COMMUNITY VISITOR PROGRAM
NORTHERN TERRITORY

Promoting and Protecting the Rights of Territorians Affected by Mental Illness

Annual Report 2005 - 2006

COMMUNITY VISITOR PROGRAM
NORTHERN TERRITORY

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 2006.

Yours sincerely

TONY FITZGERALD
PRINCIPAL COMMUNITY VISITOR

28 September 2006

AGENCY ACCESS

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

Location:	Darwin:	7th Floor 9-11 Cavenagh Street, Darwin NT 0800
	Alice Springs:	Ground Floor Centrepoint Building Hartley Street, Alice Springs NT

Postal Address: LMB 22 GPO
Darwin NT 0801

General Enquiries:	Telephone:	(08) 8999 1451
	Freecall:	1800 021 919
	TTY:	(08) 8999 1466
	Facsimile:	(08) 8981 3812
	Email:	cvpprogram.adc@nt.gov.au
	Website:	www.cvp.nt.gov.au

CONTENTS

	Page Number
INTRODUCTION	**9**
Issues	**10**
Funding	**10**
Acknowledgments	**11**
PART 1	**12**
ISSUES IDENTIFIED 2005 – 2006	**12**
Accommodation and Support	**12**
Management of Medical Problems	**15**
Assessment and Rehabilitation of Prisoners	**16**
Legal Issues	**16**
Notification of Long Term Voluntary Admission	**16**
Notification of Involuntary Admission	**17**
Access to Files	**18**
Financial Protection Orders	**19**
Inadequate and Insufficient Facilities for Young People	**19**
Cleaning in the TEMHS Inpatient Unit	**20**
UNRESOLVED ISSUES AS AT 30 JUNE 2006	**21**
REPORTING PERIOD 2004 – 2005	**21**
Fishbowl in Cowdy Ward	**21**
Liaison with GPs	**21**
Legal Issues	**22**
Information about Rights	**22**
Voluntary Admission and Informed Consent	**22**
Posters with Information about Legal Rights	**23**
Transport to Hospital	**24**
Employment of a Social Worker in TEMHS Inpatient Unit	**24**
Meals in the TEMHS Inpatient Unit	**25**
Records of Property in JRU	**25**

Page

ISSUES RESOLVED PRIOR TO REPORTING **26**
Location of Facsimile Machines in TEMHS Inpatient Unit **26**
Complaints Forms in the TEMHS Inpatient Unit **26**
Bathrooms in the TEMHS Inpatient Unit **27**
Records of Consumers' Money in Cowdy Ward **27**

PART 2 **28**

OVERVIEW OF THE COMMUNITY VISITOR PROGRAM **28**
Jurisdiction **28**
Location of the Community Visitor Program **28**
Principal Community Visitor **29**
Community Visitors Panels **29**
Community Visitors **30**

ADMINISTRATION OF THE COMMUNITY VISITOR PROGRAM **31**
Organisational Chart **31**
Staffing **31**
Personnel of the CVP **32**
Principal Community Visitor and Community Visitors **33**
Community Visitors Panel Members **34**

REPORT ON THE ACTIVITIES OF THE CVP **35**
Complaints and Enquiries **35**
Other Complaints and Enquiries **38**
Inspection of Seclusion Registers **38**
Inspections of Complaints Registers **39**
Other CVP Activities **39**
Evaluation **42**

PRIORITIES 2006 – 2007 **44**

PERFORMANCE **45**

FINANCIAL STATEMENT 2005 – 2006 **50**

	Page
APPENDIX 1: NEW RECOMMENDATIONS 2005 – 2006	**51**
ALICE SPRINGS	**51**
Mental Health Unit	**51**
Community Teams	**52**
Forensic Mental Health Service	**52**
DARWIN	**53**
TEMHS Inpatient Unit	**53**
Tamarind	**53**
Community Visitor Recommendations	**54**
APPENDIX 2: RECOMMENDATIONS CLOSED 2005 – 2006	**55**
ALICE SPRINGS	**55**
Mental Health Unit	**55**
Community Visitor Recommendations CAMHS	**59**
CAMHS Community Teams	**60**
DARWIN	**63**
TEMHS Inpatient Unit	**63**
Community Visitor Recommendations	**67**
Tamarind Centre	**69**
APPENDIX 3: RECOMMENDATIONS OUTSTANDING 30 JUNE 2006	**74**
ALICE SPRINGS	**74**
Mental Health Unit	**74**
CAMHS Community Teams	**75**
Community Visitor Recommendations	**77**
DARWIN	**78**
TEMHS Inpatient Unit	**78**
Community Visitor Recommendations	**79**
Tamarind Centre	**80**
Community Visitor Recommendations – Tamarind	**80**
APPENDIX 4: STRATEGIC PLAN	**81**

Page

TABLES

Table 1: Complaints and Enquiries Received and Actioned **35**
Table 2: Categories of Complaints and Enquiries **37**
Table 3: Comparison of Achievements of CVP over Past Three Reporting Periods **45**
Table 4: Performance – Administration of the CVP **46**
Table 5: Performance – Accessibility of the CVP **47**
Table 6: Performance – Training for Community Visitors and Panel Members **48**
Table 7: Performance – Liaison with Service Providers **49**

FIGURES

Figure 1: Complaints and Enquiries Received and Actioned **35**
Figure 2: Complaints vs Enquiries, Alice Springs and Darwin **36**
Figure 3: Source of Complaints and Enquiries NT **36**
Figure 4: Outcomes of Complaints and Enquiries NT **37**

INTRODUCTION

This annual report has two purposes; firstly it informs the Minister of Family and Community Services of the issues that affect consumers of mental health services and their carers from the perspective of the people receiving treatment and from the perspective of persons external to the system (community visitors and panel members). Its second purpose is to report to the Minister on the activities of community visitors and community visitors panels as set out in Section 115 (1) of *the Mental Health and Related Services Act (NT) 1998.*

The Annual Report is therefore presented in two parts; in Part 1 the issues noted by community visitors panels and community visitors in the Territory in the 2005 – 2006 financial year are described along with issues that are still outstanding from previous annual reports. Part 2 of the Annual Report comprises a description of the Community Visitor Program (CVP) and a report and analysis of its activities for the reporting year.

The CVP is still evolving, learning how to work most effectively with consumers and with mental health services. Its core philosophy of impartial collaboration means that whenever possible, the CVP will attempt to work with consumers and the mental health service to resolve complaints and any issues identified by the community visitors panels.

Community visitors panels are now meeting with mental health management prior to reporting and are able to report on the outcomes of attempts to resolve issues brought to the attention of mental health management. This new process is reflected in the Annual Report with a reduced number of new recommendations included in Appendix 1 and a section outlining issues resolved in the latter section of Part 1.

As stated in the previous annual report, a focus on issues may give an unbalanced view of the mental health service. It needs to be acknowledged that staff and management work in sometimes difficult circumstances and that staff have a high level expertise and commitment to mental health. Throughout the Northern Territory, this is evidenced by staff in the inpatient facilities working many double shifts to ensure that the facilities remain adequately staffed.

People with mental illness are vulnerable, and especially so when receiving involuntary treatment. The CVP sees its role as ensuring as far as possible that a person's legal rights as defined in the *Mental Health and Related Services Act (NT) 1998* (the Act) are met, and that their human rights as outlined in the *Mental Health Statements of Rights and Responsibilities* and *The United Nations Principles for the Protection of People with Mental Illness and for the Improvement of Mental Health Care* are observed.

Issues

Throughout 2005 – 2006, community visitors panels and community visitors have identified a number of issues, not all of which can be covered in this document. Those that appear repeatedly, those with significant impact, and those identified throughout the Territory have been singled out for inclusion in this report. These issues include:

- The need for appropriate community accommodation and support;
- The need for adequate medical clearance from the Emergency Departments (EDs) prior to admission to the mental health service inpatient facilities;
- Inadequate assessment and rehabilitation for prisoners with mental health problems in the NT;
- Legal issues;
- Inadequate and insufficient facilities for young people; and
- Cleaning in the Top End Mental Health Service (TEMHS) Inpatient Unit.

Some important issues identified in previous Annual Reports are still outstanding, and will be briefly commented on in this report. These are as follows:

- Fishbowl in Cowdy Ward;
- Liaison with General Practitioners (GPs);
- Legal issues;
- Transport to hospital;
- Employment of a social worker in the TEMHS Inpatient Unit;
- Meals in the TEMHS inpatient Unit; and
- Records of Property in the secure area of the TEMHS Inpatient Unit.

Funding

Funding for the CVP has been a focus of discussion in the past two Annual Reports. The CVP recognises the support provided in 2005 – 2006 by the Anti-Discrimination Commission, the Department of Justice and the Department of Health and Community Services (through the mental health program). Funding for the CVP is now guaranteed at $120,000 per annum, and this will enable the program to meet its minimum requirements as foreshadowed in the new mental health legislation. There will be some changes to the operation of the CVP, for example a phone service only will be available to rural and remote areas and community visitors panels will no longer visit the community teams; however it is envisaged that community visitor visits to the Mental Health Unit in Alice Springs will be increased.

Acknowledgments

The support provided to the CVP by Tony Fitzgerald, Principal Community Visitor and Anti-Discrimination Commissioner is acknowledged, as is the support provided by all the staff of the Anti-Discrimination Commission, some of whom act as community visitors for the program.

Community visitors and panel members work in isolated circumstances in a difficult area where judgement and initiative are crucial. Their commitment to the rights of people with mental illness and their carers and family members is gratefully acknowledged. The CVP also acknowledges the support received from people in the industry; consumers, consumer groups; carers and mental health staff.

PART 1

ISSUES IDENTIFIED 2005 - 2006

Accommodation and Support

Insufficient community accommodation and support for people with severe mental illness and complex needs has resulted in long stay admissions for patients in the TEMHS Inpatient Unit and the Mental Health Unit in Alice Springs.

In the report of their visit to the Mental Health Unit in March 2006, the Alice Springs community visitors panel stated that inadequate community accommodation for people with mental illness is even more problematic due to an apparent increase in inpatient numbers in the Mental Health Unit. Because the inpatient unit in Alice Springs is so small, even one long stay patient can have a disproportionate impact on the unit.

In Darwin, at least four people have experienced long stays in the TEMHS Inpatient Unit, with one admission lasting more than twelve months. The Darwin panel commented on the urgent need for appropriate community accommodation and support. This issue will soon be partially addressed by a program to be operated by TEAM Health in conjunction with the Mental Health Program. The program will provide 24 hour residential care for a small number of clients in the Top End of the Northern Territory.

However, the Northern Territory needs to have in place a range of accommodation types with associated levels of support to meet the diverse needs of consumers of mental health services, and consumers with co-morbid conditions such as intellectual disability or acquired brain injury. The Darwin panel noted that interstate services are able to provide intensive support for consumers in their own homes, and postulated that such a program would have the benefit of reducing the impact of long stay patients on the acute facilities and on the community teams with unrealistic case loads. In turn this would provide for treatment in the least restrictive environment, the consumer's own home.

The CVP strongly advocates for the introduction of a comprehensive accommodation and support program, to be developed in consultation with consumers and mental health professionals.

Management of Medical Problems

The community visitor in Alice Springs, when visiting the Mental Health Unit, became aware of two instances of consumers being transferred from ED while still experiencing significant physical health issues that had not been addressed.

The community visitor in Darwin was also concerned about transfers from the Emergency Department of Royal Darwin Hospital (RDH) without appropriate medical clearance.

Both community visitors referred the issue to their respective community visitors panel through the Principal Community Visitor and files were subsequently reviewed by the medical member of the panel.

Alice Springs

The Alice Springs community visitors panel reviewed the files of the two consumers concerned. One file involved transfer to the inpatient unit pending diagnosis of septicaemia. Three days after admission to the Unit, a diagnosis was confirmed and the patient transferred to a medical ward. Staff believed that there had been a failure to consider the relationship between the medical condition suffered by the consumer and the consequent exacerbation of mental illness.

Another file involved the transfer of a consumer who had sustained a fracture in her leg. While this was diagnosed in ED, the leg was not plastered and there was no evidence of any clear directions as to management of the injury on the consumer's file. Staff on the Unit had to make their own arrangements for plastering of the leg after the client made consistent complaints that she was in significant pain.

The Alice Springs panel recommended that the Central Australian Mental Health Service (CAMHS) collaborate with ASH to provide information to ED staff about mental health and the relationship between medical conditions and mental health problems, and to provide further guidelines as to medical clearance procedures.

In their visit to the Unit in March 2006, the panel noted that a psychiatric liaison nurse has facilitated a series of seminars for staff in the ED and that this nurse is also available to discuss management of particular patients.

The panel was satisfied that their recommendation had been met and could be closed.

Darwin

The community visitor in Darwin also became concerned about the quality of medical clearances prior to people being transferred to the psychiatric inpatient unit. This matter was referred to the community visitors panel through the Principal Community Visitor.

During their visit to the TEMHS Inpatient Unit in April 2006, the panel reviewed five files. They found that there were several instances where no, or inadequate medical assessment had taken place prior to transfer to the psychiatric inpatient unit.

TEMHS management has forwarded a copy of the relevant policy documents: *Medical Assessment of the Psychiatric Patient* and *Psychiatric Assessment in the ED* to the CVP. These policies outline the standards for assessment in the ED prior to transfer to the psychiatric inpatient unit, and were in place at the time the consumers, whose files were reviewed by the panel, were assessed in the ED.

The panel will review case files during future visits to the TEMHS Inpatient Unit with a view to monitoring the quality of medical clearance prior to admission to the psychiatric inpatient facility. It has suggested that a formal, confidential complaints process for doctors, and training and education for medical staff in ED and the TEMHS Inpatient Unit in existing policies and procedures may be one way forward in addressing this issue.

As well, the community visitor noted two instances of people with significant medical issues being nursed in the psychiatric inpatient unit where facilities for their medical care are less comprehensive than would be available in a medical ward in the RDH.

One involved the treatment of an elderly aboriginal man who has a diagnosis of schizophrenia and who was suffering delirium related to severe physical illness. This man was nursed in the Joan Ridley Unit (JRU), a secure ward within the TEMHS Inpatient Facility. The community visitor was informed that the consumer had less access to medical tests due to the distance of the facility from the hospital. The community visitor was also informed that medical facilities in the TEMHS Inpatient Unit are less comprehensive than would be found in a medical ward. Finally, staff informed the community visitor that the consumer was nursed on the floor because he was in danger of falling from the bed. Nursing staff had to lift him for showering and toileting.

The community visitor noted that despite the physical inadequacies of JRU, the consumer received a high standard of nursing and medical care from the staff in the inpatient unit and his physical health had improved prior to his eventual transfer to a medical bed in RDH.

Treatment of medical issues within the psychiatric inpatient unit has ramifications for the physical health and well-being as well as the dignity of the consumer.

The community visitor has requested that the mental health service retain a record of these and similar instances and provide them to the CVP in order to monitor the frequency of these occurrences and their importance as an issue. To date, no data has been provided. Given that since this request, the community visitor is aware of one instance of a consumer with primarily physical health issues being admitted to the psychiatric inpatient unit, the CVP is not confident that the lack of data provided to the program is any indication that this issue has been addressed.

Assessment and Rehabilitation of Prisoners

The Alice Springs and Darwin panels were informed that referrals are made to forensic mental health teams when the medical assessment of incoming prisoners identifies possible mental health issues, when the courts identify a prisoner as “at risk” or when correctional service officers identify that a prisoner may have a mental health issue. The forensic teams in both Alice Springs and Darwin informed the panels that there may be a significant number of prisoners with unidentified mental health problems.

Prisoners identified as being at risk may be placed in maximum security for their own safety. Prisoners in maximum security at the Alice Springs and Darwin prisons, and prisoners in remand in Darwin do not have access to rehabilitation, educational, recreational and pre-release programs.

The Darwin community visitors panel was informed by TEMHS Management that the provision of programs for prisoners is the purview of the Correctional Services Division of the Department of Justice. The panel regards this as appropriate, but nonetheless regards it as an issue that needs to be addressed.

Following their visit to the Forensic Team, the Darwin community visitors panel recommended that all incoming prisoners undergo a thorough mental health assessment and that a suitable tool should be used and interpreters employed when assessing indigenous prisoners.

The Alice Springs community visitors panel approached the issues raised during their visit slightly differently, recommending that all prisoners in remand and in maximum security are regularly reviewed, that CAMHS and Correctional services work together to facilitate assessment and easy access to prisoners by forensic mental health staff and that the Department of Health and Community Services work with the Department of Justice to improve conditions in maximum security and remand for the rehabilitation of prisoners with mental health problems.

The Mental Health Program has informed the CVP that a joint steering committee, with representatives from the Departments of Justice and Health and Community Services, is working to address the primary health, mental health and disability needs of prisoners throughout the Territory, and that resources have been allocated for this purpose.

The Alice Springs community visitors panel also expressed concern that because there is no secure mental health unit in Alice Springs, prisoners requiring hospital admission when acutely unwell are driven to Darwin. The CVP has been informed that prisoners are transferred this way because the airline refuses to fly them from Alice Springs to Darwin.

The CVP has been informed that on occasions, mental health services provide an escort for prisoners, that they are transferred in air conditioned vehicles by the Department of Correctional Services and that sufficient "comfort stops" are taken on the way. Nevertheless, the CVP is concerned that people, regardless of their legal status, who are acutely unwell are in a situation where they must travel for 15 hours in order to receive appropriate care.

Legal Issues

Notification to the Tribunal of a Long Term Voluntary Admission

Section 28 of the Act states that the Mental Health Review Tribunal (the Tribunal) and the Secretary of Health must be notified when a person has been a voluntary patient in an inpatient facility for 3 months. Following this notification the Tribunal will set a hearing date for 3 months later to comply with Section 122 (1) of the Act, which states that the Tribunal must hold a hearing to review a voluntary admission after 6 months. In the past twelve months there have been three cases (two in Darwin and one in Alice Springs) where a hearing has not been held after six months as required.

The two situations in Darwin occurred in quite different circumstances. In one case, there was simply a failure to notify the Tribunal. The lawyer representing the client concerned complained to the mental health service, and when no response was received, forwarded the complaint to the CVP. The community visitor investigated the matter and in August 2006 the Principal Community Visitor informed the CEO of the Department of Health and Community Services of a possible breach of the Act as required pursuant to Section 116 of the Act. The CVP recommends that procedures to ensure that TEMHS' legal obligations to notify the MHRT pursuant to Section 28 of the Mental Health and Related Services Act are put in place as soon as is possible.

In the second instance, the consumer's file shows that the Tribunal was notified, with this notification apparently not received by the Tribunal. A second notification to the Tribunal regarding this consumer gave an incorrect date of admission of the consumer as a voluntary patient.

In Alice Springs there was a failure to notify the Tribunal after three months as required by Section 28 of the Act. A hearing was heard immediately after the CVP brought this matter to the attention of staff in the Mental Health Unit.

Notification of Involuntary Admission

The Act specifies that the mental health service is required to notify the person, their legal representative, their carer (with the consumer's consent), the Principal Community Visitor and the Tribunal of involuntary admission for a period of 7 days or more. In 2005 – 2006, CAMHS notified the CVP of 45, or almost all, admissions compared with 29 notifications received from TEMHS. In the past six months, TEMHS has notified the CVP of approximately 7% of all involuntary admissions requiring notification, despite this issue being brought to their attention.

The CVP has been informed that the Mental Health Program is developing procedures to ensure that appropriate notification is made to all parties.

Nevertheless, it is of concern that these basic legal requirements were not addressed, despite this issue repeatedly being brought to the attention of TEMHS Management.

Access to Files

The CVP has received several requests from consumers to assist with access to their personal file. When making their initial application for access, consumers are unable to apply using Freedom of Information (FOI) rather than mental health legislation.

Section 92 of the Act allows for access to records on application in writing to an authorised psychiatric practitioner from an approved treatment facility or agency. If the request to access the file is refused, Section 92 (4) of the Act states that the person and his or her representative (if any) must be informed of the decision and of his or her right of appeal to the Tribunal against the decision. There is no legislative time limit for the mental health service to respond as is contained in the *Information Act*.

Any request for access to a file, even if the written application specifies that the request for access is under FOI, will first automatically be treated as an administrative request, and sent to the Director of Psychiatry in whichever region the consumer has received treatment. The apparent purpose is to ensure an easier process for the consumer.

In the event that access is refused, consumers may appeal the decision through appeal to the Tribunal or through FOI. Consumers wishing to appeal through FOI must submit a second application to the Information Officer in the Department of Health and Community Services to view their file under FOI. They must then wait up to 30 days for a response, and, if access is refused and they still wish to appeal the decision, submit a second written appeal to the Information Officer in the Department of Health and Community Services, waiting up to a further 30 days for a response. If access is still refused, the consumer may then appeal the decision in writing to the Office of the Information Commission.

Because there is no time required for a response to the initial request (using the administrative procedure), it can be months before a final decision to access or refuse access to the file can be received. In fact, a procedure which is meant to be easier for the consumer is cumbersome and difficult to negotiate.

The CVP has provided information to the Mental Health Program as part of the review of the Act that a decision in writing from mental health services within 30 days of the initial application for access to the file is a minimum standard that should be included in the Act and/or Approved Procedures.

Financial Protection Orders

The community visitor in Darwin received a complaint from a consumer regarding access to his finances. This consumer had been restricted from accessing his money because mental health staff believed that he was too unwell to manage it. He contacted the CVP as he was being charged a daily rate of interest because his account was overdrawn, and he needed to transfer money into the account to rectify the situation.

In other states and territories, it is possible to apply for a limited guardianship order that allows for the management of a person's financial affairs by qualified people if or when the person lacks the capacity to do so for reasons of mental impairment.

In the Northern Territory, no such order is possible under existing legislation, and there are currently no qualified services able to take on the role of managing a person's financial estate. There was no satisfactory outcome possible for this consumer due to the lack of appropriate services in the NT.

Inadequate and Insufficient Facilities for Young People

Neither the Alice Springs Mental Health Unit nor the TEMHS Inpatient Unit is able to provide a specialised facility for young people. In Alice Springs, young people are isolated in the High Dependency Unit unless it is occupied, and in Darwin they are "specialled", that is specifically assigned a nurse to remain with them.

There is no doubt that young people are provided with special care within the inpatient units in the Northern Territory, and that it is just not feasible to fund a specialised inpatient ward or facility for young people given the small number of admissions of young people. However, both the Alice Springs and Darwin panels raised this as an issue requiring further attention.

The Alice Springs panel recommended that CAMHS investigate mechanisms for providing young consumers with appropriate facilities and care. Similarly, the Darwin panel, in the report of their visit in May 2005, recommended that TEMHS develop a framework for the delivery of mental health services to young people based on best practice in other, similar sized populations. They also recommended the development of age appropriate information about mental illness for young people.

Cleaning in the TEMHS Inpatient Unit

The community visitor has received several complaints from staff and consumers in the past twelve months about the standard of cleaning in the TEMHS Inpatient Unit. The Darwin community visitors panel, during their visit in April 2006, inspected the courtyard in Cowdy Ward at 9 am and again at 2.30 pm. On both occasions, they noted dirt, cigarette butts everywhere, full ashtrays and dirty sticky tables.

The panel discussed this issue with TEMHS Management who see this as a cleaning issue. The community visitor has reported problems with the standard of cleaning on several occasions throughout the year, on one occasion contacting the Manager of TEMHS directly when an inspection of the seclusion room in Cowdy ward demonstrated that the room had not been cleaned in a week.

The community visitor has also reported the presence of butts throughout the courtyard on many occasions. This issue arises because all ashtrays are affixed to the walls, some distance from where consumers sit and smoke. If ashtrays were located near the tables the issue may not be so apparent.

The CVP is aware that TEMHS are endeavouring to address problems with cleaning the facility, however the program continues to receive complaints about the standard of cleaning in the ward.

UNRESOLVED ISSUES AS AT 30 JUNE 2006

REPORTING PERIOD 2004 - 2005

Fishbowl in Cowdy Ward

The Darwin panel has highlighted the large glassed in office for staff on Cowdy Ward on each of its previous visits. The panel is of the opinion that the glass wall impedes communication with consumers and creates high levels of frustration for them. Consumers told the panel on their most recent visit that "they always make you wait when you ask for something at the office".

The panel reported that staff appear to have a mixed response to the "fishbowl", many seeing the glass as a safety requirement and the need to be able to observe all areas. A number of staff also complained about the lack of space and high level of noise in the fishbowl, so the current layout increases frustration in staff as well as clients.

The CVP has been informed of plans to redevelop the Fishbowl as part of an overall strategy to improve the therapeutic environment in Cowdy Ward. The CVP looks forward to being able to report an appropriate resolution of this issue in its next Annual Report.

Liaison with GPs

TEMHS supports a GP clinic at the Tamarind Centre for consumers who are case managed and who experience co morbid mental health problems and physical health problems. Nevertheless, in October 2004 and again in April 2006, the Darwin panel found that there is very little liaison with GPs external to the mental health service.

The lack of communication between staff of the TEMHS Inpatient Unit and GPs was identified as a factor of concern by the Darwin panel, particularly when no case manager is assigned and a consumer is managed by a GP alone. The issue of secure communication by email was raised in discussions between the panel and TEMHS management, however the panel believes that notwithstanding difficulties with security of emails this is a significant issue that needs to be addressed.

Legal Issues

Provision of Information about Rights

Both Alice Springs and Darwin community visitors panels have made recommendations regarding the need to develop culturally appropriate information about rights for indigenous consumers. Both panels have also drawn attention to the difficulties that mental health services face in accessing interpreters, particularly after hours.

At this time, no new information has been prepared for indigenous consumers, although CAMHS unsuccessfully applied for funding to make a video to assist indigenous consumers on admission to the facility.

The difficulty in accessing interpreter services after hours relates to the limited ability of the interpreter services to provide enough skilled interpreters over a 24 hour period. The Alice Springs panel has suggested that CAMHS investigate partnerships with other services to improve the possibility of gaining 24 hour access. Neither panel is satisfied that the respective mental health service has placed enough importance on this issue.

Voluntary Admissions and Informed Consent

A large section of the CVP's 2004 – 2005 Annual Report was devoted to this issue. Briefly, the issue relates to the "voluntary" admission of consumers to an inpatient facility when the consumer is unable to leave for fear of being detained to the facility.

The CVP recognises that the intention of the mental health service is to provide the least restrictive treatment in the least restrictive environment as is required by the Act. This means that whenever possible, a consumer will be admitted as a voluntary patient if it is safe to do so.

Consumer preferences should also be considered when determining the degree of restrictiveness of any decision about treatment.

For example, the community visitor in Darwin was approached by a consumer complaining that her detention was about to be revoked and her status changed to voluntary. When the community visitor asked what being

voluntary meant, the consumer replied: “It means I have to stay here and take my medication, otherwise they’ll detain me.” The consumer stated that if she was unable to leave the facility, she wished her status to remain involuntary, so that she would retain the right of review by the Tribunal.

It could be argued that because the consumer wished to retain involuntary status, the less restrictive option in this case, if in fact the consumer could not leave the facility, was the retention of an involuntary order (as long as the criteria for involuntary detention in the Act were met).

This is an extremely complex issue, one that the CVP believes needs attention to avoid situations like the following occurring.

The CVP received a complaint from a legal organisation in Alice Springs regarding a consumer who had been detained to the Mental Health Unit under S39 of the Act, and who was not reviewed by the Tribunal within 7 days as required by the Act. In fact, the detention order lapsed after 7 days, and 24 hours later, the consumer signed an informed consent to treatment. On the day this form was signed, the consumer attempted to leave the facility and was restrained twice. The next day, a Tribunal hearing was cancelled, and the consumer clearly informed the legal representative of a wish to leave the facility. The consumer was detained later that day. A report was submitted to the person-in-charge of the approved treatment facility detailing the outcomes of the community visitor’s investigation, and a report submitted to the CEO of Health in August 2006 as required pursuant to Section 116 of the Act.

The CVP does not believe that there needs to be a decision to detain all consumers who meet the criteria for detention under the Act, but to develop a decision-making tree that ensures that consumers’ rights are observed, that their preferences are considered, that any informed consent meets the criteria for informed consent as defined in the Act and that consumers are aware that they lose the right of review by the Tribunal if their status in the facility is voluntary.

Posters with Information about Legal Rights

After their visit to the TEMHS Inpatient Facility in October 2004, the Darwin panel recommended that posters with information about consumers’ legal rights be prominently displayed in the facility.

Posters detailing health rights and responsibilities are displayed on a notice board in the corridor of the facility. To date no response has been received to the recommendation regarding the display of consumers’ legal rights.

Transport to Hospital

Consumers may be transported to hospital by police, and when this takes place, they are most often transported in the back of the caged police vehicle rather than in the back seat of the police vehicle.

A consumer contacted the CVP complaining about his experience of detention. He had been transported to the facility by police in the cage of the police vehicle, and then detained to JRU. Correctional service officers were in JRU at the time of his admission because a prisoner was in hospital at that time. This consumer believed that he had been to gaol rather than a treatment facility.

After their visit to the facility in October 2004, the Darwin panel recommended that guidelines should be negotiated between Ambulance, Police and Mental Health Services to provide for transport to hospital using the least restrictive means.

If transport to hospital by Ambulance is not possible, whenever possible consumers should be transported in the back seat of the police vehicle if police transport is necessary as a last resort. This is an issue that relates to the dignity of consumers and their right to receive the least intrusive and least restrictive treatment.

Employment of a Social Worker in the TEMHS Inpatient Unit

The Darwin community visitors panel commented on the need for a social worker in the TEMHS Inpatient Unit to ensure that the psychosocial needs of consumers are addressed. In addition, the CVP has received feedback from many service providers on the need for a social worker in the Unit.

The panel noted that TEMHS management has acknowledged the need to examine the skill mix in the inpatient unit. Nevertheless, this recommendation has still not been addressed.

Meals in the TEMHS Inpatient Unit

The "lack of choice" in meals in the TEMHS Inpatient Unit is an issue that was raised early in it is existence by the Darwin panel and is an issue continually raised by consumers of the service.

Not only is there no choice of meals for consumers, but food is often not served hot, particularly for consumers in JRU. Food for the facility is prepared at RDH and transported to the facility, however the distance and time it takes for a single person to serve the meal in Cowdy Ward and then JRU mean that food is at best tepid before it is served in JRU.

Consumers with specific dietary needs are able to order a vegetarian, diabetic or asian diet, and the community visitor was informed that consumers can also choose to order a salad meal. They cannot choose to do so however if they are not informed that this a choice available to them, and the community visitor has received several requests from consumers which indicate that they have not necessarily been informed of the alternatives.

Records of Property in JRU

When consumers are detained to JRU, extra clothes and most belongings are removed. No record of property removed or returned to consumers is kept.

Consumers have reported the loss of items such as CDs and CD players to the community visitor. When investigating, the community visitor has been unable to trace these items because no records are maintained in the facility of items removed from consumers and returned to them.

Consumers' belongings may consist of more expensive items such as CD players or items that are less expensive but which hold personal significance. The CVP believes that keeping records of property removed from consumers and returned to them would provide protection for both staff and consumers. The CVP has recently been informed that plans are in place to rectify the situation.

ISSUES RESOLVED PRIOR TO REPORTING

As stated earlier in this report, community visitors and community visitors panels will attempt to resolve issues with management of mental health services so that they are able to report on issues resolved as well as issues arising and outstanding.

For the panels, the change has been instituted only since Christmas this year, and only the Darwin panel reported on issues that were resolved in the report of their visits to the TEMHS Inpatient Facility in April 2006.

Location of Facsimile Machines in the TEMHS Inpatient Unit

Staff informed the panel that because the facsimile machine was located in the office in the TEMHS Inpatient Unit, it was time consuming for them to use the machine. Not only did this impact on the time available for patient care, but their ability to notify the Tribunal as required in the Act.

The panel was informed that facsimile machines have now been placed in all offices.

Complaints Forms in the TEMHS Inpatient Unit

The panel was informed that a consumer wishing to make a complaint is given a complaints form to fill out. This form, when completed, is then passed on to the Director of Nursing. The panel was concerned that this means that a consumer who wishes to make a complaint must first ask nursing staff for a complaint form, a process which may result in barriers to consumers feeling as if they are able to complain.

The panel therefore was of the opinion that at least in Cowdy Ward, the open section of the TEMHS Inpatient Facility, the mental health service should display information about how to make a complaint and make the complaint forms readily available to consumers in a form that allows for an anonymous and confidential complaints process.

The panel has been informed by TEMHS Management that complaints forms are now readily available throughout the ward and can be deposited anonymously.

Bathrooms in the TEMHS Inpatient Unit

The panel inspected the bathrooms in Cowdy ward. In the shared bathroom, they noted a dirty stain on the sink and on the back wall and the plaster in poor condition. The panel was advised that the plaster deteriorates easily in the humidity and is likely to be replaced next financial year.

Consumers complained that their clothes become wet in the communal bathroom due to the fact that there is no shower curtain and the shelf provided is too small to hold both clothes and toiletries.

Consumers also complained that the water only trickles out of the shower in two of the single rooms. One consumer said she could not get the shampoo out of her hair because the stream of water was so fine. The panel noted the length of time taken for the hot water to come on in a previous report.

The Management of TEMHS have undertaken to address these matters to ensure that reasonable standards are maintained. The issue related to the length of time for hot water to come on may in fact be related to Occupational Health and Safety concerns. If so, then TEMHS Management suggested that consumers are informed of the reasons for the delay.

Records of Consumers' Money in Cowdy Ward

The CVP received a complaint from a carer regarding the management of a consumer's money. On investigation, the community visitor found that the consumer's money was properly accounted for, however when the amount of money being held in the ward reaches a certain level, it is transferred to Security at RDH. There was no record of money being transferred to and from Security, and it was therefore difficult to track where the money might be.

This issue was brought to the attention of the TEMHS Inpatient Unit, and rectified immediately

PART 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 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.

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 inpatient facilities.

Two major entities, TEMHS and CAMHS are responsible for the delivery of mental health services in the Northern Territory. 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.

Location of the Community Visitor Program

The CVP is located within the Anti-Discrimination Commission. This means that the program 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 Division 3 Part 14 of the Northern Territory *Mental Health and Related Services Act 1998*.

The Minister for Family and Community Services appointed Tony Fitzgerald, the Anti-Discrimination Commissioner, to the role of Principal Community Visitor on 9 December 2005.

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 Family and Community Services. 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 Division 3 Part 14 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 visitor's role is outlined in Division 2 Part 14 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).

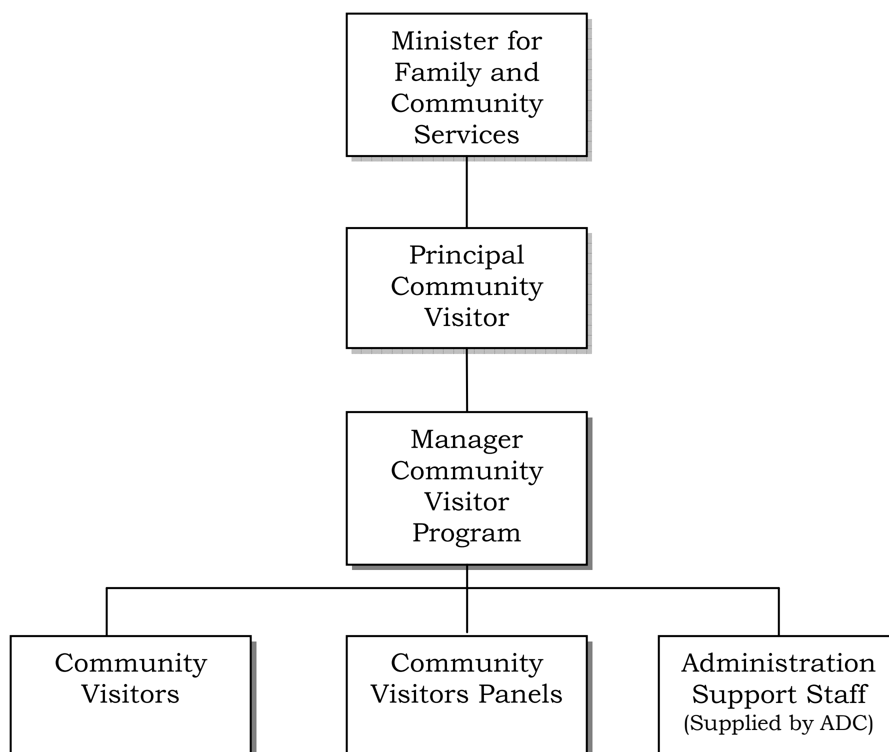
The program aims to ensure that community visitors are accessible to consumers of mental health services and their carers. This is achieved through regular visits to approved treatment facilities, and responding quickly to complaints and requests from consumers for a visit.

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.

ADMINISTRATION OF THE CVP

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 three of the community visitors in the Top End.

2. The community visitors in Alice Springs and the 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 of the CVP

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.

Terry Lisson was appointed community visitor in

Kathryn Ganley, Solicitor/Conciliator with the ADC was appointed community visitor in June 2005. Ms Ganley ceased to act as a community visitor when her appointment with the ADC ceased.

Judy Clisby, Manager of the Community Visitor Program, was appointed community visitor in June 2004.

Marilyn Starr was appointed community visitor in June 2005. Marilyn was also appointed community member of the community visitors panel on 7 June 2006.

Community Visitors Panels

Sarah McNamara, was appointed community visitor and Chairperson and legal member of the community visitors panel in Alice Springs in March 2005. Sarah resigned from both roles in February 2006.

Maya Cifali was appointed community member of the Alice Springs community visitors panel in March 2005. She is currently chairperson of the Alice Springs panel.

Sarah Giles, Chairperson and Medical Practitioner member of the community visitors panel in the Top End, was appointed in March 2004.

Kirsty Carter, CEO of TEAM Health, was appointed community member of the community visitors panel in the Top End in September 2004. Kirsty resigned this role effective as of 30 June 2006.

Jenny Devlin was appointed legal member of the Darwin community visitors panel on 7 March 2006.

Dr Christine Lesnikowski was appointed Medical member of the Alice Springs community visitors panel on 27 March 2006.

Mark O'Reilly was appointed community visitor for Alice Springs and legal member of the Alice Springs community visitors panel on 1 March 2006.

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 four 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 in mental health services, drugs and alcohol and Centrelink. She is a social worker with a keen interest in mental health. Judy has managed the CVP for two years now and is pleased that funding for the CVP is now secure to enable it to move forward and plan for its long term future.

Terry Lisson, Community Visitor

Terry moved to Darwin eleven years ago and is now a dual Australian/Canadian citizen. 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, and while she has not been as involved over the past twelve months, still acts as a Community visitor when called upon.

Simon Wiese, Community Visitor

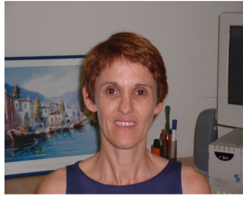
Simon is an experienced negotiator and mediator who with experience in human resource management and industrial relations. Simon is also a Community Visitor. While most of his involvement with the program over the past twelve months has been in an administrative capacity, Simon has managed to visit Cowdy Ward on a couple of occasions in response to complaints.

Marilyn Starr, Community Visitor and Community Member, Darwin Panel

Marilyn moved to the Territory in 1984 to help manage a 10,000 head buffalo station. Her family built and operated a wilderness and wildlife retreat on the Mary River in 1997 and have purchased a roadhouse near Kakadu. Marilyn says: *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. I'm a trained mediator, 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.*

Community Visitors Panel Members

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 nine years. Sarah is married and has two 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.*

Jenny Devlin, Legal Member, Darwin

Jenny grew up in the Northern Territory. She studied law in Melbourne, working with Legal Aid in Darwin prior to taking on the role of legal member of the Darwin panel. Jenny provided legal advice to clients with mental health issues and to the wider community on mental health issues. She is a trained, accredited mediator, and is now managing the mediation service at Relationships Australia. Jenny says that she has a deep interest in mental health and well-being. In addition to her other work, she teaches weekly classes of Danskinetics and Yoga. Jenny also speaks several languages, including French, Italian, Japanes and Yolgnu Mather.

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).

Christine Lesnikowski, Medical Member, Alice Springs Panel

Chris came to the NT in 1992 and says she has enjoyed working throughout the Territory. She has lived in Darwin, Katherine and Alice Springs and now calls Alice Springs home. Chris says: *I have had an interest in mental health services for many years and in addition to clinical General Practice exposure to mental health problems, I completed a diploma in GP Psychiatry in 2000 whilst home with a new baby, and while living in Katherine. The CVP has been an interesting experience and I hope I can continue to offer support to the community in the field of mental health services.*

REPORT ON THE ACTIVITIES OF THE CVP

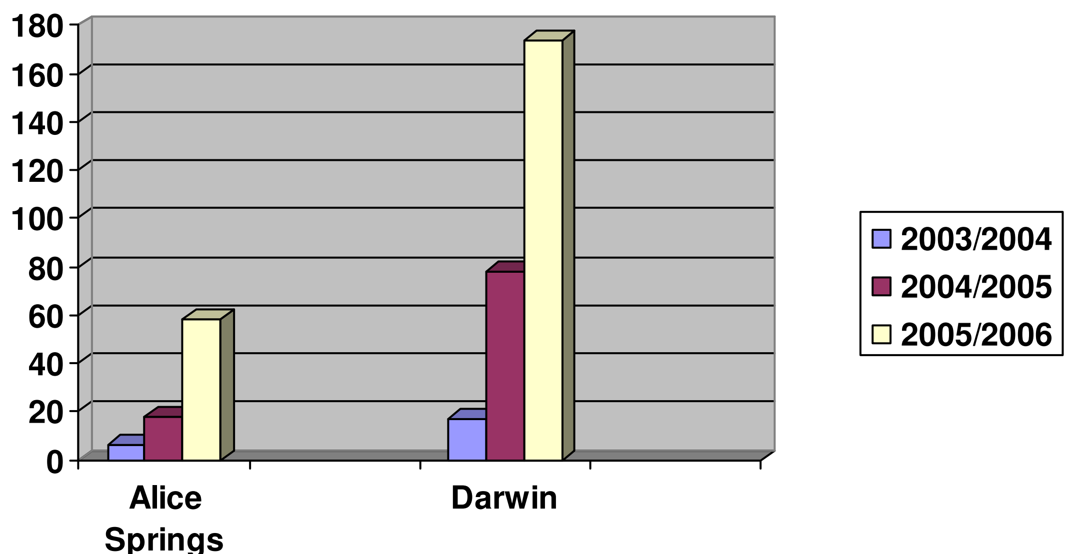
Complaints and Enquiries

There has been a greater than 100% increase in complaints and enquiries received and actioned in Alice Springs and Darwin over the past twelve months when compared to the previous twelve months. This is directly attributable to an increase in community visitor visits to the approved treatment facilities in Darwin and Alice Springs.

Table 1: Complaints and Enquiries Received and Actioned

	Darwin			Alice Springs		
	2003/ 2004	**2004/ 2005**	**2005/ 2006**	**2003/ 2004**	**2004/ 2005**	**2005/ 2006**
Complaints & Enquiries Received & Actioned	17	78	**174**	6	18	**58**

Figure 1: Complaints and Enquiries Alice Springs & Darwin 2003 - 2006

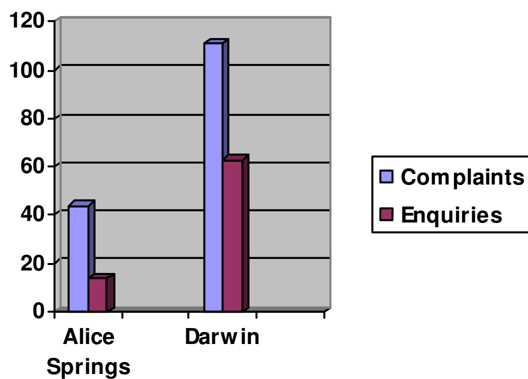


Complaint or Enquiry?

Consumers, carers and service providers contact the CVP for many reasons. Often, the contact may involve a request for information or a request for support in interacting with the mental health service. At other times, the person providing the information specifies that the issue raised is not to be handled as a complaint. All these, and similar contacts with the program are defined in all reporting from the CVP as enquiries.

Complaints are contacts of a more serious nature. They may be oral or in writing and occur when the person contacting the CVP has a grievance with the mental health service.

Figure 2: Graph of Complaints vs Enquiries, Alice Springs and Darwin

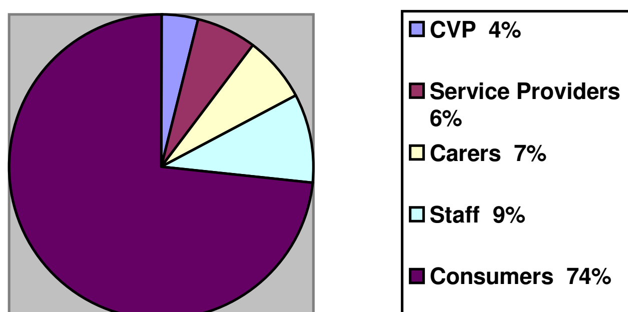


In 2005 – 2006, the CVP received a total 155 complaints and 77 enquiries. 111 complaints and 63 enquiries were received regarding services provided by TEMHS, and 44 complaints and 14 enquiries about services received from CAMHS.

Sources of Complaints and Enquiries

Complaints and enquiries are received from multiple sources, as illustrated in the chart below. Those from the CVP refer to issues followed up at the initiative of a community visitor. They are not recorded as either an enquiry or complaint.

Figure 3: Source of Complaints and Enquiries NT



Categories of Complaints and Enquiries

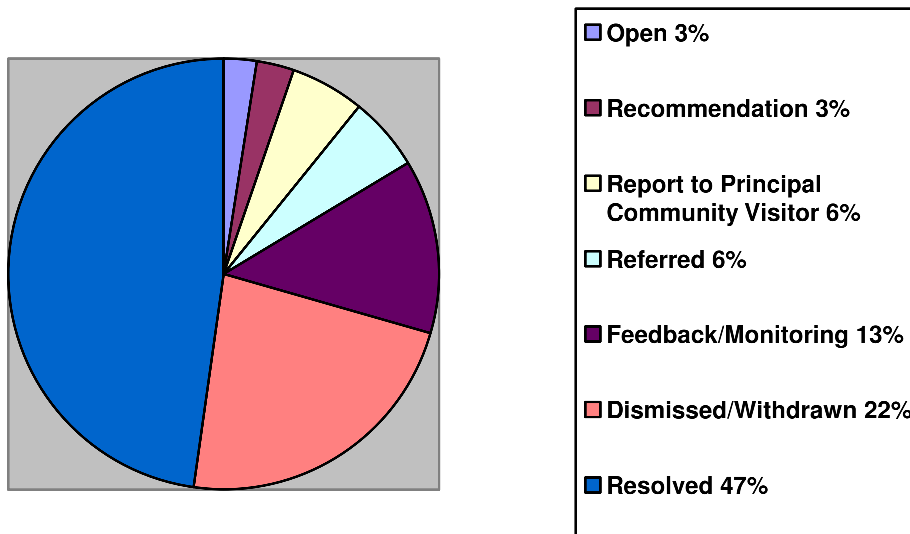
Table 2: Categories of Complaints and Enquiries

Category of Complaint/Enquiry	TEMHS	CAMHS	Total
Access to files	3		3
Advocacy	18	7	25
Confidentiality breached	4		4
Detention	11	4	15
Discharge Planning	17	4	21
Facilities	20	4	24
Legal	12	11	23
Medical	13	2	15
Medication	8	3	11
Miscellaneous	9	8	17
Staff	23	7	30
Procedures	25	4	29
Transport by police	3		3
Ward Activities	8	4	12
TOTAL	**174**	**58**	**232**

Disposition of Complaints and Enquiries

The CVP provides quarterly reports to TEMHS and CAMHS on complaints and their outcomes. If the community visitor is aware that the complaint or enquiry is indicative of a broader issue, its outcome is recorded as Recommendation, or Feedback to the Service. Thus the Resolved and Dismissed/Withdrawn portions of the pie below under-represent the high proportion of complaints that are in fact resolved.

Figure 4: Outcomes of Complaints and Enquiries NT



Other Complaints and Enquiries

In addition to complaints and enquiries about mental health services in the NT, the CVP has received a total 18 complaints and enquiries about non mental health services. These complaints and enquiries have included requests for support to advocate with both government and non-government agencies. The CVP has no role in investigating complaints against organisations external to mental health services, but may assist a consumer by providing relevant information, referral and limited advocacy. The community visitor in Darwin has also assisted in an advocacy role with consumers lodging a complaint with the Anti-Discrimination Commission.

The CVP has received several complaints about private providers such as general practitioners and private psychiatrists. These are immediately referred to the Health and Community Complaints Commission. The community visitor may assist the consumer to complete the written complaint to the Commission and liaise with the Commission if required.

Inspection of the Seclusion Registers

A community visitor is required to inspect the seclusion registers in each approved treatment facility in the Northern Territory at least once every six months pursuant to section 62 (14) of the Act.

In Alice Springs, the seclusion registers were inspected in August 2005 and again in March and April 2006. In the first inspection, the community visitor noted that several consumers had been secluded for 4 hours or more, and on each occasion a medical review was conducted as is required by section 62 (8) (b) of the Act.

During subsequent visits in March and April 2006, the community visitor noted that one consumer had multiple periods of seclusion throughout February 2006, many of them for very lengthy periods. The community visitor noted that there was no indication in the register or in the consumer's file of compliance with section 62 (8) (b) of the Act in that there was no record of any examination by medical practitioners after 4 hours as is required by the Act. This was also the case with periods spent in seclusion by other consumers. The community visitor discussed this issue with the then Clinical Nurse Manager of the Unit and again with the Acting Clinical Nurse Manager in June 2006, and will continue to monitor compliance with the Act.

The same issue was raised by the community visitor in Darwin after inspecting the seclusion records in the TEMHS Inpatient Unit in December 2005. Because it had been raised with the service on four previous occasions, in April 2006 a report was forwarded to the CEO Health and Community Services regarding possible breach of Sections 62 (8) (b) and (c) of the Act.

A second inspection of the seclusion register in June 2006 yielded only minor issues of concern which have been reported to TEMHS for follow up.

It is pleasing to be able to report that the number of seclusions in the Top End Mental Health Service (TEMHS) Inpatient Unit have approximately halved in the past financial year, from approximately 450 separate incidents of seclusion in 2004 – 2005 to approximately 220 in 2005 - 2006. The CVP is aware that this is part of an ongoing policy of reducing the use of seclusion in line with international practice, and congratulates both management and staff on their achievement.

Inspections of Complaints Registers

Section 100 (9) of the Act specifies that the mental health service must forward a report detailing the pattern of complaints to the Secretary of Health and the Principal Community Visitor at 6 monthly intervals. To date, the community visitor in Darwin has visited the approved treatment agency to inspect the register at 6 monthly intervals. Following these visits in December 2005 and June 2006, the CVP made minor recommendations regarding the way TEMHS notifies its consumers of the role and function of the CVP, and noted that some complaints that the community visitor was aware of were not contained in the complaints register. The community visitor also noted that the complaints file does not indicate whether consumers are notified of the outcome of a complaint.

The community visitor in Darwin has met with the Complaints Officer from TEMHS on two occasions to discuss complaints and how the CVP and TEMHS can work effectively together. A number of initiatives have been discussed, including sharing similar categories of complaints so that issues arising repeatedly may be identified and addressed through internal TEMHS quality improvement processes.

Other CVP Activities

Senate Select Committee on Mental Health

The Manager of the CVP and Jennifer Devlin, Solicitor from Legal Aid, lodged a joint submission to the Senate Select Committee on Mental Health. In addition to the issues already discussed in this Annual Report, the authors of the submission drew attention to the following:

- The narrowness of the definition of mental illness for the purpose of the Act in the NT (people with personality disorders specifically excluded under the Act);
- The size of case loads for case managers, particularly those working in the Top End and remote regions. The size of case loads makes it difficult to adopt an holistic case management approach;
- Reports by carers of difficulties liaising with mental health services;

- Limitations in vocational rehabilitation services in Darwin and Alice Springs;
- Separation of hospital inpatient services from mainstream services resulting in problems such as a lack of pharmaceutical oversight of prescriptions in the inpatient facility in Darwin;
- Lack of a specialist youth health centre;
- Difficulties in accessing appropriate community based services for people with co morbid conditions, particularly those with co morbid mental illness and acquired brain injury;
- Lack of a peer support program in the Territory; and
- The lack of a diversion program in the Territory for people with mental illness committing minor criminal offences.

The Manager of the CVP and the Legal Aid Solicitor were also invited to appear before the Senate Select Committee in August 2005.

Review of Mental Health Legislation

The CVP has contributed several written and verbal submissions to the new Bill anticipated to be before Parliament in November 2006.

TEMHS Inpatient Task Force

The community visitor was invited to attend the TEMHS Inpatient Task Force Meetings as an ex officio member of the group. The Task Force was a short term TEMHS initiative with the aim of resolving issues identified by staff and consumers of the TEMHS Inpatient Unit. Many of the issues covered by the Task Force were not relevant to the CVP. Other issues, relating to changes in the physical layout of the ward were the subject of a community visitors panel inspection in September 2005. The CVP was pleased to be involved in a well designed and well executed process that enabled all who were involved to make a meaningful contribution to the future planning of the Unit.

Involvement with Community Activities

One mechanism for promoting the purpose of the CVP is involvement in community activities. In the 2005 – 2006 financial year, the CVP contributed to the following:

- Mental Health Week: The CVP attended interagency planning meetings organised by the Mental Health Coalition, volunteered time and materials for a stall held for the week in Casuarina Shopping Centre and attended the consumer dinner;
- Schizophrenia Awareness Week: CVP brochures were displayed at a stall held in Browns Mart in May 2006;
- The Pride Festival: CVP brochures were displayed with promotional material from the Anti-Discrimination Commission, The Community

Justice Centre, Office of the Information Commissioner and Darwin Community Legal Service in May 2006; and
- International Day of People with a Disability: CVP brochures were displayed at a stall held by the Anti-Discrimination Commission.

Presentations to Community Groups

The CVP also delivers presentations about its role to service providers and community groups in both Darwin and Alice Springs. Fewer presentations were given over the past year due to additional time spent with complaints and subsequent reporting. However, the CVP has addressed following organisations:

- Charles Darwin University: Legal Issues and Social Work. A presentation was given to students on mental health legislation and policy in the NT, with particular reference to Part 14 of the Act: the Community Visitor Program;
- Centrelink: A brief presentation was delivered to Centrelink Social Workers;
- Mental Health Review Tribunal: The Manager of the CVP was invited as a guest speaker to the Tribunal's 2005 Annual General Meeting;
- The community visitor in Alice Springs spoke to a group of carers attending a carers' support group sponsored by NT Carers; and
- Top End Mental Health Consumer Organisation (TEMHCO): A brief talk was given to the Palmerston coffee morning group about the role of the CVP and the evaluation that was being undertaken at the time.

Networking

The Manager of the CVP attempts to stay in regular contact with mental health and other service providers with an interest in mental health. Over the past twelve months, the Manager has met with representatives from the following groups:

- ARAFMI (Darwin and Alice Springs);
- NT Carers (Darwin and Alice Springs);
- Disability Advocacy (Alice Springs);
- Offenders Aid Rehabilitation Service (OARS);
- Health and Community Complaints Commission;
- The Office of the Ombudsman;
- NT General Practice Division of Primary Health Care;
- Larrakia Nation;
- Northern Territory Council of Social Services;
- Human Services Training Advisory Council;
- Pete's Place;
- Mental Health Coalition;
- Grow;
- Mental Health Association of Central Australia; and
- TEAM Health.

Evaluation

In consultation with the Mental Health Program, the CVP conducted an evaluation to determine the effectiveness of its current operations and to determine how a community visitor program might operate in the NT into the future.

The evaluation was conducted by circulating an issues paper with attached questionnaire. Unfortunately, only a 10% response rate, comprising 18 respondents, all from the Top End, was received. The response rate may have improved if the evaluation had limited its scope to an evaluation of its current operations, or if the evaluation was targeted specifically to either consumers or service providers.

A brief outline of the outcomes of the evaluation is contained below. The 18 respondents comprised 11 consumers and 7 service providers. All respondents live in the Top End of the Northern Territory.

Complaints

Consumers who had lodged a complaint and service providers who had referred a complaint to the CVP over the past twelve months were either satisfied or very satisfied with the outcome.

Other Contact with the CVP

9 of the 10 respondents who had contact with the CVP over the past twelve months reported being very satisfied with this contact. One staff member from TEMHS reported that being able to work with the CVP was useful, particularly when this involved difficult clients. One TEMHS staff member reported dissatisfaction with the service, stating that the community visitor lacked impartiality in dealing with vexatious complaints from clients.

Access

Only half the respondents reported finding the service accessible, with one respondent describing it as “hidden away”. One other respondent described the service as less accessible to carers. Improving the accessibility of the CVP will be a priority for the program in 2006 – 2007.

Functions of the CVP

Almost all respondents believe that the CVP should retain its complaints, advocacy and monitoring functions. The monitoring/inspection and complaints functions were seen to be the most important, followed closely by individual advocacy for consumers. Consumers saw the complaints and advocacy functions as most important, and service providers found the monitoring/inspection and complaints functions most important.

Composition of the Community Visitors Panels

Approximately one half of all consumers did not respond to this question. Respondents had the opportunity to state whether panels should be comprised of: a community visitor only, 2 members, 3 members with flexible membership and 3 members comprised of a medical, legal and community member (as it now operates). Consumers' responses slightly favoured a panel of 3, while service providers equally preferred a panel of three with medical, legal and community representation and panel of three with flexible membership.

Summary of Evaluation Findings

Of all the responses, only one respondent indicated any dissatisfaction with the CVP, however this may be indicative of a more generally held perception. The CVP plans to approach both TEMHS and CAMHS with a view to providing training regarding the role and function of community visitors and procedures for handling complaints (particularly complaints about staff).

Consumers and service providers report a high level of satisfaction with operations of the CVP. However access is an issue with about half of consumers and service providers describing the program as either poorly or very poorly accessible. This will therefore be a priority area for action for the CVP over the next twelve months.

PRIORITIES 2006 – 2007

The core business of the CVP is visiting the mental health inpatient facilities, receiving and investigating complaints and carrying out the inspection functions of the program.

The priorities for the CVP over the next twelve months are designed to enhance the capability of the program to meet its core functions. These priorities are as follows:

- Problems with accessibility were identified in the evaluation, and hence strategies will be developed in an attempt to address this. These strategies will include:

    - Increasing community visitor visits to the Mental Health Unit in Alice Springs to fortnightly visits;
    - Developing a new logo for the CVP;
    - Liaising with community teams in Katherine, Tennant Creek and Nhulunbuy to ensure that their clients are informed of the CVP and that brochures are readily available; and
    - Introducing new brochures for the CVP outlining the role of community visitors, how complaints are handled and providing specific information for carers;

- In order to further evaluate how the CVP performs its functions, time spent in receiving, investigating and reporting on the complaints and enquiries functions of the program will be measured over a three month period;

- At the end of the 2006 – 2007 period, the Strategic Plan for the program will have been in place for three years. With funding for the CVP now secure, a realistic plan can be developed to take the program into the future. Development of a new strategic plan to provide a framework for the operation of the CVP 2008 – 2111 will therefore be a priority in the next twelve months; and

- The CVP will develop links with other, similar programs throughout Australia with a view to either hosting or supporting a conference to be attended by community visitors.

PERFORMANCE

The performance for the CVP during the 2005 – 2006 financial year is measured against the objectives and strategies outlined in its Strategic Plan. In light of proposed new mental health legislation and the level of funding achieved for the CVP, these objectives and strategies have been revised, allowing for only phone contact to Katherine, Nhulunbuy and Tennant Creek. In 2006 – 2007, community visitors rather than panels will be responsible for monitoring of the approved treatment agencies. The revised Strategic Plan for the CVP is included in Appendix 4.

The most obvious change for the program over the past twelve months has been a significant increase in the complaints and enquiries handled by the program.

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.

Table 3: Comparison of the Achievements of the CVP 2003 - 2006

		Darwin			**Alice Springs**		
	Legislative Requirements	2003/ 2004	2004/ 2005	2005/ 2006	2003/ 2004	2004/ 2005	2005/ 2006
Complaints & Enquiries	N/A	17	77	135	6	18	31
Visits	In response to requests/ inspection	9	50	63	3	7	22
Panel Visits Inpatient Facilities	2 (At least once every 6 months)	0	2	2	1	2	2
Panel Visits Agencies	2 (At least once every 6 months)	0	2	1	0	2	2
Inspection Seclusion Register	2 (At least once every 6 months)	1	3	2	0	2	2
Inspection Complaints Register	N/A	1	2	2	0	0	0

Table 4 Performance: Administration of the CVP

Performance Measures	Unit of Measure	Outcome 2004–2005	Proposed Action 2005-2006	Outcome 2005-2006	Proposed Action 2006 – 2007
Develop a Handbook for the program	N/A	Achieved	Update the Handbook - ongoing	Handbook updated	Ongoing Place on website
Establish a database for the CVP	N/A	Achieved	Continuous improvement of the database	Achieved	No further action
Timeliness	Visits conducted within 24 hours of notification of a request	100%	100%	100%	100%
Visits to Rural Regions	Number of visits.		Community Visitor to conduct 6 inspections of Approved Treatment Agencies in Remote NT.	One visit conducted	No further Action. Revised strategy.
Liaison with Mental Health Services	Number of meetings attended		Establish regular meetings with the Director, Mental Health Service and Managers of TEMHS & CAMHS	Meetings established between panels and TEMHS and CAMHS management post visits. 5 meetings held	Meetings with Director Mental Health Service to be established. 4 panel meetings with mental health services and 2 meetings with Director, Mental Health Program.

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.

Table 5 Performance: Accessibility of the CVP

Performance Measures	Unit of Measure	Outcome 2004-2005	Proposed Action 2005-2006	Outcome 2005-2006	Proposed Action 2006 – 2007
Quantity	Number of visits to approved treatment facilities	57	100	85	85
Develop a remote area strategy	N/A	Not Achieved	Have strategy in place ready to implement 2006 – 2007	CVP funding confirmed June 2006. Strategy revised accordingly.	Liaise with Katherine, Tennant Creek and Nhulunbuy to ensure staff and consumers are aware of the CVP.
Develop and maintain the CVP website	N/A	Partially achieved	Achieved – to be updated	Updated – ongoing	Review website content and outline
Employment of community visitors in remote NT.			Employment and Training of 3 indigenous community visitors for remote NT	CVP funding does not allow for employment of additional community visitors	No further action.
Development of a new logo			New logo developed.	Not achieved	New logo to be developed.
New Strategy	Develop brochures for carers and explaining complaint s handling function of the CVP.				Brochures developed.

Note: Visits to the approved treatment facility in Alice Springs were reduced in the second half of the financial year due to funding considerations.

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.

Table 6 Performance: Training for Community Visitors and Panel Members

Performance Measures	Unit of Measure	Outcome 2004–2005	Proposed Action 2005-2006	Outcome 2005-2006	Proposed Acton 2006-2007
Develop a Training program for community visitors and panel members		First 6 hour training program completed	Issue specific training programs developed	Partially achieved – issue specific training in place	Ongoing
Quantity	All program staff receive a minimum 6 hours training each year	100%	100%	100%	100%
Develop resources for personnel of the CVP.		Partially achieved	Ongoing	Achieved but ongoing	No further action – continual updating.
External training for community visitors and community visitors panel members			Community visitors and panel members have the opportunity to attend a National Conference	Not achieved – funding	Opportunity to attend activities in mental health week provided National Conference of Official Visitors planned.

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.

Table 7 Performance: Liaison with Service Providers

Performance Measures	Unit of Measure	Outcome 2004-2005	Proposed Action 2005 – 2006	Outcome 2005 – 2006	Proposed Action 2006-2007
Relations with consumers, service providers and mental health services	Number of meetings	68	80	55	50
Referrals from service Providers	Number of referrals from service providers			15	20
Establishment of an Advisory Structure			Establishment of an Advisory Structure	Funding does not provide for establishment of Advisory Structure	No further Action

Note: The number of meetings with consumers, service providers and mental health services are reduced due to the number of complaints and enquiries handled by the program.

CVP FINANCIAL STATEMENT 2005 - 2006

The Department of Health and Community Services provided funding totalling $90,000.00 and the Department of Justice $20,000 to the Community Visitor program. A $17,000 shortfall for the financial year was covered by Anti Discrimination Commission as a one off event. The following statement details how the funds have been allocated.

INCOME			
	$	$	$
Funding:			
Department of Health and Community Services		90000	
Department of Justice		20000	
TOTAL INCOME			**110000**
EXPENDITURE			
Salaries and Remunerations			
Salary and Accrued Leave Liability	74600		
Salary On costs	13500	88100	
Operational Expenses			
Accommodation	1000		
Communication	1170		
Consumables	620		
Marketing and Production	370		
Membership and Subscriptions	20		
Motor Vehicle Expenses	1080		
Official Duty Fares	5650		
Office Requisites and Stationery	120		
Other Equipment Expenses	220		
Training and Study Expenses	800		
Travel Allowance	1110		
Information and Technology Charges	4050		
Fees and Other Regulatory Charges	22640		
Total Operational Expenses		38850	
TOTAL EXPENDITURE			**126950**
Deficit			**(16950)**

Notes

1 $16960 contributed by the Anti Discrimination Commission to offset the loss over the 2005 – 2006 financial year.

2. The ADC also contributed in the form of indirect costs – staffing: proportion of the salary of the Principal Community Visitor and community visitors, administration staff and other costs such as motor vehicle, photocopying, use of office space and furniture and equipment.

APPENDIX 1 NEW RECOMMENDATIONS 2005 - 2006

ALICE SPRINGS

Mental Health Unit

March 2006 Visit

1. It is recommended that CAMHS investigate mechanisms to ensure that consumers under 18 years of age have access to appropriate facilities and care.

August 2005 Visit

2. It is recommended that CAMHS collaborate with ASH to
    a. provide useful information to emergency department about mental disorders and mental health problems and their relationship with medical conditions; and
    b. provide further guidelines as to medical clearance procedures, as to when it is appropriate to transfer a mental health consumer with a medical condition to the Unit and as to handover procedures regarding transfers from emergency to the Unit where a client has a medical condition requiring treatment.

3. It is recommended that CAMHS work collaboratively with ASH to initiate and participate in a range of activities designed to promote acceptance of people with mental disorders and/or mental health problems by reducing stigma in the hospital environment.

4. It is recommended that CAMHS collaborate with ASH to provide understandable information to all hospital staff about mental disorders and mental health problems.

5. It is recommended that CAMHS and ASH develop documented policies and procedures to achieve the above recommendations.

6. It is recommended that the Mental Health Unit explore the possibility of working with relevant stakeholders to conduct a primary care and preventative health check of each client on admission.

7. It is recommended that an alarm system be installed at the vehicular access point to the ward to allow for more frequent use of that access point.

Community Teams

March 2006 Visit

8. It is recommended that CAMHS re-establish lines of communication with the Central Australian Division of Primary Health Care to facilitate cooperation between GPs and the Mental Health Sector.

August 2005 Visit

9. It is recommended that the Department of Health and Community Services considers allocating increased funding with a view to increasing staff in the Child and Adolescent Service.

10. It is recommended that the manager of CAMHS liaise with the manager of the Aboriginal Interpreter Service to explore the possibility of cross training of Aboriginal Health Workers and Aboriginal Interpreters.

Forensic Mental Health Service

March 2006 Visit

11. It is recommended that all inmates in the maximum security and remand section of the prison be subject to regular review as to their mental health status.

12. It is recommended that CAMHS establish protocols with Correctional Services and prison management to facilitate timely assessment of inmates and ease of contact between Mental Health Workers and their clients.

13. It is recommended that CAMHS explore ways in which to improve the recruitment and retention of mental health staff working within the prison environment.

14. It is recommended that the Department of Health and Community Services meet with the Department of Justice with a view to improving conditions in the maximum security and remand section of the prison to ensure that inmates are in an environment conducive to the detecting, treatment and prevention of Mental Health issues.

15. It is recommended that the Department of Health and Community services meet with the Department of Justice and establish a set of protocols to ensure that all prison inmates who are consumers of CAMHS are housed and treated within the prison system in a manner consistent with their mental health treatment and provided with a rehabilitation program.

DARWIN

TEMHS Inpatient Unit

September 2005 Visit

1. It is recommended that staff and consumers and/or their representatives (in accordance with Standard 3 of the National Mental Health Standards) are fully consulted prior to implementation of any future changes; and in the interim signs assist visitors to access the ward easily.

2. It is recommended that:
    a. All superfluous signs be removed from Cowdy ward, and any signs that remain provide assistance to consumers and visitors rather than direction;
    b. Use of the vehicle be returned to the AMHW team to enhance the service they provide to indigenous clients;
    c. Identified problems with windows in JRU be addressed urgently;
    d. The inadequacy of bathroom facilities to consumers be addressed urgently in consultation with staff;
    e. The waste bin be moved from the entrance (to Cowdy Ward and Forensic services); and
    f. The outdoor walkway area opposite the original entrance be opened up and trolleys and rubbish around the walkway removed.
    g. It is recommended that:
    h. Repairs / maintenance be urgently undertaken to: the lino in room 57 – 077, the lock on the bathroom in 57 – 076, the lino in room 57 – 176, accommodate hot water to room 57 – 150; the outside toilet at JRU; and
    i. TEMHS consult with staff to solve what appears to be an ongoing issue of delays with repairs and maintenance of the inpatient facility.

Tamarind

June 2006 Visit

3. It is recommended that TEMHS explores its role in Aboriginal mental health in conjunction with other service providers (including indigenous service providers) to provide better access to services for indigenous consumers.

4. It is recommended that a thorough mental health assessment is completed on all incoming prisoners and that an appropriate tool is accessed and used when assessing Indigenous prisoners, as well as suitable interpreters.

Community Visitor Recommendations

TEMHS Inpatient Unit

5. It is recommended that the Director of Nursing notify the CVP whenever a patient of the TEMHS Inpatient Unit is unable to access a medical bed at RDH and when in the opinion of medical and nursing staff medical treatment is the primary requirement.

6. It is recommended that any plan implemented to encourage or enforce compliance with medication is to be seen as “treatment” for the purposes of the Mental Health and Related Services Act (NT) 1998, and that it must be subject to the same consent as all other psychiatric treatment, including authorisation by the Mental Health Review Tribunal under S 123 (6) of the Act.

7. It is recommended that TEMHS Inpatient Unit monitors any difficulties (including delays) experienced in referring consumers of the Inpatient Unit for medical tests, and report to the CVP as appropriate.

8. It is recommended that TEMHS evaluate its practice with respect to incidents that ought to be reviewed. It is further recommended that a report on this evaluation is provided to the Principal Community Visitor by 31 October, 2006.

9. It is recommended that procedures to ensure that TEMHS' legal obligations to notify the MHRT pursuant to S28 of the Mental Health and Related Services Act are put in place forthwith and that the CVP is formally notified of these procedures in writing.

Tamarind Community Teams

10. It is recommended that when conducting the review of discharge planning, consideration is given to ensuring that it takes place as a collaborative process between the consumer and the treating team, and that current life stressors are considered when a decision regarding discharge is taken by the treating team.

11. It is recommended that arrangements are made to ensure that only trained mental health staff triage consumer contact with TEMHS.

APPENDIX 2: RECOMMENDATIONS CLOSED 2005 – 2006

ALICE SPRINGS

Mental Health Unit

March 2006 Visit

1. In March 2004 the panel recommended that a standard format be adopted by the Mental Health Unit for documenting discharge plans and that these be used in accordance with National Mental Health Standards Standard 11.5.

   An audit of files of all patients discharged in the four weeks prior to the Panel's visit satisfied the panel that this recommendation has been met.

2. In March 2004, the panel recommended that the Department of Health and Community Services allocate sufficient funding to increase the range of flexible, alternative treatment options available, preferably in the non-government sector (such as rehabilitation, therapeutic activities, 'step down', support for people living independently).

   Since then, the Sub-acute program has been funded and is operating as a collaborative program between CAMHS and the Mental Health Association of Central Australia.

3. In March 2004 the panel recommended that the Mental Health Unit work with relevant stake holders to review its policies, procedures and protocols relevant to detection and treatment of medical conditions of inpatients. The results of this review were 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.

   In consultation with the emergency department, a set of guidelines was agreed and adopted for medical clearance for psychiatric admissions. For those few consumers who remain long-term in the ward, there is a policy of six monthly general medical check-ups, as well as weekly routine check-ups by nursing staff for all clients.

4. In March 2004 the panel recommended that CAMHS provide consumers with a choice of appropriate therapeutic programs and activities during their stay as inpatients.

Action has been taken regarding the upgrading of recreational facilities. The panel made a new recommendation regarding the need to employ an Occupational Therapist to ensure that consumers have access to a range of therapeutic program while inpatient in the Mental Health Unit.

5. In March 2005 the panel recommended that 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 either on arrival or as soon as possible after admission.

   This recommendation refers to a similar recommendation of March 2004. While the Panel is of the view that the recommendation has not been met, it considered this recommendation duplicitous and it was therefore closed. A former recommendation regarding the need for an appropriate information package remains open.

6. In March 2005 the panel recommended that staff be trained in the requirements of the Act with respect to informed consent and what those requirements mean in the context of involuntary admissions.

   During its visit in March 2006, the panel found that there had been no movement toward incorporating the concept of informed consent into staff training. The panel gained the impression that there was a perception at management level that there was no need for such training.

   The Panel expressed the view that training is required for all staff. Nevertheless the panel also believed that this recommendation needed redrafting. Accordingly this recommendation was closed and a new recommendation drafted as follows:

   It is recommended that a protocol for dealing with 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 and that staff be trained in this protocol.

7. In March 2005, the panel recommended that the Mental Health Service draft clear guidelines as to whether a patient with a clear lack of judgement can actually consent to voluntary admission.

   This recommendation was redrafted as above and closed.

8. In August 2005, the panel recommended that CAMHS collaborate with ASH to
    a. provide useful information to emergency department about mental disorders and mental health problems and their relationship with medical conditions; and
    b. provide further guidelines as to medical clearance procedures, as to when it is appropriate to transfer a mental health consumer with a medical condition to the Unit and as to handover procedures regarding transfers from emergency to the Unit where a client has a medical condition requiring treatment.

   The Panel was satisfied that this recommendation had been addressed through the introduction of a series of seminars run by the Psychiatric Liaison Nurse. The Nurse is also available to discuss management of particular patients.

9. In August 2005 the panel recommended that the Mental Health Unit explore the possibility of working with relevant stakeholders to conduct a primary care and preventative health check of each client on admission.

   Guidelines were developed as part of the health check undertaken in ED prior to admission to the Mental Health Unit.

10. In August 2005 the panel recommended that an alarm system be installed at the vehicular access point to the ward to allow for more frequent use of that access point.

    An alarm system was installed.

August 2005 Visit

1. In March 2004, the panel recommended that:
    a. complaints about the Mental Health Unit service quality from 'non clients' (such as staff, advocates or carers) be made using a similar or same form as the 'client complaint form'.
    b. 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.
    c. the Unit policies and procedures be reviewed, with comment from relevant stakeholders, to ensure that the process for dealing with complaints about the service in the Unit is robust, clearly documented and well understood by relevant stakeholders.

The panel noted that these matters have been addressed. Complaints forms have been updated and complaints appearing in the register appear to be well documented.

2. In March 2004, the panel recommended that vehicular access be re-established to allow more discreet/confidential admission to the Mental Health Unit.

   The panel noted that vehicular access has been re-established to the Mental Health Unit.

3. In March 2004, the panel recommended that a solution be found to encourage inpatients to make personal calls to family and friends without compromising the efficient running of the Mental Health Unit.

   A dedicated line with a 'walk-around' phone for use of the inpatients is now available on the ward, and clients and carers are provided with the telephone number for that line on admission to the Unit.

4. In March 2004, the panel recommended that the Department of Health and Community Services consider the problems of people with mental health problems accessing generic disability services in its planning, funding and delivery of disability services in Central Australia.

   The panel was informed that CAMHS has initiated a regular meeting with Managers of Aged and Disability, ADSCAR and Family and Children's Services with a view to establishing better interagency relationships, identifying gaps in service delivery and developing proposals/actions for the identified gaps.

   The manager also advised that the CAMHS executive had recently been altered to include a representative from other agencies and a Consumer Advisory Group (CAG) member. The panel was satisfied that CAMHS had taken significant steps to ensure that this recommendation was actioned and noted the regular contact and strong ties that CAMHS had with related service delivery agencies in the community.

5. In March 2004, the panel recommended that the Department of Health and Community Services investigate and provide alternative treatment options for people who abuse solvents and thereby reduce the admission (and disruption to other clients) of people to the Mental Health Unit who do not have a mental illness.

   The panel was satisfied that an effective referral procedure for people who abuse solvents to ADSCAR was in place and invoked where appropriate.

6. In August 2004, the panel recommended that urgent attention be paid to ensuring that record keeping for incidents of seclusion be upgraded to ensure compliance with the s62 of the MHRS Act and that the Principal Community Visitor be advised when this had been achieved.

   The panel found that a hard copy Seclusion Register had been an adopted with an intention to upgrade this register to an electronic one. A review by the community visitor in June 2005 found that record keeping for incidents of seclusion complied with s62 of the Act.

7. In March 2005, 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

   An occupational therapist was appointed to commence work in September 2005.

8. In March 2005, the panel recommended that 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.

   In their most recent visit to the Unit in March 2006, the panel determined not to close a similar recommendation from their report of their visit in March 2004 in order to ensure that analysis of the incident database was ongoing. This recommendation was closed as it duplicated the initial recommendation.

Community Visitor Recommendations CAMHS

1. In its third quarterly report 2004 – 2005, the community visitor recommended that CAMHS review its practices with respect to handover procedures when a new case manager is allocated.

   The CVP has sighted the relevant policy document and is satisfied that handover practices are now embedded into policy and practice for CAMHS.

2. In the same report, the community visitor recommended that CAMHS review its practices with respect to working with and liaising with carers, particularly carers who play a significant role in the consumer's life.

The CVP has sighted the CAMHS Model of Service Delivery and the CAMHS Consumer Participation Plan. There is clear intention throughout these documents for the mental health service to engage in meaningful collaboration with carers at an individual service level as well as at a more systemic level. This recommendation has therefore been closed.

CAMHS Community Teams

March 2006 Visit

1. In October 2004, the panel recommended that the mental health services work in partnership with the other agencies in Alice Springs to investigate the possibility of getting 24 hour access to interpreter assistance. Examples of agencies cited by the panel included Congress, Legal Aid and Crisis Care.

   This recommendation was duplicated by another, later panel recommendation and was therefore closed.

2. In May 2005, the panel recommended that CAMHS liaise with the Central Australian Division of Primary Health Care to find out why the funding to AMHW in the Barkly Region had not yet been allocated and encourage that allocation as a matter of urgency.

   The panel was advised that an Aboriginal Mental Health Worker had been employed in the Barkly Region for sixteen months as at the time of the visit to the community teams in March 2006.

3. In May 2005, the panel recommended that CAMHS 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.

   The panel was satisfied that the Remote Mental Health team had established links with other appropriate agencies in an attempt to improve access to mental health services. Aboriginal Health Workers are also receiving training in aspects of mental health care.

4. In August 2005 the panel recommended that the Department of Health and Community Services consider allocating increased funding with a view to increasing staff in the Child and Adolescent Service.

   The panel reported an increase in staff in the Child and Adolescent service since this recommendation was made. The number of youth psychologists has expanded from one to three, with one new position based in Alice Springs and the other in the remote team.

August 2005 Visit

1. In October 2004, the panel recommended CAMHS investigate partnerships with local councils and organisations such as the Division of Primary Health Care and Congress to introduce AMHW staff to communities serviced by the remote team.

   The manager reported that CAMHS had collaborated with the Division of Primary Health Care and mental health NGOs and that regular meetings were taking place with a focus on achieving this recommendation.

2. In October 2004, the panel recommended that the Mental Health Service allocate a portion of a training position permanently to CAMHS to ensure that all staff are trained in the use of CCIS (electronic record-keeping system). This would assist consistency in recording on CCIS and over time contribute to the MHS being a "paper free" system.

   The manager reported that CCIS training is ongoing and all staff (including clinicians) have received basic training and are becoming users. Advanced training was also planned.

3. In October 2004, the panel recommended that doctors record information from outpatient appointments either consistently in the paper community notes or on CCIS, and that the practice of using hospital notes to record community information should cease.

   The panel was informed that all medical documentation was increasingly being placed onto CCIS. CAMHS was also looking at allocating each clinician a "client free" afternoon to allow them an opportunity to keep up to date with their data entry. Doctors are using Dictaphones to dictate data for recording when they do not have the time to enter it themselves. Six monthly audits of client files were being planned to ensure consistency. The panel was satisfied that CAMHS had, by the actions taken in response to all recommendations regarding information recording, become much more sensitive to the need to ensure consistency between electronic and paper record keeping.

4. In October 2004, the panel recommended that 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 were prepared for discharge from the service from the time of acceptance into the service.

The panel was satisfied that the service focuses on discharge planning for clients from the commencement of their treatment and aims to engage other services to assist with rehabilitation while the community team monitors the client's mental illness.

The panel found evidence of discharge plans on all files (post June 2005) inspected by the panel and was very impressed with what appeared to be a very good use of documented care plans.

5. In October 2004, the panel recommended that staff be issued with a mobile phone for use when conducting home visits for their clients.

   The panel reported that this had been achieved.

6. In May 2005, the panel recommended that the mental health service keep abreast of changes to CCIS and advise and train CAMHS staff in those changes well in advance of them being implemented.

   This recommendation duplicated the intention of a former recommendation regarding the CCIS system which was closed (see above).

DARWIN

TEMHS Inpatient Unit

April 2006 Visit

1. In October 2004, the panel 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.

    In previous visits, the panel had commented on the fact that the number of patients on the ward has often been greater than the number of actual beds on the ward, resulting in some patients sleeping on mattresses on the floor and some voluntary patients being required to sleep in high security areas normally reserved for involuntary patients with high supervision needs.

    The panel was prepared to accept that in addition to being a resourcing issue, high bed numbers also relates to admission and discharge policies and practice, and the level of accommodation and other services in the community. The panel was satisfied that current bed numbers are adequate given the change to management procedures in the unit. The panel stated they will continue to monitor the level of bed use in future visits to the facility.

2. In October 2004, the panel 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; and
    b. a maintenance program be implemented to repair and maintain items is JRU such as the outside toilet.

    The panel reported that this issue could not be resolved without a comprehensive review of JRU and the people it services. The panel understands the limitations in place; including financial, poor building design and ethical and legal concerns about the risk of suicide. Nevertheless, the panel reiterates that the environment needs to be changed.

    The management team informed the panel of plans for new carpets, possible soundproofing for the dining room and day area and painting of the rooms. The panel was also informed of a plan to open up the dining room onto the garden to allow some natural light, fresh air,

plants and sky to be experienced. The panel recognises progress will be slow and reported being pleased to see that change is still on agenda for TEMHS.

3. In October 2004, the panel recommended that a maintenance program be implemented to repair and maintain items in JRU such as the outside toilet.

   The Panel found that improvements had been made to maintenance and cleaning on the wards and to the system for monitoring them. They expressed concern however by reports that maintenance needs were still attended to at a slow pace.

4. In October 2004, the panel recommended that 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.

   During its visit in April 2006, the Panel was impressed with the improvements that had taken place since its last visit in relation to the practice of seclusion, as well as to its recording and monitoring. It noted the reduction in seclusion rates between July and December 2005 and the expressed goal of management to work towards eliminating seclusion altogether. The panel expressed confidence that appropriate systems were now in place to monitor seclusion rates.

5. In October 2004, the panel recommended that a full time Discharge Co-ordinator be appointed to the TEMHS Inpatient Unit.

   A full time Discharge Co-ordinator has now been appointed.

6. In October 2004, the panel recommended that the AMHW team be restructured to create another position and that this appointment should reflect the gender ratios of indigenous clients in the approved treatment facility.

   The panel has been informed that AMHW position in the TEMHS Inpatient Unit has been advertised with no suitable applicants. The panel was satisfied that TEMHS would fill this position as soon as possible.

7. In October 2004, the panel recommended that there should be evidence on consumers’ files that they had been provided with information about their rights.

   During their visit in April 2006, the panel noted that a check list is now being used to ensure that consumers are routinely provided with information about their rights. The panel also reported that the

Occupational Therapist raises issues of legal rights with patients as part of their morning ward meeting.

8. In October 2004 the panel recommended that Authorised Psychiatric Practitioners (APPs) 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 could not be given and the APP nevertheless concluded that it was not in the best interest of the consumer to notify the carer.

   The panel reported being unable to assess this recommendation since it was first made due to the lack of information on files with respect to carers and their notification. The panel is aware that once the new Act is in force, it will be easier to assess the level of appropriate notification of carers and, if no notification is made, notification to the Tribunal. The panel determined to close this recommendation, with the issue to be revisited at a later date when proper examination of the documentation can be undertaken.

9. In October 2004, the panel 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.

   The panel was pleased to note considerable improvement in case note documentation. Checklists were in place and well used.

10. In May 2005, the panel recommended that orientation and induction for all staff should incorporate information on the role of the Occupational Therapist and the role of therapy in improved outcomes for consumers in acute inpatient facilities. The panel also recommended that provision be made for backfilling the position of the Occupational Therapist when on leave.

In their report of April 2006, the panel noted the formal, structured program developed by the Occupational Therapist and general acknowledgement of the importance of this program.

The panel was informed by TEMHS Management that it is currently looking at issues related to skill mix on the ward, and identifying solutions to the problem of lack of rehabilitation services on the ward when the Occupational Therapist is on leave. The panel was satisfied that this recommendation could now be closed. The panel plans to review progress in achieving the goal of ensuring a year round rehabilitation program during its next visit.

11. In September 2005, the panel recommended that:
    a. staff and consumers and/or their representatives (in accordance with Standard 3 of the National Mental Health Standards) are fully consulted prior to implementation of any future changes to the physical layout of the TEMHS Inpatient Unit; and
    b. In the interim signs assist visitors to access the ward easily.

The panel was pleased to hear that a Task Force had been convened to oversee changes to the TEMHS Inpatient Unit. The membership of the Task Force comprised staff of the Unit, consumer and carer representatives and the community visitor (as observer). The panel was also pleased to note that the outside sign directing visitors to the former entrance to the Inpatient Unit had been removed, and that appropriate signage was in place.

12. In September 2005, the panel recommended that:
    a. All superfluous signs be removed from Cowdy ward, and any signs that remain provide assistance to consumers and visitors rather than direction;
    b. Use of the vehicle be returned to the AMHW team to enhance the service they provide to indigenous clients;
    c. Identified problems with windows in JRU be addressed urgently;
    d. The inadequacy of bathroom facilities to consumers be addressed urgently in consultation with staff;
    e. The waste bin be moved from the entrance (to Cowdy Ward and Forensic services); and
    f. The outdoor walkway area opposite the original entrance be opened up and trolleys and rubbish around the walkway removed.

During its visit in April 2006, the panel noted that:

a. all superfluous signs had been removed and only necessary signs remained in place;
b. The vehicle had been returned to the AMHW team for their use;
c. The “blacking” on some windows in JRU had been removed and they are now opaque to ensure privacy;

d. TEMHS Management has undertaken to address existing inadequacies with bathrooms. The panel determined to review this during its next visit to the facility;
e. While the waste bin at the former entrance to the Inpatient Unit remains, it was not problematic for the inpatient unit because the entrance has been moved; and
f. Trolleys and rubbish in walkway opposite original entrance had been removed.

13. During their visit in September 2005, the panel recommended the following repairs and maintenance be undertaken:
    a. Repairs / maintenance be urgently undertaken to: the lino in room 57 – 077, the lock on the bathroom in 57 – 076, the lino in room 57 – 176, accommodate hot water to room 57 – 150; the outside toilet at JRU; and that
    b. TEMHS consult with staff to solve what appears to be an ongoing issue of delays with repairs and maintenance of the inpatient facility.

Prior to its visit, the panel was informed that:

a. The lino in rooms 57 – 077 and 57 – 176 had been repaired;
b. The lock on the bathroom 57 – 076 had been repaired; and
c. The outside toilet in JRU had been repaired.

The panel was concerned that there still appears to be delays in repairs and maintenance to the facility. At the same time, discussions with management have satisfied the panel that action is being taken to improve the turnaround time between maintenance requests and action.

Community Visitor Recommendations

Third Quarterly Report 2005 - 2006

1. In the second quarterly report of 2004 – 2005, the community visitor 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 is kept warm in the oven prior to serving; and
    c. staff be 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.

The CVP was informed that the way food is provided in the TEMHS Inpatient Ward was being reviewed for a number of reasons, including

the current accreditation process being undertaken by the RDH food service. These recommendations were therefore closed.

2. In the second quarterly report of 2004 – 2005, the community visitor recommended that the policy of locking consumers alone in the lunch area in JRU cease as soon as safe cutlery was delivered to the ward.

   The CVP was informed that consumers were no longer locked alone in the lunch area in JRU.

3. In the third quarter of 2004 – 2005, the community visitor recommended that TEMHS 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.

   While the CVP received no formal feedback from the mental health service regarding this recommendation, the community visitor noted the differential application of voluntary/involuntary admission, with three complaints to the program which, on follow up, have demonstrated that the mental health service has appropriately used judgement according to individual circumstances.

4. In the fourth quarter of 2004 – 2005, the community visitor recommended that the mental health service consider the institution of craft as one of its activities on the ward.

   The CVP is aware that activities on the ward have been upgraded, with the inpatient morning program now operating at good capacity and receiving support from nursing staff on the ward. Activities are now available in JRU. The CVP will continue to advocate for a broad range of activities to be provided in the afternoons as well as in the mornings.

Second Quarterly Report 2005 - 2006

1. In the first quarterly report of 2004 – 2005, the community visitor recommended that a policy regarding consumer access to items of religious and cultural significance in Cowdy Ward be developed and staff awareness raised.

   The community visitor had discussed this issue with TEMHS with no clear action taken. The recommendation was closed because no new complaints had been received by the CVP.

2. In the first quarterly report of 2004 – 2005, the community visitor recommended that serious consideration be given to the facilities in JRU as follows:
    a. The provision of a closed outside area with some greenery
    b. Painting/decoration of the walls to make the area less dehumanising

   The community visitor further recommended that mental health services, as part of future planning, plan for 2 levels of secure environment to be used flexibly according to existing inpatient conditions.

   The CVP was informed of plans to provide an open area for consumers on the other side of the dining room in JRU once this area is secure and, subject to the availability of funds, to improve the internal appearance of JRU.

   The CVP is aware that the ability to provide 2 levels of secure environment is dependent on the level of funding available for the inpatient facility. This recommendation was closed, however it this is an issue that impacts on the experience of people receiving treatment from the inpatient facility and the CVP will therefore continue to advocate for funding to enable the provision of 2 levels of secure environment within the Unit.

3. In the fourth quarterly report of 2004 – 2005, the community visitor recommended that the outside area of JRU be cleaned regularly to provide sanitary and pleasant conditions for inpatients of JRU. It was further recommended that this matter be referred to the Community Visitors Panel for review during their next inspection.

   This issue was referred to the Community Visitors Panel for follow up and comment.

4. In the fourth quarterly report of 2004 – 2005, the community visitor recommended that recreational programs be made available to clients of JRU.

   This issue has also been raised by the Community Visitors Panel.

Tamarind Centre

Because it is envisaged that a change in legislation will mean that the community visitors panels will no longer visit the approved treatment agencies, the Darwin panel conducted its last visit to the Tamarind Centre in June 2006. Most recommendations were closed because the panel will be unable to follow up progress in achieving their recommendations.

June 2006 Visit

1. In December 2004, the panel recommended that all staff, including staff currently employed by the Tamarind Centre, have the opportunity to attend induction training.

   Prior to its visit, the panel requested evidence that staff at the Tamarind Centre are attending induction training. At the time of writing this report, no documents had been provided to the panel.

2. In December 2004, the panel 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.

   The panel noted considerable improvement in the use of formal assessment tools and reported that it was satisfied that the service would continue to increase its use of these tools. The panel is satisfied that TEMHS Management is committed to their use, and has processes in place to ensure compliance.

3. In December 2004, the panel 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).

   TEMHS Management acknowledged the need to improve services to indigenous clients and to clarify their role in relation to other services. The recommendation was closed and replaced with a new recommendation (see below)

   It is recommended that TEMHS explores its role in Aboriginal mental health in conjunction with other service providers (including indigenous service providers) to provide better access to services for indigenous consumers.

4. In December 2004, the panel 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.

The panel was informed that changes to legislation would soon allow longer prescriptions to be written for discharge. They were also informed that case managers attend inpatient meetings and that management is committed to improving the interface between inpatient and outpatient services.

The CVP was also informed that all staff are oriented to the inpatient and outpatient sectors, with all orientation under review by the Education and Training Team.

The panel were satisfied that all staff are now trained in the use of Electronic Record Keeping System (CCIS).

5. In December 2004, the panel recommended that the 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.

   During its visit in June 2006, the panel noted that documentation is not always accurate. They also noted only 50% compliance with the development of management plans. Nevertheless, the panel was satisfied that there will be continued improvement in practice in this area.

6. In December 2004, 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 panel was informed that the rehabilitation program provided in the inpatient unit is available to consumers after discharge from the unit. Rehabilitation otherwise takes place in community based services. The panel was satisfied that the Tamarind Centre does not have the resources to provide for the recreational and rehabilitation needs of consumers.

7. In December 2004, the panel recommended that:
    a. Discharge planning commence on entry into the service and be reviewed regularly throughout the case management process; and
    b. A discharge format be developed and documented to include at a minimum: a relapse prevention plan, interventions and their outcome, medication and referrals to external organisations including GPs.

    The panel was informed that the role of case management is under review and should lead to more effective discharge processes. The panel was also informed that TEMHS is keen to build relationships with other providers of mental health services, including general practice.

8. In May 2005, the panel recommended that:
    a. The current child and family waiting area be closed in and air conditioned;
    b. Therapeutic rooms, separate from offices, be designated for child and family use; and
    c. Minor maintenance, including the removal of the desk from the room with the 2-way mirror be carried out promptly.

    In its most recent report, the panel recognised the financial and other constraints faced by TEMHS, and hence that this recommendation could only be met with the provision of appropriate resources. The panel was also aware that the service had been working toward improving the speed at which maintenance was carried out in both the inpatient facility and the community agency.

9. In May 2005, the panel recommended that
    a. A separate Forensic Mental Health Unit be 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.

    The panel recognised that while policy is not explicit about a forensic unit being built beyond the prison boundary, NT government policy, with the adoption of all 71 recommendations of the Caya Management Consulting Report entitled *A Path to Good Corrections,* will ensure the availability of appropriate facilities for prisoners with mental health treatment needs.

    The panel was also informed that all Corrections staff will be receiving training in the Mental Health First Aid, with the first module to be delivered by staff of the Forensic Team.

10. In May 2005, the panel 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 be amended to ensure that a member of this team attends the meeting held each Friday; and
    c. TEMHS immediately appoint a staff member to administer and document the administration of medication.

With the renewal of the contract for the medical service provider, this recommendation is closed.

11. In May 2005, the panel recommended that the forensic team place priority on ensuring that individual management plans are developed for each consumer.

The panel was pleased to note that 70 – 80% of consumers of the forensic team now have a documented management plan, and documented consumer involvement in the plan. The panel was pleased to be able to close this recommendation.

12. In May 2005, the panel recommended that:
    a. 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
    b. The mental health service cost the purchase of a server for the service to avoid wastage of valuable staff time.

The Manager of the CVP was informed by the Mental Health Program that work is currently being done to ensure that the two systems are able to interface effectively and that this will be possible in the foreseeable future. The panel was therefore satisfied that this recommendation could be closed.

The recommendation regarding the purchase of the server was included in the panel report in response to difficulties faced by staff in using the existing computer system. Given that this was the panel's last regular visit to the approved treatment facility, the recommendation was closed.

APPENDIX 3

RECOMMENDATIONS OUTSTANDING JUNE 30 2006

ALICE SPRINGS

Mental Health Unit

March 2006 Visit

1. It is recommended that CAMHS investigate mechanisms to ensure that consumers under 18 years of age have access to appropriate facilities and care.

August 2005 Visit

2. It is recommended that CAMHS work collaboratively with ASH to initiate and participate in a range of activities designed to promote acceptance of people with mental disorders and/or mental health problems by reducing stigma in the hospital environment.

3. It is recommended that CAMHS collaborate with ASH to provide understandable information to all hospital staff about mental disorders and mental health problems.

4. It is recommended that CAMHS and ASH develop documented policies and procedures to achieve the above recommendations.

March 2004 Visit

5. It is recommended that 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 inpatients to gain information about rights, mental illness and effective introductions to relevant services and supports.

6. It is recommended that 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.

7. It is recommended that standard formats for reports and referrals be developed and/or used to improve the service to the consumer. This should be introduced in a way that encourages more consistent communication between service providers, reduces variations in different files for the same client and encourages collaboration across specialisations/services. As a minimum this should include a standard discharge plan form.

8. It is recommended that 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.

9. It is recommended that a report be provided to the Principal Community Visitor regarding the appropriateness of the use of 12 hour detentions under Section 34A of the Mental Health and Related Services Act for a six month period. The report should include details of the time lapse between detention and the completion of the assessment and estimates of travel time or distance of the client from the person doing the assessment.

10. It is recommended that the Central Australian Mental Health Service use Standard 11.4.E.5 to record, report and assess progress in regard to maintaining acceptable standards for continuity of care.

11. It is recommended that a protocol for dealing with 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 and that staff be trained in this protocol.

CAMHS Community Teams

March 2006 Visit

12. It is recommended that CAMHS re-establish lines of communication with the Central Australian Division of Primary Health Care to facilitate cooperation between GPs and the Mental Health Sector.

13. It is recommended that all inmates in the maximum security and remand section of the prison be subject to regular review as to their mental health status.

14. It is recommended that CAMHS establish protocols with the Correctional Services and prison management to facilitate timely assessment of inmates and ease of contact between Mental Health Workers and their clients.

15. It is recommended that CAMHS explore ways in which to improve the recruitment and retention of staff working within the prison environment.

16. It is recommended that the Department of Health and Community Services meet with the Department of Justice with a view to improving conditions in the maximum security and remand section of the prison to ensure that inmates are in an environment conducive to the detecting, treatment and prevention of Mental Health issues.

17. It is recommended that the Department of Health and Community services meet with the Department of Justice and establish a set of protocols to ensure that all prison inmates who are consumers of CAMHS are housed and treated within the prison system in a manner consistent with their mental health treatment and provided with a rehabilitation program.

August 2005 Visit

18. It is recommended that the manager of CAMHS liaise with the manager of the Aboriginal Interpreter Service to explore the possibility of cross training of Aboriginal health workers and Aboriginal interpreters.

May 2005 Visit

19. It is recommended that the Mental Heath Service work with the Interpreter Services in Alice Springs, the NT 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.

20. It is recommended that CAMHS 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.

21. It is recommended that CAMHS consider ways to raise community awareness of the availability and scope of the after hours service.

22. It is recommended that CAMHS liaise with carers and explore ways to make the after hours call out service more effective in accommodating needs of carers and consumers.

23. It is recommended that CAMHS designate and fit-out more interview room facilities that allow greater quiet and privacy than the existing one.

October 2004 Visit

24. It is recommended that CAMHS investigate ways of ensuring consistency of case note recording in the CCIS and paper system between clinicians in the community team.

25. It is recommended that 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 providing GP care for the youth in the community.

Community Visitor Recommendations

Fourth Quarter 2005 - 2006

26. It is recommended that the Manager of CAMHS consider the availability of funding to enhance dining facilities to increase the number of dining chair and table spaces.

DARWIN

TEMHS Inpatient Unit

May 2005 Visit

1. It is recommended that:
   a. 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; and
   b. 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.

2. It is recommended that:
   a. New videos are purchased to assist with the education of young people and their carers;
   b. Pamphlets with information about services for young people are provided;
   c. Age appropriate information about mental health, mental illness and medication is provided for young people; and
   d. Equipment is purchased to enable restricted access to the internet to enable young people to access their own information.

October 2004 Visit

3. It is 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.

4. 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; and
   b. identifying and referring to preferred ongoing General Practitioners.

5. It is recommended that:
   a. 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

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

6. 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.

7. 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.

8. It is recommended that consumers in the facility have the same choices and quality for evening meals as other patients in the hospital.

9. It is recommended that TEMHS explore and provide some additional low stimulus recreational activities in JRU.

10. It is recommended that discharge plans show evidence of consumer involvement through inclusion of the consumer's signature on the plan.

Community Visitor Recommendations

Third Quarterly Report 2005 – 2006

11. It is recommended that procedures to ensure that TEMHS' legal obligations to notify the MHRT pursuant to S28 of the Mental Health and Related Services Act are put in place forthwith and that the CVP is formally notified of these procedures in writing.

12. It is recommended that procedures to ensure TEMHS' legal obligations to notify the CVP pursuant to S41 and S43 of the Mental Health and Related Services Act are put in place forthwith and that the CVP is formally notified of these procedures in writing.

Second Quarterly Report 2005 - 2006

13. It is recommended that any plan implemented to encourage or enforce compliance with medication is to be seen as "treatment" for the purposes of the Mental Health and Related Services Act (NT) 1998, and that it must be subject to the same consent as all other psychiatric treatment, including authorisation by the Mental Health Review Tribunal under S 123 (6) of the Act.

First Quarterly Report 2005 – 2006

14. It is recommended that the Director of Nursing notify the CVP whenever a patient of the TEMHS Inpatient Unit is unable to access a medical bed at RDH and when in the opinion of medical and nursing staff medical treatment is the primary requirement.

2004 – 2005 Fourth Quarterly Report

15. It is recommended that a list is kept of any property removed from consumers when admitted to Cowdy Ward, and that this list is checked with consumers as soon as possible after admission. It is further recommended that the consumer sign the list when property is returned.

Tamarind Centre

June 2006 Visit

16. It is recommended that TEMHS explores its role in Aboriginal mental health in conjunction with other service providers (including indigenous service providers) to provide better access to services for indigenous consumers.

17. It is recommended that a thorough mental health assessment is completed on all incoming prisoners and that an appropriate tool is accessed and used when assessing Indigenous prisoners, as well as suitable interpreters.

Community Visitor Recommendations – Tamarind Centre

First Quarterly Report 2005 – 2006

18. It is recommended that when conducting the review of discharge planning, consideration is given to ensuring that it takes place as a collaborative process between the consumer and the treating team, and that current life stressors are considered when a decision regarding discharge is taken by the treating team.

19. It is recommended that arrangements are made to ensure that only trained mental health staff triage consumer contact with TEMHS.

APPENDIX 4: 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.