ANNUAL REPORT
2007 – 2008

COMMUNITY VISITOR PROGRAM
NORTHERN TERRITORY

The Hon Ms Malarndirri McCarthy MLA
Minister for Children and Families
Parliament House
State Square
DARWIN NT 0800

Dear Minister,

Pursuant to section 115 of the *Mental Health and Related Services Act*, please find attached the Annual Report on the operations of the Community Visitor Program for the period 1 July 2007 to 30 June 2008.

Yours sincerely

TONY FITZGERALD
PRINCIPAL COMMUNITY VISITOR

26 September 2008

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Tony Fitzgerald:
Principal Community Visitor
Anti-Discrimination Commissioner

In accordance with my obligation under section 116 of the *Mental Health and Related Services Act* ("the Act") I have great pleasure in presenting the Annual Report for the Community Visitor Program (CVP) to the Minister for Children and Families.

Operation of the CVP

The CVP has a fundamental role in ensuring that the human rights of people receiving treatment under the Act are observed. The principal areas of CVP activity, as prescribed under the Act, are to conduct inquiries into the standard of mental health services and facilities; to hear and resolve complaints; to inspect seclusion registers held at the psychiatric inpatient units; and to conduct six monthly Community Visitors Panel visits to each psychiatric inpatient unit.

The CVP is located in the Anti-Discrimination Commission (ADC) to ensure its independence, and I am appointed Principal Community Visitor and Commissioner of the ADC. The location of the Program within the ADC results in advantages to both agencies.

The CVP benefits from the knowledge of ADC staff who are experienced in the investigation and conciliation of complaints. The program is also well supported by the administrative staff employed by the Commission.

The ADC benefits from the mental health knowledge and experience of Community Visitors who are consulted when enquiries about discrimination on the grounds of mental illness (impairment) are received.

During this year's 'reporting period' (July 2007 to June 2008) the CVP's complaints resolution procedures were reviewed by Rachael Dunn, a Conciliator with the ADC, as part of her Masters in Alternate Dispute Resolution. As a result, the CVP has altered its complaints handling function to incorporate conciliation between complainants and the mental health service.

In May 2008, the ADC funded the CVP Manager's attendance at Conciliation Training delivered by the Australian Human Rights Commission in Sydney. The training will enhance the CVP's capacity to provide a high quality dispute resolution service.

Staffing

The approved staffing level for the CVP is one, the Manager of the Program. The CVP also employs Community Visitors in both Darwin and Alice Springs who work on a sessional basis. Community Visitors Panels are established in Darwin and Alice Springs to visit psychiatric inpatient facilities once every six months.

No annual report would be complete without acknowledging the outstanding contribution of Judy Clisby, the Program Manager.

When Judy commenced duties some four years ago, the CVP was a stagnant and largely ineffective agency. Since then she has considerably raised the profile of the CVP and achieved some outstanding results.

Judy is indefatigable and creative. She is the only full time employee of the program. She frequently prepares regular, insightful and comprehensive reports for me to read, liaises with the Health Department, recruits Community Visitors, visits mental health facilities and attends to the many other duties required by the Program.

Mental health is an area which is continually under-resourced and the Northern Territory is no exception. The CVP runs to a very modest budget. It is a great credit to Judy that the Program has achieved so much under her stewardship.

This year the CVP handled a total 271 complaints and enquiries, a 35% increase from complaints and enquiries received in 2006 – 2007. This is directly related to an increase in the number of visits to the psychiatric inpatient facilities in Darwin and Alice Springs. There is a relationship between CVP presence and requests for assistance.

Unfortunately and predictably, there is a significant amount of unmet need for monitoring and advocacy within mental health services in remote NT. One of the CVP's duties has been to attempt to meet that need within the scope of the *Mental Health and Related Services Act* through Community Visitors Panel visits to approved treatment agencies, which include mental health teams operating in remote settings. Rather than address the unmet need, Government has now removed the Panel's responsibilities for remote NT by legislative amendment.

A CVP presence in remote areas is only possible if Community Visitors are employed to act in these areas or if regular visits (at least six monthly) are conducted to mental health services in remote NT. Neither option is possible because it is outside the scope of services the CVP is funded to deliver. The lack of CVP presence is reflected in the receipt of only one complaint from remote NT in 2007 – 2008.

PART 1

INTRODUCTION

The Annual Report for the Community Visitor Program (CVP) informs the Minister responsible for mental health in the Northern Territory 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 NT *Mental Health and Related Services Act* ("the Act").

The Annual Report is presented in four parts. Part 1 comprises the introduction to the report and a brief overview of the key issues which affect people in the Territory who are receiving treatment pursuant to the Act. In Part 2, the issues noted by Community Visitors Panels and Community Visitors in the Territory in the 2007 – 2008 financial year are described, along with issues that are still outstanding from previous Annual Reports. Case examples are used throughout this report to illustrate specific issues, however in all cases details such as gender or diagnosis and even location may be changed to protect confidentiality. Part 3 comprises a report on Inspections of the Seclusion Register as required by section 62(14) of the Act. Part 4, the final section of the Annual Report, provides of a brief description of the CVP and a report and analysis of its activities for the reporting year.

New Logo for the CVP

The CVP is pleased to introduce its new logo which is featured on the front cover of the Annual Report. It is based on a picture of two Jabirus in a nest, taken by the program Manager, Judy Clisby. The nest has been replaced so that the Jabirus are cupped in two hands, representing the multicultural nature of the NT. The birds themselves represent the twin concepts of freedom and rights. The top end of the Territory is represented by the choice of Jabirus for the logo, while the orange background is reminiscent of the colours of Central Australia.

Role of the CVP

People with mental illness are vulnerable, and especially so when receiving involuntary treatment. The CVP, along with other mechanisms such as the Mental Health Review Tribunal (MHRT) and legal services, is an essential component of the system of checks and balances which safeguards the rights of people receiving involuntary treatment. The CVP sees its role as ensuring as far as possible that a person's legal rights as defined in the Act are observed, 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 protected.

The role of Community Visitors within the Northern Territory is probably the most complex of any similar program in Australia. It is the only jurisdiction where Community Visitors are required to advocate for consumers of mental health services and at the same time impartially investigate their complaints. In order for the complaints function of the CVP to be effective, the CVP must be seen to be impartial by all parties. This task is made even more difficult by the size of the program, such that these conflicting roles often rest with the one person.

This issue was discussed extensively in a research report written by Rachael Dunn, Conciliator with the Anti-Discrimination Commission (ADC) in May 2007 entitled *What are Appropriate Alternative Dispute Resolution Processes for the Mental Health Community in the Northern Territory?* Dunn recommends that whenever possible, advocacy and complaint functions should be separated by ensuring that two Community Visitors work on each complaint so that one Community Visitor handles the advocacy function and the second Community Visitor the complaint and conciliation function. It is recognised however that this is difficult in light of the size of the CVP.

In her study, Dunn also explored the dispute resolution style of the CVP. The CVP uses a variety of dispute resolution mechanisms, including informal and formal negotiation, mediation and conciliation. The outcomes of this study will form the basis for the ongoing development of the way the CVP manages its complaints handling function, with an increased focus on conciliation as the primary mechanism for complaints resolution.

Significant Issues in the NT

Community Visitors and Community Visitors Panels identified a number of issues in 2007 - 2008, not all of which can be covered in this document. Issues which appear repeatedly or have significant impact, and those that are common throughout the Territory are included in this report.

Two issues which the CVP believes have a major impact on the lives and experiences of people with mental illness are discussed at length Part 2 of this report. These issues are as follows:

1. People with complex issues that include mental illness and a combination of alcohol and other drug problems, intellectual disability, acquired brain injury and/or challenging behaviours still experience long admissions to hospital due to difficulty accessing necessary and appropriate housing and support in the community.

2. People with mental illness, when acutely unwell, are often transported to hospital in a police vehicle, and when transported by Police are most often transported in the cage of the police vehicle.

A third issue which the CVP has not been able to raise directly in reports to TEMHS or CAMHS because it is a Territory wide rather than a local issue, refers to the visibility of mental health services in the NT. The only entries under the heading "Mental Health" in the phone book are the two non-government organisations whose names begin with "Mental Health". A person who has not had previous contact with mental health services in the NT will not find its phone number unless the person knows that the Mental Health Program is a division of the Department of Health and Families.[1] The CVP strongly suggests that this situation is rectified.

Mental Health Services in the NT

Systems advocacy is seen as one of the primary roles of the CVP, and for this reason issues which affect people with mental illness and their carers are raised in reports to mental health services. These issues are also addressed in the Annual Report which constitutes the primary vehicle for communication with the Minister responsible for mental health service delivery.

At the same time, this can result in an unbalanced view of the service. The CVP recognises that all involved in the mental health service industry are committed to providing a quality service for people with mental illness living in the NT.

The CVP recognises the significant increase in funding to the non-government mental health sector over the past four years. This has enabled non-government community mental health services to provide community accommodation with support for people with mental illness along with "Step Up and Step Down" services to assist consumers either avoid hospital admission or to be discharged earlier than they would otherwise be without the availability of a high level of support.

The CVP also congratulates the TEMHS Inpatient Unit on its inclusion as a beacon site for the Australian Seclusion Reduction Strategy. The CVP is able to report that the number of seclusion episodes in the NT has reduced since the program first began its inspections of seclusion registers in 2004.

Although the CVP has no exact data, inspections have revealed that periods of seclusion are shorter; that is, a person who once may have been secluded for a lengthy period of time is now more likely to be secluded for a short period, and then re-secluded if still unsafe. Given that this practice should result in an increased number of seclusion episodes, it is significant that the number of seclusions has in fact declined. The CVP looks forward to being able to report on a further reduction in the seclusion of clients of mental health services in future Annual Reports.

There have been major changes to the TEMHS Inpatient Facility over the past twelve months:

- A High Dependency Unit (HDU) in Cowdy Ward is now operational and available for use for nursing vulnerable people at high risk;

[1] Department of Health and Community Services until June 30th, 2008

- The environment in the Joan Ridley Unit (JRU) has been significantly improved;

- The Tidal Model of Nursing is being introduced into nursing practice in the TEMHS Inpatient Unit, and over time should result in improved engagement of consumers with the service;

- The introduction of activities in both Cowdy Ward and JRU, including daily walks for clients of Cowdy has led to a more engaging and home-like atmosphere in the ward; and

- The TEMHS Inpatient Unit became a non-smoking facility on 31st May 2008.

The CVP also congratulates the Mental Health Unit in Alice Springs for its innovations in partnering with external agencies to improve its inpatient services for young people.

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 gratefully acknowledged. 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). Simon Wiese has acted in this capacity for the past five years, and his contribution to the CVP is appreciated.

Other staff within the ADC provide additional support to the program and this also is gratefully acknowledged. The CVP acknowledges Karyn Jessop for her administrative assistance and enthusiasm, Somsong Albert for managing the CVP budget, Melanie Campbell for her creativity, Rachael Dunn for assisting with an understanding of Alternate Dispute Resolution and Surya Silva for acting as a "sounding board". Finally, the CVP acknowledges Lisa Coffey for her invaluable assistance in interpretation of mental health law and policy.

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.

PART 2

UNRESOLVED ISSUES AS AT 30 JUNE 2008

SIGNIFICANT ISSUES

Housing and Support for People with Complex Needs

Not only do all people have a right to safe and secure housing, there is considerable evidence to support the link between mental health and the availability of suitable housing[2]. Yet the Community Visitor Program (CVP) has been reporting difficulties for consumers of mental health services accessing appropriate supported accommodation in its Annual Report every year since 2004.

The Mental Health Program has substantially increased funding to the non-government sector to provide accommodation and support services for people with mental illness. However, twenty four hour support, at least in the short term, may be necessary to support the community tenure of people with complex issues that include mental illness and a combination of alcohol and other drug problems, intellectual disability, acquired brain injury and/or challenging behaviours. The cost of providing this intensive support is a significant barrier to people with complex issues accessing housing in the community.

People most affected by the lack of ready availability of appropriate housing and support include young people with multiple and complex issues (typically under the guardianship of the Minister), adults with challenging behaviours and elderly people with challenging behaviours. Some brief case examples are provided to illustrate the range of people who are affected, and the way this lack of services impacts on others with mental illness.

A young man who does not experience a mental illness was placed in the High Dependency Unit (HDU) of the TEMHS Inpatient Unit as a secure setting to allow respite from behaviours that were particularly unsafe for himself and others. The young man was placed in the Unit under an Order pursuant to the *Community Welfare Act*. At the time of his placement in the ward, the young man was under 18 years of age and under the care of the Minister.

No comment is made on the appropriateness of this intervention, except that a purpose built facility, operating from an evidenced based model of service delivery and specifically designed for young people in this situation would be a far more beneficial placement.

[2] Eg Elly Robinson and Ren Adams / Australian Family Relationships Clearinghouse Housing (2008) *Stress and the Mental Health and Wellbeing of Families*

The CVP must look at this situation from the perspective of the consumer of mental health services. From this perspective, it is an example of facilities designed to improve the experience and well-being of people with mental illness being used for other purposes. The HDU was developed specifically for flexible use within the Inpatient Unit for vulnerable people with mental illness who need to recover in a quiet and safe area. It has been used effectively to nurse young people experiencing psychosis as well as young mothers with new babies.

A woman with a psychotic illness and challenging behaviours was detained to the ward for more than six months, despite her mental illness having resolved. She was there because she needed accommodation with significant support and it was not available.

From August to November 2007, the CVP received phone calls at least once a week from this woman who was pleading to be "released". She told Community Visitors that she felt like a prisoner, that she was tired of being around sick people who said "dumb things" to her. She absconded from the Unit regularly. In order to manage her, the Unit was locked, but even so, the locks were broken on at least one occasion and the woman managed to leave. The consumer was secluded 15 times in a six month period, with these seclusions occurring primarily when she was attempting to leave the facility.

The effect on her was a coercive intervention that over time became increasingly counter-therapeutic. The Unit is set up as a therapeutic environment to treat people with mental illness and is therefore not suited to behaviour modification plans that directly target challenging behaviours. Any long term admission contributes to increasing institutionalisation over time, with consequent loss of independent living skills.

Staff were placed in a situation of having to work coercively with a client who no longer met the strict criteria for involuntary detention. It was difficult for Community Visitors to cope when the person was begging to be discharged – it must have been extraordinarily difficult for staff who had to manage their own reactions to the person constantly begging to leave the facility.

Other consumers who were unwell also had to deal with the increased emotional arousal in the ward directly related to the consumer's presence. The ward was locked for more than three months, and this impacted on the treatment of all other consumers during this time.

Principle 3 of the *Principles for the Protection of People with Mental Illness and the Improvement of Mental Health Care* states that "every person with a mental illness shall have the right to live and work, to the extent possible, in the community". This is echoed in the Part 2, Fundamental Principles, of the *Mental Health and Related Services Act*.

Howard Bath, in the Executive Summary of his Report on the *Northern Territory Community Services High Risk Audit* (2007:13), recommended that a Complex Needs Coordination Strategy is developed across the program areas of the Department of Health and Families.

As can be seen in the case examples provided in this report, the issues are complex and there cannot be a "one size fits all" response. The Mental Health Program alone cannot provide a service for these very challenging clients without taking necessary resources from services for clients with mental illness. For this reason the CVP supports Bath's call for a cross-program strategy to provide appropriate services for people with complex needs.

In order for people to live and work in the community the provision of a range of accommodation types with individualised support and treatment packages is essential. There is clearly a need for a short term secure care facility for adolescents with challenging behaviours and a separate but similar facility for adults. There is also a need for a range of accommodation types that might include individual accommodation, cluster housing and small group facilities, all with varying levels of support. These accommodation and support packages need to be readily available to avoid lengthy hospitalisations and the subsequent difficulties faced by the consumers involved, staff and fellow consumer inpatients.

Police Transport to Hospital

In its 2005, 2006 and 2007 Annual Reports, the CVP reported that consumers are often transported to hospital by Police in the cage of a police vehicle, despite section 10(b) of the Act which states that as a matter of principle Police should transport only as a last resort.

This issue is highlighted in the Annual Report because it is fundamental to the person's right to be treated with dignity and respect. The CVP recognises that all players: mental health professionals, ambulance officers and police officers respond as best they can in circumstances as they exist now in the Territory.

The CVP contends that the problem has two parts:

1. Transport of consumers by Police to the psychiatric inpatient units for treatment appears to be routine practice throughout the Territory, accepted as the norm by all players. This results in the expectation that NT Police is the agency responsible for responding to mental health emergency situations when a more appropriate role may be to support and safeguard mental health and/or ambulance staff; and

2. When a consumer is transported to hospital by Police, this transport is most often carried out in the cage of the police vehicle.

The Request for Transport to Hospital by Police Appears Routine

The CVP has received several complaints from consumers, their families and other service providers about this issue. People complain that if they contact mental health services concerned about a friend or family member, they are told to contact Police. There may be many reasons for this, including concerns for safety, availability of ambulances for transport or availability of mental health staff to assess the consumer.

When there are issues of personal safety, the CVP recognises the need for Police involvement. After investigation of three of these complaints however, it was found that options were not explored with the person contacting the mental health service prior to advice to contact Police being given. This indicates that a change in the way consumers are transported to hospital must be based on a change in culture to ensure that transport by Police is truly "the last resort". Outlined below are examples of complaints received by the CVP, or situations brought to the program's attention where routine practice, rather than individual assessment, resulted in either a recommendation to contact Police or actual Police transport to hospital.

A consumer in Alice Springs complained that he had been transported to hospital in the cage of a police vehicle. When queried about the inappropriateness of transporting the consumer this way, the Registrar said he was not exactly sure who had organised it but that "I think it is just our protocol. You can't transport a suicide risk in a car". "It's just about risk".

The practice of contacting Police for transport appears to be so routine that the Registrar at the Mental Health Unit (MHU) believed that it was "protocol". While not necessarily indicative of the beliefs of all mental health staff, this is an excellent example of how practice becomes part of culture, and health professionals no longer see the experience from the consumer's perspective.

A service provider contacted mental health staff in Alice Springs concerned about the wellbeing of a consumer who had recently been discharged from the MHU. There were no apparent safety issues, yet the service provider was counselled to contact Police. A few days later, when they had assessed the consumer as requiring further involuntary admission, mental health staff transported the consumer to hospital.

The fact that mental health staff transported the consumer to hospital indicates that it was always the case that they could have done so and that the advice to contact Police was unnecessary.

During their visit to the TEMHS Inpatient Unit in November 2007, the Darwin Community Visitors Panel reviewed a consumer's notes which suggested that he was transported from a motor vehicle accident, in a state of agitation, to Emergency Department where he was subsequently assessed for neck, chest and abdominal injuries prior to admission for psychiatric assessment. The patient was transported in the cage of a police vehicle, not an ambulance.

The Panel did not comment on the circumstances that led to a decision to transport this consumer to hospital by Police rather than Ambulance. However, it is hard to imagine any circumstance other than an indication of mental illness that would result in transport by Police in the cage of a police vehicle (and therefore without any restraint) rather than by ambulance when physical injuries related to the motor vehicle accident were a possibility.

Transport is Most Often in the Cage of the Police Vehicle

The CVP has been arguing that when the only available mode of transport appears to be by Police, whenever possible this transport should be in the car rather than the cage of the vehicle. Again, this applies only when there are no assessed safety issues, yet Police presence is necessary because the person is unwilling to go to hospital. Outlined below are two examples of complaints received by the CVP in the past twelve months.

A consumer complained about transport to hospital by Police. The Community Visitor was informed that the consumer's case manager had arranged to transport the consumer to hospital, however before this happened, her parents had contacted Police. The case manager stated that when the consumer knew she was to be transported by Police, she resisted, saying over and over "Not in the cage".

The case manager informed the Community Visitor that once Police had been called, it was unlikely that the consumer would have agreed to transport by mental health services. The case manager stated that he believed that the consumer would have consented to transport in the back seat of the Police car had that option been available to her.

A doctor contacted Police from the medical clinic requesting transport to hospital for one of his mental health patients. The doctor had assessed his patient as requiring transport to hospital by Police because he had not agreed to a hospital admission, however the risk of aggression had been assessed as very low.

This complaint provides a strong example of both aspects of the problem under discussion. If the option of transport to hospital by mental health staff with police present had been routine practice, there is no doubt that Police would have been involved only in a support role.

Nevertheless, Police were contacted, and when they arrived, the consumer was immediately led to the cage of the police vehicle. The doctor had promised his patient that he would remain with him and so despite an offer by Police to transport him in the car, the doctor elected to travel with his patient in the cage. It is reasonable to assert that, given the low risk of aggression, the doctor and his patient could have been transported in the back seat of the police car.

CVP Actions and Outcomes

The Darwin Community Visitors Panel first recommended changes to the way consumers are transported to hospital in the report following their first visit to the TEMHS Inpatient Unit in October 2004. They reported extensively on this issue following their visit to the TEMHS Inpatient Unit in November 2007. The Panel was so concerned about the issues involved and the seeming lack of response to recommendations in place since 2004, that it wrote to the Principal Community Visitor requesting that he write to TEMHS and Northern Territory Police outlining the human rights issues with respect to transport of people with mental illness to hospital and asking that they take the necessary action to comply with the Panel's recommendations in respect of this issue.

In May 2008, the Principal Community Visitor wrote to Commissioner White APM outlining the issues raised by the Panel. This letter was copied to the Director Mental Health Program with the request that the CVP be involved in meeting with representatives from Mental Health and Police with a view to resolution of this issue.

The Commander GDRC NT Police phoned the Manager of the CVP to discuss these issues in June 2008 and supplied copies of General Orders and directions given to Police. The CVP was informed that the rear seat of police vehicles is used to store operational equipment, although Police should assess each situation as it arises.

There appears to be a commitment by NT Police to ensuring that people with mental health issues living throughout the Territory are transported safely and respectfully to hospital. There also appears to be support for the idea that the CVP should be involved in discussions with Police and mental health services on this issue. The CVP is aware that the Mental Health Service is also committed to ensuring that consumers are transported to hospital appropriately and respectfully. Just prior to the publication of this Report, the CVP attended a meeting organised by the Director Mental Health Program with a view to resolution of this issue.

The CVP is of the view that the goodwill evident from all parties means that this crucial issue can be resolved. It is hoped that in its next Annual Report, the CVP will be able to report that consumers are transported to hospital in a way that is respectful of human dignity, and that Police are involved only as a last resort.

PART 2: UNRESOLVED ISSUES AS AT 30 JUNE 2008

ISSUES IDENTIFIED 2007 – 2008

Timely Review of Involuntary Admission

A young man diagnosed with mental illness and complex needs was detained to the TEMHS Inpatient Unit. His illness quickly resolved, and the treating team planned to discharge him within five days. His Tribunal Hearing, due four days after admission, was accordingly cancelled. On the day of discharge, mental health were informed that the consumer could not leave because arrangements for his accommodation and support in the community had fallen through. The young man remained in the Inpatient Unit as an involuntary client for a further five days, two days after the detention should have been either reviewed or revoked.

The consumer was assessed as being at risk, and could not be discharged from the Unit without the necessary supports in place. He was not prepared to remain in hospital as a voluntary patient. The treating team was therefore faced with the dilemma of adhering to s123 of the Act, which states that the Tribunal must review an involuntary patient on the grounds of mental illness not later than seven days after the person is admitted, or honouring their duty of care to the consumer by continuing to detain him even though the detention had lapsed.

The team chose to continue the detention out of time with the result that the young man remained locked in the Unit two days after the detention should have been revoked. This action placed the service at risk of a civil action for false imprisonment.

While the CVP sympathises with the dilemma which faced TEMHS staff, the situation could have been avoided had the treatment team arranged for a Tribunal Hearing when they had the opportunity, four days after the consumer was admitted. The CVP recommends that in future TEMHS does not cancel the Tribunal Hearings of consumers who are detained in the facility and who are due to appear before the Tribunal.

A consumer was detained to the TEMHS Inpatient Facility pursuant to s42(1) of the Act which provides that a person may be detained on the grounds of mental disturbance for 72 hours. The consumer complained to the CVP that his detention was not reviewed until 24 hours after the order had expired, and that he was kept locked in JRU during this time.

The Community Visitor reviewed the consumer's case notes to find that the consumer had informed his nurse that his detention was out of time. The records showed that the second psychiatric review was 13½ hours out of time.

Accordingly, the Community Visitor emailed the Director of Psychiatry who reported that the consumer had been reviewed the day before the detention had expired, that the decision from this interview was that the detention should continue and failure to complete the appropriate form until the next day constituted an administrative error. It is the view of the CVP that the consumer was nevertheless falsely detained in JRU for 13½ hours after his detention had expired.

Right to be Treated with Dignity and Respect

Section 8(b) of the Act provides that "in providing for the care and treatment of a person who has a mental illness and the protection of members of the public … any interference with their rights, dignity, privacy and self respect is kept to the minimum necessary in the circumstances".

While reviewing case notes during a visit to the TEMHS Inpatient Unit the Community Visitor noted that a Behavioural Management Plan was included at the front of two sets of case notes. Each plan detailed a series of interventions in the event that the consumer exhibited particular behaviours. Seclusion for a period of one hour was listed as the final intervention.

The Community Visitor expressed concern that a person with a mental illness, unwell enough to be detained to the facility and therefore seemingly unable to control his or her behaviour, should be placed in seclusion as a final consequence in a behavioural management plan. The Community Visitor was also concerned that use of seclusion in this way is contrary to the provisions of s62 of the Act. These concerns were expressed in an email to, and a subsequent meeting with, the Director of Nursing and the Clinical Nurse Manager (CNM) of the Unit.

The CNM acknowledged that the plans may have given the impression that seclusion would be used punitively. This was not the intention, and she stated that she would follow up to ensure no similar management plans were included in case notes.

Adequacy of Facilities

Alice Springs Mental Health Unit

The Alice Springs Community Visitors Panel inspected the facilities in the Mental Health Unit during visits in November 2007 and May 2008. The Panel reported that while there had been some improvement, the amenities in the Unit still needed upgrading.

In particular, the Panel recommended that:

- Facilities to enable consumers to lock up personal items should be provided;
- Activities in the recreation room should be upgraded;
- Lighting and heating should be improved;
- Courtyards should be upgraded;
- Comfortable chairs should be placed in the "quiet room";
- Venetian Blinds throughout the Unit should be repaired; and
- The need for improved dining seating should be assessed.

The Panel reported that these changes, while not costly and relatively insignificant, would at the same time provide real benefits to consumers by improving their inpatient experience.

Alice Springs Community Mental Health Facilities

The Community Visitors in Alice Springs visited the Central Australian Mental Health Service (CAMHS) outpatient facilities in June 2008 and reported that there are no rooms in the building for case managers to see clients (ie interview rooms), with the result that case managers regularly hold interviews outside.

The Community Visitors noted that whilst some consumers may be comfortable with this, others may be better engaged if there is an option to go somewhere private. Apparently, the outpatient clinic contains rooms which are used by psychiatrists and which are sometimes available for case manager interviews. When these rooms are not available, case managers have no choice but to interview clients outside.

The Community Visitors found that the lack of appropriately private and safe interviewing space, which compromises the ability of consumers to meet with case managers confidentially, is a breach of the consumer's right to be treated with dignity and respect and potentially compromises the safety of consumers and staff. The Community Visitors recommended that the Community Visitor Program support any attempt by CAMHS to obtain funding to improve their facilities.

The CVP has since been informed that plans to move the Child and Adolescent Team to a nearby office should free up space for interview rooms within the building. This issue will be revisited by the Community Visitor during the next visit to CAMHS.

Joan Ridley Unit (JRU)

The Darwin Community Visitors Panel first commented on the inadequacy of the JRU environment during its visit in October 2004. The Panel commented on its loud and "echoey nature", and on the lack of access to fresh air for consumers in JRU. Since that time, there has been significant refurbishment of JRU, with areas carpeted and a real attempt to reduce the level of echoing noise in the Unit.

Over the past twelve months this refurbishment has continued. The interview room in the corridor has been assessed for noise and the walls carpeted to reduce noise from outside the room. The environment within JRU and the outside covered courtyard is now clean and pleasant.

However, consumers who are inpatients in JRU are still unable to go outside, sometimes for weeks. The area available to consumers, while now well ventilated, is still undercover. Indigenous people have informed Community Visitors and Panel members that they need to see, hear, touch and smell plants and see the sky. Many consumers have talked about their need to go outside, feel the sun and perhaps go for a walk.

The ability to go outside provides the ability for consumers to get some "grounding" by experiencing a reality that is very different to the artificial environment of JRU. The CVP strongly encourages the Department of Health and Families to undertake the capital works necessary to allow an outside space for consumers.

Services for Young People in the TEMHS Inpatient Unit

The Darwin Community Visitors Panel undertook a comprehensive assessment of services for young people during their visit to the TEMHS Inpatient Facility in November 2007. Prior to the visit, the Panel asked for the case notes of all young people under the age of 18 years who had been inpatient in the Unit in the previous six months.

Panel members were surprised to find that in the six months prior to their visit, at least 13 young people under the age of 18 years had been admitted to either Cowdy Ward or JRU despite the policy that, wherever possible, children under 18 with mental illness are managed by the psychiatric team on the paediatric ward.

In its 2006 – 2007 Annual Report, the CVP commented that a separate environment within the TEMHS Inpatient Unit is necessary to care appropriately for young people under the age of 18 years. The newly refurbished, separate area in Cowdy Ward is a significant improvement in facilities. As well, TEMHS has continued to ensure that as far as possible young people are nursed separately from adults and are assigned one-to-one nursing.

The Panel identified four issues related to the care of young people from their inspection of the TEMHS Inpatient Unit and the review of case notes. The first, the lack of alternate secure care and accommodation and support services has already been discussed in this Report in the section entitled "Significant Issues".

Young People: Informed Consent to Admission and Treatment

When any person is admitted to the psychiatric inpatient unit, his or her ability to give informed consent to admission as well as informed consent to treatment must be assessed. Section 7(3)(k) of the Act provides that when determining whether informed consent is given, due regard must be given to factors such as age, culture, disability and impairment. This means that the effect of the person's age on their capacity to give informed consent must be assessed, and this assessment should be documented in case notes. The question of whether a 14 year old, for example, has the capacity to give informed consent and the impact of their age on this capacity should be assessed and documented.

The Panel reported that there was no evidence that when a young person is admitted to the Unit, the effect of the person's age on their ability to give informed consent is assessed.

Notifying Parents, Guardians or Authorised Persons

The Panel commented that it appears that attention is not paid to s26(2) of the Act which requires that guardians, parents or authorised persons should be notified of admission where the person admitted is under 18 years of age.

The service is required to notify parents or guardians when a person under the age of 18 years is admitted as a voluntary patient, unless it is not in the interests of the person to do so. The service is also required to notify a person's primary care provider in the event of involuntary admission, again unless it is not in the person's best interests. Notification of parents/guardians/care providers should be clearly documented in case notes, and any decision not to notify should also be clearly documented along with the rationale for this decision.

Suitable Activities for Young People

Young people who are patients in the TEMHS Inpatient Unit are not provided with information about mental illness in a manner that is appropriate for young people. There are also no activities in the Unit specifically designed for young people.

Section 9(f) of the Act states that treatment and services for a person with a mental illness should be 'appropriate having regard to the age and gender of the person'. The Panel has been reporting on what they describe as the lack of suitable information and activities for young people since the 2005 – 2006 reporting period. The Panel has suggested, for example, that access to computers and computer games may be appropriate for young people. While limited access to a computer is available, the Panel commented that computer games appear to be Occupational Therapy (OT) based rather than recreational.

Services for Aboriginal People

Infrastructure in Aboriginal Communities

A letter was received from a Solicitor for the North Australian Aboriginal Justice Agency (NAAJA) expressing concerns about an elderly Aboriginal man who had his arm broken when he was restrained by Police prior to being brought to hospital in Darwin.

The Community Visitor investigated the complaint by speaking to the consumer, reviewing his case notes and speaking to health workers in the community. The Community Visitor concluded that in fact all involved, including Police and health workers, acted in the best interests of the consumer as well as they could in very difficult circumstances.

The Community Visitor identified that the situation arose in the context of a lack of capacity for services on the community to cope with a complex, ongoing situation along with a lack of infrastructure in the community itself. This situation highlights the challenges health workers in isolated circumstances face when trying to manage people with very complex behaviours without a comprehensive range of services to which they can refer.

Use of Interpreters: TEMHS Inpatient Unit

The Darwin Community Visitors Panel reviewed services for Indigenous consumers during their visit to the TEMHS Inpatient Unit in May 2008. For the visit, the Panel arranged to be accompanied by an interpreter from the Aboriginal Interpreter Service (AIS) accredited in the East Arnhem, Bururra and Kriol languages (amongst others). The Panel noted that most Aboriginal consumers were very happy to use an interpreter, including those who had a level of English comprehension.

Section 8(f) of the Act provides that a person who has a mental illness and needs language, interpreter, advocacy, legal or other services to assist him in communicating should have access to those services. The Panel found that the need for interpreter assistance does not appear to be recorded in case notes and there does not appear to be widespread use of interpreters when Indigenous consumers, whose first language is not English, are being assessed.

On the day of the visit, the Panel was aware that medical staff were about to assess a young Aboriginal consumer without an interpreter, despite the fact it was acknowledged an interpreter was needed. The Interpreter accompanying the Panel was pleased to be able to assist medical staff with the assessment.

This incident and information gained from a general meeting with medical staff reinforced the Panel's view that an assessment with up to six people in the room and without family support or an interpreter present is intimidating and creates a barrier to effective communication. The Panel also expressed the view that accurate assessment can only occur when the consumer's first language is used, especially in times of distress. The CVP suggests that the way assessments are conducted is reviewed in light of the issues raised by the Panel and s8(g) of the Act which provides that the person's assessment, treatment and care is consistent with the person's cultural beliefs and mores.

The Panel also noted from discussions with medical staff that often an accredited interpreter from the Aboriginal Interpreter Service is not obtained, but rather a family member is used for medical assessments of Indigenous consumers, particularly where it is deemed a more timely way to assess the person. The Panel expressed their concern that a family member or boarder may not act as an independent or accurate interpreter.

In their meeting with the Panel, TEMHS Management reported that the inpatient unit uses the interpreter service more than any other department at the Royal Darwin Hospital (RDH). The Panel was also informed that the reasons for not using interpreters include timing and difficulty accessing appropriate interpreters.

Since the panel visit, the CVP has been informed the need for interpreters is discussed daily at nursing handover. Relevant nursing policies which document requirements for use of interpreters for nursing admission and ongoing management within the ward have also been forwarded to the CVP.

To support cultural safety, the CVP is advocating for an active policy which supports the use of interpreters for all aspects of assessment (including medical assessment) and management of people whose first language is not English, including Tribunal appearances. This requires clear documentation of first language on admission. Even where it is not possible to obtain an interpreter urgently when a consumer is admitted to the facility, the CVP advocates that regular interpreter bookings should be made for the duration of that consumer's admission.

Information Management: Family Details

The Community Visitor visited the TEMHS Community Mental Health Teams based at the Tamarind Centre in January/February 2008. As part of the inspection, the Community Visitor viewed records maintained in the Community Care Information System (CCIS) and corresponding paper based notes of five consumers managed by each team (On Call Team, Adult Team and Child and Adolescent Team). Each record was examined to determine whether carers/familiy members were identified, what assessments had been undertaken and whether service plans were current and signed by the consumer.

A close relative was named for each consumer, but only in the paper based file and the location of the information varied from record to record. When asked why this information wasn't contained in the appropriate place in CCIS, members of the Adult Team stated this information could only be entered if the person already had a medical record in the NT. If no medical record exists, the case manager needs to enter information regarding the relative's date of birth, and they are understandably reluctant to ask for this information.

The CVP strongly suggests that the CCIS system be amended to allow staff to easily enter the names and contact details of relatives without the need for the entering of details such as Date of Birth. To do so, removes one barrier to effective liaison between mental health professionals and family members.

PART 2: UNRESOLVED ISSUES AS AT 30 JUNE 2008

REPORTING PERIOD 2006 – 2007

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 Authorised 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 is pleased to be able to report that in the past twelve months there has been significant improvement in both the TEMHS Inpatient Unit and the Mental Health Unit in Alice Springs with respect to adherence to the legislated timelines for medical review and the way reviews are documented in case notes.

Nevertheless, the CVP identified one incident of failure to conduct a medical review within the timeframes specified in the Act during a visit to inspect the seclusion register in the TEMHS Inpatient Unit in December 2007, and a second incident during the inspection of the seclusion register in Alice Springs in June 2008.

Darwin

The consumer affected was a young man who was secluded on 24 occasions during his stay in the TEMHS Inpatient Unit in August 2007. A management plan in the consumer's notes included the provision that medical review would take place at least four hourly during seclusion episodes.

Incident Report Forms contained in the hard copy register and case notes indicate that on 23rd August 2007 the consumer was secluded at 5.15 pm. Seclusion was broken at 9 pm and the consumer provided with medication, food and drink. A doctor was contacted, but there was no evidence that the doctor attended the ward in order to conduct a medical review. The consumer was immediately re-secluded, with the seclusion broken at 10.30 pm.

The Community Visitor considered that the consumer was continuously secluded for 5¼ hours from 5.15 – 10.30 pm and that failure to conduct a medical review constituted a breach of s62(8)(b) of the Act.

Alice Springs

When reviewing the seclusion register in Alice Springs in June 2008, the Community Visitor noted one instance where it appeared that a medical review was not conducted within four hours as required by the Act. The Community Visitor noted that contact was made with a medical practitioner after four hours, and the medical practitioner approved that the seclusion continue for a further two hours. It appeared from the notes that no actual examination was carried out. The consumer was therefore secluded for six hours without medical review in breach of s62(8)(b) of the Act.

Discharge from TEMHS Community Team

In its 2006 – 2007 Annual Report, the CVP commented on the effect of inadequate discharge planning on consumers who are discharged from the Tamarind Centre.

In early 2008, a consumer, who had been case managed by the Tamarind Centre for approximately 10 years was discharged from the service after a review by two doctors determined the she did not have a mental illness. The consumer was the subject of an Administration Order from South Australia.

In South Australia (SA), Administration Orders are implemented after a hearing before the Guardianship Board. Once the order is made, the person's finances are managed through the SA Office of the Public Trustee. A liaison officer is always appointed, usually the mental health case manager. In general, the client is not permitted to directly contact their Public Trustee Officer, and without a liaison officer is unable to organise any additional funds they might need.

The consumer was paid small amounts of money several times a week to assist with purchase of items like food and cigarettes. At the time of discharge from the Tamarind Centre, the consumer was at risk of homelessness. She was unable to arrange for money to assist her to obtain accommodation and no firm arrangements were in place to assist her with ongoing access to money.

The Community Visitor was contacted by a service provider external to mental health services requesting information about how she might work with the Public Trustee to ensure the consumer, who was then homeless, could access some money.

The Community Visitor, concerned that the consumer had been discharged from Tamarind without adequate arrangements in place, contacted the Team Leader of the Adult Team. The Community Visitor was informed that when the consumer was discharged, an email was sent to the Public Trustee Officer in SA advising that the consumer should be paid her full pension each fortnight. The Public Trustee was also advised that the mental health service in NT would no longer act in the liaison role. The Community Visitor was informed no response was received from the Public Trustee.

The consumer was apparently informed that she should travel to South Australia to appeal the Administration Order. The Community Visitor informed the Team Leader that this was unnecessary and that application could be made in writing (by the mental health service) and a hearing conducted by teleconference.

The Community Visitor accessed the website of the Office of the Public Advocate in South Australia. Information freely available at this site states: "If a liaison person no longer wishes to have this role or is unable to continue in this role, then he or she needs to inform the Guardianship Board in writing. If the liaison person knows of someone else who could perform this role, details of the proposed person should be given. The new arrangements will then be formalised at an appropriate time."

Failure to follow through appropriately meant that in this case the consumer continued with her previous financial arrangements which consisted of small amounts placed into her bank accounts every few days. The consumer was homeless, and could not buy additional food or pay for overnight accommodation because she could not contact the Public Trustee. It was fortunate that she sought help from a service provider who was prepared to assist with negotiations with the Public Trustee Officer in SA. This was an arrangement that should have been put in place before the consumer was discharged from TEMHS who were aware that the service provider was willing to work with the consumer in this way.

Liaison with Family

In the 2007 – 2008 financial year, the Community Visitor received five complaints from parents who were having difficulty contacting their (adult) child's doctor despite constant phone calls. Two of these families were interstate, and very concerned about the wellbeing of their child.

Two complaints from parents living locally were resolved immediately when the Community Visitor arranged a meeting between the doctor and the family member. A similar complaint from a family member who was unable to contact the doctor over the weekend was resolved at a meeting arranged between the family and the doctor. During this meeting, the doctor was able to explain the difficulties experienced by medical staff over weekends.

Complaints from family interstate were resolved after the Community Visitor contacted the doctor concerned to find that attempts had already been made to contact family. In the meantime, the Community Visitor visited the consumer in hospital and with the consumer's permission phoned the family member to reassure them that the person was coping well with the admission.

A family who had a close family member admitted to the TEMHS Inpatient Unit suffering first episode psychosis had not met with the doctor or staff from the Unit in the first two days after the admission. The Community Visitor, while on a visit to the facility, met the family and asked them how they were coping with the person's illness and admission to hospital. They had little knowledge or understanding of mental illness and appeared quite bewildered by their experience.

The Community Visitor spoke to the family about supports available in the community and about the social work service now offered through the ward. The family stated that they would find it helpful to speak to the social worker and agreed for the Community Visitor to contact the social worker to arrange a meeting. The social worker followed up immediately and met with the family the next working day.

The CVP suggests that a meeting between the family and the treating team of a person admitted to the inpatient unit, particularly when it is the person's first admission, should occur as a matter of course within the first few days following the admission.

PART 2: UNRESOLVED ISSUES AS AT 30 JUNE 2008

REPORTING PERIOD 2005 - 2006

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 2007 – 2008, TEMHS notified the Principal Community Visitor of only 38% of such admissions.

The CVP has in the past been particularly concerned about the low rate of notification from TEMHS, and has reported on this issue in each quarterly report since the third quarter in 2005 – 2006 (ie there have been 10 reports to TEMHS about the inadequacy of notification). This is now the third Annual Report in which this issue is raised.

Mental health services have the capacity and the duty to restrict a person's liberty when the person suffers a mental illness and poses a risk to him/herself or to the community. When a person's freedom is curtailed however, systems must be in place to ensure that this occurs both within the confines of the relevant legislation and that appropriate safeguards are in place. This is no different from the systems which protect people who are accused of committing a crime from unlawful detention.

Systems such as notifying the Principal Community Visitor act as one such safeguard. This notification is required by sections 41(2) and 43(2) of the Act. The continued failure to take this requirement seriously is of real concern, and indicates that the mental health service has no real understanding of the power that is held with respect to people's freedom and the need to ensure that this is offset by appropriate protections.

This power will increase once amendments to the Act are implemented. These amendments increase the period of detention pursuant to sections 39(1)(b) and 39(3)(b) of the Act from seven to 14 days. The CVP suggests that TEMHS take urgent action to ensure that systems are in place to ensure timely notification of detentions to the Principal Community Visitor.

PART 2: UNRESOLVED ISSUES AS AT 30 JUNE 2008

REPORTING PERIOD 2004 - 2005

Voluntary Admission and Informed Consent to Treatment

No definition of the term "voluntary" is included in the Act. It is therefore implied that if a person does not meet the criteria for involuntary admission as defined in s14 of the Act, the admission is voluntary as long as a medical practitioner is satisfied that the person has given informed consent to admission (s25). Section 29(2) of the Act states that "a person must be informed of his or her right to leave the approved treatment facility on being admitted as a voluntary patient".

There are two aspects to voluntary admission; informed consent to admission and informed consent to treatment. Informed consent to treatment needs to be given without "any inducement being offered" (s7(2)(a)), and like informed consent to admission, a voluntary consumer has the right to refuse treatment and withdraw consent "at any time while the treatment is being undertaken" (s7(3)(e)).

The complicating factor is that the Act provides as a matter of principle that every effort should be made to avoid admitting the person as an involuntary patient. The underlying principle is the principle of "the least restrictive alternative", which means that the state should intervene as narrowly as possible. This means placing the minimum restriction on the person's freedom required to ensure the safety of the person and others. When a consumer complains to the CVP about his or her status, the Community Visitor will speak to the consumer about the difference between voluntary and involuntary admission, and explore his or her preference regarding admission status. There are times when it is very important to the consumer to be admitted voluntarily, even if this status is only nominal. In these cases, once there has been a conversation with the consumer, the Community Visitor will consider the matter resolved. However, if the voluntary consumer states that he or she wishes to leave the facility, and is prevented from doing so, then the Community Visitor will investigate the complaint.

In past Annual Reports, the CVP has commented on complaints received from consumers in Alice Springs who had been admitted as voluntary patients and then informed that if they tried to leave the facility, their status would be changed to involuntary. In 2005, the Alice Springs Community Visitors Panel recommended that "a protocol for dealing with admissions be established to take 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".

The Manager of the CVP and the Medical Member of the Alice Springs Panel met with the Director, Mental Health Program, Senior Psychiatric Consultants and the Acting Clinical Nurse Manager in Alice Springs in November 2007 to discuss this issue.

The CVP received no complaints from that time until the Panel visit in May 2008. During this visit, the Panel noted that all consumers were aware of, and understood their status, whether it was voluntary or involuntary. Accordingly the Alice Springs Community Visitors Panel closed their recommendation.

In the month following the Panel visit, the CVP received a complaint from a young woman who had been detained to the Mental Health Unit. The woman had arrived in Australia a few years ago and obtained work in Alice Springs. Her psychiatrist had agreed to change her status to voluntary, contingent on her signing the Informed Consent to Treatment. She was refusing because she did not wish to take the medication.

The consumer had been informed that if she did sign the informed consent to treatment, she would be able to continue to work. She was also under the impression that an application for Australian Residency was more likely to be successful if she was treated as a voluntary patient.

The Community Visitor expressed some concern that voluntary status for this consumer appeared contingent on her accepting treatment. The Community Visitor was also concerned that the ability to go to work and attain status as an Australian resident were factors adding extra pressure to the consumer to consent to treatment. The CVP will continue to monitor the way the Act is interpreted with respect to voluntary/involuntary status for consumers.

Records of Outpatient Medical Appointments in Alice Springs

In its 2006 – 2007 Annual Report, the CVP reported that some outpatient psychiatric appointments are still recorded on the hospital paper file rather than CCIS or the community based paper file. The problem is that hospital paper files are stored in medical records in Alice Spring Hospital and community files are stored in the community mental health building which is separate from the hospital. It means that unless there is close liaison between case manager and doctor, the doctor may not have access to information about the consumer's current functioning and the case manager may not be aware of any changes to the consumer's medication.

The Community Visitor recommended that the practice of using hospital notes for outpatient appointments cease, and that notes from all outpatient appointments should be recorded on CCIS. No response was received from CAMHS regarding this recommendation.

This issue was revisited by Community Visitors during a visit to CAMHS in June 2008. They reported that there had been no real change in the recording of information in case notes by some Consultant Psychiatrists who continue to use hospital files for outpatient appointments.

The Team Leader of the Adult Team in Alice Springs indicated to the Community Visitors that there was an increased awareness on the part of case managers about ensuring continuity and consistency of information across all files (including hospital files) and the possibility for serious error in treatment that could arise if this was not properly managed.

The CVP concurs, and will continue to advocate for a change in practice so that all information about a consumer's community management is stored in the one place.

PART 3

INSPECTION OF SECLUSION REGISTERS

Mental Health Unit

The Community Visitor inspected the seclusion register in the Mental Health Unit in November 2007 and June 2008, reviewing 44 episodes of seclusion for the period 1 July 2007 – 18 June 2008.

In her report following the November 2007 review, the Community Visitor noted that all seclusions took place in accordance with section 62 of the Act. All timelines for medical review of seclusions were met and appropriately case noted. The Community Visitor stated that it was obvious from the review of case notes that a protocol for medical review of seclusions was in place and being conscientiously followed.

Two issues of concern were reported following the review in June 2008. The first related to one episode of seclusion where medical review did not take place within four hours as required by s62(8)(b) of the Act. In addition, three incidents of seclusion were reported in which observations were not all documented as taking place at regular 15 minute intervals contrary to s62(8)(a) of the Act. The Principal Community Visitor requested that CAMHS report to him regarding the records of these observations. At the time of publication of this report, the Manager of CAMHS had responded with details of actions taken by CAMHS to prevent future offences against s62(8)(a) and s(62)(8)(b) of the Act.

TEMHS Inpatient Unit

Seclusion registers in the TEMHS Inpatient Unit were inspected in December 2007 and again in June 2008. A total 356 episodes of seclusion were reviewed for the period from 1st July 2007 until 31st May 2008. In the second inspection, the Community Visitor noted that the number of episodes were inflated by three consumers who, between them, were secluded a total 75 times. The Community Visitor also reviewed the case notes of all consumers who were secluded for four hours or more.

The Community Visitor reported the following concerns from these reviews:

- One instance of apparent breach of s62(8)(b) of the Act when a consumer was secluded for five hours and 15 minutes without medical review (outlined earlier in this Report);
- Lack of clarity in documentation by medical staff. At times it was difficult to work out when medical reviews had taken place because the time of the medical review was not recorded either in case notes or in the record of seclusion;
- The possibility that time frames for seclusion still at times appeared to be tied to the need for medical review. The Community Visitor noted the phrase "not exceeding 4 hours or until settled" on several occasions during the November review. In the June 2008 review, the Community Visitor reported that three consumers had been secluded for exactly four hours and seclusion ceased at four hours when there appeared to be no documented change in their presentation. This indicated that seclusion was ceased to avoid the medical review rather than because the consumer no longer needed secluding; and
- There was very little evidence of Aboriginal Mental Health Worker (AMHW) involvement either before or after seclusion despite the fact that the seclusion of Indigenous consumers comprised at least 50% of all seclusions.

Following the review of the seclusion register in June 2008, the Community Visitor commended TEMHS on the professional documentation of seclusion. In particular, the Community Visitor reported the following improvements:

- Notes documenting precipitating events, action taken to defuse a situation to avoid seclusion and post seclusion intervention are clearly marked in the margin of case notes with a "clinical incident" stamp;
- Nursing staff are documenting pre-seclusion interventions, in some cases quite lateral interventions that include changing the consumer's environment and contacting family in an attempt to de-escalate a situation;
- Post seclusion interventions, at times multiple interventions, are documented for 72% of all seclusions occurring within the period of the second review, with the rate steadily increasing from December 2007 until the end of May 2008; and
- The Community Visitor noted that Management Plans for consumers experiencing high rates of seclusion are included in case notes and referred to both on hard copy seclusion forms and case note documentation.

PART 4

ADMINISTRATION OF THE COMMUNITY VISITOR PROGRAM

PROGRAM OVERVIEW

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

Jurisdiction

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

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.*

The Minister has approved both the Royal Darwin Hospital and the Alice Springs Hospital as approved treatment facilities under section 20(1)(a) of the Act.

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 (ADC) to ensure 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*. The Minister for Family and Community Services[3] appointed Tony Fitzgerald, the Anti-Discrimination Commissioner, to the role of Principal Community Visitor on 9 December 2005.

[3] At time of Publication, Minister for Children and Families

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 Children and Families. 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 Community 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.* It relates to the inspection and monitoring functions of the program.

Panel members are required as a group to visit the facility and agency in respect of which they have been appointed not less than once every six months. On 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. Amendments to the Act allow for a Community Visitors Panel to visit an approved treatment agency in certain circumstances but do 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 role of Community Visitors is outlined in Division 2 Part 14 of the Northern Territory *Mental Health and Related Services Act.* They perform the advocacy, complaints handling and inquiry/inspection functions of the CVP.

Community Visitors 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).

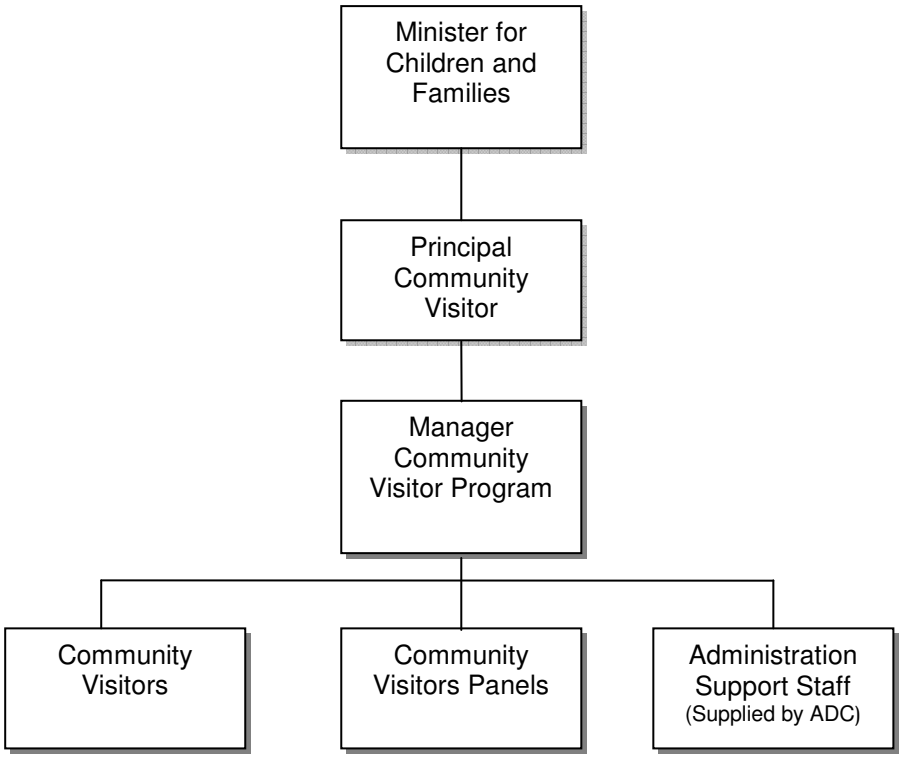
The program aims to ensure that Community Visitors are accessible to consumers of mental health services and their carers. This is achieved through regular visits to approved treatment facilities, and responding quickly to complaints and requests from consumers for a visit.

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 4: 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 two 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.

Principal Community Visitor

Tony Fitzgerald: Commissioner ADC and Principal Community Visitor

Tony has been the NT's Anti-Discrimination Commissioner and Principal Community Visitor for six years. One of his former roles as a lawyer 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.

Community Visitors & Panel Members

Judy Clisby: Manager CVP and Community Visitor

Judy has managed the CVP for four years now, having been appointed Community Visitor in June 2004. She is a social worker with a keen interest in mental health policy and human rights. Judy has trained as a mediator and has seven years experience working as a social worker across mental health settings. Judy has also been involved in special mental health projects including Early Psychosis, Borderline Personality and Accommodation for People with Complex Needs.

Simon Wiese: Community Visitor

Simon was appointed Community Visitor in November 2003. He is an experienced negotiator and mediator. Most of his involvement with the CVP is now in an administrative capacity, supporting sessional community visitors when the Program Manager is on leave.

Marilyn Starr: Community Visitor and Community Member, Darwin Panel

Marilyn was appointed Community Visitor in June 2005 and Community Member of the Darwin Community Visitors Panel in June 2006. Marilyn is a trained mediator, counsellor and small business manager with 16 years history of working in Indigenous communities. Marilyn was formerly the Project Officer with the Mental Health Coalition NT and has since worked with the Commonwealth Department of Health and Ageing.

Rebecca Lowe: Community Visitor and Community Member, Darwin Panel

Rebecca was appointed Community Visitor in October 2007 and Community Member of the Community Visitors Panel in November 2007. Rebecca undertook her third year social work placement with the ADC. She is interested in ensuring that all people have adequate access to well resourced facilities. Rebecca believes that consumers have the right to fair treatment and to a voice. Rebecca resigned from the CVP to concentrate on her final year social work studies.

Carly Ingles: Community Visitor Alice Springs

Carly was appointed Community Visitor for Alice Springs in May 2007. 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 Service (CAALAS). Carly has developed an interest in mental health through her work in Alice Springs.

Georgia Stewart: Community Visitor and Community Member, Alice Springs Panel

Georgia was appointed Community Visitor for Alice Springs in May 2007 and Community Member of the Community Visitors Panel in September 2007. 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 Corporation, working with dialysis patients from the Western Desert, providing advocacy, practical, family and other support. Georgie is able to be understood at a basic level in a number of desert languages.

Sarah Giles: Chairperson and Medical Member, Darwin Panel

Dr Sarah Giles, Chairperson and Medical Practitioner Member of the Community Visitors Panel in the Top End, was appointed in March 2004. 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.

Mark O'Reilly: Community Visitor and Legal Member, Alice Springs Panel

Mark O'Reilly was appointed Community Visitor Alice Springs and Legal Member, Alice Springs Community Visitors Panel in March 2006. Mark is Principal Legal Officer with the CAALAS in Alice Springs. Mark states that his interest in Mental Health Services started on a personal level when a family friend who was intellectually disabled was diagnosed with schizophrenia. Through his work at CAALAS Mark works with many clients who are charged with criminal offences and who are suffering for mental illness and/or cognitive delay.

Maya Cifali: Community Member, Alice Springs Panel

Maya was appointed Community Member of the Alice Springs Community Visitors Panel in March 2005. She is currently Chairperson of the Alice Springs Panel. 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

Dr Christine Lesnikowski was appointed Medical Practitioner Member of the Alice Springs Community Visitors Panel in March 2006, and Chairperson for the Panel visit in October 2007. Chris has lived in Darwin, Katherine and Alice Springs and now calls Alice Springs home. She has had an interest in mental health for many years, and completed a Diploma in GP Psychiatry in 2000. Chris has been working in the mental health GP project with CAMHS. Due to her many commitments, Chris resigned from the CVP in May 2008.

Georgia McMaster: Legal Member, Darwin Panel

Georgia was appointed Legal Member of the Darwin Community Visitors Panel in November 2007. Georgia has experience as a volunteer Legal advisor with Darwin Community Legal Service and has acted as a solicitor for the Darwin Domestic Violence Service. Georgia also has broad experience working as a Crown Prosecutor and as a Solicitor for Police, Fire and Emergency Services. She now works as a Barrister in her own Chambers at Bees Creek.

Alison Hanley: Legal Member, Darwin Panel

Alison Hanley was appointed Legal Member of the Darwin Community Visitors Panel in November 2007. Alison has a strong commitment to human rights law. Since 2001 Alison has worked as part time Solicitor with the Family and Civil Section of NAAJA, working in areas such as mental health advocacy, prisoner rights, victims of crime compensation and anti-discrimination law.

Alison has a strong commitment to NAAJA's client group, demonstrated through her advocacy at the Mental Health Review Tribunal. She has a sound knowledge of the mental health system and an interest in developing her own mental health knowledge. These qualities enable Alison to represent the interests of people receiving treatment under the Act.

PART 4: ACTIVITIES OF THE CVP 2007 – 2008

Involvement with Mental Health Services

The CVP appreciates the opportunity to work collaboratively with Mental Health Services on issues that affect people with mental health problems in the Territory. Accordingly, the CVP is pleased to be represented at COAG Reference Group meetings and COAG Care Coordination meetings. The Manager of the CVP has also attended Seclusion Reduction Meetings held at the TEMHS Inpatient Unit.

The Manager of the CVP also acted as an independent person on the Panel for selection of a senior nurse within the TEMHS On Call Team.

Social Work Student

The Manager of the CVP has supervised a social work student for each of the past three 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. Once students have completed their degree and commenced work in the human services sector, they are aware of the purpose and functions of the CVP and are likely to refer consumers to the program as well as provide information about the CVP to their colleagues.

Involvement with Community Activities

One mechanism for promoting the purpose of the CVP is involvement in community activities. In the 2007 - 2008 financial year, the CVP contributed to the following:

- Mental Health Week: The CVP attended interagency planning meetings organised by the Mental Health Coalition for the purpose of organising Mental Health Week;
- International Day of People with a Disability: CVP brochures were displayed at a stall held by the Anti-Discrimination Commission;
- International Human Rights Day: the CVP was actively involved in an event held at the Supreme Court;
- International Women's Day: the CVP was actively involved in the planning for this event 2008, and remains on the organising group 2009;
- Mapping Mental Health and Life Promotion: a representative of the CVP attended a half day workshop and met separately with the Project Officer; and
- Alcohol and Other Drugs Project: a CVP representative has attended group and individual consultations.

Conferences

The Manager of the CVP presented papers at two conferences in 2007 – 2008:

- Judy Clisby and Marilyn Starr presented a paper entitled: *The Least Restrictive Alternative. Is it too restrictive?* to a session at the THEMHS Conference in Melbourne in September 2007. The paper was heard by approximately a hundred people. It has since been published in the THEMHS Book of Proceedings.
- Judy Clisby presented a paper entitled *Fairness in Mental Health* at the NTCOSS Conference in April 2008.

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 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;
- TEAM Health: a presentation on the CVP was given to a meeting of TEAM Health Team Leaders; and
- Carers NT: a presentation was made to staff of this organisation.

Networking

The Manager of the CVP stays 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 NT (Darwin and Alice Springs);
- NT Carers (Darwin and Alice Springs);
- Disability Advocacy (Alice Springs);
- Legal Aid (Darwin);
- Community Justice Centre (Darwin);
- Mission Australia;
- Aged and Disability Services, Central Australia;
- Health and Community Complaints Commission;
- Northern Territory Council of Social Services;
- Pete's Place;
- Mental Health Coalition;
- Legal Aid – the Manager of the CVP meets regularly with the legal representative from Darwin Legal Aid; and
- Mental Health Association of Central Australia.

PART 4: PRIORITIES 2008 – 2009

The core business of the CVP is visiting the mental health inpatient facilities, receiving, investigating and resolving complaints and enquiries and carrying out the inspection and monitoring 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 information management: by the end of the 2008 – 2009 financial year, the CVP should have the capacity to generate all statistical reports automatically. In addition, the CVP is refining the way complaints are categorised.
- Updating CVP procedures and training in relation to amendments to the Act:
    - In 2007 – 2008 all Community Visitors and Panel members received basic training in amendments to the Act (with training prepared by the Mental Health Program). In 2008 – 2009, the training will be repeated and expanded to incorporate Approved Procedures.
    - The CVP has already begun to clarify the way complaints are handled and over the next twelve months will work with the Management of CAMHS and TEMHS to ensure agreement on the most appropriate procedures for the program, including timelines for reporting.
    - In the last Annual Report, plans for Community Visitors to visit community mental health teams in Darwin and Alice Springs twice and those in Tennant Creek, Katherine and Nhulunbuy at least once were reported. As will be seen from the Performance section of this report, this has not been achieved due to the high workload of complaints and enquiries received by the program. The CVP is not funded to visit remote NT. It will however continue to try to visit all community mental health teams at least once each year.
- Improving promotional material for the CVP:
    - A new logo was adopted by the CVP during 2007 – 2008. Existing materials were subsequently updated. The CVP has updated its existing information pamphlet and written a new pamphlet to explain the role of the Community Visitor in plain English. CVP pamphlets also need to be translated into the common Aboriginal Languages.
    - The CVP needs to develop additional promotional material and some style of media portraying information about rights in mental health. An upgraded website is long overdue. These activities are planned for 2008 – 2009 depending on the availability of funds.

- Training for Community Visitors and Panel Members: The following opportunities for professional development would enhance CVP capacity (and are only possible with increased CVP funding):

    - Mediation training for all Community Visitors: The CVP is changing its complaints handling to a focus on complaints resolution through conciliation between parties involved in the complaint. Community Visitors will be more effective in this role if they have the opportunity to attend mediation training.

    - An annual face to face meeting for the CVP, comprising forward planning and a conference/training program. An annual CVP meeting has numerous advantages including:

        - The opportunity to develop a strategic plan for the CVP;
        - Business planning;
        - Identification of training needs across the CVP;
        - The promotion of a consistent approach between Darwin and Alice Springs for Community Visitors and Community Visitors Panels respectively; and
        - Opportunities for professional development.

    - The second national "Official Visitors" Conference will be held in Sydney following the NSW Annual Conference in May 2009. Funding Community Visitors and Panel Members to attend the conference will assist with an understanding of the role of Visitors Programs throughout Australia and with an understanding of national mental health issues and how they translate to individual jurisdictions.

PART 4: PERFORMANCE OF THE CVP 2007 - 2008

Performance for the 2007 – 2008 year is measured against the legislative requirements for the CVP. This section of the Annual Report also reports on the number, categories and outcomes of complaints and enquiries received by the CVP.

Visits and Inspections

Table 1: Comparison of the Achievements of the CVP 2005 – 2008

		Alice Springs			Darwin		
	Legislative Requirements	2005/ 2006	2006/ 2007	2007/ 2008	2005/ 2006	2006/ 2007	2007/ 2008
Visits[1]	In response to requests/ inspection	22	21	26	63	55	63
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	2	2	2
Timeliness[2]	Percentage visits conducted within 24 hours of notification of a request	100%	100%	100%	100%	100%	100%

Notes:

1. The number of visits to CAMHS includes two visits to inspect the approved treatment agency (CAMHS Community Teams) and one visit to Barkly. The number of visits to TEMHS includes one visit to the Community Teams based at the Tamarind Centre.

2. Section 108(4) of the Act requires that a Community Visitor visit within 48 hours of a request for a visit. The internal performance measure for the program is 24 hours (except when the request is received over weekends).

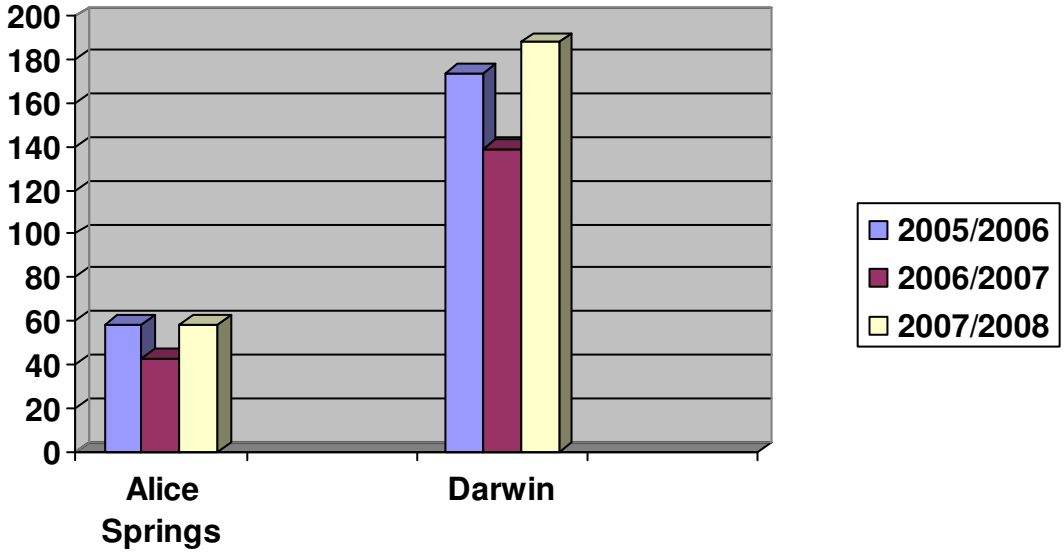
Complaints and Enquiries

The number of complaints and enquiries actioned by the CVP appears to be directly related to the number of visits to the approved treatment facilities. The number of complaints and enquiries in 2007 – 2008 has increased by 35% when compared to complaints and enquiries received in 2006 – 2007, although it is very similar to the number of complaints received in 2005 - 2006. Community Visitors have visited the approved treatment facilities slightly more often over the past twelve months, again with the number of visits very similar to those conducted in 2005 – 2006.

Table 2: Complaints and Enquiries Received

	Alice Springs			Darwin		
	2005/06	2006/07	2007/08	2005/06	2006/07	2007/08
Complaints & Enquiries Received	58	43	58	174	139	188

Figure 1: Complaints and Enquiries Alice Springs & Darwin 2005 - 2008

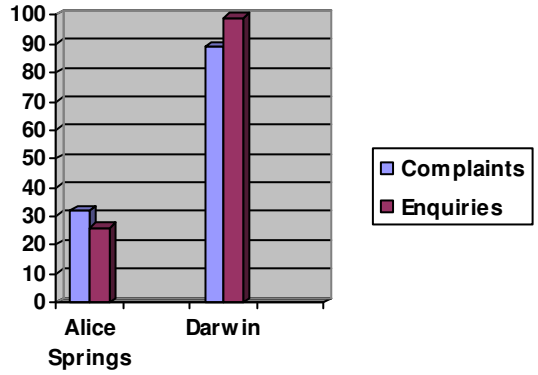


Complaint or Enquiry?

Consumers, carers and service providers contact the CVP for many reasons. Often, the contact may involve a request for information or a request for a Community Visitor to support the consumer during interactions with the mental health service (for example by attending meetings with the doctor). At other times, the person asks the CVP not to treat their issue as a complaint. All these, and similar contacts with the program are defined as enquiries in all reporting from the CVP.

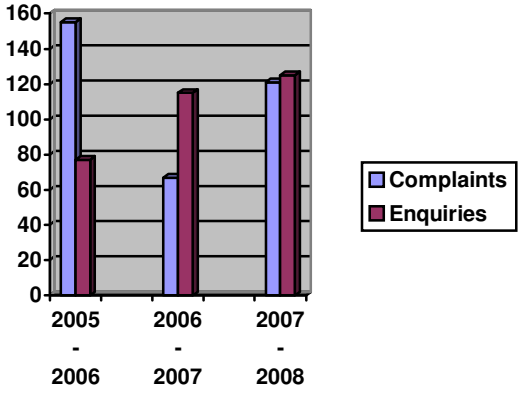
Complaints are contacts of a more serious nature. They may be oral or in writing and occur when the person contacting the CVP has a grievance with the mental health service, and/or specifically describes their contact as a complaint. In past Annual Reports, if a Community Visitor, in the course of investigating a complaint or enquiry, learned of a new issue requiring follow up with the mental health service, this was also recorded as a complaint. While these issues are still followed up by the CVP they are not recorded in the 2007 – 2008 complaint/enquiry figures.

Figure 2: Graph of Complaints vs Enquiries, Alice Springs and Darwin 2007 - 2008



In 2007 - 2008, the CVP received a total 121 complaints and 125 enquiries. 89 complaints and 99 enquiries were received regarding services provided by TEMHS, and 32 complaints and 26 enquiries about services received from CAMHS.

Figure 3: Graph of % Ratio Complaints:Enquiries 2005 – 2006 to 2007 - 2008

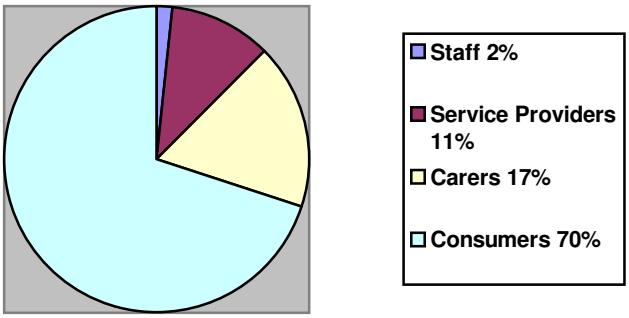


In its 2006 – 2007 Annual Report, the CVP reported that the proportion of complaints to enquiries when compared with 2005 - 2006 had reversed. The CVP expected this to continue. This trend has not continued in the twelve months 2007 – 2008 when, as can be seen from Figure 3, the number of complaints and enquiries were about equal.

Sources of Complaints and Enquiries

Complaints and enquiries are received from multiple sources, as illustrated in the figure below.

Figure 4: Source of Complaints and Enquiries NT 2007 - 2008



The term "staff" refers to any person employed by the mental health service. Service providers refer to organisations such as the non government mental health bodies, legal aid and other government and non government organisations.

Categories of Complaints and Enquiries

Table 3: Categories of Complaints and Enquiries 2007 - 2008

Category of Complaint/Enquiry		CAMHS	TEMHS	Total
Advocacy		10	31	**41**
Information	Access to Files		2	**2**
	Provided to Consumer/Carers/ Service Providers	6	34	**40**
Medication		5	10	**15**
Miscellaneous		1	8	**9**
Quality of Service Provision	Access to AMHW		2	**2**
	Assessment & Treatment	2	6	**8**
	Consultation – Carer		10	**10**
	Discharge Planning	3	4	**7**
	Facilities		7	**7**
	Procedures	1	9	**10**
	Communication/Relationship with Staff	9	33	**42**
Rights	Community Accommodation	4	1	**5**
	Detention	7	10	**17**
	Legal	5	7	**12**
	Location of Admission		5	**5**
	Respect for Dignity	2	2	**4**
	Seclusion	2	2	**4**
	Transport by Police	1	5	**6**
TOTAL		**58**	**188**	**246**

Other Complaints and Enquiries

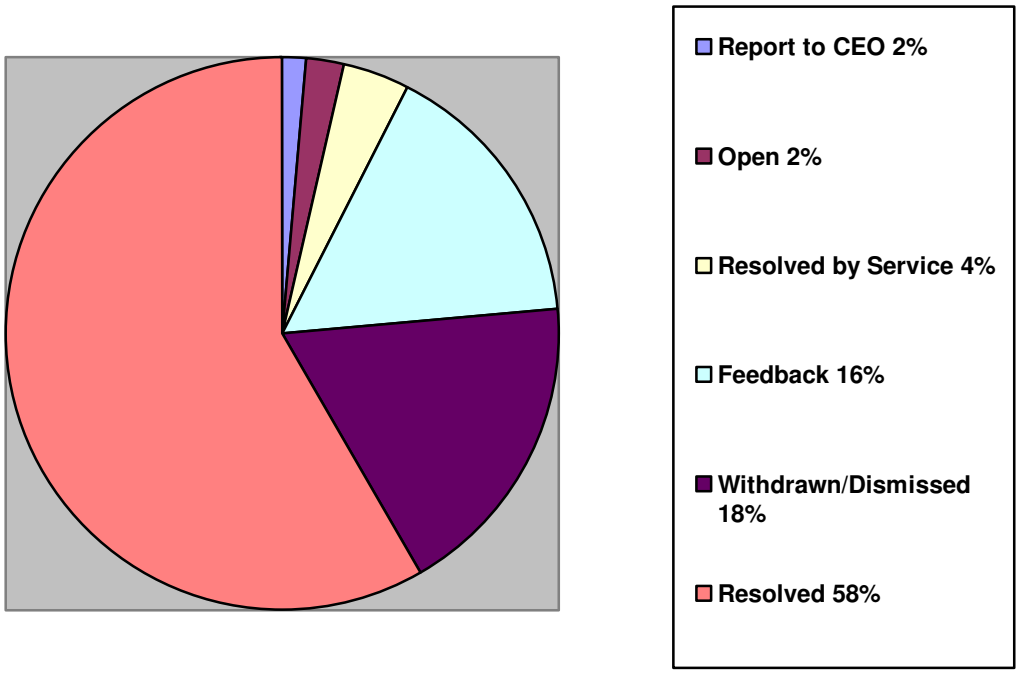
In addition to complaints and enquiries about mental health services in the NT, the CVP received a total of four complaints and 21 enquiries about non mental health services. These enquiries have included requests for information about accessing Treating Doctors Reports for Centrelink purposes, requests for advocacy with non-government mental health organisations and requests for assistance for people on Interstate and/or Territory Administration Orders.

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 advocacy. The Community Visitor in Darwin has also assisted in an advocacy role with consumers lodging a complaint with the Anti-Discrimination Commission.

Outcomes of All Complaints and Enquiries

The CVP provides quarterly reports to TEMHS and CAMHS on complaints and their outcomes. If the Community Visitor is aware that a complaint or enquiry is indicative of a broader issue, its outcome is recorded as 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 25 complaints and enquiries received about facilities other than CAMHS and TEMHS. The total number of complaints and enquiries for 2007 – 2008 is N = 271

Figure 5: Outcomes of Complaints and Enquiries NT 2007 - 2008



CVP FINANCIAL STATEMENT 2007 – 2008

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	78300		
Salary On costs	13940	92240	

Operational Expenses

Accommodation	2800		
Communication	1600		
Consumables	270		
Library Services	30		
Membership and Subscriptions	60		
Motor Vehicle Expenses	70		
Office Requisites and Stationery	260		
Official Duty Fares	2200		
Power	100		
Recruitment expenses	130		
Training and Study Expenses	1860		
Travel Allowance	480		
Information and Technology Charges	3570		
Fees and Other Regulatory Charges	18040		
Total Operational Expenses		31470	
TOTAL EXPENDITURE			**123710**
Deficit			**(3710)**

Notes

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. 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 2007 - 2008

After conducting a visit to an approved treatment facility, Community Visitors Panels meet with mental health management prior to submitting their report to the Principal Community Visitor. This provides an opportunity for the Panel to report on issues that are resolved in this way. Issues not resolved are incorporated into the Panel report, and will form part of the Panel's investigation during their next visit. If the issue is still not resolved, the Panel may then make a recommendation in their report to the Principal Community Visitor. This report is then forwarded to the person in charge of either the Central Australian Mental Health Service (CAMHS) or Top End Mental Health Service (TEMHS), whichever is appropriate. Thus the new Panel recommendations contained in Appendix 1 of this Annual Report refer to issues that CAMHS and TEMHS respectively have been aware of for at least six months.

ALICE SPRINGS

Mental Health Unit

May 2008 Community Visitors Panel Visit

1. It is recommended that there be a general upgrading of amenities in line with the "suggestions" raised by the Panel in this and the previous visit report as follows:
   (a) Provision of facilities for consumers to store personal items;
   (b) Refurbishment of the recreation room, including structured activities;
   (c) Improvement to lighting, heating and courtyard in the HDU;
   (d) Improvement to garden and paving in main courtyard;
   (e) Continued improvement of the Quiet Room;
   (f) Repairs to Venetian blinds throughout the Unit; and
   (g) Assessment of the need for improved dining seating.

DARWIN

TEMHS Inpatient Unit

November 2007 Community Visitors Panel Visit

1. It is recommended that for those under 18 admissions to the inpatient unit that are unavoidable, TEMHS develop with urgency a comprehensive framework for a "youth friendly" inpatient service which also ensures youth under 16 have access to expert assessment and management.

May 2008 Community Visitors Panel Visit

2. It is recommended that there are systems to ensure that Aboriginal Mental Health Workers are integrated into the clinical care of all Aboriginal consumers. There should be documented evidence of their role in individual consumer care.

Tamarind Centre

2007 – 2008 Third Quarterly Report

3. It is recommended that when working with young people with early psychosis, TEMHS maintain the case management service through the late recovery phase of early psychosis, that is for at least 18 months following acute treatment.

4. It is recommended that TEMHS investigate mechanisms for ensuring that Recovery Plans (including documented early warning signs from consumer, family and clinician perspectives and relapse prevention strategies) and Crisis Management Plans are easily accessible on CCIS. It is further recommended that the priority for the first stage of implementation of these plans should be young people who fit the criteria for early psychosis intervention.

APPENDIX 2: RECOMMENDATIONS CLOSED 2007 – 2008

ALICE SPRINGS

Mental Health Unit

May 2008 Community Visitors Panel Visit

1. In March 2005 the Panel recommended that a protocol for dealing with admissions be established to take into account the need to allow a voluntary 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.

   During the visit in May 2008, the Panel asked consumers about their understanding of their voluntary/involuntary status. The Panel found no suggestion of confusion on the part of consumers. Further, no complaints about this issue had been raised with the Panel by the Principal Community Visitor. The Panel therefore accepted that there had been a change in culture and practices and that this recommendation could be closed. Because this issue is integral to the right of consumers to be treated according to the least restrictive alternative, the Panel determined to continue to monitor this issue on subsequent visits to the Unit.

2. In August 2005, the Panel recommended that CAMHS work collaboratively with Alice Springs Hospital to initiate and participate in a range of activities designed to promote acceptance of people with mental disorders and/or mental health problems by reducing stigma in the hospital environment.

3. The Panel noted that a full-time psychiatric consultation liaison position is now in place and that one role of this position is to educate hospital staff generally about the particular characteristics and needs of mental health consumers. This recommendation was therefore closed.

4. In March 2006 the Panel recommended that CAMHS investigate mechanisms to ensure that consumers under 18 years of age have access to appropriate facilities and care.

   In their visit to the Mental Health Unit in May 2008, members of the Panel formed the view that as far as possible in the circumstances the unit is sensitive to the needs of young consumers and is innovative in the way it goes about trying to address those needs. Innovations include referrals to services in other jurisdictions when appropriate, giving access to the HDU as means of separating young people from the general population of the unit, using the assistance of the paediatric unit for very young consumers, accessing assistance from local youth groups and referring young people to a specialist psychologist.

October 2007 Community Visitors Panel Visit

5. In October 2006, the Panel recommended that an Occupational Therapist or Recreation Officer be reinstated on the Mental Health Unit.

   The recommendation refers to the need for an activities program on the ward and the recommendation was closed in the understanding that this role had been filled by a Social Worker. The Social Worker has since resigned. The Panel will continue to monitor the need for an activities program in the ward.

Community Visitor Quarterly Reports

Third Quarterly Report 2007 - 2008

6. After inspecting the Seclusion Register in April 2007, the CVP 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.

   No response was received from CAMHS regarding this recommendation. However the Nursing Manager of the Unit informed the Community Visitor that the service has had access to sufficient staff to ensure that HDU could be adequately staffed.

   The Community Visitor was also informed that changed practices as a result of the Seclusion Reduction Program mean that seclusion is less likely to be employed as an intervention in the Unit.

   The CVP was satisfied that this recommendation could be closed, and re-opened should the issue arise in the future.

7. After inspecting the Seclusion Register in April 2007, the CVP 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 were notified to the Principal Community Visitor and the Mental Health Review Tribunal within seven days.

   The Community Visitor made this recommendation after becoming aware of instances where a person had been detained for 24 hours pursuant to S39(1)(a) of the Act, then for a further 72 hours pursuant to S42(1) and then for 7 days pursuant to S42(2). This meant that theoretically, a consumer could be detained for 10 days prior to the review of the detention by the Mental Health Review Tribunal, despite Section 123 (1) which states that the Tribunal must review the admission of a person within seven days.

Amendments to the Act which extend the period that a person can be detained pursuant to sections 39(1)(b) and 39(3)(a), essentially make this recommendation irrelevant. It is expected that these amendments will be implemented some time in the 2008 – 2009 Financial Year.

CAMHS Community Teams

June 2008 Community Visitor Visit

8. In August 2005 the Community Visitors Panel 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.

   This recommendation was closed because it duplicates a Panel recommendation of May 2005.

DARWIN

TEMHS Inpatient Unit

November 2007 Community Visitors Panel Visit

1. In May 2005, the Panel 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.

   During the same visit in May 2005, the Panel also recommended that:

   (a) New videos be purchased to assist with the education of young people and their carers;

   (b) Pamphlets with information about services for young people be provided;

   (c) Age appropriate information about mental health, mental illness and medication be 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.

   The Panel reported that upgraded facilities in Cowdy Ward to provide improved opportunities for appropriate inpatient care for adolescents had been completed. With respect to the provision of specific information and activities for young people, the Panel noted that while it appeared that there was some access to computers, the Panel was not convinced that any other aspects of this recommendation had been met. In light of the fact that this recommendation had been in place for over two years, the Panel urged TEMHS to take urgent action.

   After a visit during which services for young people were extensively reviewed, the Panel determined to close the two recommendations above to be replaced by a single recommendation addressing the need to develop a comprehensive framework for the assessment and care of youth admitted to the Unit.

2. In October 2004, the Darwin Community Visitors Panel recommended that TEMHS explore and provide some additional low stimulus recreational activities in JRU.

   The Panel was pleased to report that an Activities Nurse had been appointed in the JRU three days a week. During the visit, consumers informed the Panel that they enjoyed the organised morning activities. The Panel expressed the hope that the two month trial period would lead to plans for the purchase of further equipment (foreshadowed as being a collapsible basketball ring, fish tank, stereo cupboard and pot plants), facilities and staff systems to sustain the program long term.

Community Visitor Quarterly Reports

Fourth Quarterly Report 2007 - 2008

3. In the Fourth Quarterly Report of 2004 – 2005, the Community Visitor recommended that a list be kept of any property removed from consumers when admitted to Cowdy Ward, and that this list be checked with consumers as soon as possible after admission. It was further recommended that the consumer sign the list when property was returned.

   No complaints about lost property were received by the CVP from January to June 2008, and the Manager of the CVP had sighted a draft policy covering procedures for recording of consumers' property during admission. The recommendation was therefore closed.

Tamarind Centre

First Quarterly Report 2007 - 2008

4. In the First Quarterly Report of 2006 – 2007, the CVP recommended that a discharge process be implemented that includes as a minimum a relapse prevention plan, documentation of interventions and their outcome, medication and referral to external organisations, including GPs.

   The CVP was provided with a draft copy of NT Mental Health Service Discharge Planning Policy which identifies that a discharge summary is to be sent to external organisations, and specifically identifies GPs as a group to be notified of discharge. Accordingly, this recommendation was closed.

   However, as detailed in the body of this report, the Community Visitor received complaints from consumers, carers and service providers about the quality of discharge planning from the Tamarind Centre. This aspect of Tamarind's service will therefore be extensively reviewed during the next Community Visitor visit to the approved treatment agency.

APPENDIX 3: OPEN RECOMMENDATIONS 30 JUNE 2008

The Community Visitors Panel attempts to review all open recommendations during each visit to an approved treatment facility. This is not always possible for many reasons, including time considerations and availability of relevant mental health staff.

The Panel may consider that progress has been made towards achieving a particular recommendation, with closure dependent on factors such as evidence (ie policy, or documentation in case notes). The recommendations contained in this section of the report may therefore be in various stages of resolution. In their report to the Principal Community Visitor, the Panel comments on each open recommendation and the reasons for it remaining open.

ALICE SPRINGS

Mental Health Unit

May 2008 Visit

1. It is recommended that there be a general upgrading of amenities in line with the "suggestions" raised by the Panel in this and the previous visit report as follows:

   (a) Provision of facilities for consumers to store personal items;
   (b) Refurbishment of the recreation room, including structured activities;
   (c) Improvement to lighting, heating and courtyard in the HDU;
   (d) Improvement to garden and paving in main courtyard;
   (e) Continued improvement of the Quiet Room;
   (f) Repairs to Venetian blinds throughout the Unit; and
   (g) Assessment of the need for improved dining seating.

March 2004 Visit

2. 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.

3. 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.

CAMHS 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.

March 2006 Panel Visit

The Alice Springs Community Visitors Panel no longer visits the approved treatment agency in Alice Springs and there has therefore been no opportunity to review the recommendations below. The Community Visitor conducted visits to CAMHS in November 2007 and June 2008 but was unable to meet with the Forensic Team (recommendations 5 and 6 below refer to the service offered within the prison). No report has been made to the CVP about these recommendations and thus while the issues may no longer be current, the recommendations remain outstanding.

5. 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.

6. 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.

May 2005 Panel Visit

7. It is recommended that the Mental Health Service work with the Interpreter Services in Alice Springs, the NT Aboriginal Interpreter Service, the Hospital Interpreter service and other agencies (such as Australian Aboriginal Congress, Central Australian Aboriginal Legal Aid Service and the Institute for Aboriginal Development) to explore ways to improve the availability of interpreters generally but in particular in cases where crisis intervention is required and after hours.

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

9. 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 2008 Visit

1. It is recommended that there are systems to ensure that Aboriginal Mental Health Workers are integrated into the clinical care of all Aboriginal consumers. There should be documented evidence of their role in individual consumer care.

November 2007 Visit

2. It is recommended that for those under 18 admissions to the inpatient unit that are unavoidable, TEMHS develop with urgency a comprehensive framework for a " youth friendly " inpatient service which also ensures youth under 16 have access to expert assessment and management.

May 2007 Visit

3. 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.

4. 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.

5. It is recommended that 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

6. 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.

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

8. 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.

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 providing greater access to Aboriginal Health Workers including when admitted out of hours, advocating for improvements to the interpreter service and providing appropriate visual material; and

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

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.

2005 – 2006 Community Visitor Third Quarterly Report

13. 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.

Tamarind Centre

2007 – 2008 Community Visitor Third Quarterly Report

14. It is recommended that when working with young people with early psychosis, TEMHS maintain the case management service through the late recovery phase of early psychosis, that is for at least 18 months following acute treatment.

15. It is recommended that TEMHS investigate mechanisms for ensuring that Recovery Plans (including documented early warning signs from consumer, family and clinician perspectives and relapse prevention strategies) and Crisis Management Plans are easily accessible on CCIS. It is further recommended that the focus for the first stage of implementation of these plans be young people who fit the criteria for early psychosis intervention.

June 2006 Panel Visit

The Darwin Community Visitors Panel no longer visits the Tamarind Centre, and there has therefore been no opportunity to review the recommendations below. The Community Visitor conducted a visit to TEMHS in January and February 2008 but did not meet with the Forensic Team (recommendations 16 and 17 below refer to the service offered within the prison). No report has been made to the CVP about these recommendations and thus while the issues may no longer be current, the recommendations remain outstanding.

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

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