visitors Panel members receive fees consistent with the Determination of Remuneration, Allowances and Expenses under the *Remuneration (Statutory Bodies) Act* for Expert Panels.

Personnel

Community Visitors

- Mr Tony Fitzgerald, Commissioner of the Anti-Discrimination Commission (ADC) is the Principal Community Visitor.
- Simon Wiese, Conciliator with the ADC was appointed Community Visitor in November 2003.
- Kathryn Ganley, Solicitor/Conciliator with the ADC was appointed Community Visitor in June 2005.
- Judy Clisby, Manager of the Community Visitor Program, was appointed Community Visitor in June 2004.
- Marilyn Starr, project officer for the Mental Health Coalition, was appointed Community Visitor in June 2005.
- Ruth Morley, a legal practitioner in a private firm in Alice Springs, was appointed Community Visitor for Central Australia in December 2003.

Community Visitors Panels

- Geoff Harris, Chairperson of the Community Visitors Panel in Alice Springs and the community member, was appointed in December 2003. Geoff resigned in October 2004 when he moved to Adelaide.
- Arman Yazdani, the medical practitioner member of the Community Visitors Panel in Alice Springs was appointed in December 2003.
- Victoria Shiel, the legal practitioner member of the Community Visitors Panel in Alice Springs was appointed in December 2003. Victoria resigned in December 2004 when she moved back to Brisbane.
- Sarah McNamara, was appointed Chairperson and legal member of the Community Visitors Panel in Alice Springs in March 2005. She was also appointed Community Visitor for Central Australia in March 2005.
- Maya Cifali, a consultant and member of the Board of the Mental Health Association of Central Australia (MHACA) was appointed community member of the Alice Springs Community Visitors Panel in March 2005.
- Sarah Giles, Chairperson and medical practitioner member of the Community Visitors Panel in the Top End, was appointed in March 2004.
- Terry Lisson, Director Conciliaition, Policy and Law (ADC) was appointed Community Visitor in November 2001. She continues to act as a community visitor, however her major role over the past twelve months has been legal member of the Community Visitors Panel in the Top End.
- Kirsty Carter, CEO of TEAM Health, was appointed community member of the Community Visitors Panel in the Top End in September 2004.

Principal Community Visitor and Community Visitors

Tony Fitzgerald: Commissioner ADC, Principal Community Visitor

Tony has been the NT's Anti-Discrimination Commissioner and Principal Community Visitor for three years now. Tony practised law in the NT for 18 years in a variety of positions. Whilst employed as Deputy Director of the NT Legal Aid Commission (1990-1994), one of his roles was to represent "involuntary" patients at Cowdy Ward at Magistrates Court hearings. During this time Tony realised both how isolated those suffering from mental illness can become, and how difficult were many of the problems they had to face. Accordingly Tony is very pleased to have the opportunity to oversee the CVP - a scheme which is able to respond to complaints from patients, assist in complaint resolution, and carry out inspections of NT treatment facilities.

Judy Clisby, Manager CVP, Community Visitor

Judy has a background working in mental health services, drugs and alcohol and Centrelink. She is a social worker with a keen interest in mental health. She says: *It is my view that citizenship should be the core component of mental health service provision, and that this means that services are provided with a minimum of compulsion and with the stated goal of recovery*.

Simon Wiese, Community Visitor

Simon is an experienced negotiator and mediator who has worked in human resource management and industrial relations roles with the Office of the Commissioner for Public Employment, NT Correctional Services and Department of Justice. Simon is also a Community Visitor. While most of his involvement with the program over the past twelve months has been in an administrative capacity, Simon has managed to visit Cowdy Ward on a couple of occasions in response to complaints.

Kathryn Ganley, Community Visitor TEMHS

Kathryn has significant complaint resolution / management experience in the Health and Community Sector. She has acted as solicitor for Alice Springs Hospital and staff in mental health applications and negligence claims during the period 1996 to 2000. In 2000 she was employed with the Health and Community Services Complaints Commission as Conciliator / Investigator. Kathryn is on a 6 month transfer to the Anti-Discrimination Commission, in this capacity she has acted as Community Visitor.

Ruth Morley, Community Visitor, Alice Springs

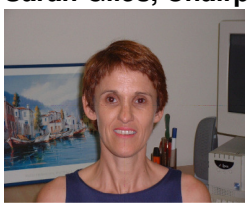
Ruth Morley has been a practising solicitor in Alice Springs over the last 12 years and has experience in the operation of the anti discrimination legislation, as well as a community profile in areas including the arts, sport, environment and social justice.

Marilyn Starr, Community Visitor, TEMHS

Marilyn says: *I came to the Territory in 1984 to help manage a 10,000 head buffalo station. In 1997 my family built and operated a wilderness and wildlife retreat on the Mary River and then in 2000 we bought a roadhouse near Kakadu. During all of these changes I've been interested in mental health issues and eventually signed up to study for a Bachelor of Behavioural Science which I'm still completing. I'm also a trained mediator and counsellor and small business manager with 16 years history of working in Indigenous communities for the purpose of carrying out their elections. I am a Justice of the Peace and I work part time for the NT Mental Health Coalition, the NT Peak Mental Health Body, and I'm finding the work I do as a Community Visitor from time to time very rewarding and informative.*

Community Visitors Panel Members at 30th June 2005

Sarah Giles, Chairperson and Medical Member, Darwin



Sarah is from Country South Australia. She worked in the Kimberley for seven years, and has been a full time GP in Darwin for the past eight years. Sarah is married and has two early teenage children, rides her bike to work and likes to camp, talk and to cook. Sarah has an interest in mental health – she says that*: working in rural and remote Australia and even in Darwin has given me lots of work in mental health. I am part of a GP network of mental health providers and on the Board of the Division of General Practice*.

Kirsty Carter, Community Member, Darwin

Kirsty will graduate soon with a Master of Management from the University of Technology, Sydney. She has worked as an administrator in a mental health advocacy organisation, as a support worker in disability services, and as a case worker in family support. Currently, Kirsty is the CEO of TEAM Health. Kirsty is interested in music, creative writing and travel.

Terry Lisson, Legal Member and Community Visitor, Darwin

Terry moved to Darwin eleven years ago and is now a dual Australian/Canadian citizen. She practiced law in Canada from 1980 to 1986 before going sailing and travelling for 8 years. Since moving to Darwin she has acquired considerable experience as a complaint handler/conciliator working first for the Human Rights and Equal Opportunity Commission and for the past 4 years with the Anti-Discrimination Commission. Terry was extensively involved in the early stages of setup of the CVP program, has acted as a Community Visitor when called upon and for the past eight months has acted as the legal member for the Darwin Community Visitors Panel.

Sarah McNamara, Chairperson and Legal Member, Alice Springs

Sarah graduated from the University of Sydney with Arts (Hons) in 1990, majoring in Australian Literature and Italian Studies. She undertook a Bachelor of Laws, graduating in 1993. Sarah was admitted as a legal practitioner in the NSW Supreme Court in 1994. After completing practical training at the College of Law, Sydney, between 1995 and 1995, she was employed as a solicitor in Commercial Law Practice in Sydney and at Cridlands in Darwin. Sarah moved to Alice Springs in 1999 where, after working with the local firm, she co-established and managed a law firm for Budrikis and McNamara Lawyers. Sarah wound up the practice in 2002 to focus on children but has managed to maintain an active involvement in areas of particular interest as well as her current involvement with the community visitors panel. Sarah is employed as a special project officer with CAALAS and is Chairperson and Public Officer for the Central Australian Women's Legal Service and advises the service in relation to policy matters.

Dr Arman Yazdani, Medical Member Alice Springs

Arman graduated in Western Australia and has worked in Central Australia ever since. He has been a GP for the past nine years. He also does a few sessions for the Emergency Department of Alice Springs Hospital and one session a week for Northern Territory General Practice Education. Arman says: *Mental Health is quite central to the work of a GP and advocating for patients is not an uncommon role for a GP to play. These, plus the fact that at the time there were no other GPs in Central Australia who were available to take this task on, lead me to be involved with this program*.

Maya Cifali, Community Member, Alice Springs

Maya was born in Alexandria, Egypt from Italo-French descent and arrived in Australia in 1966. Maya has many qualifications, including a degree in linguistics, legal studies, political science, management of enterprises and translation efficiency from Paris University (Sorbonne). She has broad teaching experience and is a highly accredited interpreter with an established reputation for excellence in Aboriginal Languages Interpreter Training. Since 1994, Maya has worked as a Consultant in Alice Springs. She is currently on the Board of the Mental Health Association of Central Australia (MHACA).

Finance

The Department of Health and Community Services provided funding totalling $70,000.00 to the Community Visitor program. The following statement details how the funds have been allocated.

Income	$	$	$
Funding: Department of Health and Community Services			70000
Expenditure			
Salaries and Remunerations			
Manager CVP		82400	
Operational Expenses			
Accommodation	750		
Communication	1250		
Consumables	20		
Marketing and Production	380		
Motor Vehicle Expenses	450		
Official Duty Fares	3350		
Office Requisites and Stationery	100		
Training and Study Expenses	100		
Travel Allowance	900		
Information and Technology Charges	3500		
Fees and Other Regulatory Charges	19900		
Total Operational Expenses		30700	
Total Expenditure			**113100**
Deficit			**43100**

Notes

1. $40,000 contributed by Department of Justice.
2. $3,100 contributed by the Anti Discrimination Commission
3. The Anti Discrimination Commission has also contributed in the form of indirect costs – Staffing: Proportion of the salary of the Principal Community Visitor and Conciliators who also act as Community Visitors, administration staff and other costs such as motor vehicle, photocopying, use of office space and furniture and equipment.

Chapter 6: Finale

Future Challenges for the CVP

Funding

People with mental health related issues are regularly described as being one of the most disenfranchised groups within the population. A program such as the CVP can assist people to find a voice, at an individual level through advocacy and assistance with complaints, and at a systemic level through recommendations made about the quality of delivery of mental health services.

The future of the CVP and its ability to provide a service throughout the Northern Territory, will be dependent on the success of the cabinet submission currently with the Department of Justice. If the submission is unsuccessful, the Principal Community Visitor will need to consider whether he is able to continue in that role.

Acknowledgment of Mental Health Services

Because the work of the CVP centres on receipt of complaints and commenting on issues in services, the more positive aspects of mental health services are not acknowledged. Mental Health Services conduct their business in a difficult environment, subject to high public expectations and public criticism.

During many visits to Cowdy Ward and the Mental Health Unit, consumers expressed their satisfaction with the service they were receiving.

We would like to thank the staff of TEMHS, CAMHS and the Mental Health Policy Unit for their support, their openness and their willingness to work with the CVP. It is appropriate to finish this report with an example of excellent practice in Cowdy Ward.

Case Example 8 : The least restrictive alternative in Cowdy Ward

While on a visit to Cowdy Ward, the community visitor was approached by a nurse who was concerned that a consumer was feeling too restricted in the ward. The nurse asked the community visitor to speak to the consumer about what some of his options might be. The community visitor agreed to do so after meeting with another consumer who had contacted the CVP.

When the community visitor tried to speak to the consumer referred by the nurse, she found that the nurse had discussed options with the consumer and successfully negotiated that the consumer go home and return the following day for review by an APP. The consumer had already left the ward, happy with this plan.

Appendix 1:
Summary of Recommendations Outstanding at 30th June 2004

Community Visitors Recommendations

TEMHS

The CVP has made a number of recommendations to TEMHS subsequent to visits to Cowdy Ward. They are forwarded as part of a quarterly report to the Director of Mental Health Services, the Manager of TEMHS and the Acting Director of Psychiatry. The recommendations included below are those that have not yet been actioned by mental health services.

Recommendation: Facilities in JRU
It is recommended that:
(a) serious consideration be given to the facilities in JRU as follows:
- *The provision of a closed outside area with some greenery*
- *Painting/decoration of the walls to make the area less dehumanising*

(b) mental health services, as part of future planning, plan for 2 levels of secure environment. These could be used flexibly according to existing inpatient conditions, so that at different times males are separated from females, prisoners from non-prisoners, or separation on the basis of level of acuity.

Recommendation: Items of Religious and Cultural Significance
It is recommended that:
(a) a policy regarding consumer access to items of religious and cultural significance in Cowdy Ward be developed and staff awareness raised.

Recommendation: Meals
It is recommended that:
(a) consumers of Cowdy ward are given the choice of salad or hot meal for their evening meal (in the same way as patients in Royal Darwin Hospital);
(b) whenever possible (ie when inpatients of JRU comprise only a few people) that food for inpatients of JRU is kept warm in the oven prior to serving; and
(c) staff are informed that they can contact the kitchen for a replacement meal if there is a mistake which affects the quality of food served for consumers of Cowdy Ward.

Recommendation: Admission of Voluntary Patients
It is recommended that:
(a) the mental health service review its practice of admitting consumers to the approved treatment as voluntary patients when they meet the criteria for involuntary detention and where the intention is to detain if they try to leave.

CAMHS

The CVP has made two recommendations to CAMHS as a result of visits to the ward in the past twelve months. Each of these has been addressed by the Manager of CAMHS and the principles contained in them incorporated into the policies and procedures of the service. Over time, the CVP will monitor how these are translated into practice.

Community Visitors Panels Recommendations

TEMHS

Cowdy Ward

Recommendation: Resourcing
It is recommended that:
(a) the approved treatment facility be funded at a level consistent with its usage; and
(b) the mental health service make plans to resource an approved treatment facility designed to cater for the growing mental health needs of people living in the Top End of the Northern Territory.

Recommendation: Fishbowl in Cowdy Ward
It is recommended that:
(a) a physical upgrade be undertaken in Cowdy Ward to allow for a private, secure area for staff to write notes and make phone calls, and an open counter area for working with consumers.

Recommendation: Standard of Buildings and Facilities in JRU
It is recommended that:
(a) the roof be opened in the outside area and lawn and plants be planted to ensure that all consumers have access to an outdoor environment;
(b) maintenance program be implemented to repair and maintain items is JRU such as the outside toilet; and

Recommendation: Monitoring Seclusion
It is recommended that:
(a) the facility investigate involvement in the ACHS national benchmark system for monitoring use of seclusion as a mechanism for measuring and improving its own performance.

Recommendation: Discharge Planning
It is recommended that discharge planning procedures be improved by:
(a) implementing all criteria of Standard 11.5 of the National Standards for Mental Health – planning for Exit;
(b) appointing a full-time Discharge Coordinator to oversee the implementation of the Standards; and
(c) identifying and referring to preferred ongoing General Practitioners.

Recommendation: AMHW Team

It is recommended that:

(a) the AMHW team is restructured to create another position and that this appointment should reflect the gender ratios of indigenous clients in the approved treatment facility.

Recommendation: Provision of Information about Rights

It is recommended that:

(a) consumers' files show evidence of (1) the provision of information about rights occurring at a time when the consumer is able to understand and (2) the consumer having understood his/her rights;

(b) information services to aboriginal consumers be improved by providing greater access to Aboriginal Health Workers including when admitted out of hours, advocating for improvements to the interpreter service and providing appropriate visual material; and

(c) posters giving information about legal rights be prominently displayed in both Cowdy Ward and JRU.

Recommendation: Notification of the Primary Carer

It is recommended that:

(a) the APP's adhere to section 43(5) of the Act and refer to the Mental Health Tribunal all decisions not to notify the primary carer as soon as practicable after admission in situations where consent is unable to be given and the APP nevertheless concludes that it is not in the best interest of the consumer to notify the carer.

Recommendation: Documentation

It is recommended that:

(a) staff of the facility complete documentation to demonstrate that they have adhered to all sections of Part 5 and Part 6 of the NT Mental Health and Related Services Act 1998;

(b) evidence of medical and psychiatric assessments being carried out for all consumers be lodged on all consumer files and medical conditions are clearly identified; and

(c) checklists for each consumer be completed and filed on the consumers' file, and that these checklists:

- *are modified to be consistent with recommendations included in sections 3.2.1 to 3.2.5 of this report;*
- *include evidence that clients have been consulted as to who they want informed of their admission;*
- *include evidence that the primary carer has been informed of the admission when the consumer consents to the sharing of this information; and*
- *include evidence when the Mental Health Review Tribunal has been notified under S43(5) of the Act.*

Recommendation: Transport to Hospital

It is recommended that:

(a) copies of all assessment warrants be lodged on the consumer files;

(b) TEMHS communication systems be improved so that police receive a copy of an assessment warrant prior to apprehending all involuntary consumers;

(c) TEMHS and Police work together to determine, develop and deliver suitable training for police in relation to mental health consumers, including specific training about mental illness; and

(d) guidelines be negotiated between Ambulance, Police, and Mental Health Services to provide for transport of involuntary patients to the ward in the least restrictive and most appropriate means.

Recommendation: Employment of a Social Worker
It is recommended that:
(a) Social Worker be appointed to deal with many of the tasks which currently take up the time of medical and nursing staff. This would have an added advantage if the social worker also acted as discharge co-ordinator.

Recommendation: Meals
It is recommended that:
(a) consumers in the facility have the same choices and quality for evening meals as other patients in the hospital.

Recommendation: Recreational Activities in JRU
It is recommended that:
(a) TEMHS explore and provide some additional low stimulus recreational activities in JRU.

Recommendation: Consumer Involvement in Discharge Planning
It is recommended that:
(a) discharge plans show evidence of consumer involvement through inclusion of the consumer's signature on the plan.

The Tamarind Centre

Recommendation: Facilities for the Child and Adolescent Team
It is recommended that:
(a) The current child and family waiting area is closed in and air conditioned;
(b) Therapeutic rooms, separate from offices, are designated for child and family use; and
(c) Minor maintenance, including the removal of the desk from the room with the 2-way mirror is carried out promptly.;

Recommendation: Inpatient Facilities for Forensic Clients
It is recommended that
(a) A separate Forensic Mental Health Unit is built beyond the boundary of the prison; and
(b) Prison staff receive appropriate training to assist them when working with prisoners who experience mental health problems.

Recommendation: Co-ordination of Service Provision
It is recommended that:
(a) The mental health system and justice systems work together to provide a single service for prisoners with mental health problems;
(b) That in the interim, the contract with prison medical service is amended to ensure that a member of this team attends the meeting held each Friday; and
(c) TEMHS immediately appoints a staff member to administer and document the administration of medication.

Recommendation: Documentation
It is recommended that:
(a) The forensic team place priority on ensuring that individual management plans are developed for each consumer.

Recommendation: Electronic Record Keeping
It is recommended that:
(b) The mental health service look at options for using CCIS in Cowdy Ward and in the community sector in order to ensure consistent record keeping (in Alice Springs is same hospital and community); and
(c) The mental health service cost the purchase of a server for the service to avoid wastage of valuable staff time.

Recommendation: Staff Induction
It is recommended that:
a) All staff, including staff currently employed by the Tamarind Centre, have the opportunity to attend induction training.

Recommendation: Use of Formal Assessment Tools
It is recommended that:
(a) TEMHS implement the use of HoNOS during initial assessment, and thereafter at regular intervals to evaluate the effectiveness of clinical interventions; and
(b) In addition to the use of HoNOS, TEMHS review the evidence for the use of other clinician report and consumer self report assessment tools, identify appropriate tools and implement them into everyday practice.

Recommendation: Cultural Safety
It is recommended that:
(a) The Tamarind Centre endeavour to develop formal links with Danila Dilba Emotional and Spiritual Well-being Service;
(b) The Tamarind Centre inquire into the accessibility of its service to Aboriginal people and implement any recommendations; and
(c) Resources are made available to enable the Tamarind Centre to implement recommendation 2(b).

Recommendation: Continuity of Care – Hospital to Community
It is recommended that:
(a) Consumers, where appropriate, are discharged from Cowdy ward with 5 days medication and a prescription so that further medication can be accessed if there is a delay in doctors completing the discharge summary;
(b) All staff inducted into mental health services receive orientation across the inpatient and outpatient sectors;
(c) Mental health services implement an effective electronic record keeping system common to hospital and community settings;
(d) All staff are trained in the use of the electronic client record keeping system ; and
(e) The efficacy of the electronic client record system is reviewed and monitored regularly.

Recommendation: Management Plans
It is recommended that:
(a) Tamarind Centre place priority on ensuring that individual management plans are developed for each consumer, that they are developed in collaboration with the consumer and signed by the consumer.

Recommendation: Discharge Planning
It is recommended that:
(a) Discharge planning commence on entry into the service and is reviewed regularly throughout the case management process; and
(b) A discharge format be developed and documented to include at a minimum: the relapse prevention plan, interventions and their outcome, medication and referrals to external organisations including GP's.

CAMHS

Mental Health Unit

Recommendation: Information about Rights
It is recommended that:
(a) the Mental Health Unit staff work with other stakeholders (in particular the Mental Health Association of Central Australia, NT Carers, Disability Advocacy Service and relevant Aboriginal organisations) to improve outcomes relevant to NSMHS Standard 1 Rights and 11.4.E Inpatient Care in assisting in-patients to gain information about rights, mental illness and effective introductions to relevant services and supports.

Recommendation: Discharge Planning
It is recommended that:
(a) a standard format be adopted by the Mental Health Unit for documenting discharge plans and that these be used in accordance with NSMHS Standard 11.5.

Recommendation: Incident Reports
It is recommended that:
(a) the incident reports be reviewed regularly (eg six monthly) by a person with appropriate experience and authority to analyse patterns and to assess whether appropriate follow up has happened.

Recommendation: Complaints Register
It is recommended that:
(a) the response to complaints be documented and attached to the complaint in the complaints register and include details of date action was taken, outcome and who reviewed and acted on the complaint.
(b) the Unit policies and procedures be reviewed, with comment from relevant stakeholders, to ensure that the process for dealing with complaints about service in the Unit is robust, clearly documented and well understood by relevant stakeholders.

Recommendation: Accommodation

It is recommended that:

(a) the Department of Health and Community Services establish a process to fast-track finding a prompt solution for people in cases where it is identified that a person admitted to the MHU is likely to be difficult to discharge once their mental condition becomes stable, due to the absence of suitable accommodation, facilities or support. An appropriate timeframe to identify a practical solution (with funding if required) for people in danger of becoming 'long-termers' in the Mental Health Unit is less than 3 months

Recommendation: Medical conditions of inpatients

It is recommended that:

(a) the Mental Health Unit work with relevant stakeholders to review its policies, procedures and protocols relevant to detection and treatment of medical conditions of inpatients. The results of this review are to be provided to the Principal Community Visitor prior to 31st December 2004 and should include issues identified, actions taken and timelines for future actions.

Recommendation: Information about rights

It is recommended that:

(a) Recommendation 1 of the panel's previous report dated 21 March 2004 which stated that "the Mental Health Unit staff work with other stakeholders ……to improve outcomes relevant to NSMHS Standard 1 Rights and 11.4E Inpatient Care in assisting in-patients to gain information about rights, mental illness and effective introductions to relevant services and supports" be revisited. Urgent consideration should be given to the development of an information package in more than one language and to pursue the development of an informative video to be given to consumers and carers on arrival or as soon as possible after admission.

Recommendation: Informed consent to treatment

It is recommended that:

(a) staff be informed of this very concerning issue and be trained in the requirements of the Act with respect to informed consent and what those requirements mean in the context of involuntary admissions.

(b) a protocol for dealing with involuntary admissions be established that takes into account the need to allow a consumer an absolute ability to exercise their right to refuse or consent to treatment without the threat of involuntary admission being raised in the course of their decision making process.

(c) MHS draft clear guidelines as to whether a patient with a clear lack of judgement can actually consent to voluntary admission.

Recommendation: Employment of an Occupational Therapist

It is recommended that:

(a) the Department of Health and Community Services consider providing funding for the employment of an occupational therapist in the Unit and that further funding be allocated to enhance the range of recreational materials and activities available to consumers at the Unit

Recommendation: Incident Reports database
It is recommended that:
(a) CAMHS advise the current status of the incident database and six monthly analyses referred to in their response to the panel's recommendations dated January 2005.

Community Teams

Recommendation: Cultural Safety
It is recommended that:
(a) the MHS work in partnership with other agencies in Alice Springs to investigate the possibility of getting 24 hour access to interpreter assistance. Examples of agencies may include Congress, Legal Aid, and Crisis Care.
(b) CAMHS investigate partnerships with local Councils and organizations such as the Division of Primary Health Care and CAA to introduce AMHW staff to communities serviced by the Remote team.
(c) CAMHS work with GP's through the Division of Primary Health Care to develop and train GP's who would be interested in working in collaboration with CAMHS and clients with mental health difficulties. (There have been similar models in the past in providing GP care for the youth in the community).
(d) CAMHS should liaise with the Division to find out why the funding has not yet been allocated and encourage that allocation as a matter of urgency.
(e) CAMHS should liaise with mental health organisations to explore the possibility of providing some support services (such as education for carers, consumers and community members) to remote communities
(f) *CAMHS should consider establishing links with community based organisations that have their own health workers that visit communities and work with those organisations to improve access to mental health services.*

Recommendation: Discharge planning
It is recommended that:
(a) a discharge process similar to that being implemented for the inpatient system be implemented with the community teams so that consumers accepted for case management are prepared for discharge from the service from the time of acceptance into the service.

Recommendation: After Hours Service
It is recommended that:
(a) CAMHS consider ways to raise community awareness of the availability and scope of the after hours service.
(b) CAMHS liaise with carers and explore ways to make the after hours call out service more effective in accommodating needs of carers and consumers.

Recommendation: Interview Rooms
It is recommended that:
(a) CAMHS designate and fit out more interview room facilities that allow greater quiet and privacy than the existing one.

Appendix 2: Overview of the Community Visitor Program

The Community Visitor Program (CVP) is established pursuant to Part 14 of the *Mental Health and Related Services Act* (NT) 1998 (the Act). The program, designed to be independent of health services, is a fundamental mechanism for ensuring that the human rights of people receiving treatment under the Act are observed. It also acts as one of several mechanisms to ensure the provision of a quality mental health service. In broad terms, the CVP has monitoring, inspection/inquiry, advocacy and complaint handling functions.

There is extensive policy background to the institution of a community visitor program. At an international level, in 1991, the General Assembly of the United Nations adopted the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health by Care. These principles are reflected in Part 2 of the Act.

In particular, Principle 22 states:

Monitoring and Remedies:

States shall ensure that appropriate mechanisms are in force to promote compliance with these Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.

At a national level, the National Mental Health Strategy outlines its aims as follows:

- To promote the mental health of the Australian community;
- To, where possible, prevent the development of mental disorder;
- To reduce the impact of mental disorder on individuals, families and the community; and
- To assure the rights of people with mental disorder (National Mental Health Plan 2003 – 2008).

A Statement of Rights and Responsibilities, which addresses the consumer's right to advocacy support and complaints mechanisms, was incorporated into the first National Mental Health Policy and Plan in 1992 and thereafter in each successive plan in 1998 and 2003. These policy documents have formed the basis for the development and institution of community visitor programs in each State and Territory in Australia, with the exception of South Australia.

Jurisdiction

The Department with responsibility for mental health services is the Department of Health and Community Services.

The jurisdiction of the Northern Territory Community Visitor Program includes all treatment facilities and treatment agencies approved under the *Mental Health and Related Services Act 1998.*

The Minister has approved both the Royal Darwin Hospital and the Alice Springs Hospital as approved treatment facilities under subsection 20(1)(a) of the Act. These hospitals are considered to have conditions and staffing levels sufficient to provide an appropriate standard of treatment and care to people admitted as involuntary patients under the Act. Both hospitals have in-patient facilities.

There are seven agencies considered to have conditions and staffing adequate for designation as approved treatment agencies under section subsection 20(1)(c) of the Act. Six of the seven agencies are administered through two major entities, Top End Mental Health Services (TEMHS) and Central Australian Mental Health Services (CAMHS). TEMHS covers the geographical area north of Elliott and the CAMHS covers the area from Elliott to the South Australian border. TEMHS and CAMHS provide mental health services directly to consumers through government facilities and agencies in their regions and also provide funding to community agencies. The seventh agency, the Aerial Medical Services, comprises a 24 hour medical consultation service, 24 hour emergency evacuation and routine medical and nursing visits to remote communities in the Top End.

Location of the Community Visitor Program

The CVP is located within the Anti-Discrimination Commission. This means that the program, while funded by Territory Health Services, is operationally independent of mental health service providers. This independence is seen as integral to the success of the program.

Principal Community Visitor

The Role of the Principal Community Visitor is outlined in Part 14 of Division 3 of the Northern Territory *Mental Health and Related Services Act* 1998.

The Minister for Health appointed Tony Fitzgerald, the Anti-Discrimination Commissioner, to the role of Principal Community Visitor on 25 November 2002.

The Principal Community Visitor has overall responsibility for the program and has a range of responsibilities under the legislation. These include establishing standards, principles and protocols for the program, disseminating information, overseeing the program, referring matters to other organisations and reporting on the activities of the program to the Minister for Health. The Principal Community Visitor's role is primarily a management role and the Principal Community Visitor is not required to personally undertake any visits to facilities, agencies or consumers.

Community Visitors Panels

The Act provides for the establishment of a Community Visitors Panel for each approved treatment facility and approved treatment agency. In practice, the program aims to establish one panel for the Top End and one for Central Australia. The Panels consist of three (3) members: a Medical Practitioner, a Legal Practitioner and a member who represents the interests of consumer organisations and who has a special expertise or interest in mental health. The Principal Community Visitor appoints one of the members of each panel as chairperson of the panel. The position of chairperson is not restricted to one member and can be varied from visit to visit.

The Role of the Community Visitors Panel is outlined in Part 14 of Division 3 of the Northern Territory *Mental Health and Related Services Act* 1998. It relates to the inspection and monitoring functions of the program.

Panel Members are required as a group to visit the facility or agency in respect of which they have been appointed not less than once every six months. On these visits they inquire into such matters as the adequacy of opportunities and facilities for recreation, education, training and rehabilitation; the extent to which the least restrictive alternative guides the treatment of consumers, the quality of assessment, treatment and care provided, the adequacy of information provided about complaints and legal rights; any matter that may be referred by the Minister or the Principal Community Visitor, or; any other matter that the panel may consider appropriate.

After every visit to a facility or agency, the chairperson of the panel must forward a report of the visit to the Principal Community Visitor.

Community Visitors

The Community Visitors' role is outlined in Part 14 of Division 2 of the Northern Territory *Mental Health and Related Services Act* 1998.

Community Visitors perform the advocacy, complaints handling and inquiry/inspection functions of the CVP. They respond to enquiries and complaints from consumers of mental health services, and may assist by supporting the consumer to make a complaint using internal complaints processes or by accessing external complaints mechanisms such as the Health and Community Services Complaints Commission. They may also assist a consumer to use the review and appeal mechanisms set out in Part 15 of the Act (Mental Health Review Tribunal).

The program aims to ensure that Community Visitors are accessible to consumers of mental health services and their carers. This is achieved through regular visits to approved treatment facilities, and responding quickly to complaints and requests from consumers for a visit.

While visiting an approved treatment facility or agency, a community visitor may inquire into the adequacy and standards of services and facilities, the failure of persons employed in facilities or agencies to comply with the Act, or any other matter referred by the Minister or the Principal Community Visitor.

After every visit to a facility or agency, the Community Visitor must forward a report of the visit to the Principal Community Visitor.

Appendix 3: Draft Strategic Plan

Vision

The NT Community Visitor Program is a key instrument for the protection and promotion of the rights of Territorians affected by mental illness.

Mission

To monitor the attainment of the rights, responsibilities and standards of care required under the National Mental Health Strategy from an independent community perspective.

Objectives

1. To operate the Community Visitor Program in accordance with requirements of the *Mental Health and Related Services Act 1998.*

- Complete the development and implementation of administrative procedures for the program, including the development of a handbook for the program and mechanisms for recording contacts with, and work done by the CVP;
- Ensure that Community Visitors Panels are able to meet their legislative requirements with respect to inspections of approved treatment facilities, and where possible approved treatment agencies;
- Ensure that Community Visitors carry out inspections of seclusion registers as required by the Act;
- Continue to respond to enquiries and complaints within legislative timeframes;
- Report as required on the activities of the program to the Principal Community Visitor and to the Person in Charge of approved treatment facilities and agencies;
- Follow up with the progress of recommendations made by the CVP; and
- Receive reports from approved treatment facilities and agencies as required by the Act.

2. To increase accessibility of the CVP to consumers, carers and service providers.

   - In consultation with relevant government and non-government agencies, develop and implement a remote area strategy;

   - Visit approved treatment centres regularly and to increase access to the program by consumers and their carers;

   - Ensure that material published by the program is readily available to persons receiving treatment under the Act, and that this material is in a form which is readily understandable; and

   - Develop and maintain the CVP website.

3. To develop, maintain and share a comprehensive knowledge of mental health policy and evidence based mental health practice.

   - Further develop the CVP website;

   - Develop a comprehensive resource facility for personnel of the CVP and links to other, appropriate resources; and

   - Establish a training program for staff and personnel of the CVP.

4. To develop and maintain relationships with key players within the Northern Territory - consumers, carers and service providers.

   - Establish links with consumer and carer organizations throughout the Northern Territory to ensure that the CVP is aware of issues confronting people affected by mental illness;

   - Ensure that links are maintained with key staff within government and non-government agencies; and

   - Develop a relationship with government and non-government agencies to improve their knowledge of the CVP and referral options.