COMMUNITY VISITOR PROGRAM

ANNUAL REPORT
2006 - 2007

COMMUNITY VISITOR PROGRAM
NORTHERN TERRITORY

The Hon Ms Marion Scrymgour 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

TERRY LISSON

ACTING PRINCIPAL COMMUNITY VISITOR

28 September 2007

AGENCY ACCESS

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

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PART 1

INTRODUCTION

The Annual Report for the Community Visitor Program (CVP) informs the Minister of Family and Community Services of the issues identified by community visitors and community visitors panels as affecting consumers of mental health services and their carers. It also reports 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 presented in three parts; Part 1 comprises the introduction to the report and a brief overview of the functions and operations of the CVP. In Part 2, the issues noted by community visitors panels and community visitors in the Territory in the 2006 – 2007 financial year are described, along with issues that are still outstanding from previous annual reports. Where specific complaints or issues relating to a particular consumer are used to illustrate an issue, details such as gender or diagnosis may be changed to protect confidentiality. Part 3 of the Annual Report comprises a brief description of the CVP and a report and analysis of its activities for the reporting year.

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.

The CVP is still in its infancy. The way it interacts with mental health services and the processes that support these interactions are changing. In the 2005 – 2006 Annual Report, the CVP reported that community visitors panels were meeting with mental health management prior to reporting in an effort to resolve issues before recommendation. This process is still in place and, as a result, there are fewer recommendations arising from this reporting period and many recommendations outstanding from previous reporting periods have been closed. Issues commented on in this report include new issues raised by community visitors and community visitors panels as well as those issues raised in previous Annual Reports that have not yet been resolved.

As stated in the previous annual report, a focus on issues may give an unbalanced view of the mental health service. The commitment of Management and mental health staff to providing a quality service for consumers with mental health problems should be acknowledged.

In particular, the CVP congratulates the Top End Mental Health Service (TEMHS) on alterations to the environs of the TEMHS Inpatient Unit (comprising Cowdy Ward and the Joan Ridley Unit (JRU)). The physical environment has been improved significantly as a result of extensive refurbishment of the Unit. Plans to offer four levels of care within the Unit, if implemented, should increase the flexibility of both Cowdy Ward and JRU to provide services for consumers with varying levels of acuity of illness or with particular issues that may be more effectively treated in a separate setting. Changes within the physical environs, along with changes to management within the Unit have also contributed to a changing culture. Staff appear energised, and this is reflected in the atmosphere within the Unit.

Issues Resolved/in Process of Resolution

The CVP is pleased to be able to report that a number of issues identified by community visitors and panel members during their visits in the period covered by this report and in previous Annual Reports have been resolved. These issues include:

- Meals in the TEMHS Inpatient Unit;
- Discharge planning from the TEMHS Inpatient Unit;
- Management of Medical Problems;
- Fishbowl in Cowdy Ward;
- Employment of a social worker in the TEMHS Inpatient Unit; and
- Updating the Emergency Trolley in the TEMHS Inpatient Unit.

Issues

Throughout 2006 – 2007, community visitors panels and community visitors have identified a number of issues, not all of which can be covered in this document. Issues that appear repeatedly or have significant impact, and those that are common throughout the Territory are included in this report. These issues include:

- Lack of adherence to the legislative requirement for four-hourly medical review of people being secluded in both Alice Springs and Darwin;
- Access to complaints forms in the inpatient units in Alice Springs and Darwin available only through requests to staff;
- Need for routine use of interpreters for assessment and Mental Health Review Tribunal Hearings; and
- Access to an outside area in JRU.

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

- Accommodation and support, particularly for consumers with dual disability in Alice Springs;
- Police transport to hospital in the cage of police vehicles;
- Liaison with General Practitioners (GPs); and
- TEMHS continued failure to notify the Principal Community Visitor of detentions as required pursuant to *the NT Mental Health and Related Services Act 1998* (the Act).

Acknowledgments

The CVP is independent of mental health services. This is achieved by having its budget administered by the Anti-Discrimination Commission (ADC), with whom the CVP is co-located.

Tony Fitzgerald, the Anti-Discrimination Commissioner, is also the Principal Community Visitor, and the support he provides to the CVP 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. No funding is provided to the CVP for costs of the Principal Community Visitor and community visitors who are also employed in the Anti-Discrimination Commission (ADC). All staff carry out these roles in addition to their full time roles within the ADC, and their contribution to the CVP is appreciated.

The CVP would also like to thank the Mental Health Program for checking this Annual Report to ensure that it contains no errors of fact.

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, mental health professionals and staff of the Mental Health Program.

Finally, the CVP is grateful for the support provided by the Mental Health Program in securing additional funding. The CVP is now able to plan for its future with certainty.

OVERVIEW OF THE COMMUNITY VISITOR PROGRAM

The 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 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 co-located with the Anti-Discrimination Commission in order 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 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 member 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.

The CVP is not funded for panel visits to approved treatment agencies. The amendments to the Act allow for a community visitors panel to visit an approved treatment agency in certain circumstances but does not require a visit every six months. Neither the Darwin nor the Alice Springs community visitors panel has conducted a visit to an approved treatment agency in the period covered by this Report.

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.

PART 2

ISSUES RESOLVED 2006 – 2007

Management of Medical Problems

In its report of October 2006, the Alice Springs community visitors panel reported one instance of a consumer having delayed access to medical treatment from the inpatient facility. The panel was, however, reassured that this was a "one-off" event. There have been no reports since from either the panel or the community visitor.

Top End Mental Health Services (TEMHS) has instituted procedures to ensure that consumers requiring medical treatment have timely access to the necessary care. The service agreed to notify the Community Visitor Program (CVP) each time an incident occurred whereby access to treatment was delayed. No such notifications have been made, and after discussions with TEMHS, the CVP is satisfied that no incidents have occurred in the period of this report.

Fishbowl in Cowdy Ward

The existing Nurse's Station ("fishbowl") is located centrally within Cowdy ward. Three sides of the fishbowl, open to the ward, have glass from desk to ceiling to enable nurses to observe the ward. The area is used for documenting case-notes and brief handover meetings. Consumers are often to be seen waiting at the "fishbowl" to speak to a nurse.

The CVP is pleased to be able to report that alterations to the Cowdy Ward environment will mean that the glass can be removed from the Nurses' Station. These alterations include changing the entrance to the ward back to the original entrance, building in an enclosed office for nursing staff to meet and document case notes in privacy, and a proposed change in the model of nursing in the Unit.

Employment of a Social Worker in the TEMHS Inpatient Unit

During its first visit to the TEMHS Inpatient Unit in the 2004 – 2005 financial year, the Darwin community visitors panel recommended that a social worker be employed. The CVP is pleased to report that a social worker has commenced work in the inpatient unit, with the social work position to be evaluated after twelve months.

Emergency Trolley in the TEMHS Inpatient Unit

Emergency trolleys contain resuscitation equipment for use in emergency situations. In its visit to the TEMHS Inpatient Unit of April, 2006, the panel was informed that the Unit's Emergency Trolley was in urgent need of updating.

The panel discussed this issue with TEMHS Management, and documented it in its report without recommendation. The panel followed up during its visits of November 2006 and May 2007 and was pleased to report that the Emergency Trolley had been updated and that processes were in place to ensure that it is regularly monitored.

Discharge Planning in the TEMHS Inpatient Unit

During its visit to the TEMHS Inpatient Unit in May 2007, the Darwin community visitors panel investigated the standard of discharge planning by interviewing Aboriginal Mental Health Worker (AMHW) staff, medical staff, the Community Discharge/Liaison Officer and by reviewing case notes.

The panel was pleased to report that discharge planning for consumers from remote areas and those with complex issues is of high quality. The Community Liaison/Discharge Planning Officer has developed links with government and non government agencies and meets regularly with them to enhance opportunities for discharging consumers with complex issues.

Meals in the TEMHS Inpatient Unit

After a visit to the TEMHS Inpatient Unit in October 2004, the Darwin community visitors panel recommended that consumers in the Unit have the same access to choice and quality of meals as other patients in RDH.

The issue of meals within the Unit has been difficult to resolve. The community visitor inspected a lunch time meal of fish and chips during the year, and commented that the fish comprised fish nuggets which were described as greasy and tasteless. During a discussion with staff, the community visitor was informed that staff could choose whether nuggets, crumbed or grilled fish were served in the Unit. Staff decided that they would trial each option. On her next inspection, the community visitor noted that the meal of crumbed fish was delicious.

Difficulties in serving hot meals have been partially resolved through the employment of Patient Care Assistants (PCAs) to ensure that meals are served concurrently in Cowdy Ward and JRU. Consumers now have the choice of a hot or salad meal, and the community visitor has observed that this choice is both available and being taken up by consumers.

ISSUES IDENTIFIED 2006 – 2007

Legal Issues

Seclusion – Requirement for Medical Review after 4 hours

Section 62(8) (b) of the Act states that a person kept in seclusion must be reviewed by a medical practitioner at intervals of not longer than four hours. An Approved Psychiatric Practitioner (APP) may vary this interval, however pursuant to Section 9.6.2 of the Approved Procedures the interval can only be varied downwards. In other words, medical review may take place more frequently than every four hours, but never less frequently.

The CVP has identified incidents of failure to conduct a medical review within the timeframes specified in the Act during a visit to inspect the seclusion register in the Alice Springs Mental Health Unit (MHU) in April 2007 and during both inspections of the seclusion register in the TEMHS Inpatient Unit in December 2006 and June 2007.

Alice Springs

The community visitor, when reviewing the seclusion register in the Alice Springs Mental Health Unit in September 2006, commented that earlier concerns about the requirement for medical review had been addressed. However during an inspection in April 2007, the community visitor noted one instance where medical review of the consumer was not carried out in accordance with the Act. When seclusion commenced, the APP authorising seclusion case-noted a plan to conduct medical and psychiatric reviews concurrently every six hours. This seclusion episode lasted 18 hours, with two medical reviews undertaken after six hours, then at the 12 hours and 50 minutes point rather than at the four, eight, 12 and 16 hour points as required by the Act.

A further medical review was undertaken another five hours and 10 minutes later when seclusion ceased. The purpose of the plan to increase the intervals of medical review and to conduct them concurrently with the six hourly psychiatric review was “to avoid disruption” for the consumer, who was extremely unwell. Nevertheless, it is of concern that APPs appear to be unaware of the provisions of the Act, in place to protect consumers.

The Manager of CAMHS informed the community visitor that processes are now in place to ensure that the time frames for medical review pursuant to the Act are met. This will be reviewed during the next inspection of the seclusion register in October 2007.

Darwin

During the inspection of the Seclusion Register of the TEMHS Inpatient Unit in December 2006, the community visitor noted one incident of a consumer secluded for eight hours and 15 minutes with a break of 15 minutes after four hours and 15 minutes. In another incident, the same consumer was secluded for a period of 11 hours with two breaks, one of 15 minutes and one of one minute. No medical review took place. In her report to TEMHS, the community visitor questioned whether a break of 15 minutes, much less one minute, is sufficient to "restart the clock" with respect to the requirement for medical review, and noted that in cases such as these, practice in the ward appeared to conform with the letter of the Act rather than its intention.

During the inspection in June 2007, the community visitor noted two incidents where the requirement for a medical review after four hours was breached. In one incident, seclusion ceased after four hours and 30 minutes. In the second, more serious incident, a consumer was placed in seclusion for 34 hours and 15 minutes, including one break of 15 minutes. The psychiatric registrar conducted the first review after three hours and 30 minutes. At this time, he documented a plan to review the consumer in a further six hours. Medical reviews took place at the following points in the seclusion episode; three hours and 30 minutes, nine hours and 30 minutes, 15 hours and 15 minutes (including a 15 minute seclusion break), 21 hours and 15 minutes, 27 hours and 15 minutes and 34 hours and 15 minutes. There were therefore five breaches of the Act during the one seclusion episode.

Problems in the TEMHS Inpatient Unit with respect to four hourly medical reviews of seclusion episodes are of particular concern given that on 4 May, 2006, the Principal Community Visitor notified the CEO of the Department of Health and Community Services of an incident of failure to conduct a medical review within the timeframes required by the Act.

Detentions Reviewed by the Mental Health Review Tribunal

In 2006 – 2007, approximately 53% of people detained to the Mental Health Unit in Alice Springs were either discharged or had their status changed to voluntary and did not appear before the Mental Health Review Tribunal (MHRT). In the TEMHS Inpatient Unit in Darwin, only approximately 28% of people detained to the facility were either discharged or had their status changed to voluntary prior to review by the MHRT.

The CVP monitors regional differences to determine whether differences in practice impact on the rights of people receiving treatment under the Act. At this stage, reasons for the difference outlined above cannot be determined, but may in fact relate to a higher proportion of people detained in Alice Springs on the grounds of mental disturbance rather than mental illness

(approximately 27% in Alice Springs compared to approximately 3% in Darwin).

This would have a dual impact as firstly, automatic review of detentions for mental disturbance occurs within 10 days compared to 7 days for people detained on the grounds of mental illness. Additionally, it can be postulated that people detained for reasons of mental disturbance are likely to recover more quickly once in a contained environment.

Differences between Alice Springs and Darwin are flagged in this Annual Report because it is significant, and reasons for it ought to be further examined and addressed if necessary.

Interpreter Services

There appears to be a lack of clarity about who is responsible for arranging Interpreter assistance for Mental Health Review Tribunal (MHRT) Hearings for consumers in the TEMHS Inpatient Unit.

The Darwin community visitors panel was informed by various stakeholders during their visit to the TEMHS Inpatient Unit in May 2007 that it is the MHRT responsibility, the doctor's responsibility or the responsibility of nursing staff. The panel was informed that in fact, the North Australian Aboriginal Justice Agency (NAAJA) most often takes responsibility for ensuring interpreters are organised for its clients for Tribunal hearings.

In their report, the panel stated that this issue needs to be clarified, recommending that TEMHS identify the need for Interpreter assistance when the consumer is first admitted to the Unit so that the consumer can be assessed appropriately. Further, the panel stated that if the consumer's status is involuntary pursuant to S39 (b) or S42 (2) of the Act, Interpreter assistance should be organised for the MHRT at the time this determination is made.

Access to Complaints Forms

Consumers in the TEMHS Inpatient Unit in Darwin and the Mental Health Unit in Alice Springs must first ask a staff member for a complaint form if they wish to make a complaint.

In the past twelve months, both the Darwin and Alice Springs community visitors panels have commented that complaints forms need to be freely available in the ward. This recognises that the act of having to ask staff for a complaint form may interfere with access to the complaints system for consumers who are less assertive.

The CVP acknowledges that best practice in complaints resolution is to speak first to the person about whom the complaint is to be made. However, it should be recognised that consumers in a psychiatric inpatient unit may feel powerless for a number of reasons including their legal status and symptoms of illness, and may in fact not feel able to ask a staff member for a complaint form.

Liaison with Family

A mother contacted the community visitor with complaints concerning liaison with the TEMHS Inpatient Unit about her daughter, while she was a patient in the Unit. The mother felt that she should be able to provide information to the treating staff, and stated that she felt actively excluded from her daughter's care. Her initial complaints were resolved, however problems persisted after her daughter had been discharged from hospital.

While investigating the mother's complaints, the community visitor was informed by nursing staff that the consumer did not want her mother present on the ward and that she had stated that she did not give permission for staff to speak to the mother. The community visitor noted that even if staff could not provide information to the mother, they could listen to any concerns she might have raised about her daughter's health, given that these concerns would have been based on her knowledge of her child. These complaints were resolved early at a meeting arranged with the Director of Nursing and the Director of Psychiatry (and attended at short notice by both in an effort to resolve the complaint).

The consumer returned interstate, and contacted the community visitor requesting access to her file. The consumer was unhappy with statements in the Discharge Summary which she felt to be untrue. The community visitor contacted TEMHS to arrange for a copy of the file to be sent to the consumer.

The process proved difficult. Despite the request from the consumer being relayed through the community visitor, TEMHS required a letter from the consumer and proof of signature prior to releasing the file. In the end, the consumer and her mother travelled to the NT (for other reasons) and arrangements were made through the office of the Director of Psychiatry for her to access her file.

When they attended the office, the consumer and her mother were informed that only the consumer and the community visitor could meet with the doctor to view the file. When the community visitor asked why this was the case, the community visitor was informed (in front of the consumer and her mother) that "the consumer is an adult and doesn't need her mother present".

This statement reflected the belief (despite the community visitor having informed the service that all requests had come from the consumer), that the reason for the consumer seeking her information was that her mother wished to see it. It reflected the belief that the mother's involvement was somehow problematic. It was particularly frustrating because the community visitor had clearly been informed by the consumer that she wanted her mother involved.

This complaint was considered resolved because, in the end, the consumer was given access to her file and the Discharge Summary amended to her satisfaction. The mother's experience of the service was included in a community visitor's report to TEMHS for feedback.

JRU Environment

Indigenous people have informed community visitors and panel members that they need to see, hear and smell plants and see the sky while receiving treatment in an inpatient unit. There is no opportunity for consumers in the JRU to go outside.

Consumers admitted to JRU are likely to spend the entire time inside, and this can be problematic when it is a long admission. The panel has been informed that plans to open the dining room in JRU on to a back garden area have been deferred subject to funding.

The panel sees access to fresh air and a garden as imperative for consumers, particularly consumers who are so unwell they are confined to JRU for long periods of time.

Discharge from TEMHS Community Team

A consumer who had an unresolved complaint with TEMHS tried to make an appointment to see her doctor and was informed this was not possible as she had been discharged from the service. The consumer stated that she had not been informed of her discharge, and it certainly had not been discussed with her.

The issue was discussed with the Team Leader of the Adult Team and with the Manager of TEMHS, and arrangements made for the consumer to meet with the Team Leader. The CVP was later informed that the consumer also complained to her local member and that an apology was received from the mental health service.

It is of concern that the consumer, who has a significant medical condition, was not informed of her discharge and it appears that her GP was not informed either.

In a visit to the Tamarind Centre in December 2004, the Darwin community visitors panel recommended that a discharge format be developed and documented to include at a minimum: the relapse prevention plan, interventions and their outcome, medication and referrals to external organisations including GPs. This recommendation was closed for administrative reasons (i.e. the panel no longer conducting visits to the Tamarind Centre) together with the assumption that a review of case management services would result in improved discharge practices. It is clear from the consumer's experience that in this case at least, standard, basic discharge planning processes, such as collaborating with the consumer, developing a relapse prevention plan and ensuring that other service providers are aware of the consumer's discharge from the service, were not followed.

UNRESOLVED ISSUES AS AT 30 JUNE 2007

REPORTING PERIOD 2005 - 2006

Community Accommodation for People with Dual Disability

The need for appropriate community accommodation in Darwin and Alice Springs was raised in the 2005 – 2006 Annual Report. It has become apparent that this needs to be addressed urgently in Alice Springs.

The Mental Health Unit in Alice Springs is an eight bed facility, with six beds in the open section of the ward and two beds in the High Dependency Unit (or closed section). Over the past 12 months at least 20% of bed space has been used to support people with dual disability who had recovered from an acute phase of mental illness, but who could not access alternative accommodation due to their need for 24 hour support.

There are two key issues. Firstly, there appears to be no alternative secure facilities for people with acute behavioural disturbance related to intellectual disability and/or acquired brain injury. A person experiencing psychosis with behavioural disturbance may be admitted to the Mental Health Unit, even where the primary issue appears to be behavioural disturbance. Secondly, there is insufficient supported community accommodation. The person, once admitted to the Mental Health Unit, may remain as an inpatient until accommodation becomes available. Historically, for some clients this has taken longer than twelve months.

The result is that the small eight bed unit is placed under additional pressure. Community visitors have reported that bed use is often higher than the allocated eight beds (on a visit 8/11/06, the community visitor reported 12 admissions to the Unit). The outcome can be increased stress for consumers who are in hospital and needing a quiet therapeutic environment to aid their recovery. It is also more stressful for staff working in a unit that is being used beyond its capacity.

The Manager of the CVP recently met separately with Vicki Stanton, Manager CAMHS and Lynda Jarvis, Senior Manager Aged and Disability Services, Alice Springs to discuss this issue.

In the Northern Territory, the cost of maintaining a single person in their own home with 24 hour support is estimated at around $350,000 per year. A person with severe intellectual disability or acquired brain injury may

require this level of support indefinitely. Aged and Disability Services lacks two important resources necessary to provide this support; sufficient staffing and funding. Staffing of all human service organisations providing care to community members is always problematic in Alice Springs, as is the level of funding required to pay for it even if staff were available.

At present, unless a bed is available in one of the few 24 hour group accommodation facilities in Alice Springs, the only way a consumer requiring 24 hour supported accommodation can be discharged from the Mental Health Unit is if accommodation becomes available to share with another consumer. Staffing, and staffing costs can then be shared. The outcome may be that consumers remain in the Mental Health Unit long term until the conditions for their discharge are met – that is, the housing is available, another compatible consumer who wants to share the house is available, a non-government organisation is funded for the ongoing care and staff are recruited and trained.

Possible alternative options investigated by Aged and Disability Services include the use of cluster housing, where three - four consumers live independently in small units/homes clustered together with one unit allocated for support workers. Advantages of this style of supported accommodation include financial and human resource savings from shared use of support workers and the generation of informal support between consumers whilst still maintaining independent living. A potential disadvantage of this style of housing is that it may compromise consumer choice. Regardless, there seems to be no immediate plans to implement this option.

In the interim, processes may be put in place that will aid earlier discharge from the Mental Health Unit. Co-ordination between the services responsible for ensuring a successful return to independent living is crucial, and there is evidence of increased liaison between mental health and disability services. Early referral to disability services is essential, and would be improved by the ability to share electronic records so that admission of a client managed through Aged and Disability Services to the Mental Health Unit is automatically flagged on their system.

In her final report of the 2006 – 2007 financial year, the Alice Springs community visitor recommended that delays in discharging consumers with dual disability from the Mental Health Unit be referred to the community visitors panel. In 2007 - 2008, on each of their fortnightly visits to the Mental Health Unit, community visitors will record the number of beds that are being occupied by people who are inpatients awaiting accommodation for discharge. This information will be provided to the community visitors panel for further investigation and comment.

Legal Issues

Notification of Involuntary Admission

The Act specifies that the person-in-charge of an approved treatment facility 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 seven days or more. In 2006 – 2007, the Central Australian Mental Health Service (CAMHS) notified the CVP of approximately 79% of all admissions compared with 15% notifications received from TEMHS. In the past three months, TEMHS has improved its performance to notify the CVP of approximately 40% of all involuntary admissions requiring notification.

This issue was reported in the 2005 – 2006 Annual Report and included in each quarterly report to TEMHS. In 2005 – 2006, the CVP was informed and reported that the Mental Health Program was committed to developing procedures to ensure that appropriate notification would be made to all parties. These procedures will become operational at the same time as the amendments to the Act.

Once the amendments are implemented, automatic review of involuntary admission by the MHRT will occur within 14 days of admission as compared to seven days as is the case now. It is imperative therefore that timely notification of the Principal Community Visitor occurs to ensure that consumers are advised of their legal rights. Despite TEMHS' improved rate of notification throughout the 2006 – 2007 year, the CVP remains concerned that these basic legal requirements have not been fully addressed.

Facilities for Young People in the TEMHS Inpatient Unit

In the past 12 months, the community visitor became aware that at least three young people under the age of 18 years were admitted to the TEMHS Inpatient Unit. Two of these people were cared for in JRU, the secure section of the inpatient unit.

A young person with a diagnosis of a psychotic illness and intellectual disability was admitted to Cowdy Ward, the open ward within the TEMHS Inpatient Unit. The psychosis settled within a few days, and the service responded as quickly as possible to discharge the consumer and ensure that treatment occurred in an appropriate environment.

Discharge was achieved by liaising with the Department of Family and Community Services (FACS), Disability Services and TEAM Health. FACS recruited staff to work with the consumer, staff from mental health services provided training, and intensive support on discharge was provided by TEAM Health. A nurse from the ward stayed with the consumer for 10 days after discharge, working with FACS staff and Disability Services to ensure the consumer's needs were met and that discharge was successful.

The CVP congratulates TEMHS on its excellent response in this situation.

In another instance, a young person at risk of self harm was admitted to JRU for a short period of time. To ensure physical and psychological safety, the consumer was nursed separately in the Intensive Care Unit within JRU, accompanied by a Patient Care Assistant at all times.

The community visitor was informed by staff that the consumer had settled very quickly after admission to the ward and that discharge was dependent on finding appropriate accommodation. Staff were concerned that while the admission may have been appropriate, in view of the young person's youth and disability, the consumer should have been discharged as soon as the behaviour had settled due to the potential impact of being in JRU.

A third young person was admitted to JRU with a diagnosis of psychosis and mental disturbance. This person was nursed one to one ("specialled") within the general ward environment.

The CVP understands that JRU must be used at times for people at risk of harm to self or others and/or at risk of absconding from the Inpatient Unit. At the same time, it is potentially a traumatic environment for young people, with possible long term consequences.

The CVP is aware of TEMHS' plans to provide four levels of care within the inpatient unit subject to the availability of funding. This should enhance care for vulnerable people, and in particular ensure a more appropriate and safe environment for young people experiencing psychosis and needing inpatient psychiatric care.

It is important that this funding is made available to ensure that young people are treated in a separate environment that is more suited to their special needs.

Cleaning in the TEMHS Inpatient Unit

The community visitor has continued to receive complaints from consumers and staff about the cleanliness of the Unit. These complaints have been substantiated after inspection by the community visitor.

The CVP is aware that TEMHS is trying to address this issue, and the Darwin community visitor panel found improvements to cleaning in the inpatient unit during both its visits. Nevertheless, the CVP received the following complaints throughout the period covered by this Report:

- On 8/9/06 the community visitor was approached by consumers about cigarette butts and spit in the courtyard. Another consumer complained that the toilets were not clean. These complaints were substantiated;
- On 20/11/06 following a complaint from staff, the community visitor inspected the Treatment Room and found that is looked as if it had not been cleaned for several days. On a follow up inspection 23/11/06, the community visitor noted the Treatment Room was exceptionally clean;
- On 21/12/06 the CVP received a complaint from staff that the courtyard in JRU was covered in slime. It was inspected at a later date and found to have been cleaned appropriately;
- On 12/1/07 after complaints from staff, the community visitor found bathrooms, toilets and floor in Cowdy Ward in a poor state of cleanliness and smelling of urine; and
- On 1/6/07 the community visitor received a complaint that the bins in the kitchen of JRU had not been emptied. The community visitor noted that the bins were full and smelled. On follow up inspection two days later, the community visitor noted that the bins had been emptied.

REPORTING PERIOD 2004 - 2005

Legal Issues

Voluntary Admissions and Informed Consent

The Act specifies that consumers should be admitted to hospital voluntarily whenever possible. This may lead to problems with consumers admitted as voluntary patients, who are told they are not able to leave the facility. If the voluntary admission is negotiated with the consumer, then the CVP believes that the principle of the least restrictive alternative is being enacted. If it happens without consumer involvement and consent, the practice may be more restrictive as the procedural safeguard of review before the MHRT is lost.

Throughout the period covered by this report, the community visitor for the TEMHS Inpatient Unit was approached by consumers requesting information about their status on seven occasions. Consumers were not complaining about their voluntary or involuntary status, they were seeking clarification as to whether they were voluntary, and if this meant they could leave the Inpatient Unit.

On 27/7/06, the community visitor was approached by a consumer in the TEMHS Inpatient Unit who informed the community visitor her status was voluntary and that she was unable to leave the Unit. At the time the consumer approached the community visitor, she was making significant threats against staff and other clients. The community visitor reviewed the case notes, and noted two concerns. Firstly, the consumer was voluntary and at the same time clearly stating that she wished to leave the facility. Secondly, she had not signed an "Informed Consent to Treatment Form" as is required for consumers who are being treated as voluntary patients. The situation was discussed with nursing staff who stated that the client was voluntary because her health had been improving, but that her condition had recently deteriorated. Her status was changed to involuntary later that day after review by an APP.

In August 2006, a consumer in the Mental Health Unit in Alice Springs contacted the community visitor about his status on the ward. His status was voluntary, however he reported to the community visitor that he was not free to leave the hospital and that he had been told if he did so, he would be admitted on an involuntary basis. The consumer stated that he would prefer his status to be involuntary so that he could have the opportunity for review before the MHRT (in a similar case to the one reported in the CVP Annual Report last year). The consumer's status was changed to involuntary.

The Alice Springs community visitors panel discussed this issue with medical staff during a visit to the Mental Health Unit in October 2006. Medical staff stated that as part of "less restrictive practices" attempts are made to come to some agreement with consumers. The panel stated that they understand the potential benefits of this approach, but believe more care needs to be taken and that consumers, family and staff need to be involved and to comprehend the process to avoid confusion. The panel expressed the view that where a consumer meets the criteria for involuntary detention and clear bilateral agreement cannot be reached the consumer should be made involuntary and advised of his or her rights before the Mental Health Review Tribunal.

Recently, a nursing staff member from the Mental Health Unit contacted the CVP with concerns about a consumer who had been admitted involuntarily. There were genuine concerns for the safety of the consumer whose status had been changed to voluntary 24 hours after admission. Nursing staff had been instructed to detain the consumer if she tried to leave. The community visitor reviewed case notes, spoke to the consumer and spoke to nursing and medical staff. He formed the view that this was a good example of "least restrictive practice". The consumer was happy with her status, and happy not to leave the ward. She understood the reasons for being voluntary, and for the decision to detain her if she tried to leave.

While reviewing case notes in response to a complaint, the community visitor noted a case note entry of some concern. The consumer was a voluntary patient in the Mental Health Unit. He had an agreed contract with the treating team – and broke the terms of the contract. The case note entry stated that the contract would be renegotiated, and that the consumer was to be informed that if he broke the agreement, he would be sectioned for four weeks and administered a one-off dose of medication.

The community visitor acknowledges that staff were attempting to manage a difficult situation in the least restrictive manner. However, this is an example of how practice that does not strictly adhere to the terms of the Act can result in an intervention which, viewed externally, appears unduly punitive and restrictive.

The above examples illustrate the complexities involved when discussing this issue, and how an individual approach that is transparent, negotiated and clearly understood by all parties – the consumer, the consumer's family, nursing and medical staff - can work to benefit the consumer while in the ward. Dangers exist when the process is not transparent, and if a "one size fits all" approach is undertaken.

Provision of Information about Rights

Recommendations regarding the need to develop appropriate information about rights for all consumers are still outstanding in both Alice Springs and Darwin.

The Darwin community visitors panel has a long term recommendation regarding the need for posters to be placed on the walls of the TEMHS Inpatient Unit to ensure that consumers are aware of their legal rights. The CVP has been informed that these posters are being developed as part of the information packages to be made available to consumers when the amendments to the Act become operational.

The Alice Springs community visitors panel has focussed its attention on the need for information for Indigenous consumers, noting that the form in which information is currently provided is not necessarily appropriate for consumers from remote regions.

Liaison with GPs

After visiting the TEMHS Inpatient Unit in May 2007, the Darwin community visitors panel noted that Discharge Summaries do not necessarily record whether or not the consumer has a GP. Hence GPs are not always advised of discharge from the unit or of any changes in medication.

The panel reported that in seven of eight case notes reviewed, the name of the GP was not recorded. The panel acknowledged that this may in fact represent the number of consumers unable to identify their GP, given that historically mental health consumers are less likely to access primary health care. Nevertheless, the panel believes that if the consumer does not have a GP, the Discharge Summary should reflect this.

Medical staff informed the panel that they would like improved access to GPs willing to work with consumers with mental illness on discharge from the Inpatient Unit. The panel intends to investigate this issue further during its next visit in November 2007.

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.

Information from NT Police confirms that Police will avoid transporting consumers to hospital and attempt to use the less restrictive alternative of transport to hospital by ambulance, if necessary with police escort. Anecdotally, it appears that consumers are being transported to hospital more often by ambulance. This policy is in line with a proposed national framework for transport to hospital in accordance with the least restrictive alternative and recognises that consumers of mental health services are transported to hospital because they are ill.

The community visitor in Darwin received two complaints regarding transport by Police in the last half of the 2006 – 2007 financial year. In the first complaint, a legal representative contacted the CVP with a complaint about transport in the cage of the police vehicle. The community visitor discussed the issue with the consumer, who stated that he did not wish to go to hospital, and that he would not have travelled by Ambulance. He also confirmed that it would not have been safe to transport him in the back seat of the police vehicle.

The second complainant was an adult woman who was admitted to hospital for the first time. Two weeks prior to her admission, she had been transported to ED at RDH by Police in the cage of the police vehicle. After assessment, she was allowed to return home. Two weeks later, when the consumer refused mental health intervention, she was detained and police again called to her home. Eventually she agreed to travel to hospital via Ambulance. She states that she would have done so the first time, had the opportunity been given to her. The consumer stated that she was embarrassed and appalled at the manner in which she was transported to RDH by police.

The Darwin community visitors panel, following its visit to the TEMHS Inpatient Facility in May 2007, recommended that a consumer transported to hospital by police must be transported in the back seat of the vehicle rather than the cage if at all possible.

Records of Outpatient Medical Appointments in Alice Springs

In a visit to the community teams in Alice Springs in June 2007, the community visitor found evidence that some outpatient psychiatric appointments are still recorded on the hospital paper file rather than on the electronic case notes (CCIS). Hospital paper files are stored in medical records at Alice Springs Hospital. This practice means that unless there is close liaison between doctor and case manager, the treating doctor/psychiatrist may not have access to information about a consumer's level of functioning in the community to assist with the assessment at Outpatient Appointments. Similarly, any changes to a consumer's medication may not be communicated to the case manager

In its final visit to the approved treatment agency in March 2006, the Alice Springs community visitors panel reported that it was satisfied that there had been appropriate training in the use of CCIS and that it was increasingly being used by all clinicians.

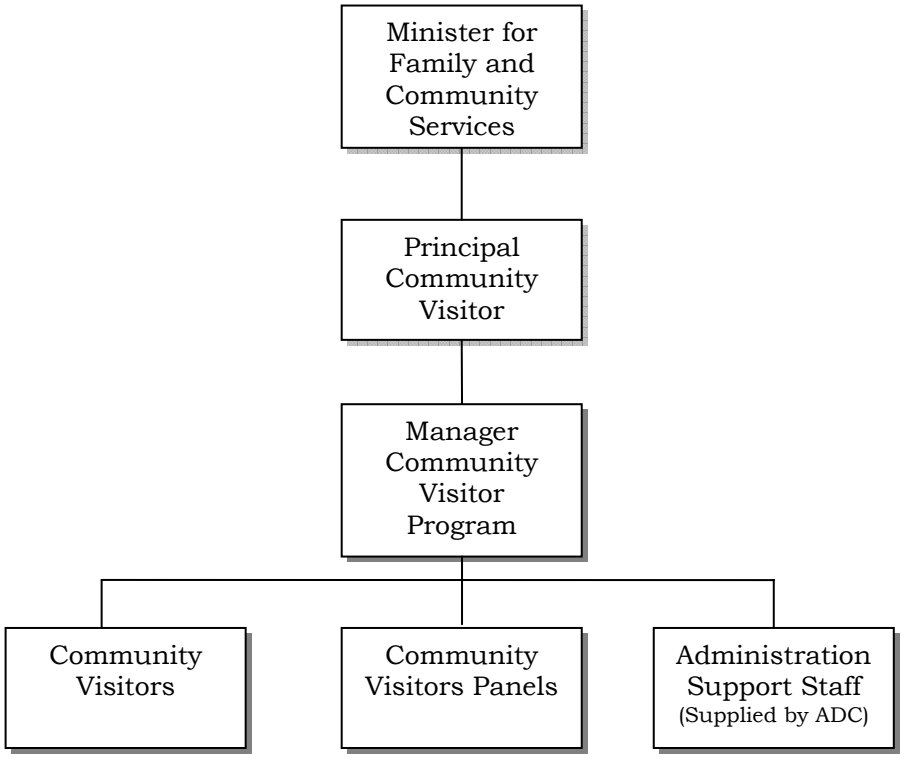
The community visitor was satisfied on this visit that this is indeed the case, and that on the whole, communication between case manager and doctor is of a high standard and is documented either on CCIS, the outpatient notes or both. However, one instance of a change of medication not communicated to either the case manager or GP was noted. The community visitor also noted two instances where there were records of visits on the hospital outpatient notes but where there were no CCIS notes because the consumer was not being case managed.

The community visitor expressed the view that reliance on oral communication between doctor and case manager or on the case manager attending an outpatient appointment is problematic, and increases the possibility of mistake. It is imperative that all members of the treating team are able to communicate through the documentation of their contact with consumers. This will only occur when a single system is used.

PART 3

STAFF 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. Community visitors (except those employed by the ADC and other NT Government agencies) 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.
- Terry Lisson was appointed community visitor in November 2001. Terry also acts as Principal Community Visitor in Mr Fitzgerald's absence.
- Simon Wiese was appointed community visitor in November 2003.
- Judy Clisby, Manager of the Community Visitor Program, was appointed community visitor in June 2004.
- Marilyn Starr was appointed community visitor in June 2005 and community member of the Darwin community visitors panel on 7 June 2006.
- Mark O'Reilly was appointed community visitor Alice Springs and legal member, Alice Springs community visitors panel in March 2006.
- Debra Harrison was appointed community visitor in July 2006. Debra was employed by the CVP half time while the Manager was on leave over Christmas 2006-2007 and co-ordinated the program from March until early June 2007.
- Carly Ingles was appointed community visitor for Alice Springs in May 2007.
- Georgia Stewart was appointed community visitor for Alice Springs in May 2007.

Community Visitors Panels

- Dr Sarah Giles, Chairperson and Medical Practitioner member of the community visitors panel in the Top End, was appointed in March 2004.
- 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.
- Kathryn Ganley was appointed Legal Practitioner member of the Darwin community visitors panel in June 2005.
- Jenny Devlin was appointed Legal Practitioner member of the Darwin community visitors panel in March 2006.
- Dr Christine Lesnikowski was appointed Medical Practitioner member of the Alice Springs community visitors panel in March 2006.

Principal Community Visitor

Community Visitors & Panel Members

Tony Fitzgerald Commissioner ADC
Principal Community Visitor

Tony has been the NT's Anti-Discrimination Commissioner & Principal Community Visitor for five years. One of his former roles was to represent "involuntary" patients at Cowdy Ward at Magistrates Court hearings. Tony realised then 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.

Judy Clisby Manager CVP
Community Visitor

Judy is a social worker with a back-ground in mental health and drugs and alcohol. She is a social worker with a keen interest in mental health and human rights. Judy has managed the CVP for three years now.

Simon Wiese
Community Visitor

Simon is an experienced negotiator and mediator. While most of his involvement with the CVP is now in an administrative capacity, Simon has managed to visit Cowdy Ward on a couple of occasions in response to complaints.

Terry Lisson,
Community Visitor

Terry has considerable experience as a complaint handler/ conciliator working first for the Human Rights and Equal Opportunity Commission and for the past 5 years as Director of Conciliation, Policy and Law at the ADC. Terry was the legal practitioner member of the community visitors panel and still acts as a Community visitor when called upon.

Debra Harrison
Community Visitor, Darwin

Debra was appointed community visitor while undertaking a social work placement with the CVP. She brings a wide variety of experience to the position, including several years living in an Indigenous community. Debra has a strong interest in mental health and hopes to work in the area in future.

Marilyn Starr, Community Visitor
Community Member, Darwin Panel

Marilyn is a trained mediator, counsellor and small business manager with 16 years history of working in Indigenous communities. She is now employed in the Department of Health and Aging.

Community Visitors & Panel Members

Carly Ingles, Community Visitor Alice Springs

Carly was admitted as a Barrister and Solicitor of the Supreme court of Victoria in 2002 and as a Legal Practitioner in the NT in 2005. Carly is employed as a criminal lawyer with the Central Australian Aboriginal Legal Aid Society. Carly has developed an interest in mental health through her work in Alice Springs.

Georgia Stewart
Community Visitor Alice Springs

Georgie has a Graduate Diploma in Social Policy. She is employed as a Patient Support Worker and Philanthropic Researcher by the Nganampa Walytja Palyantjaku Aboriginal Corp. She works with dialysis patients from the Western Desert, providing advocacy, practical, family and other support.

Sarah Giles Chairperson
Medical Member, Darwin

Sarah is from Country SA. She worked in the Kimberley for seven years, and has been a full time GP in Darwin for the past ten years. Sarah has an interest in mental health and is 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 is a long term Territorian who spent most of her childhood in Arnhem Land. She has a keen interest in human rights and in ensuring that the needs and views of all members of society are represented. While employed by the NT Legal Aid Commission Jenny acted as the duty lawyer responsible for representing involuntary patients subject of applications to the MHRT. Jenny is also a mediator & is currently the Manager of the Family Dispute Resolution Service of Relationships Australia NT.

Maya Cifali, Community Member, Alice Springs

Maya 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 has lived in Darwin, Katherine and Alice Springs and now calls Alice Springs home. Chris has had an interest in mental health for many years, and completed a Diploma in GP Psychiatry in 2000. Chris hopes that she can continue to offer support to the community in the field of mental health services.

ACTIVITIES OF THE CVP 2006 - 2007

Inspection of Seclusion Registers

Pursuant to section 62 (14) of the Act, 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.

Alice Springs

The seclusion registers maintained in the Mental Health Unit were inspected in September 2006 and again in April 2007. In the first inspection, the community visitor found no issues of concern, reporting that in fact the use of seclusion had diminished since his previous visit.

When the community visitor inspected the seclusion register in April 2007, she noted that a third of all seclusions lasted more than four hours, with a median seclusion period of three hours and 20 minutes. As stated earlier in this report there was one incident where the requirement for medical review after four hours was not met. In her report to the person-in-charge of the Mental Health Unit, the community visitor expressed concern that on at least one occasion, the use of seclusion appeared to be linked to difficulties with staffing the High Dependency Unit, the closed section of the ward.

Darwin

The community visitor inspected the seclusion register in the TEMHS Inpatient Unit in December 2006 and June 2007. During the first inspection, the community visitor identified that forms were not necessarily being signed by doctors and multi-disciplinary reviews of seclusion not documented. Significant improvements in documentation were reported after the second inspection in June 2007.

Issues identified with the scheduling of medical reviews for consumers in seclusion longer than four hours have been discussed earlier in this report. With the exception of this issue, the community visitor was impressed with the continued reduction in the use of seclusion and the emphasis on this as an intervention of last resort.

The community visitor was shown proposed new forms to record episodes of seclusion and agrees that they will capture all the information currently on forms completed by staff more efficiently. A proposal to ensure the forms are used throughout the NT will provide for consistency in seclusion practice.

The community visitor was also impressed by the proposed Clinical Register of Incidents Database which will provide the opportunity to view seclusion episodes as an "incident" - along with Transfers, Absences from the Ward, Restraints and other clinical incidents.

The CVP acknowledges the *TEMHS Analysis of the 2005 - 2006 Seclusion Register*. This document identifies the relatively high proportion of seclusions occurring with Indigenous clients in the 2005 - 2006 financial year and significantly adds to the understanding of the use of seclusion in the TEMHS Inpatient Unit. Its recommendations, if implemented, should ensure the reduction of use of seclusion and of its potential negative impact on consumers and concurrently ensure that seclusion occurs only in accordance with the provisions of the Act.

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.

Prior to this year, the community visitor has initiated visits to inspect complaints registers held at the approved treatment agencies for CAMHS and TEMHS. This year, the Manager of the CVP decided to inspect complaints registers on the basis of reports submitted by CAMHS and TEMHS as required by the Act.

A report detailing the activities of CAMHS was forwarded to the CVP on 29 June 2007. This report outlines the 17 complaints received during the 2006 – 2007 reporting period. It includes details of the substance of each complaint, action taken in response to the complaint as well as providing details of any further action. On the basis of this report, the CVP is satisfied that complaints are well followed up and action is taken to prevent the recurrence of any systems issues identified in the complaint.

The Manager of the CVP met with the complaints officer from TEMHS in November 2006. The complaints officer brought the complaints register with her to the meeting for examination. No issues were identified with the TEMHS complaints process at this time.

Other CVP Activities

Review of Mental Health Legislation

The CVP was included and participated fully in the consultation process for the new Bill, passed through Parliament on the 19th April, 2007.

Council of Australian Government (COAG) Initiatives

The CVP attended initial consultations conducted by the Commonwealth Departments of Family and Community Services and Indigenous Affairs and Health and Ageing. The CVP appreciates the invitation to remain involved. A representative of the CVP attends COAG Reference Group meetings and Care Coordination meetings.

Social Work Student

The Manager of the CVP has supervised a social work student for each of the past two years. While this adds slightly to the cost of the program, benefits accrue from the promotional opportunities this provides with CDU and other social work students. These opportunities extend to service providers once students have completed their degree and commenced work in the human services sector.

Involvement with Community Activities

One mechanism for promoting the purpose of the CVP is involvement in community activities. In the 2006 - 2007 financial year, the CVP contributed to the following:

- Mental Health Week: The CVP attended interagency planning meetings organised by the Mental Health Coalition, assisted with setting up the Art display in Darwin, assisted with preparation for a community forum, compiled a booklet of entries for the poetry competition and sponsored a sausage sizzle in both Darwin and Alice Springs. The Principal Community Visitor presented prizes to the winners of the art and poetry competitions in Darwin. The Manager of the CVP was also interviewed by an interstate University Radio Program putting together a compilation of comments for Mental Health Week;
- International Day of People with a Disability: CVP brochures were displayed at a stall held by the Anti-Discrimination Commission; and
- Early Childhood Week: The Manager of the CVP presented a brief paper entitled *Visions of a Child Friendly Community for Children of Parents with a Mental Illness*.

Presentations to Community Groups

The CVP also delivers presentations about its role to service providers and community groups in both Darwin and Alice Springs. During the period covered by this report the CVP has addressed the 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. The presentation was recorded by CDU for use in its online learning program for students living outside Darwin;
- Top End Aboriginal Bush Broadcasting Association (TEABBA): the Manager of the CVP was interviewed about the program and issues faced by people with mental health problems;
- Central Australian Aboriginal Congress; and
- The Consumer Advisory Group (CAG): a presentation was given to members of the CAG on issues identified by the CVP from complaints and enquiries by consumers and carers.

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:

- Mental Health Carers (Darwin and Alice Springs);
- NT Carers (Darwin and Alice Springs);
- Disability Advocacy (Alice Springs);
- Red Cross (Alice Springs);
- Salvation Army (Alice Springs);
- Alice Springs Library;
- Remote Community Nursing (Alice Springs);
- NT Housing (Alice Springs);
- NT Police (Alice Springs);
- St Vincent de Pauls (Alice Springs);
- YMCA (Alice Springs);
- Health and Community Complaints Commission;
- Official Visitors Program (NT);
- Top End Division of General Practice;
- Northern Territory Council of Social Services;
- Pete's Place;
- Mental Health Coalition;
- Grow;
- Mental Health Association of Central Australia; and
- TEAM Health.

PRIORITIES 2007 – 2008

The core business of the CVP is visiting the mental health inpatient facilities, receiving and investigating complaints, resolving enquiries 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:

- Improving its information: the CVP is gradually refining the data-base used to record complaints and enquiries and the number of visits to mental health inpatient facilities. By the end of the 2007 – 2008 financial year, the CVP should be able to generate statistical reports automatically;

- Updating CVP procedures and training in relation to amendments to the Act:
    - Plans are in place for implementation of amendments to the Mental Health and Related Services Act. The Mental Health Program is currently developing Approved Procedures to accompany the amendments to the Act. The CVP will update its handbook to ensure that all protocols are consistent with the new Procedures. This will provide an opportunity to review existing complaints procedures in consultation with community groups and mental health services;
    - Community visitors and panel members need to be conversant with the Act and its approved procedures. In 2007 – 2008, all community visitors and panel members will receive training in the changes to the legislation (with training prepared by the Mental Health Program); and
    - Because community visitors panels will no longer be visiting the approved treatment agencies, community visitors will endeavour to visit the agencies in Darwin and Alice Springs at least twice each year, and agencies in Tennant Creek, Katherine and Nhulunbuy at least once;

- Updating promotional materials: the CVP's promotional materials are out of date. Funding has now been made available through the ADC which will provide opportunities to develop new promotional material for the program. Updating materials in the 2007 – 2008 year will coincide with the introduction of the amendments to the Act; and

- Prioritising CVP activities: time spent in receiving, investigating and reporting on the complaints and enquiries functions of the program was measured over the final three months of 2006 – 2007. This information will be analysed in early 2007 – 2008 to assist with future planning.

PERFORMANCE OF THE CVP 2006 - 2007

In past Annual Reports, the performance of the CVP for the years has been measured against the objectives and strategies outlined in its Strategic Plan. As part of the ongoing evolution of the program, the CVP believes that it is more appropriate that this style of reporting is more properly contained in its business plan.

Performance for the 2006 – 2007 year is measured against the legislative requirements for the CVP, along with records of its activities in responding to consumer enquiries and complaints.

Table 1: Comparison of the Achievements of the CVP 2004 – 2007

		Alice Springs			**Darwin**		
	Legislative Requirements	2004/ 2005	2005/ 2006	2006/ 2007	2004/ 2005	2005/ 2006	2006/ 2007
Visits [1]	In response to requests/ inspection	7	22	21	50	63	55
Panel Visits Inpatient Facilities	2 (At least once every 6 months)	2	2	2	2	2	2
Inspection Seclusion Register	2 (At least once every 6 months)	2	2	2	3	2	2
Timeliness	Percentage visits conducted within 24 hours of notification of a request	100%	100%	100%	100%	100%	100%

Note: 1. Number of visits to CAMHS includes one community visitor inspection of the community facilities in CAMHS.

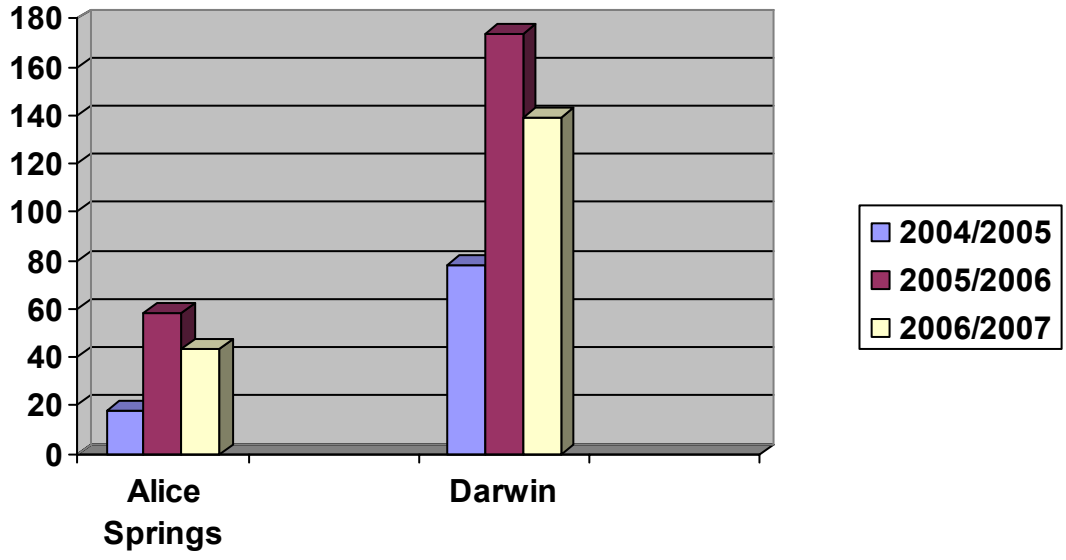
Complaints and Enquiries

The CVP has received fewer complaints in the 2006 – 2007 reporting period than in the previous twelve months. Fewer visits have been conducted during this period, and this may account for a proportion of this reduction. However, it may also be explained by the considerable improvements of services offered, in particular in the TEMHS Inpatient Unit, resulting in consumers who are more content and less likely to lodge a complaint.

Table 2: Complaints and Enquiries Received

	Alice Springs			Darwin		
	2004/ 2005	2005/ 2006	2006/ 2007	2004/ 2005	2005/ 2006	2006/ 2007
Complaints & Enquiries Received	**18**	**58**	**43**	**78**	**174**	**139**

Figure 1: Complaints and Enquiries Alice Springs & Darwin 2004 - 2007

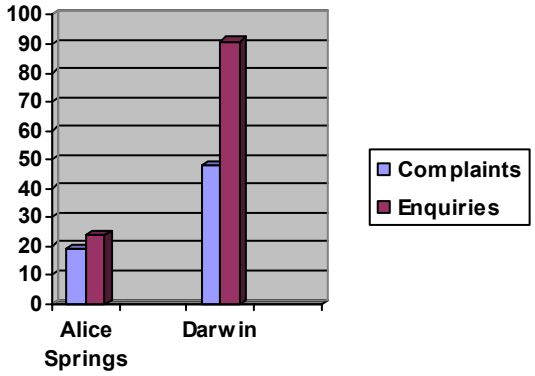


Complaint or Enquiry?

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, and specifically describes their contact as a complaint. If a community visitor, in the course of investigating a complaint or enquiry, learns of a new issue requiring follow up with the mental health service, this is also recorded as a complaint.

Figure 2: Graph of Complaints vs Enquiries, Alice Springs and Darwin 2006 - 2007



In 2006 – 2007, the CVP received a total 67 complaints and 115 enquiries. 48 complaints and 91 enquiries were received regarding services provided by TEMHS, and 19 complaints and 24 enquiries about services received from CAMHS.

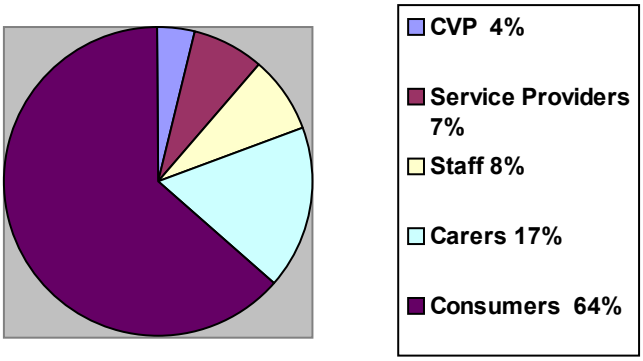
Figure 3: Graph of % Ratio Complaints:Enquiries 2005 – 2006 and 2006 - 2007

An interesting difference between the 2005 – 2006 and the 2006 – 2007 reporting periods is the reversal of the ratio of complaints to enquiries. This may be attributable to changes in services offered within the inpatient units, along with differences in the way community visitors approach consumers.

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.

Figure 4: Source of Complaints and Enquiries NT



Categories of Complaints and Enquiries

Table 3: Categories of Complaints and Enquiries

Category of Complaint/Enquiry	CAMHS	TEMHS	Total
Access to files		5	5
Advocacy	8	42	50
Detention	1	5	6
Discharge Planning	6	8	14
Facilities	3	9	12
Legal	3	5	8
Medication	1	5	6
Miscellaneous	1	7	8
Procedures		4	4
Quality of Service Provision	13	22	35
Request for Information	2	14	16
Rights	2	5	7
Transport by police		3	3
Voluntary/Involuntary Status	3	4	7
Ward Activities		1	1
TOTAL	**43**	**139**	**182**

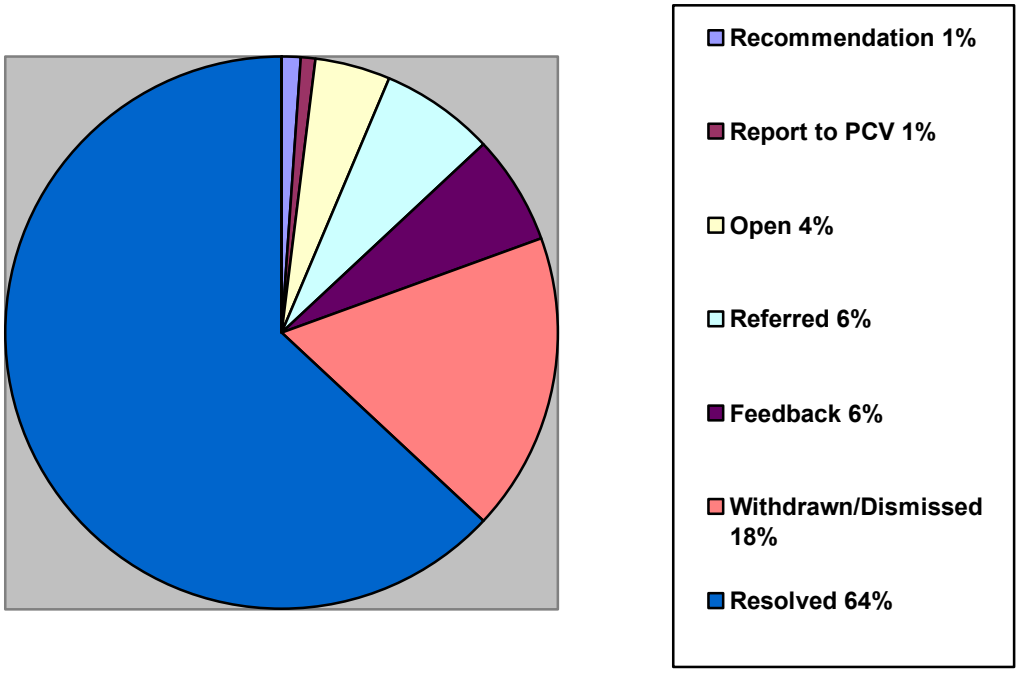
Other Complaints and Enquiries

In addition to complaints and enquiries about mental health services in the NT, the CVP has received a total 19 enquiries about non mental health services. These 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.

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. Complaints may also be referred back to a mental health worker or on to another complaints organisation such as the Health and Community Services Complaints Commission. The table below includes the 19 enquiries received about facilities other than CAMHS and TEMHS. The total number of complaints and enquiries for 2006 – 2007 is N = 201

Figure 5: Outcomes of Complaints and Enquiries NT



CVP FINANCIAL STATEMENT 2006 - 2007

The Department of Health and Community Services provided funding totalling $120,000 to the Community Visitor Program. The following statement details how the funds have been allocated.

INCOME

	$	$	$
Funding:			
NT Government		120000	
TOTAL INCOME			**120000**
EXPENDITURE			
Salaries and Remunerations			
Salary and Accrued Leave Liability	78040		
Salary On costs	13010	91050	
Operational Expenses			
Accommodation	700		
Communication	1535		
Consumables	620		
IT Hardware and Software	270		
Marketing and Promotion	700		
Membership and Subscriptions	70		
Motor Vehicle Expenses	760		
Office Requisites and Stationery	160		
Official Duty Fares	920		
Training and Study Expenses	1030		
Travel Allowance	1440		
Information and Technology Charges	3690		
Fees and Other Regulatory Charges	18865		
Total Operational Expenses		30760	
TOTAL EXPENDITURE			**121810**
Deficit			**(1810)**

Notes

1. The ADC contributes to the CVP in the form of indirect costs. The CVP is not funded for the time the Principal Community Visitor, community visitors and administration staff spend with the program. In 2006 – 2007 the CVP made a minor contribution to ADC administration staff time ($3,000 less $1810 = $1190). Other costs such as motor vehicle use, photocopying, use of office space, power and furniture and equipment were borne by the ADC.

APPENDIX 1 NEW RECOMMENDATIONS 2006 - 2007

ALICE SPRINGS

Mental Health Unit

October 2006 Community Visitors Panel Visit

1. It is recommended that a position for an Occupational Therapist or Recreation Officer be reinstated on the mental Health Unit.

April 2007 Inspection of the Seclusion Register by Community Visitor

2. The community visitor recommended that in the interim period prior to the implementation of the amendments to the Act, the mental health service keep to the timelines in S62 (7) of the Act and 9.6.2 of the Approved Procedures.

3. It is recommended that CAMHS respond to the CVP with respect to the issue of initial detention pursuant to S39 of the Act and confirmation of detention pursuant to S42 of the Act with a view to ensuring that all detentions are notified to the Principal Community Visitor and the Mental Health Review Tribunal within 7 days.

Community Teams

June 2007 Community Visitor Visit

4. It is recommended that the practice of using hospital notes for outpatient appointments cease, and that notes from all outpatient appointments are recorded on CCIS.

DARWIN

TEMHS Inpatient Unit

May 2007 Community Visitors Panel Visit

1. It is recommended that the Mental Health Service ensure that interpreters are present at assessment for all consumers whose first language is not English and who are not proficient in English.

2. It is further recommended that interpreter assistance is then arranged for all further assessments and to assist the consumer at any hearing before the Mental Health Review Tribunal.

3. It is recommended that if a consumer must be transported to an approved treatment facility by police, then all efforts are made to transport the consumer in the car rather than in the cage of the vehicle.

November 2006 Community Visitors Panel Visit

4. It is recommended that a comprehensive accommodation and support model is developed, adequately resourced and provided in the Top End of the Northern Territory (in addition to the accommodation currently provided through the Manse).

5. It is further recommended that the model takes into account the varied and diverse circumstances of consumers in the NT, and is developed collaboratively with consumer groups and mental health professionals.

6. It is recommended that a complaints system be put in place that allows consumers to access and lodge forms independently of staff.

7. It is recommended that funding is made available for the major works required to enable consumers in JRU to spend some time outside each day.

Community Visitor Quarterly Reports

2006 – 2007 First Quarterly Report

8. It is recommended that TEMHS take action immediately to cease unsafe food practices, such as leaving food on the counter and reheating it, or chilling the food and reheating it later.

Tamarind Centre

2006 – 2007 First Quarterly Report

9. It is recommended that a discharge process is implemented that includes as a minimum a relapse prevention plan, documentation of interventions and their outcome, medication and referral to external organisations, including GPs.

APPENDIX 2: RECOMMENDATIONS CLOSED 2006 – 2007

ALICE SPRINGS

Mental Health Unit

April 2007 Community Visitors Panel Visit

1. In July 2004 the Alice Springs community visitors panel 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.

   The panel acknowledged the serious lack of appropriate facilities in Alice Springs for people in need of supported accommodation and that this has been very problematic for the Unit. The panel believes however that this is not a shortcoming of the Unit but of Health and Community services more broadly. Furthermore, in its report, the panel urged CAMHS to continue to press for appropriate services in Alice Springs. The recommendation was closed because the panel recognised that it is not an issue the Unit is able to address.

October 2006 Community Visitors Panel Visit

2. In July 2004, the panel 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.

   The panel was satisfied that the practice of reviewing incident reports is in place. They were informed of the implementation of a Northern Territory wide quality assurance process being implemented adopting uniform policies and procedures in relation to the reporting and following up of incidents. The Panel understood that this would mean that regular reviews of incidents reports would occur and procedures for follow up would be clear.

3. In July 2005, the panel recommended that standard formats for reports and referrals be developed and/or used to improve the service to the consumer.

The panel further recommended that this be introduced in a way that encouraged more consistent communication between service providers, reduced variations in different files for the same client and encouraged collaboration across specialisations/services. As a minimum the panel recommended this should include a standard discharge plan form.

The panel reported a change in the format of discharge documentation since their previous visit. The audit of files revealed that there was a consistent use of discharge forms, although it was noted that there was carelessness at times in ensuring that all sections of the form were completed. This often related to information about the notification of other agencies, carers or General Practitioners.

4. In July 2004, the panel 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 panel further recommended that 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.

   No report was ever received. The panel enquired as to the use of 12 hour detentions and was satisfied that these detentions are rarely used and do not give rise to any issue of concern. The recommendation was thereby closed.

5. In August 2005, the Alice Springs community visitors panel recommended that CAMHS collaborate with ASH to provide understandable information to all hospital staff about mental disorders and mental health problems.

   The panel was of the view that this recommendation was duplicitous with another recommendation relating to a need to work with staff from ASH to reduce the stigma related to mental illness. Accordingly, this recommendation was closed.

Community Visitor Quarterly Reports

Fourth Quarterly Report 2006 - 2007

6. In 2005 – 2006 the community visitor 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.

   The Manager CAMHS informed the community visitor that a table has been purchased and the recommendation was closed. However it appears there was a misunderstanding, and that CAMHS is in process

of purchasing a table. The recommendation duplicates an existing panel recommendation and will remain closed.

7. During an inspection of the Seclusion Register in April 2007, the community visitor recommended that in the interim period before implementation of the new Mental Health and Related Services Act, the mental health service keep to the timelines in S62(7) of the Act and 9.6.2 of the Approved Procedures.

   The Manager CAMHS informed the community visitor that the service has taken action to ensure that the timelines required in S62 (7) of the Act are met. Accordingly, the recommendation was closed, and will be reviewed during the next inspection of the Seclusion Register.

CAMHS Community Teams

June 2007 Community Visitor Visit

8. In October 2004, the community visitors panel 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.

   The community visitor noted evidence that CAMHS has attempted to develop its links with the Division through the Consultation Liaison person at Alice Springs Hospital. The Manager of CAMHS is also negotiating with the Division to develop a GP service within CAMHS to improve mental health consumers' access to primary health care.

9. In May 2005, the community visitors panel 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.

   The community visitor reported that, with the assistance of an Aboriginal Mental Health Worker (AMHW), CAMHS was adapting the Mental Health First Aid Program so that it would be more appropriate for people from remote communities. CAMHS was also planning to deliver the program in a "train the trainer" format to allow for the ongoing education of community members.

10. In May 2005, the community visitors panel recommended that CAMHS designate and fit-out more interview room facilities to allow for greater quiet and privacy for consumers.

    The community visitor reported that facilities for interviewing clients could only be improved if the service moved to a new location or the existing buildings were substantially altered. As funds are not

available for these major capital works, this recommendation was closed.

11. In March 2006, the community visitors panel 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.

    The community visitor closed this recommendation in the knowledge that the mental health service has established working contact with the Division of Primary Health Care.

12. In March 2006, the community visitors panel 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.

    The community visitor was informed that nurses from the forensic team have the capacity to visit inmates of the maximum security and remand sections of the prison on a daily basis if necessary. Additionally, the CVP was informed by Ms Bronwyn Hendry, Director of the Mental Health Program, that a forensic psychiatrist, employed at Royal Darwin Hospital, visits the prison every two weeks.

    Comments from both the Director, Mental Health Program and Brent Mansell, Acting Team Leader, Forensic Team, indicated that the mental health service consider that "regular, mandatory psychiatric reviews" would constitute an infringement of the rights of people in the prison system, who, as with other members of the community, should have the right to "seek or not seek" mental health services. Mr Mansell also stated that he responds to referrals from prisoners, Prison Officers, Lawyers, the Prison Medical Service and from his own knowledge of prisoners currently in custody in Alice Springs.

    The CVP was sympathetic with the view outlined above. Indeed, Principle seven of The National Statement of Principles for Forensic Mental Health 2002, states that the capacity or right to consent is not forfeited as a result of a history of offending or status as a prisoner. Further, Principle four of the same document states that appropriate referrals and assessment procedures should be conducted if the person is behaving in such a way to indicate that there may be a mental health problem. It appeared from reports given to the CVP by Ms Hendry and Mr Mansell that the mental health service was meeting these standards.

    A report by the AMA in their Report Card Series on Aboriginal people and Torres Strait Islanders in Prison (2006) cites a 2003 NSW Health study that found that over one third of sentenced inmates suffered from a mental disorder, including psychotic, affective and anxiety disorders. A full mental health screening as part of the medical

screening undertaken when a prisoner is first admitted into custody would enable early detection and treatment of mental health issues as appropriate.

Accordingly, the community visitor determined to close this recommendation and follow up the issue of mental health assessment at the time a person is incarcerated during the next visit to CAMHS.

13. In March 2006, the Alice Springs community visitors panel recommended that CAMHS explore ways in which to improve the recruitment and retention of staff working within the prison environment.

    The community visitor was informed that the Forensic Team is currently recruiting a second nurse and an AMHW. The CVP accepted the proposition that the team links well with the prison medical service, is well supported by the visiting psychiatrist, and will be linking with forensic services at a national level, and that these links serve to reduce the isolation reported by staff in the previous panel report.

14. In March 2006, the community visitors panel recommended that the Department of Health and Community Services (DHCS) meet with the Department of Justice (DoJ) 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.

    The Manager of the CVP contacted the Mental Health Program regarding the status of this recommendation. Ms Bronwyn Hendry, Director Mental Health Program responded that there is a Joint Steering Committee for Mental Health and Disability In-reach Services. DHCS is liaising with DoJ regarding primary health services and potential development of a facility to cater for people with mental illness, acquired brain injury or intellectual disability.

    It is unlikely that any new facility will be developed in the immediate future. However, as stated above, the Acting Team Leader of the Forensic Team maintained that he has ready access to prisoners and is able to follow up any referrals for assessment and treatment. Accordingly, this recommendation was closed.

DARWIN

TEMHS Inpatient Unit

May 2007 Community Visitors Panel Visit

1. In October 2004, the Darwin community visitors panel recommended that discharge planning procedures be improved by implementing all criteria of Standard 11.5 of the National Standards for Mental Health – Planning for Exit;

   Standard 11.5 of the National Standards for Mental Health identifies the following elements as minimum expectations for discharge planning:
   - An exit plan is developed during entry to the Mental Health Service (MHS);
   - The exit plan to be reviewed with the consumer, and with consent their carers;
   - Consumers and carers are informed of available community services;
   - A process is in place to ensure a nominated service provider is involved as early as possible;
   - The MHS follows through to ensure satisfactory contact is made with service providers on exit from the service;
   - All mental health services are planned and delivered with the briefest possible duration consistent with best outcomes for the consumer;
   - Documented policies and procedures to achieve the above are in place; and
   - The MHS monitors its performance with respect to the above and uses data to improve its performance.

   The panel believed that following the appointment of the Community Liaison Officer/Discharge Planner, consumers are:
   - Consulted;
   - Appropriately informed of community services for follow up; and
   - That the Discharge Planner follows through with service providers, particularly accommodation and particularly remote communities.

   The panel expressed some concern that documentation is not complete, however it was informed that the discharge planner is working to improve this. Accordingly, this recommendation was closed.

2. In October 2004, the panel recommended that guidelines be negotiated between Ambulance, Police and Mental Health Services to improve transport to hospital.

   The panel was aware of proposed national guidelines for transport to hospital. A letter from NT Police to the Community Visitor Program confirmed that Police see their role as transporting consumers to hospital only as a last resort. The outstanding issue for the panel was transport to hospital in the cage of a police vehicle. Accordingly, this recommendation was closed and a new recommendation specifically addressing the mode of transport opened.

3. In October 2004, the Darwin community visitors panel 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.

   The panel was informed that interviews for a twelve month trial social work position were being held the day after the panel visit. The panel was very pleased to be able to close this recommendation.

4. In October 2004, the panel recommended that consumers in the facility have the same choices and quality for evening meals as other patients in the hospital.

   The CVP is aware that Management within the TEMHS Inpatient Unit have trialled a number of alternatives to improve the quality and array of meals provided within the Unit. Currently, two PCAs are employed to prepare meals so that they are served concurrently in JRU and Cowdy Ward. Salad meals are also available for consumers if they choose this rather than a hot meal.

November 2006 Community Visitors Panel Visit

5. In October 2004, the panel recommended that copies of all assessment warrants used in police transport to hospital be lodged on the consumer files.

   The Director of Nursing informed the panel that files would be checked to determine whether warrants were maintained in the files. If a problem was identified, a protocol would be developed to address this issue. On each of the visits conducted since this recommendation was made, the panel found no further instances of warrants not being placed on files. Given the above two circumstances, the panel was happy to close this recommendation.

The panel further recommended that TEMHS communication systems be improved to ensure that police receive a copy of an assessment warrant prior to apprehending all involuntary consumers.

The Clinical Nurse Manager informed the panel that police do not receive copies of assessment warrants. Proposed changes to the Mental Health Act allowing for the apprehension of consumers by police without a warrant meant that implementation of this recommendation was no longer feasible, and accordingly, it was closed.

6. In October 2004, the Darwin community visitors panel recommended that discharge plans show evidence of consumer involvement through inclusion of the consumer's signature on the plan.

   The panel noted that as this recommendation duplicated the comprehensive recommendation on discharge planning, it was therefore closed.

Community Visitor Quarterly Reports

Fourth Quarterly Report 2006 - 2007

7. In the first quarterly report of 2005 – 2006, the community visitor recommended that the Director of Nursing notify the CVP whenever a patient of the TEMHS Inpatient Unit was unable to access a medical bed at RDH and when in the opinion of medical and nursing staff medical treatment was the primary requirement.

   The CVP was informed that since the time this recommendation was first introduced, there had been no instances where mental health services were unable to access a bed in RDH when required. Accordingly, it was closed.

8. In the second quarterly report of 2005 – 2006, the community visitor recommended that any plan implemented to encourage or enforce compliance with medication should 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.

   The Director of Psychiatry informed the CVP that he agreed that it is appropriate to view a plan to enforce compliance with medication as a treatment plan to be subject to authorisation by the Mental Health Review Tribunal. Further, he stated that he planned to discuss this with his Consultants. Accordingly, the recommendation was closed.

9. In the third quarterly report of 2005 – 2006, the community visitor recommended that TEMHS evaluate its practice with respect to incidents that ought to be reviewed and notify the CVP once a policy was in place.

   The community visitor was shown procedures for the reporting of all incidents, including incidents of seclusion, on a new database. Additionally, the community visitor attended a meeting facilitated by the Director of Nursing to "unpack" the elements of the incident that precipitated this recommendation.

10. In the first quarterly report of 2006 – 2007, the community visitor recommended that TEMHS take action immediately to cease unsafe food practices, such as leaving food on the counter and reheating it, or chilling the food and reheating it later.

    TEMHS employed staff to ensure that food is served concurrently in Cowdy Ward and JRU. Staff were also notified that it is unsafe to reheat food.

First Quarterly Report 2006 - 2007

11. In the third quarterly report of 2005 – 2006, the community visitor 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.

    The Principal Community Visitor wrote to the CEO of the Department of Health and Community Services as required by S116 of the Act. The recommendation was closed after a response was received stating that new procedures were being developed in conjunction with the review of the Act. In fact, as discussed earlier in this Annual Report, TEMHS is still not meeting its notification obligations. While the recommendation remains closed, the CVP will continue to monitor the rate of notification from TEMHS.

Tamarind Centre

First Quarterly Report 2006 - 2007

12. In the first quarterly report of 2005 – 2006, the community visitor recommended that when conducting the review of discharge planning, consideration be 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.

    Following the investigation of a complaint to the CVP, this recommendation was closed, and replaced by the new recommendation detailed below.

    It is recommended that a discharge process is implemented that includes as a minimum a relapse prevention plan, documentation of interventions and their outcome, medication and referral to external organisations, including GPs.

13. In the first quarterly report of 2005 – 2006, the community visitor recommended that arrangements are made to ensure that only trained mental health staff triage consumer contact with TEMHS.

    This recommendation was made after a complaint was received from a consumer, who was feeling at risk of self harm, had contacted TEMHS and was unable to speak to a clinician. The Team Leader of the Adult Team informed the community visitor that all clinicians were attending training, and administration staff were managing telephone contact and passing on urgent contacts to team members. The CVP has been assured that while administrative staff in TEMHS are responsible for receiving incoming phone calls, all information is passed on to the relevant clinician for follow up. The CVP is satisfied that the circumstances that led to this recommendation will not arise again.

APPENDIX 3

RECOMMENDATIONS OUTSTANDING JUNE 30 2007

ALICE SPRINGS

Mental Health Unit

October 2006 Visit

1. It is recommended that an Occupational Therapist or Recreation Officer be reinstated on the Mental Health Unit.

March 2006 Visit

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

August 2005 Visit

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.

March 2005 Visit

4. 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.

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 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.

Inspection of Seclusion Register April 2007

7. It is recommended that CAMHS investigate and respond to the perceived link between an inability to use HDU due to staffing issues and the use of seclusion.

8. It is recommended that CAMHS respond to the CVP with respect to the issue of initial detention pursuant to S39 of the Act and confirmation of detention pursuant to S42 of the Act with a view to ensuring that all detentions are notified to the Principal Community Visitor and the Mental Health Review Tribunal.

CAMHS Community Teams

June 2007 Community Visitor Visit

9. It is recommended that the practice of using hospital notes for outpatient appointments cease, and that notes from all outpatient appointments are recorded on CCIS.

March 2006 Panel Visit

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

11. 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 Panel Visit

12. 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 Panel Visit

13. It is recommended that the MHS 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.

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

15. 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.

DARWIN

TEMHS Inpatient Unit

May 2007 Visit

1. It is recommended that the Mental Health Service ensure that interpreters are present at assessment for all consumers whose first language is not English and who are not proficient in English.

2. It is further recommended that Interpreter assistance is then arranged for all further assessments and to assist the consumer at any hearing before the Mental Health Review Tribunal.

3. It is recommended that if a consumer must be transported to an approved treatment facility by police, then all efforts are made to transport the consumer in the car rather than in the cage of the vehicle.

November 2006 Visit

4. It is recommended that a comprehensive accommodation and support model is developed, adequately resourced and provided in the Top End of the Northern Territory (in addition to the accommodation currently provided through the Manse). It is further recommended that the model takes into account the varied and diverse circumstances of consumers in the NT, and is developed collaboratively with consumer groups and mental health professionals.

5. It is recommended that a complaints system be put in place that allows consumers to access and lodge forms independently of staff.

6. It is recommended that funding is made available for the major works required to enable consumers in JRU to spend some time outside each day.

May 2005 Visit

7. 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.

8. 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

9. 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.

10. It is recommended that discharge planning procedures be improved by identifying and referring to preferred ongoing General Practitioners.

11. It is recommended that:
    (a) Information services to aboriginal consumers be improved by:
        i. providing greater access to Aboriginal Health Workers when an Indigenous consumer is admitted out of hours,
        ii. advocating for improvements to the interpreter service; and
        iii. providing appropriate visual material; and
    (b) Posters giving information about legal rights be prominently displayed in both Cowdy Ward and JRU.

12. It is recommended that 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

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

2005 – 2006 Third Quarterly Report

14. 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.

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

2006 – 2007 First quarterly Report

16. It is recommended that a discharge process from the Tamarind Centre is implemented that includes as a minimum a relapse prevention plan, documentation of interventions and their outcome, medication and referral to external organisations, including GPs.

June 2006 Visit

The Darwin community visitors panel did not visit the Tamarind Centre during 2006 – 2007. There has been no opportunity to follow up the status of these recommendations and they therefore remain outstanding. The community visitor will visit the Tamarind Centre at least once in the next twelve months.

17. 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.

18. 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.