



**Northern Territory
COMMUNITY VISITOR PROGRAM**



**ANNUAL REPORT
2008 - 2009**



COMMUNITY VISITOR PROGRAM NORTHERN TERRITORY

The Hon 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 enclosed the Annual Report on the operations of the Community Visitor Program for the period 1 July 2008 to 30 June 2009.

Yours sincerely

A handwritten signature in blue ink, appearing to be 'P. McCarthy', is written over the typed name.

PRINCIPAL COMMUNITY VISITOR

30 September 2009

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LIST OF ACRONYMS AND ABBREVIATIONS

ADC	Anti-Discrimination Commission
AMHW	Aboriginal Mental Health Worker
APP	Approved Psychiatric Practitioner
ASH	Alice Springs Hospital
CAALAS	Central Australian Aboriginal Legal Aid Service
CAMHS	Central Australian Mental Health Services
CAT	Crisis Assessment Team
CCIS	Community Care Information System
CNM	Clinical Nurse Manager
CVP	Community Visitor Program
ED	Emergency Department
FACS	Family and Children's Services
JRU	Joan Ridley Unit
MHACA	Mental Health Association of Central Australia
MHU	Mental Health Unit
MoU	Memorandum of Understanding
NMHSRP	National Mental Health Seclusion Reduction Project
NT	Northern Territory
NTMHS	Northern Territory Mental Health Service
RDH	Royal Darwin Hospital
TEMHS	Top End Mental Health Services
The Act	The Mental Health and Related Services Act
Tribunal	Mental Health Review Tribunal

MESSAGE FROM THE PRINCIPAL COMMUNITY VISITOR

I am pleased to present the eighth Annual Report for the Community Visitor Program (CVP). The report must begin with recognition of the contribution of Tony Fitzgerald, Principal Community Visitor from November 2002 until his death in February 2009. Tony's commitment to the human rights of all people was epitomised in his work with the CVP. He was a powerful advocate for people with mental illness and for the CVP itself.

2008-2009 has been a productive year for the CVP. Community Visitors have conducted 107 visits to the inpatient units and community agencies, responding to 113 complaints and 140 enquiries from consumers, carers, staff and service providers about Mental Health Services in the Northern Territory (NT). The two Community Visitors Panels have conducted two visits to the inpatient facility in their area, each providing me with two substantial reports detailing the outcomes of their inquiries.

One major highlight in 2008-2009 was the introduction of the new CVP website (www.cvp.nt.gov.au). The website went "live" for a short time just before 30 June 2009, and permanently from 9 July 2009. It contains detailed information about the rights of consumers of mental health services and their carers in easy to read language; and uses case studies to illustrate how the CVP works with people to ensure that their complaints and enquiries are addressed.

The CVP continued to engage constructively with Northern Territory Mental Health Services in 2008–2009. A second major highlight for the year was the opportunity for the CVP Manager to deliver presentations about the role of the CVP to mental health staff in Nhulunbuy, Katherine, Alice Springs and Darwin as part of their training on the *Mental Health and Related Services Act* ("the Act") and Approved Procedures. The CVP thanks the Mental Health Program for allowing us to be part of this training and gratefully acknowledges their financial contribution to our travel costs.

In the 2007–2008 Annual Report, the CVP reported on two significant issues affecting people with mental illness in the NT: the lack of appropriate housing and support for people with complex issues including mental illness; and the way people with mental illness are transported to hospital. Significant progress towards resolving these two issues is outlined in Part 2 of this report, and is the basis for some optimism about the future of services for people with mental illness in the NT.

Other issues however have not been resolved. People admitted to the Joan Ridley Unit (JRU) in the Darwin mental health ward may spend long periods, sometimes months, locked inside with no access to fresh air. JRU is an alien environment for any person; for Aboriginal people from remote areas it must be terrifying. The CVP has reported on this issue in its 2007 and 2008 Annual Reports. It still has not been addressed.

The role of Community Visitors and Community Visitors Panels as set out in sections 104 and 111 of the Act is to inquire into the adequacy of services and facilities for people receiving mental health treatment in the Territory. It is also to ensure that people receive appropriate information on admission to an inpatient facility and that their rights as set out in the Act are observed. In performing these functions the CVP most commonly focuses on issues of concern connected with the delivery of mental health services. However these concerns do not tell the whole story. It is important to acknowledge that those involved in the mental health service industry are committed to providing a quality service for people with mental illness living in the NT.

Finally, I would like to thank the Community Visitors and Community Visitor Panel members for their excellent reports, hard work and commitment in 2008/09; and the staff at the Anti-Discrimination Commission for their practical support and expertise. The key member of the CVP remains our manager, Judy Clisby. As this report demonstrates, the CVP is a small program that manages to achieve a great deal. On behalf of all involved with the CVP I thank Judy for making this possible through her expertise, hard work and dedication.

PART 1

CVP OVERVIEW

The CVP is established pursuant to Part 14 of the Act. The program, independent of mental health services, is an essential component of a system of checks and balances designed to ensure as far as possible that a person's legal and human rights as defined in 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 jurisdiction of the Northern Territory Community Visitor Program includes all treatment facilities and treatment agencies approved under the Act.

Two major entities, Top End Mental Health Service (TEMHS) and Central Australian Mental Health Service (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 Act. Tony Fitzgerald was appointed Principal Community Visitor in November 2002 and remained in that role until his death in February 2009. The Minister for Children and Families appointed Lisa Coffey, the Acting Anti-Discrimination Commissioner, to the role of Principal Community Visitor on 7th April 2009.

The Principal Community Visitor has overall responsibility for the CVP and has a range of responsibilities under the legislation. These include establishing standards, principles and protocols for the program, disseminating information, referring matters to other organisations and reporting on the activities of the CVP 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, with members appointed by the Minister for Children and Families. In practice, the CVP establishes 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 consumers 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 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 at least once every six months. During 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.

Amendments to the Act allow for the Principal Community Visitor to establish a Special Community Visitors Panel to investigate and report on the overall operation of an approved treatment agency. The Principal Community Visitor may convene a Special Community Visitors Panel if a number of complaints are received about a particular approved treatment agency, or if a visit to both the approved treatment facility and agency is necessary in order to investigate a particular aspect of treatment and care. 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 Act. They perform the advocacy, complaint handling and inquiry/inspection functions of the CVP. The Minister for Children and Families appoints Community Visitors for three year terms.

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 bodies 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 CVP 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, whenever possible, to complaints and requests from consumers for a visit.

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

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

PART 2: ISSUES IN MENTAL HEALTH

Case examples are used to illustrate specific issues throughout Part 2 of the CVP Annual Report. In all cases details such as gender or diagnosis and even location may be changed to protect confidentiality.

SIGNIFICANT ISSUES - PROGRESS 2008 - 2009

Access to Mental Health Services

In the 2007–2008 Annual Report, the CVP commented that a person, new to the Territory, would find it difficult to contact mental health services because it lacked visibility in the phone book. This situation has been addressed, and mental health services can now be easily found by looking up “mental health” in the white pages or by googling “mental health NT” in White Pages Online.

Supported Housing

Sections 104(1)(f) and 111(2)(h) of the Act empower Community Visitors and Community Visitors Panel members respectively to inquire into any matter that is considered appropriate having regard to the principles and objectives of the Act. The principle that people with mental illness should receive the least restrictive treatment in the least restrictive environment, as stated in section 8 of the Act, is also implicit in sections 9(b) and 9(c) of the Act which provide that treatment and care should be designed to assist the person to live and participate in the community to the fullest extent possible. For a few people with mental illness who experience significant disability, either because of their mental illness or associated co-morbid disability, community living may only be possible with high levels of support.

Supported Housing for People with Complex Needs

In the past two Annual Reports, the CVP has reported on the impact of the lack of services for people with mental health and co-morbid disorders (including intellectual disability, physical disability, acquired brain injury and substance use) along with challenging behaviours. Progress has been made in 2008–2009 with the announcement of plans for an additional six beds in both Darwin and Alice Springs to allow for the assessment of people with possible psychotic illness in addition to other disability. Funding for an additional 32 secure beds in the NT, 16 to be managed by Aged and Disability Services and 16 to be managed by Family and Children’s Services (FACS) will mean that people whose primary presenting problem is not mental illness will have the opportunity to receive a specialised service in an appropriate facility.

The secure care will be available for variable periods of time depending on the level of disability a person suffers and the degree of rehabilitation possible. To avoid setting up another bottleneck in secure care facilities, it will be necessary to develop sufficient places in supported community accommodation to allow those able to live independently to transition through these facilities.

Supported Housing for People with Psychiatric Disability

A small proportion of people with mental illness experience significant disability. A person with a psychiatric disability may have many problems trying to live independently, including problems with self care and ability to manage daily living skills (ie organising and keeping appointments, shopping, cooking, household tasks). The person may also find it hard to socialise, and become increasingly withdrawn and isolated.

It is pleasing to be able to state that at the time of writing this report, the CVP is aware of one instance where services in the Territory have worked together to provide a person with severe impairment the support he needs to live outside an institutional environment. Options are being explored for a second person.

A middle aged man with a long history of mental illness, who had lived independently all his adult life, developed a life threatening illness. It became apparent that this man needed people nearby 24 hours a day. The non-government organisation (ngo), funded by mental health services to provide supported group accommodation, was not able to accept a referral due to the need for nursing care. Despite his obvious inability to care for himself, the man did not immediately meet the criteria for aged and disability services or nursing home care because of his age.

The efforts and good will of service providers, including mental health and aged and disability services have resulted in a successful placement for this consumer. The Community Liaison Nurse from the TEMHS Inpatient Unit secured a bed in a private nursing facility, organised meetings with all support services and advocated strongly for the consumer to receive an individual funding package to assist with the costs of the bed in the nursing facility. Funding was provided by Aged and Disability Services. Ongoing support was provided by Palliative Care, TEMHS Inpatient Unit staff and the consumer's case manager. This was a "one off" event however; successful placement was largely due to the commitment of mental health staff involved and to the availability of a private placement.

This case example is evidence of the benefits for consumers when mental health and aged and disability services are able to work together. However, there are still many people who have spent long periods in hospital or who live on the margins; on the streets, in prisons or in inadequate conditions and for whom this will not change until there is substantially more support available to them.

An Indigenous woman with a severe psychotic disorder has been nursed as an involuntary patient in the inpatient units in Alice Springs and Darwin for three months. She clearly states that she wants to leave the facility. It is also clear that she is just too unwell. The person remains in an inpatient facility waiting for accommodation with a level of support that will enable her to live independently of the hospital.

At the time of writing this report, the CVP is able to report that mental health and aged and disability services are working together to explore options for long term supported accommodation for this woman. It is hoped that in the next Annual Report, the CVP will be able to report a positive outcome for her.

Traditionally, the funding for living support for people with severe psychiatric disability in the Northern Territory has been at levels that are just too low to allow for the level of support needed for independent living. This is not the fault of mental health or aged and disability services, it is about the way psychiatric disability is viewed, and is a problem Australia wide. The CVP contacted Mission Australia and TEAM Health to determine the level of support available through the Commonwealth funded Personal Helpers and Mentors (PHaM) Program. The program at Mission Australia operates from 8 am until 4 pm Monday to Friday, offering four (4) hours support a week to consumers requiring “intensive” support. This can be increased in the short term in the event of crisis.

There is no doubt that this level of funding provides opportunities for services to work with the majority of consumers towards their recovery. However, it is not sufficient for a person with severe impairment. In the absence of long term supported accommodation in the NT, this can result in bleak institutional living for the individuals involved.

A middle aged Aboriginal man with a long history of schizophrenia, challenging behaviours that included a high risk of assaulting others and high degree of impairment, had been living in an area specifically set up for him in a facility operated by an ngo. After suffering an episode of degenerative illness, he was admitted to Royal Darwin Hospital (RDH). The CVP was contacted in December 2007 regarding the ngo’s refusal to allow him to return to their facility to live. The man, because of his age, the fact that he suffered no discernible intellectual impairment and his primary problem was mental illness, was not eligible for an individual funding package. He was not placed in any community facility such as a nursing home. He remained in a ward in RDH for 17 months, with discharge to a nursing home possible only because his degenerative illness had reached the stage where there was no longer any risk of assault.

The Community Visitor agreed that return to the ngo would have a significant adverse impact on other residents. At the same time, the lack of an appropriate facility or a home with an appropriate level of support meant that this man, whose primary problem was mental illness, remained in hospital with very little quality of life.

There are a number of consumers in addition to the person described above who have experienced long admissions to hospital because the level of their disability precludes independent living without considerable support; support which is not readily available. As stated above, other consumers live 'independently' but at the margins in the community; in private hostels, on the streets, in prison and/or barely managing in their own accommodation.

The Manager of the CVP has been pleased to sit on the reference group for a project in Central Australia auspiced by the Mental Health Association of Central Australia (MHACA) and funded by the Mental Health Program. Consumers, carers and service providers have been consulted regarding current housing and living situations and preferred models of support. A report, due before the end of 2009, should provide a way forward in Alice Springs. Hopefully, the methodology used for the report, and even some of its findings and recommendations, will also provide a way forward in the Top End.

Police Transport to Hospital

In its 2005, 2006, 2007 and 2008 Annual Reports, the CVP discussed concerns about consumers being transported to hospital in the cage of a police vehicle. In early 2008, the Principal Community Visitor wrote to Commissioner White APM, copying the letter to Bronwyn Hendry, Director Mental Health Program, outlining the human rights issues with respect to transport in the cage of a police vehicle. The Manager of the CVP was subsequently invited to meetings between the Mental Health Program, NT Police and NT Ambulance Service to develop transport protocols as a prelude to a new Memorandum of Understanding (MoU) between mental health services and police.

It is pleasing to report that although the MoU had not been signed off at 30 June 2009, protocols developed by mental health services designed to accompany the MoU were in place. These protocols prescribe the way people with mental illness are to be transported to hospital according to a hierarchy of assessed level of risk. For example, a person who is assessed as low risk of harm to self or others may travel to hospital privately, in a taxi or in a mental health vehicle. A person assessed at medium risk, may be transported by mental health services or ambulance and accompanied by police, with police either travelling in the car or providing an escort for the car. A person assessed as very high risk, depending on the situation, may need transport by police in a police vehicle. It is very pleasing to report that the CVP is aware of instances where consumers have been transported by mental health professionals with police in the car, and congratulates NT Mental Health Services and NT Police on progress made.

As stated above, there are some situations where the only safe way of transport to hospital is by police. Police use caged vehicles as their primary operational vehicles. The rear seat of these vehicles is used to store operational equipment. This means that any person with mental illness who is transported to hospital by police will be transported in the cage of the police vehicle.

In addition to the protocols for transport to hospital; the Act, the Approved Procedures and Clinicians Guides to the Act reinforce the principle that police will transport a consumer to hospital only as a last resort. It was further reinforced in training provided to mental health professionals throughout the Territory, and in training provided to police in regional centres. The CVP has been informed that training for police in the urban areas of Darwin and Alice Springs is scheduled for the 2009–2010 reporting year.

Two complaints to the CVP over the past twelve months are outlined below. The first occurred before the protocols had been put into practice and before training had been provided to mental health staff.

A consumer approached the Community Visitor during a visit to the TEMHS Inpatient Facility and complained that she had been transported to hospital in the cage of a police vehicle. At the time of the visit, the consumer appeared to be in very poor health. She informed the visitor that she had just returned from interstate where she had been receiving chemotherapy.

It appeared on investigation that the consumer had been brought to the Emergency Department (ED) of RDH by a friend, but left before she was reviewed by mental health services. It appears that Police were contacted and asked to return the consumer to hospital. There was no evidence in case notes of any attempt to either contact the friend who had brought her to hospital in the first place or the On Call Team to assist with her return to hospital. It is hoped that this situation would not be managed in this way now.

While investigating a complaint about the quality of service provision to a young woman in Alice Springs, the Community Visitor became aware that family, who had contacted the Crisis Assessment Team (CAT) due to their fears that her mental health was deteriorating, were told to contact the police. The family member had described escalating symptoms which included some aggression.

The Community Visitor investigating the complaint spoke to members of CAT, who reported that it is general practice that if there are reports of a consumer being aggressive, family will be told to contact police. Members of CAT will then meet police in ED and take over from there. The visitor was informed that it was an occupational health and safety issue.

There is no argument that if a person is described as being aggressive, police should be contacted. It is reasonable though that mental health staff should attend with police, particularly if the consumer is well known to the service. Attending with police should ensure the safety of the mental health staff involved and provide an opportunity for both parties to assess the situation. Mental health staff and police can then decide the most appropriate form of transport based on this assessment and an assessment of risk; although police, as the agency responsible for the safety of the consumer and staff, are responsible for the final decision about mode of transport.

Summary

There has been significant movement on this issue over the past twelve months. New protocols to accompany the MoU are in place and specify who should be involved in transport and how transport should take place. Approved Procedures to the Act and Clinical Practice Guidelines support the principle that consumers should be transported by police only as a last resort. This principle was reinforced during training for mental health staff throughout the Territory prior to the implementation of amendments to the Act.

There is evidence of change in practice. Fewer complaints have been received about police transport to hospital, and consumers have told Community Visitors about their experiences of transport in a mental health vehicle with police present.

Case studies included in this section of the report indicate that there will be times when police are contacted or family will be told to contact police, sometimes inappropriately. The CVP will continue to monitor and report on consumers' experiences of transport to hospital.

PART 2: ISSUES IN MENTAL HEALTH

RIGHTS

The CVP sees the protection of the rights of people receiving treatment from mental health services as one of its core functions. Sections 104(1) and 111(2) of the Act allow Community Visitors and Community Visitors Panels to look into the adequacy of services for assessment and treatment of persons subject to the Act, as well as any failure of a person employed by mental health services to comply with the Act. Visitors and Panel members can also inquire into any other matter that they consider appropriate having regard to the principles and objectives of the Act.

Because the protection of rights is such an important function of the CVP, this section of the Annual Report will look at rights issues that have arisen in the 2008 – 2009 reporting period. During this period Community Visitors were asked to pay particular attention to the review of involuntary admissions to ensure that they have been undertaken in accordance with the Act.

Right to Review

Timely Review of Involuntary Admission

A person admitted involuntarily on the grounds of mental illness (s39) must have his or her detention reviewed by an Approved Psychiatric Practitioner (APP) within 24 hours of admission. A person admitted involuntarily on the grounds of mental disturbance (s42) must have the detention reviewed by an APP within 72 hours.

Involuntary admissions must then be reviewed by the Tribunal in line with the time frames set out in section 123 of the Act (prior to the amendments no later than 7 days after admission, now between 10 and 14 days after admission).

The Tribunal sits every Wednesday in Darwin and every Friday in Alice Springs. Before time frames for Tribunal review were extended in March 2009, most people subject to an involuntary order for seven days or more would appear before the Tribunal on the Wednesday or Friday following their admission. If medical staff believed that the consumer would be able to be released from involuntary detention within seven days, and so not require a Tribunal review, they would not always submit the paperwork to the Tribunal. This presented a risk, because if the consumer's mental health did not improve as expected, and he or she needed to remain involuntary, the detention would not be reviewed by the Tribunal within the required timeframe.

A Tribunal hearing for an involuntary consumer was cancelled as his doctor made an assessment that he would be discharged before his involuntary order expired. In fact, the consumer's mental health deteriorated and at the time his order expired, he was still being treated involuntarily in JRU, the locked ward. One day later, the consumer's involuntary admission order was revoked and he was transferred to Cowdy Ward. The consumer, now voluntary, went shopping and spent a considerable amount of money, arriving back in the ward with no money left. The next day, when he announced that he was going shopping again, he was detained. The consumer, who was now involuntary, was due to appear before the Tribunal on its next sitting. This hearing was also cancelled.

The Community Visitor investigated the situation outlined above after becoming aware that the consumer's appearance before the Tribunal had been cancelled for the second time. The Director of Psychiatry was contacted. He stated that the consumer did not attend the Tribunal the first time due to the timeframe for presentation to the Tribunal "escaping their notice". He stated that when he was informed by the responsible Consultant that the consumer's detention would not be reviewed as required by the Act, a decision was made to let the order expire. The Director of Psychiatry agreed that failure to appear before the Tribunal on the second occasion was unfortunate, describing this as an administrative error in a ward that was extremely busy at the time.

In her report to the Principal Community Visitor, the Community Visitor stated that the consumer was held 24 hours out of time in the first instance. She expressed her concern that referring to the second instance as an "administrative error" downplayed the importance of ensuring that people are detained in line with the requirements of Act, and are reviewed by the Tribunal as required by the Act.

The Community Visitor also believed that the spending undertaken by the consumer when his status was changed to voluntary may have been related to his mental state. She recommended that the consumer be reimbursed for this spending, and TEMHS agreed to do so.

Audit of Legal Forms in Case Notes - Darwin

After the investigation outlined above, Community Visitors conducted an audit of the admission case notes for all consumers newly admitted to the TEMHS Inpatient Unit. The purpose of the audit was to determine whether admission processes were in line with the requirements of the Act and Approved Procedures. A total 23 admission records were inspected in September 2008. The audit revealed problems with 15 of these 23 records.

- In eight cases, detention and review times were not recorded on the paper based medical record. This meant that the Community Visitor could not determine (except by inference) whether reviews took place within the time frame required by the Act.
- In one instance confusion may have impacted on a consumer's care. The person was admitted to the ward as a voluntary patient. Three days later he was involuntarily admitted on the grounds of mental illness. There was no record of a doctor reviewing the consumer within 24 hours of involuntary admission as required by the Act. Three days later, the doctor noted "Reports being well. Went home over the weekend (patient on section!)". Later that day, the consumer absconded. He was detained again two days later, with this detention reviewed within 24 hours as required.
- In two instances, consumers had been admitted as voluntary patients but had not signed an "Informed Consent to Treatment" form as required by s7(2)(c) of the Act.
- The psychiatric registrar case-noted that a consumer who had been admitted on a voluntary basis should be sectioned if he tried to leave. This instance is discussed below in the section titled *Rights of People Admitted Voluntarily to an Approved Treatment Facility*.
- One instance of administrative error where incorrect dates were recorded in the medical record was found.
- There were two instances where incorrect procedure was followed after the suspension of a Community Management Order (CMO). If a consumer on a CMO refuses medication and/or meets the criteria for involuntary admission to hospital, the CMO may be suspended and the consumer admitted involuntarily to hospital. In both cases, the consumer was rightly detained under the Act, however a review of the detention was not conducted within 24 hours as required. In both cases the consumers continued to be detained involuntarily without a documented formal review of their involuntary status or subsequent notification to the Tribunal.

The Community Visitor reported the findings from the case note audit to TEMHS, noting probable confusion with the way the Act operates with respect to suspension of CMOs. The CVP strongly recommended that medical staff document times of review in case notes to ensure the transparency of compliance (or non-compliance) with the Act. Both issues have been addressed by TEMHS.

Similar audits were conducted at intervals for the remainder of the year, resulting in a further review of 29 admissions. Outcomes from these reviews were much improved, although six of the 14 consumers whose status were voluntary at the time of CVP review, had not given informed consent to treatment in writing as required by s7(2)(3) of the Act.

Audit of Legal Forms in Case Notes – Alice Springs

Four sets of case notes were reviewed by the Community Visitor in Alice Springs during a visit to the Mental Health Unit in May 2009.

The Community Visitor found one instance where the involuntary admission of a consumer on the grounds of mental illness was reviewed three hours and thirty minutes outside the 24 hour requirement of section 39 of the Act

No other issues were identified. In August 2009 the Management of CAMHS was notified that a consumer had been held out of time. Because it was a one off event, no response from CAMHS was requested.

Review of Administration Order

A person with a diagnosis of schizophrenia moved to the Territory several years ago. When he was living interstate, he was on an Administration Order, because he had problems managing his money. This meant that his money was managed by the Public Trustee in that state. When the interstate Public Trustee Officer was unable to act for him in a matter in the NT, the NT Public Trustee made an application to the NT Supreme Court to enable them to manage his financial estate. In every other jurisdiction, Administration Orders are automatically reviewed at least every three years. This man can only appeal his order by applying to the Supreme Court.

In order to seek a review of the order from the NT, the person must pay an initial application cost (refundable in some circumstances). He must access legal help to organise the paper work. He must have the support of mental health services who must have the capacity to assess his ability to manage his finances.

People who lack the capacity to manage their finances benefit from being subject to a financial management order, but it needs to be understood that such orders are restrictive. While the Public Trustee makes every effort to act in consultation with the person, the reality is that a person who is the subject of an order from the NT has no power to make any decisions about his or her money or how it should be spent. While under this order, the person is unable to make a will and if he is unsuccessful in contesting the order, will die intestate. The man in the case example outlined above is unable to make a will, despite his clear wish to ensure that his goods will be left to his son.

The CVP looks forward to a time in the NT when limited guardianship orders similar to the interstate Administration Orders are available for the benefit of Territorians who lack the capacity to manage their own finances. Ensuring that all such orders are regularly reviewed will mean that people with mental illness, who are placed on an order, will have the opportunity for it to be revoked should they recover enough to be able to manage their own finances.

Right to a Second Opinion

The right to seek a second opinion is contained in the *Mental Health: Statement of Rights and Responsibilities* and the *Northern Territory Code of Health and Community Rights and Responsibilities*. The case study below demonstrates how a rights-based approach provides protection for people receiving involuntary mental health treatment.

A man who was a patient in JRU contacted the CVP to request a visit. He complained that he had been voluntarily admitted to the TEMHS Inpatient Unit. That morning he had left the ward after being assessed by a doctor. When he returned, he was detained involuntarily and placed in the locked Joan Ridley Unit (JRU).

The Community Visitor reviewed his medical record and found that he had been assessed by an APP early that morning after he informed nursing staff he wished to go out. The outcome of this assessment was a finding that the consumer did not meet the criteria for involuntary admission, and could therefore leave the hospital. While he was away, the Consultant responsible for the consumer's care decided that if the consumer returned he would be sectioned and placed in JRU, but if he did not return within two days he would be discharged. On return to the ward, the consumer was reviewed by another APP, sectioned and transferred to JRU.

After being informed of his rights, the consumer informed the Community Visitor that he wanted a second opinion to assess his status. If his status was still involuntary he then wished to have his detention reviewed by the Tribunal the following day. Nursing staff contacted the consumer's Consultant to request a second opinion. The second opinion was provided by a Consultant Psychiatrist who was in JRU at the time. The Community Visitor phoned the inpatient unit later that day and was informed the consumer was no longer involuntary and had been discharged from the ward.

Right to be Treated with Dignity and Respect

Section 8, the interpretation of the Act, states that any power or function conferred by the Act should be exercised or performed so that: ...

(b) ... any restriction on the liberty of the person and any other person who has a mental illness, and any interference with their rights, dignity, privacy and self respect is kept to the minimum necessary in the circumstances;

When people are secluded, it is standard practice in the NT to remove their clothes and place them in a non-tear gown. The Acting Manager TEMHS has informed the CVP that this is a safety measure as hanging and self-strangulation are the most common methods of attempted self-harm for clients in the NT admitted to the inpatient units. She stated that there is a duty of care to provide non-tear garments for clients for whom there is a history and/or risk of self-harm. She also stated that staff try to maintain client dignity during this process.

The CVP has received complaints from two women who had their clothes removed while in seclusion. Both women reported that they had woken on the bed in the seclusion room, covered with a blanket, to find they had no clothes on.

After receiving the first complaint, the Community Visitor spoke with the Senior nurse who was present when the consumer was secluded. The nurse stated that she had held a towel over the consumer while her clothes were removed, and that the consumer went to sleep with a towel over her to preserve her dignity. A folded non-tear gown was left next to the bed.

The consumer appeared genuinely surprised when she was told that the gown was next to her bed. The nurse was happy to meet with the consumer to discuss the circumstances of the seclusion, however the consumer stated her complaint was resolved once she was aware how her clothes were removed and that a gown had been available for her.

After receiving the second complaint, the Community Visitor reviewed the consumer's medical record and spoke to the Clinical Nurse Manager (CNM) of the ward. It appeared that the second consumer had been secluded without a gown because there had been a number of seclusions (the ward was under pressure at the time with a large number of admissions of people who were extremely unwell) and no non-tear gowns were available. This complaint was resolved when the CNM provided the consumer with a letter of apology.

The same two consumers complained that they had to urinate on the floor while secluded. The first consumer had no access to toilet facilities, and no choice but to urinate on the floor. The second consumer stated that a paper mache container had been left in the room, but she had filled it and then had to urinate on the floor. Both consumers report being humiliated by their seclusion experience.

After the first episode, the senior nurse informed the Community Visitor that paper mache containers had been ordered and would be placed in seclusion rooms. It appears from the second consumer's experience that further action must to be taken to ensure that consumers' dignity is respected in these circumstances.

Right to Accessible Information

The very nature of psychosis is frightening, and the experience of involuntary detention, perhaps for the first time, daunting. It can be even harder for a person whose first language is not English. It is imperative that appropriate information is available so that the person can understand what is happening to them, what is likely to happen, why it is happening and what his or her rights are.

The following two sections of this report refer to investigations into the availability of information for Indigenous consumers in both Darwin and Alice Springs. The findings apply equally to all consumers whose first language is not English.

There is a policy and legal requirement to provide appropriate and accessible information to mental health consumers. Section 9 of the Act, *Fundamental principles*, states that when providing treatment and care to a person who has a mental illness

“the person is to be provided with appropriate and comprehensive information about his or her mental illness, proposed and alternative treatment and services available to meet the person’s needs.”

Section 87(2) of the Act states that “as far as possible” information about rights must be

“given both orally and in writing, in a language and form in which the person to whom it is given is used to communicating in and in a culturally appropriate manner including, where necessary, through the use of interpreters.”

In 2004, Community Visitors Panels in Darwin and Alice Springs reported that information provided to consumers in the inpatient units was available only in English and only in written form. Both panels recommended that appropriate information should be made available to consumers in an accessible form, particularly in light of difficulties accessing Interpreter assistance.

Neither of these recommendations has been closed, although in Alice Springs in particular there has been some progress. Information for consumers admitted to the Mental Health Unit in Alice Springs is now available in at least two local Indigenous languages as well as English. The Alice Springs panel was informed that funding had been secured to produce a DVD in conjunction with TEMHS. The script has been finalised and it was anticipated that it would be translated into seven Aboriginal languages, including three from Central Australia. The panel decided to keep its recommendation open pending the release of the DVD.

The Darwin Panel also reported significant improvement in the array of information available to consumers, drawing attention to the updated information booklet entitled *What Now? The Inpatient Guide Working Towards Recovery* as well as a booklet entitled *Our Journey*, a recent publication developed for families of people diagnosed with schizophrenia. The booklet is in plain English and uses illustrations to present information in a user friendly manner.

Northern Territory Mental Health Service Publications

The scope of the publications which have accompanied the commencement of amendments to the Act is impressive. They provide information to consumers, carers, clinicians and service providers about the Act and the rights of all involved.

The Darwin Panel was disappointed to find, however, that brochures and consumer and carer guides to the Act were available only in English. It was the Panel’s view that in its current form, the information does not meet the needs of a significant proportion of Indigenous consumers and carers whose first language is not English and who have low English literacy levels.

The Panel recommended that urgent attention be given to the development of information in a form appropriate to the NT population in order to assist staff to comply with the Act, and to protect the rights of consumers.

Right to Interpreter Assistance

Approved Procedure 27 states that

“Government policy and legislation requires NTMHS [Northern Territory Mental Health Service] to ensure that people who cannot speak English, or who speak limited English, have access to professional interpreting services where significant decisions are concerned and where essential information is being communicated.”

An accredited interpreter should be used when requested by a consumer, carer or family member; when a staff member cannot understand a consumer or when a consumer, carer or family member cannot understand what is being said to them.

Darwin

It is the view of the Darwin Community Visitors Panel that the test of whether an interpreter is used in a mental health context should be lower than that outlined in Approved Procedure 27. The Panel believes that interpreters should be used for the assessment, treatment and ongoing management of any consumer whose first language is not English. The Panel made this recommendation in their report of May 2007.

The CVP recognises that 24 hour Interpreter assistance for Indigenous consumers is not available in either Darwin or Alice Springs, and that this is the reason that some assessments occur in the absence of an Interpreter. The Darwin Panel has noted that the consumer’s first language is not always documented during admission, raising concerns that the obligations of the mental health service have not been adequately met at this stage.

Alice Springs

As stated above, CAMHS has made considerable progress in the provision of information for Indigenous consumers by ensuring that some information has been translated into two Central Australian languages.

Consequently, during their visit to the Mental Health Unit in November 2008, the Alice Springs Community Visitors Panel was surprised when one staff member informed them that “most Aboriginal consumers have a working knowledge of English and that interpreters are required only occasionally”.

During their visit in May 2009, the Panel followed up on their concerns in relation to the above comments, meeting with the Aboriginal Mental Health Worker (AMHW) and with management. Panel members were informed that it was hard to access interpreters with experience in a mental health setting. The Panel recommended that using interpreters in line with Approved Procedure 27 would provide the opportunity for interpreters to develop their skills in working with mental health staff and consumers.

To date, the CVP has monitored the use of interpreters in inpatient settings only. The following complaint indicates that the CVP needs to broaden its focus to monitor the use of interpreters in a community setting.

A service provider complained about a court ordered mental health assessment of Jane, an Indigenous woman who had no prior history of mental illness. The service provider stated that Jane, whose first language is not English, was assessed without an interpreter present.

The Community Visitor in Alice Springs investigated this complaint. The consumer was in fact seen at different times by three staff from CAMHS. On the first occasion, a mental health nurse reviewed her in the Emergency Department of Alice Springs Hospital (ASH). The nurse noted that Jane had a limited grasp of English and recommended that an interpreter be used for a full assessment.

A CAMHS psychiatric nurse later undertook a more comprehensive assessment, again without an interpreter present. Documentation indicates that Jane made minimal eye contact during the interview process, however the nurse assessed that she understood what was said, although how this conclusion was reached was not documented. An interpreter joined the assessment some time after it had already commenced.

A second and complete mental health assessment was then conducted by a Forensic Consultant Psychiatrist. This assessment was also completed without an interpreter present. In his report, the Consultant referred to his choice to assess Jane without an interpreter, stating that clinically it was preferable to commence an assessment without an interpreter, and then to decide whether or not an interpreter is required.

The practice of assessing a consumer, whose first language is not English, without an interpreter present may be contrary to the requirements of Approved Procedure 27. The Community Visitor concluded that in general, best practice would require the presence of an interpreter. The Visitor acknowledged, however, that a clinical rationale for choosing not to use an interpreter had been included in the Assessment Report.

Rights of People Admitted Voluntarily to an Approved Treatment Facility

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 requirements for voluntary admission to an approved treatment facility; informed consent to admission and informed consent to treatment.

Informed consent to treatment is consent given without “any inducement being offered” (s7(2)(a)). Like informed consent to admission, a voluntary consumer has the right to refuse treatment or withdraw consent“ at any time while the treatment is being undertaken” (s7(3)(e)).

The Act also 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 person should receive the least restrictive or least intrusive treatment in the least restrictive environment.

This issue has been addressed in Approved Procedure Five which states that:

“It is not appropriate for a predetermined direction to be given to ATF staff to ‘detain the patient should he/she try to leave’. If there is concern in advance the patient is unwell enough to meet the criteria for involuntary admission the APP must make the appropriate order.”

Training in the application of the Approved Procedures has been made available to all Northern Territory mental health staff, including APPs.

In 2005 the Alice Springs Community Visitor 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”. A discussion of this issue has been included in every Annual Report since that time.

The recommendation was closed in May 2008 on the grounds that no complaints had been received from people receiving treatment in the Mental Health Unit in the previous twelve months. When they spoke to consumers in the Unit during their visit, the Panel found that they understood and were able to explain their voluntary/involuntary status. The Panel reported that its members were happy to accept that a change in culture and practice had taken place.

Unfortunately, the CVP has become aware of four separate incidents (two in the TEMHS Inpatient Unit and two in the Mental Health Unit) where voluntary consumers have been prevented from leaving the facility or nursing staff have been instructed to detain a voluntary consumer if he or she tries to leave. Three of these incidents took place prior to the implementation of amendments to the Act and training of APPs. One incident in Alice Springs occurred after this time.

Alice Springs

A young man rang the Community Visitor Program complaining that he was a voluntary patient but had been informed he could not leave the ward.

The CVP arranged for a Community Visitor to visit the Mental Health Unit. By the time she arrived, the consumer's status had been changed to involuntary. Apparently the young man had been admitted involuntarily to the Mental Health Unit. His status had been changed to voluntary, although it was not clear why this was the case when he was not free to leave. The APP's reasons for deciding to change the consumer's status to involuntary again were also not clear (casenotes recorded that the consumer raised the issue of trying to leave but did not record a deterioration in his mental health).

Of particular concern was the fact that the consumer showed very little understanding or knowledge of the rights attaching to his voluntary/involuntary status. He believed that an appearance before the Tribunal would result in a longer admission despite an explanation from the Community Visitor that length of admission was dependent on his mental health, not on whether he was voluntary or involuntary. Because his status was changed to involuntary after he contacted the CVP, the consumer believed that the CVP contact led to his change in status, and he was reluctant to speak to a Community Visitor again throughout his admission.

While investigating a complaint from a service provider about the admission and treatment of a young woman in the Mental Health Unit, the Community Visitor became aware of an instruction to nursing staff that the young woman, admitted on a voluntary basis, should be detained if she tried to leave the Unit. It is of particular concern that this instruction was given after training was provided on the requirements of the Act and Approved Procedures.

The Community Visitor conducted an exhaustive investigation of the complaint, reviewing the consumer's medical record, speaking with all relevant parties and providing the mental health service with the opportunity to comment on her findings before they were finalised.

The Visitor found that the young woman had requested admission to the Mental Health Unit. She was admitted voluntarily, however she refused to sign the Informed Consent to Treatment for over a week after admission. After being in the ward for two days, the consumer was granted and took weekend leave, returning to the ward in time. In the meantime, the mental health service received several phone calls from people in the community concerned about the consumer's behaviour while on leave.

On her return, nursing staff were instructed by the APP that should the consumer insist on leaving the ward at any time within the next two days, they should section her for six hours and contact the APP. In fact, two days later, the consumer did request leave from the ward and in the absence of the consumer's Consultant,

another Consultant agreed to grant the leave given her voluntary status. The findings in the Community Visitor's report have been forwarded to CAMHS for comment and action.

Darwin

While auditing medical records to determine whether procedural requirements for admission of consumers to the TEMHS Inpatient Unit were being met, the Community Visitor noted that after admitting a person to the Unit voluntarily, the Psychiatric Registrar had case noted: "If tries to leave will need sectioning".

This incident was recorded in the first quarterly report to TEMHS as part of the report on the audit of legal forms in case notes. The Community Visitor was satisfied with responses from both the Manager of TEMHS and the Director of Psychiatry which indicated that all matters raised in the report were taken seriously and action taken to address them.

While reviewing the seclusion register in December 2008, the Community Visitor became aware that a consumer had been admitted involuntarily to JRU. Later, her status was changed to voluntary, but she was kept in JRU awaiting a free bed in Cowdy Ward (the open Ward). According to case notes, the consumer became increasingly upset and threatened to leave the ward and harm staff if the doors were not opened. Her status was changed to involuntary again.

The consumer had been secluded for more than 12 hours when she was first admitted to JRU. The APP conducting a medical review of the seclusion decided to release her from seclusion, change her status to voluntary and refer her to services external to mental health. A nursing case note stated that a decision had been made to make the consumer voluntary and "potentially" transfer her to Cowdy Ward once a bed was free. It stated further that staff explained to the consumer that should she demonstrate behaviour that placed herself or others at risk, or should she wish to be discharged, then her circumstances would be reviewed by the treating team. According to this documentation, the consumer accepted this and "freely signed sect 25 paperwork..." [reference to section 25 of the Act, voluntary admission].

In a draft report forwarded to TEMHS on 6th February 2009, the CVP noted that the instruction to the consumer that her voluntary status was contingent on her remaining in the inpatient unit appeared to be at odds with s29(2) of the Act which 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*. The Community Visitor also questioned whether it was appropriate that the consumer was kept in a locked area while voluntary, and the possible impact of this on her behaviour. At this time, no response to this report has been received.

PART 2: ISSUES IN MENTAL HEALTH

FACILITIES

Section 104(1)(b) of the Act states that a Community Visitor may inquire into and make recommendations about the standard of facilities for the assessment and treatment of persons in approved treatment facilities or by approved treatment agencies. The duties of Community Visitors Panels, pursuant to section 111(2)(a), include inquiring into the adequacy of facilities for the treatment of persons receiving care at the facility. The outcomes of Community Visitor and Panel inquiries are outlined in this chapter of the CVP Annual Report.

TEMHS Inpatient Unit

Joan Ridley Unit (JRU)

The Darwin Community Visitors Panel first talked about the inadequacy of the JRU environment during its visit in October 2004, commenting in particular on how sound echoed throughout the ward. Since that time TEMHS has purchased carpet for the floors and soundproofed some walls, greatly improving this aspect of the JRU environment.

However, the JRU environment remains bleak. Three issues with JRU are discussed in this section of the report: it has no outdoor area; the safety of staff and consumers is compromised; and the stainless steel toilets with no toilet seats are dehumanising. The environment is not consistent with the concept of a therapeutic hospital environment aimed at assisting the recovery of people experiencing mental distress.

Access to Outside

JRU is a secure ward for people who are acutely ill and who pose a risk to themselves or others or who are at risk of “absconding” from the hospital. It is designed as a “low stimulus environment”, achieved through neutral décor and the availability of only low key activities. An area about three quarters of the size of a basketball court, covered and enclosed, is attached to the ward.

A consumer, who had been detained to JRU for over four weeks, spoke to a Community Visitor about his experience. He described himself as an active person who found the lack of access to outside air confining and difficult to cope with.

It is not unusual for a person to be detained to JRU for longer than four weeks, which means that a person can be in the ward for that length of time without spending any time outside. In November 2006, the Darwin Community Visitors Panel recommended that funding be made available for the major works required to enable consumers in JRU to spend some time outside each day. The reason for this recommendation was that Indigenous consumers told Panel members that they feel better if they are able to smell, see and touch plants and trees. There has been no change since the Panel first made its recommendation, despite this issue being included in the Annual Report in 2007 and 2008.

Safety

Over the past twelve months, staff in the TEMHS Inpatient Unit have been working under pressure with high numbers of extremely unwell people, some with treatment resistant illness. A substantial increase in the number of episodes of seclusion in comparison with the reporting period for the previous year is evidence of the stress placed on the ward over the past twelve months.

These factors, along with the inadequacy of the JRU facility, have adversely affected the safety of consumers.

A consumer in JRU informed the Community Visitor that she feared for her safety in JRU. She had been kicked in the chest by another consumer. During a visit to JRU soon afterwards, a second consumer informed the Community Visitor that he needed to have his hand x-rayed. He stated that he had hurt his hand when he punched another consumer who had assaulted him.

After receiving these two reports, the Community Visitor decided to monitor the incidence of harm to others when conducting the six monthly review of the seclusion register. On ten occasions between November 2008 and May 2009 the reason given for seclusion was actual assault of another client. On four other occasions, the reason given was attempted assault.

Although the JRU design does not allow for the easy separation of consumers, there are three areas where consumers are nursed (if not in a seclusion area); the enclosed courtyard, a large room in the centre of the ward (which provides access to the courtyard) and a corridor behind the nurses' station. Consumers who pose an active risk to others may be nursed in the corridor area (with one to one nursing) and/or separately in the courtyard. They may also be placed in seclusion.

As has been the case over the past twelve months, when JRU is being used at or above capacity with several people who are acutely unwell, it is not possible to separate all consumers, and safety is compromised. It becomes in fact a "high stimulus environment" which is more about containment rather than a safe, therapeutic environment for people to become well.

For this reason, the CVP looks forward to early completion of the proposal for an additional six beds in the hospital wing adjacent to JRU. This will provide an extra two separate areas to care for people who are acutely unwell (as well as the assessment of people with challenging behaviours and possible psychosis).

Toilets in JRU

The father of a young woman detained in JRU for more than two weeks contacted the CVP complaining about the effect of the JRU environment on his daughter's mental health. He said that she had been unwell in the past, but that she had not recovered as she usually did when treated in interstate facilities and he felt this was due in part to the environment in JRU. He said he could understand how a person, transferred to hospital in the cage of a police vehicle, placed in the low stimulus, spartan JRU environment, having to use stainless steel toilets with no seats and perhaps sharing the facility with prisoners and prison officers, might have difficulty believing he or she is in hospital.

The Darwin Community Visitors Panel referred to the "prison standard toilets" in JRU during both visits to the TEMHS Inpatient Unit during the 2008–2009 reporting period. In their report of the May 2009 visit, the Panel described the toilets as "cold, uncomfortable and frightening to sit on", and noted that staff commented that they do not believe the toilets are appropriate in a treatment facility for acutely unwell people. The Panel reported that they would like to see exploration and costing of alternatives.

Showers in the TEMHS Inpatient Unit

In April 2009, the Community Visitor commenced weekly regular visits to the TEMHS Inpatient Unit on Friday mornings (in addition to visits at the request of consumers). This allowed the visitor to attend the morning meeting which is held daily.

On four occasions between April and June 2009, consumers talked about the inadequacies of the showers in the TEMHS Inpatient Unit. They stated that showers were cold and needed to run for at least five minutes before they were at least warm. They also stated that the water pressure is very low.

Consumers also raised this issue with the Darwin Community Visitors Panel when they visited the ward in May 2009. As a consequence, Panel members tested the water by running taps for several minutes. They agreed that the water temperature was tepid and combined with low ambient temperature in the ward and a frail stream of water, showering would be "un-pleasurable".

The Panel recommended that TEMHS investigate ways of ensuring that consumers are able to enjoy hot showers while in the TEMHS Inpatient Unit. The CVP is aware that numerous, albeit unsuccessful attempts have been made to resolve this issue, and looks forward to a time when consumers are able to enjoy hot showers with sufficient pressure to enable them to wash their hair.

Tamarind Centre

A consumer complained that changes to the reception area at the Tamarind Centre resulted in it developing an “institutional” feel. He said that he felt watched while waiting in the reception area. The consumer also expressed concern about facilities for people with physical disabilities. He stated the design of the reception desk meant that a person in a wheelchair would have difficulty conversing with reception staff. He also stated that access to a toilet for people with a disability was only possible through two locked doors and would require assistance from staff.

Some aspects of the consumer’s complaint were resolved in a meeting with the Manager of TEMHS – other aspects were acknowledged by the Manager as being not easily addressed. As a result of the consumer’s complaint, the Community Visitor, when conducting a visit to the Tamarind Centre in June 2009, inspected the waiting room, including the reception area.

The Visitor agreed that any person with a disability requiring the use of a wheelchair would have difficulty communicating with reception staff, who sit behind a high reception desk with perspex glass above the desk. There are small holes in the perspex to facilitate communication with the person behind the desk. Conversing with reception staff would be almost impossible for a person in a wheelchair who would be in the position of staring at the solid reception desk. The Community Visitor also agreed that a person in a wheelchair could only gain entry to the access toilet with the assistance of staff.

The waiting room is a long narrow room open towards the reception desk, with a half wall down one side and a one way mirror on the other. A large mirror set high opposite the one way mirror adds to the sensation of surveillance of people sitting in the waiting room (who can be seen from reception, through the one-way mirror and from the front of the building over the half wall). The Community Visitor agrees with the consumer that this room, with its institutional furniture and total lack of privacy, is not conducive to the comfort of consumers attending the Tamarind Centre.

CAMHS Mental Health Unit

After a visit to the Mental Health Unit in Alice Springs in May 2008, the Community Visitors Panel reported that inpatient facilities for consumers in Alice Springs were comfortable, and with a few changes would be very comfortable.

The Panel recommended the following improvements to the Unit:

- provision of facilities to store personal items;
- refurbishment of the recreation room;
- improvements to lighting, heating and courtyard HDU;
- improvements to garden and paving in main courtyard;
- continued improvement in quiet room;
- repairs to Venetian blinds; and
- dining seating.

Improvements noted by the Panel during the 2008–2009 reporting period include upgrading of games and puzzles in the Activity Room and improvement to the gardens in the courtyard with Arrente Council engaged to landscape the area. The Panel also reported improvements to the “Quiet Room” which is no longer used as a store-room and in which some furnishings, including decorations, bean bag seating and a small television have been placed. The Panel recommendation remained open pending painting of the paving in the courtyard and the provision of locked cupboards for consumers to store personal belongings.

CAMHS Community House

The Community Visitor in Alice Springs inspected the physical facilities at CAMHS Community House during her visit to the approved treatment agency in June 2009.

The Visitor reported that there are few interview rooms in the agency and this impedes case managers’ ability to provide a therapeutic intervention for their clients in an environment where their dignity and confidentiality is protected.

The conference room in the Community Team Building is used by the Adult Team when working with consumers. In addition, the Adult team may have access to two rooms in the facility used by the Child and Adolescent Team, as well as Outpatient consulting rooms in the Annex when the Clinics are not operating. It is good practice for interview rooms to have two doors as this allows both the mental health practitioner and the consumer quick and safe exit from the room. There is only one interview room with two doors.

The Community Visitor was informed that it is possible that the space being vacated by the Child and Adolescent Team may be available for use by the Adult Team. It is important that the therapeutic function of mental health services is supported through the provision of safe and appropriate facilities, and the CVP therefore supports any plans for the development of interview rooms for use by mental health professionals in Alice Springs.

PART 2: ISSUES IN MENTAL HEALTH

QUALITY OF SERVICE PROVISION

Legal/Procedural Issues

Notification of Involuntary Admission

The Act specifies that the person-in-charge of an approved treatment facility is required to notify the person, their legal representative, their carer (with the consumer's consent), the Principal Community Visitor and the Tribunal of involuntary admission for a period of seven days or more. In every quarterly report since the third quarter in 2005 – 2006, the CVP has commented on the inadequacy of notifications received from TEMHS.

It was anticipated that the rate of notification would improve with the commencement of amendments to the Act on 2nd March 2009 due to the development of new forms and the provision of training to all mental health staff.

From 1 July 2008 until 2 March 2009, TEMHS notified the Principal Community Visitor of approximately 56% of all involuntary admissions. From 3 March until 30 June 2009 the Principal Community Visitor was notified of approximately 49% of all admissions. Due to some confusion with the way the new forms were being used, notifications that occurred since March 2009 (and counted as notifications of involuntary admission) were generally notifications that the consumer's status had been changed to voluntary.

In past Annual Reports the CVP has expressed concern at failure to improve the rate of notification. At the time of writing this report, the CVP is satisfied that the Acting Manager of TEMHS is treating the issue seriously. There has been considerable improvement since 20 June 2009, in that the Principal Community Visitor is now notified of most involuntary admissions.

Complaints Register

People receiving treatment from mental health services have a number of avenues of complaint if they are unhappy with any aspect of their treatment or care. In addition to the CVP and the Health and Community Services Complaints Commission, section 100 of the Act outlines the internal complaints procedures for any person receiving treatment in an approved treatment facility or agency.

Section 100(8) states that the person-in-charge of an approved treatment facility or agency is responsible for ensuring that a record of complaints is kept and made available to a Community Visitor on request. Section 100(9) states that a report must be forwarded to the Principal Community Visitor at six monthly intervals, and that this report must detail the pattern of complaints and any attempts to prevent their recurrence.

There appear to be no systems in place in either Darwin or Alice Springs to ensure that the complaints report is forwarded to the Principal Community Visitor at six monthly intervals.

One report covering the twelve months from July 2008 until June 2009 was received from CAMHS after the Manager of the CVP contacted relevant staff by email in April 2009. A similar email sent to relevant staff in TEMHS received no response. Two follow up phone calls prior to June 30th 2009 resulted in a promise to send the required report. At the time of writing this Annual Report, it has not been received.

Mechanical Restraint

Case note entries on page 127 of the 2009 Ombudsman's Report titled *Investigation into the Unjustified Use of Restraint and Detention at Royal Darwin Hospital (Interim Report)*¹ detail the mechanical restraint of a person held at RDH pursuant to the Act. Prior to the release of this report, the CVP had not been aware that any people receiving mental health treatment pursuant to the Act had been mechanically restrained.

When reviewing the seclusion register for the TEMHS Inpatient Unit in June 2009, the Community Visitor became aware that two other people, detained pursuant to the Act, had been shackled. In the first instance a consumer was shackled while in the Emergency Department (ED) of RDH and released on arrival at JRU. On the second occasion, a consumer, detained on the grounds of mental illness, was transferred to a medical ward for surgery and mechanically restrained prior to return to the psychiatric inpatient unit.

Section 61 of the Act details the circumstances under which mechanical restraint may be applied, requirements for monitoring and documentation of the restraint and external monitoring. It requires that a Register is maintained and that this register be inspected by the CVP at six monthly intervals.

On both occasions the restraint was commenced by non-psychiatric practitioners in RDH, not trained in the Act or its Approved Procedures.

¹ Ombudsman NT (April 2009) Investigation into the Unjustified Use of Restraint and Detention at Royal Darwin Hospital (Interim Report)

The CVP is of the view that internal procedures must be developed to ensure that mental health service staff who become aware of the mechanical restraint of a person involuntarily admitted pursuant to the Act, act in a way to ensure the requirements of section 61 of the Act are met.

Treatment and Care

Records of Outpatient Medical Appointments in Alice Springs

In its 2007 and 2008 Annual Reports, the CVP reported that notes from some outpatient psychiatric appointments in Alice Springs were still recorded on the hospital paper file rather than the community based electronic or paper files. Hospital paper files are stored in medical records in ASH and community paper files in the community mental health building, separate from the hospital and some distance away.

It is pleasing to be able to report that there has been a change of practice in that the Community Team no longer holds separate Community Team paper files – the hospital files are used and returned to the hospital at the end of each day. Members of the Community Team enter their notes directly onto the Community Care Information System (CCIS), and routinely scan letters and documents onto the electronic system, with the hard copy going on the hospital file.

Unfortunately there has still been no change in the recording of information in case notes by some Consultants, who still use hospital files to document outpatient appointments.

The CVP will continue to advocate for a change in practice so that the practice of using hospital notes for outpatient appointments ceases, and notes from all outpatient appointments are recorded on CCIS. This will reduce the risk of mistake by ensuring that communication between doctor and case manager is documented on a record that is used, and hence seen by both the doctor and case manager.

Involuntary Client Granted Unescorted Leave

A staff member contacted the CVP concerned that a consumer who had been admitted involuntarily to the Mental Health Unit in Alice Springs was granted a half hour unescorted leave from the Unit. The decision was made during a Ward Round, despite nursing staff expressing the opinion that the consumer was not managing well in the Unit and would be likely to abscond if given leave. The staff member stated that the consumer had indeed absconded, not returning for 24 hours.

A Community Visitor spoke to the staff member, reviewed case notes and spoke to the consumer. The Visitor was unable to speak to the Consultant responsible for the decision as he had left Alice Springs after working in the Unit on a locum basis.

There is no dispute of the facts of this complaint. The consumer stated that he had repeatedly asked for unescorted leave from the Doctor. He stated that he had run away while on unescorted leave and had unprotected sex during that time.

The CVP is of the view that the mental health service has a duty of care to consumers admitted involuntarily to its inpatient units. The mental health service has custody of the person admitted involuntarily, and is thereby responsible for his/her safety and well being.

Contact with Family

The CVP was contacted by the friend of a person detained in JRU. The friend said that letters written for a consumer by her children had not been given to her. The friend said he had delivered the letters to JRU and then contacted JRU the following day to make sure the letters had been given to the consumer. He said he had been assured the consumer had the letters. Two days later, he found out that this was not the case.

On investigation, the Community Visitor was informed that JRU was very busy on the night the letters were delivered, and while the nurse who took them intended to pass them on to the consumer, she had forgotten to do so when several people were admitted to JRU.

There was no explanation for the complainant being told the letters had been passed on when this was not the case, and when it would have been easy to find out that this was not so (ie just by asking the consumer). The fact that the staff member did not take the time to check meant that the consumer had no contact with her children for the first four days of her admission.

The complaint was discussed at a meeting with the Clinical Nurse Manager (CNM). She stated that she would apologise to the consumer and inform her that protocols were being developed in JRU to ensure that a similar complaint could not recur. The consumer was happy to meet with CNM, and stated that a verbal apology would resolve the issue for her.

PART 3

INSPECTION OF SECLUSION REGISTERS

Amendments to the Act commencing on 2nd March 2009 included a change to s62 of the Act relating to seclusions. Prior to this time, s62(8)(b) of the Act provided for the medical review of a person in seclusion at least every four hours. NT Mental Health Services planned to gradually reduce the period of time when medical review was required, and to facilitate this reduction, moved the time requirements from s62(8)(b) of the Act to the Approved Procedures. When the amendments commenced, the Approved Procedures provided for medical review after three hours.

A substantial increase in the number of seclusions in the TEMHS Inpatient Unit meant that medical staff lacked the capacity to conduct medical reviews every four hours. There appeared to be no way that medical staff could conduct medical reviews every three hours as required when the Act changed. As a result, the Approved Procedures were amended from 15th May 2009 to again provide for four hourly medical review.

CAMHS Mental Health Unit

The Seclusion Register in the Mental Health Unit was inspected in January 2008 and again in June 2009. 85 episodes of seclusion occurring between 1st July 2008 and 14th June 2009 were reviewed. This constituted an increase of 93% over the same period in the previous year when there were 44 episodes of seclusion. Most seclusion episodes (73) took place in the first half of the year. The seclusion of two consumers accounted for 50% of these 73 episodes.

In her report following the January 2008 review, the Community Visitor noted four incidents of seclusion where there was at least one occasion where observations were not documented as taking place at regular 15 minute intervals as required by section 62(8)(a) of the Act. A draft copy of the Community Visitor's report was forwarded to CAMHS for comment.

Responses were received from the CNM of the Mental Health Unit and from the Quality Officer. It was clear from their response that CAMHS regularly audits the seclusion register and that this occurs as a consequence of the Community Visitor's findings in her review of the seclusion register the previous reporting year. A copy of the most recent audit was forwarded to the Manager of the CVP. It demonstrated that the problem with recording observations had already been identified in the CAMHS audit. An agenda item was incorporated into the next Mental Health Unit staff meeting to remind staff of their obligations with respect to s62 of the Act. Plans were in place for a further audit to be carried out in March 2009. The CVP was impressed with this response and the commitment to quality practice it demonstrated.

In the same review, the Community Visitor reported four episodes of seclusion where it appeared that medical review did not take place within 4 hours as required by section 62(8)(b) of the Act. This was reported to CAMHS, however no response was received.

In the report of the inspection in June 2009, the Community Visitor noted some irregularities in paperwork, but no substantive problems and no indication of any occasion when the requirements of s62 of the Act were not met. The CVP is aware that CAMHS will attempt to maintain three hourly medical review of seclusions, despite changes in the Approved Procedures to increase this to four hourly review.

TEMHS Inpatient Unit

Seclusion Registers in the TEMHS Inpatient Unit were inspected in January and June 2009. A total 637 episodes of seclusion for the period 1 July 2008 until 31 May 2009 were reviewed. This represented an 89% increase in the number of seclusion episodes over the previous year; related to high bed use, high acuity and staff under pressure.

For a short period of time between the 2 March 2009 until 14 May 2009, the requirement for medical review was altered from four hours to three hours. This provided the opportunity to test the effect of change in legislation on seclusion practice.

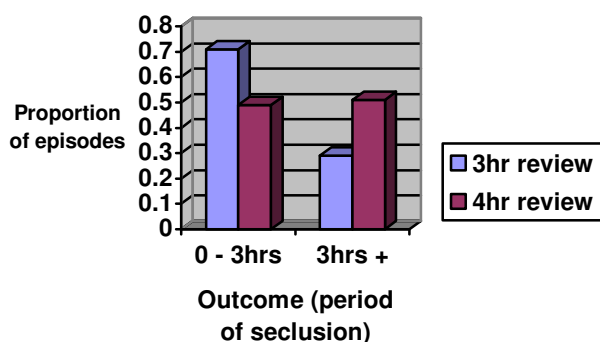
The following question was asked:

Is a shorter seclusion period the likely outcome of a shorter review period?

To test this possibility, seclusion periods were broken into two categories; those lasting between 0 and three hours and those lasting more than 3 hours. Data from the second review of the seclusion register, from 1st December 2008 until 31st May 2009 was used. To avoid the effect of consumers being secluded overnight and longer in accordance with management plans skewing the results, all seclusions lasting longer than 10 hours (39) were excluded from the data set.

Table 1: Table of 'short' and 'long' seclusion episodes under each review period

Period of Medical Review	Duration 0 – 3 hours	Duration 3 hours +	TOTAL
Three hours	51	21	72
Four hours	110	116	226
	161	137	298

Figure 1: Proportion of 'long' and 'short' seclusion episodes under each review period

The graph indicates that when medical reviews were conducted every four hours, there is no real difference between short and long seclusions.

It indicates strongly however that a higher proportion of shorter seclusions took place when a three hourly medical review period was required by Approved Procedures to the Act. In the presence of no other obvious changes during the two periods (ie while the Act and Approved Procedures required four hourly reviews as opposed to three hourly reviews), this indicates that shorter seclusions are the likely outcome of legislative requirement for shorter medical review.

The fact that seclusion practice changed when the legislative time frames for medical review of seclusion changed is not necessarily an argument for shorter time frames for medical review. The decision to release a person from seclusion should be contingent on the person's presentation irrespective of whether a medical review is due. If this is the case, then one could not expect the period of seclusion to change with a change in legislation. At the time of writing this report, the CVP is aware that TEMHS is addressing this through the NT Mental Health Service quality framework.

Medical Review of Seclusions

It was clear from the January review that medical staff lacked the capacity to conduct four hourly medical reviews of consumers in seclusion as required by s62(8)(b) of the Act. When reporting the outcomes of this review, the Community Visitor reported that medical reviews were conducted 30 minutes or more out of time on 45 occasions between 1st May 2008 and 31st December 2008. During the second review of the Seclusion Register in June 2009, the Community Visitor reported a further 21 occasions when medical reviews were conducted 30 minutes or more out of time.

After receipt of the Community Visitor's report of the June 2009 review of the seclusion register, the Acting Manager of TEMHS responded that medical reviews due between 8 am and 9 am may be problematic because staff are at "handover". At other times some delays may be caused by the need to wait for security staff to attend before opening the doors to the seclusion room. At the time of writing this report, new procedures in place to manage these situations include ensuring a medical officer reviews all seclusions before handover, and contacting security an hour in advance if there is an assessed need for security to be present.

Documentation

In the 2007–2008 reporting year, TEMHS was selected as a ‘Beacon site’ for the National Mental Health Seclusion Reduction Project (NMHSRP), a collaboration between the Australian Government and State and Territory Governments with the aim of reducing the use of seclusion and restraint in public mental health services. Because the Territory is so small, both inpatient units participated in the strategy.

In 2007-2008, the Community Visitor in the Top End noted considerable improvements to the way seclusion incidents were documented in the Medical Record. In 2008–2009, the Community Visitor reported that some improvements, such as the use of a clinical incident stamp to mark an episode of seclusion in clinical notes, were not maintained at the previous high level. On the whole however, documentation from nursing staff remained at a high standard, especially considering the pressures on the ward with high acuity, high numbers of seclusions and high levels of aggression.

The Community Visitor also reported an impressive improvement in the way Medical Officers document reviews of clients in seclusion. On the whole, Medical Officers are now noting the time and date of their documentation of the seclusion review in the margin of case notes. This improvement has made it easier to check that medical reviews do take place in accordance with the requirements of the Act and Approved Procedures.

Inspecting Seclusion Registers – the Year Ahead

Despite a commitment to reducing seclusion in the inpatient units, and participation in the NMHSRP, the incidence of seclusion in the inpatient units in Alice Springs and Darwin increased significantly in 2008–2009.

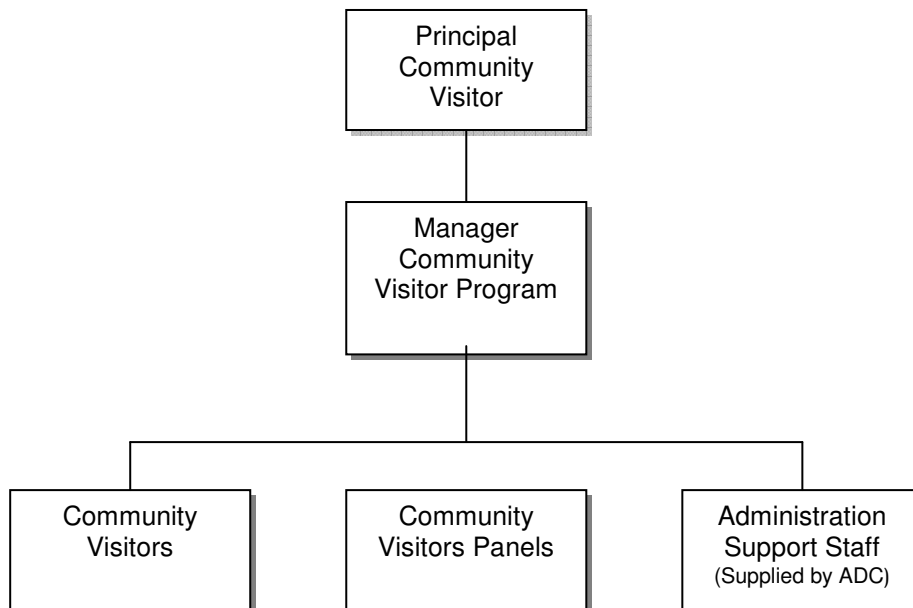
The CVP is of the view that the increase in seclusion is related to a number of factors, including a sharp increase in the number of admissions to hospital of people who were acutely unwell. In the Top End, the design of JRU and the inability to separate consumers may also have contributed to the use of seclusion. The large number of seclusions meant that medical staff in Darwin in particular found it difficult to meet their obligation to medically review people in seclusion as required by the Act. The relationship between the number of admissions to the inpatient units and the rate of seclusion will be monitored by Community Visitors in 2009-2010.

At the time of writing this report, the Manager of the CVP has attended a meeting of the NT Mental Health Services quality committee to discuss CVP findings with respect to the effect of change of legislation on periods of seclusion. When reviewing seclusion registers in 2009–2010, Community Visitors will monitor observations of consumers in seclusion and documentation of reasons for ceasing seclusion.

PART 4: ADMINISTRATION OF THE CVP

STAFF OF THE CVP

Organisational Chart



Staffing

The CVP team is as follows:

1. The Anti-Discrimination Commissioner is appointed Principal Community Visitor.
2. At 30 June 2009, five staff of the Anti-Discrimination Commission, employed under the *Public Sector Employment and Management Act*, were appointed as Community Visitors.
3. Community Visitors (except those employed by the ADC) and all Community Visitors Panel members receive fees consistent with the Determination of Remuneration, Allowances and Expenses under the *Remuneration (Statutory Bodies) Act* for “Other Member” Expert High Impact Panels.

Principal Community Visitor 2008 - 2009



Tony Fitzgerald



Lisa Coffey

Community Visitors and Panel Members 2008 - 2009



Judy Clisby
Manager CVP



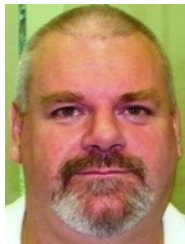
Simon Wiese



Rachael Dunn



Karyn Jessop



Phil Dempster



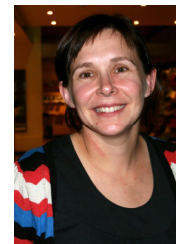
Sarah Bassiuni



Shanna Satya Pamela Trotman



Marilyn Starr



Carly Ingles



Georgia McMaster



Mark O'Reilly



Alison Hanna



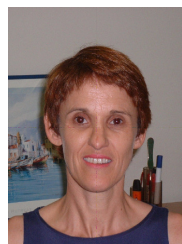
Susan Wearne



Garry Halliday



Georgie Stewart



Sarah Giles
Chair, Darwin Panel



Maya Cifali
Chair, Alice Springs Panel

PART 4

PERFORMANCE OF THE CVP 2008 - 2009

Visits and Inspections

As can be seen from the table below, in 2008 – 2009 there was a 35% increase in the number of visits to the approved treatment facility in Darwin. This increase was due to three factors; an increase in requests for visits following provision of training to mental health staff, repeat visits to a few consumers who were asking for considerable Community Visitor involvement during their inpatient stay and the incorporation of regular visits on Friday mornings. Prior to this, if a consumer requested a visit, the Community Visitor would visit the person and then conduct a visit with other inpatients of the facility at the same time. Now, the Community Visitor will visit on Friday mornings irrespective of a request for a visit earlier in the week.

Similar changes have occurred in Alice Springs, where fortnightly visits are now conducted on Wednesday evenings. In 2008 – 2009, there were fewer than the 26 visits proposed for the year. This occurred because there was a period of time in August 2008 when no Community Visitors were available to conduct routine visits to the Mental Health Unit, although a Visitor was always available to respond to a request for a visit.

Table 2: Comparison of the Achievements of the CVP 2006 – 2009

	Legislative Requirements	Alice Springs			Darwin		
		2006/2007	2007/2008	2008/2009	2006/2007	2007/2008	2008/2009
Visits ¹	In response to requests/inspection	21	26	22	55	63	85
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%	95%	100%	100%	100%

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

² From 2nd March 2009, Section 108(4) of the Act requires that a Community Visitor contacts, or attempts to contact a person requesting a visit within one working day of the 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

In the past, the number of complaints and enquiries actioned by the CVP appears to be related to the number of visits to the approved treatment facilities. This trend did not continue in the Top End in 2008–2009, where there was a 15% increase in complaints and enquiries as opposed to a 35% increase in the number of visits. In Alice Springs, a decrease in the number of complaints and enquiries appears to relate to a decrease in the number of visits.

Complaint or Enquiry?

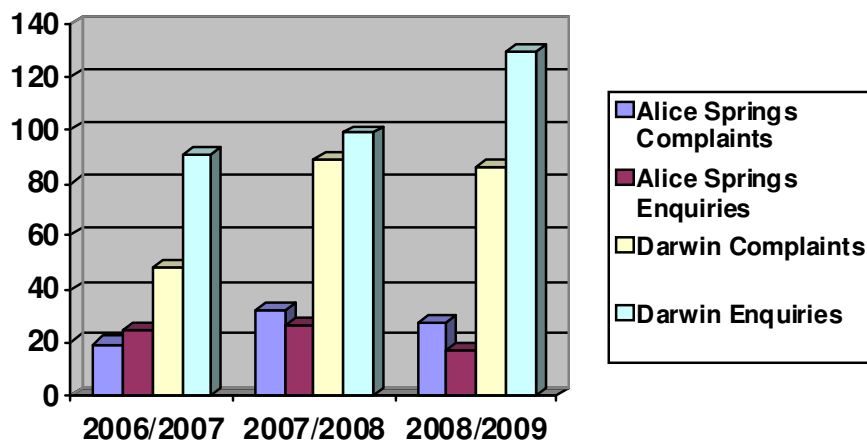
Consumers, carers and service providers contact the CVP for many reasons. Often, the contact may involve a request for information or a request for a Community Visitor to support the consumer during interactions with the mental health service (for example by attending meetings with the doctor). At other times, the person asks the CVP not to treat their issue as a complaint (even though it might be very serious). 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. A Community Visitor, in the course of investigating a complaint or enquiry, may learn of a new issue requiring follow up with the mental health service. This is not recorded as a complaint or enquiry.

Table 3: Complaints and Enquiries Received 2006 - 2009

	Alice Springs			Darwin		
	Complaints	Enquiries	Total	Complaints	Enquiries	Total
2006/07	19	24	43	48	91	139
2007/08	32	26	58	89	99	188
2008/09	27	17	44	86	130	216

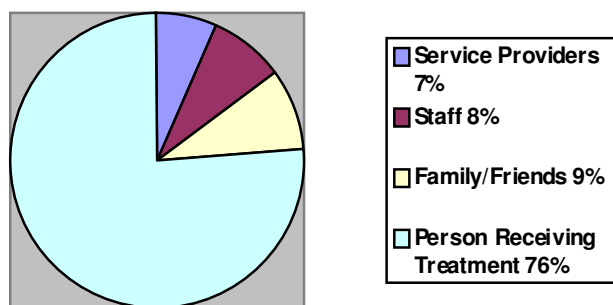
Figure 2: Complaints and Enquiries Alice Springs & Darwin 2006 - 2009



Sources of Complaints and Enquiries

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

Figure 3: Source of Complaints and Enquiries NT 2008 – 2009

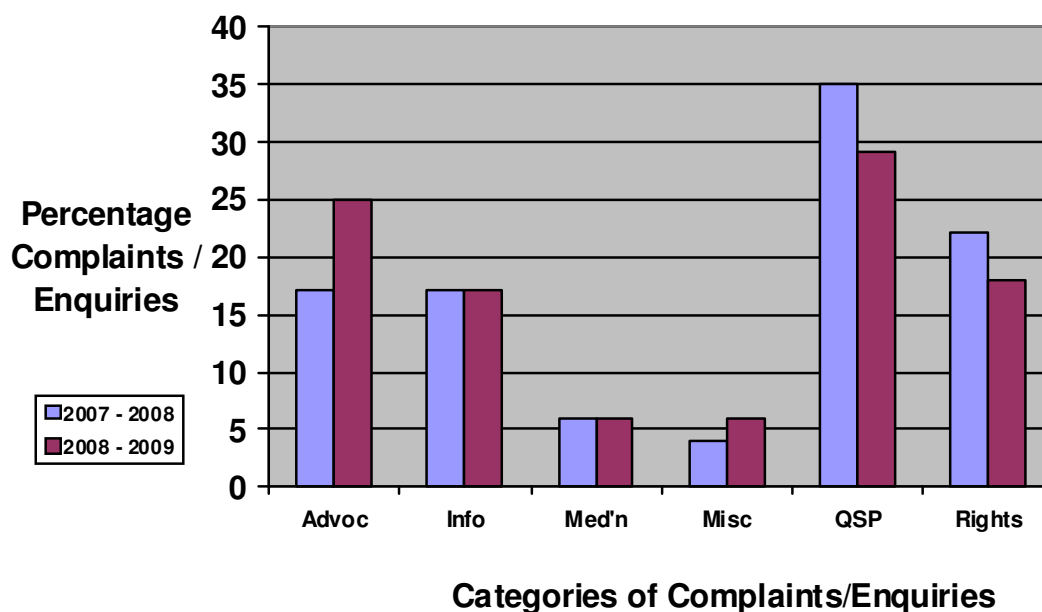


The term “staff” refers to any person employed by the mental health service. Service providers refer to organisations such as the non-government mental health bodies, legal aid and other government and non-government organisations.

Categories of Complaints and Enquiries

Table 4: Categories of Complaints and Enquiries 2008 - 2009

Category of Complaint/Enquiry		CAMHS	TEMHS	Total
Advocacy		9	57	66
Information	Access to Files	1	6	7
	Inaccurate information on file		3	3
	Provided to Consumer/Carers/Service Providers by CVP		34	34
Medication		3	12	15
Miscellaneous		2	10	12
Quality of Service Provision	Activities	2	1	3
	Assessment & Treatment	10	18	28
	Consultation Consumer/Carers	4	8	12
	Discharge Planning	4	3	7
	Facilities		10	10
	Management Plan		5	5
	Procedures		10	10
Rights	Detention	3	10	13
	Least Restrictive Alternative	2	8	10
	Legal	3	9	12
	Respect for Dignity	1	4	5
	Safety		2	2
	Transport by Police		3	3
Visit	Request		3	3
TOTAL		44	216	260

Figure 4: Percentage Complaints/Enquiries by Category by Reporting Period

During 2008–2009, Community Visitors noted that an activities program had commenced in Cowdy Ward, the open ward in the TEMHS Inpatient Unit (the source of most enquiries and complaints). Consumers meet with staff four mornings a week, have the opportunity to go out for an early morning walk and to be involved in regular daily activities. In 2008-2009 Community Visitors reported a noticeable change in atmosphere to the Principal Community Visitor.

One would expect that if consumers are happier in the inpatient ward, there would be fewer complaints and enquiries about the way services are provided. The table above demonstrates that this is the case, with a reduction in the number of complaints/enquiries about the quality of service provision (QSP) over the past twelve months.

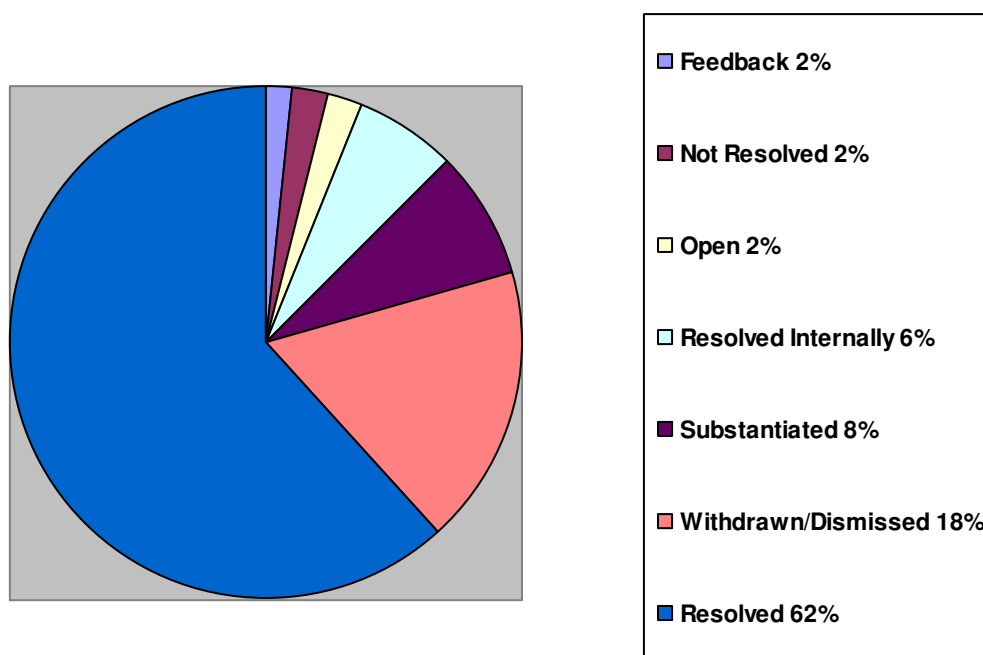
Other Complaints and Enquiries

In addition to complaints and enquiries about mental health services in the NT, the CVP received a total of four complaints and 27 enquiries about non mental health services. These enquiries have included 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.

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 31 complaints and enquiries received about facilities other than CAMHS and TEMHS. The total number of complaints and enquiries for 2008 - 2009 is N = 291

Figure 5: Outcomes of Complaints and Enquiries NT 2008 - 2009



PART 4

OTHER CVP ACTIVITIES 2008 – 2009

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. The opportunity to travel with staff from the Mental Health Program to provide information about the CVP to mental health staff was greatly appreciated.

The Manager of the CVP has acted as an independent person on the Selection Panel for a senior nurse within the TEMHS On Call Team and for the selection of a psychologist with the TEMHS Adult Team.

The Manager of the CVP has also attended meetings regarding operational protocols for transport to hospital.

Involvement with Community Activities

One mechanism for promoting the purpose of the CVP is involvement in community activities. In the 2008-2009 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;
- the Manager of the CVP assisted with a stall for Mental Health Week at CDU;
- the Manager of the CVP assisted with a Mental Health Week Stall held by TEMHCO and Headspace at Palmerston;
- the CVP has been a member of the Reference Group for the Accommodation in the Centre project sponsored by MHACA;
- the CVP is now a member of the Mental Health Coalition;
- International Human Rights Day: the CVP was actively involved in an event sponsored by the ADC;
- International Women's Day (IWD): the CVP was actively involved in the planning for this event 2009 and with the Darwin IWD Photographic Exhibition – Women with Disability;
- Careers Expo – held in August 2008 at Marrara Stadium; and
- meetings convened by the President of the MHRT to develop Practice Directions to coincide with the commencement of amendments to the Act.

Conferences

The Manager of the CVP attended the Annual NSW Official Visitors Conference held in May 2009. A meeting of representatives from all Community/Official Visitors Programs was held the day prior to the conference. The Manager of the NT CVP gave a brief presentation on the following:

- Safety and Aggression Management; and
- Standards of Delivery of Mental Health Services.

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:

- while travelling with the “Roadshow”, addressed public meetings in Darwin, Nhulunbuy and Katherine and meetings with staff and consumers of MHACA and Alice Springs legal services;
- met with TEAM Health staff;
- met with staff from Carers NT; and
- given a presentation on the role of the CVP to year 12 Students, Casuarina college

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 people from the following groups:

- Mental Health Carers NT (Darwin and Alice Springs);
 - Carers NT Alice Springs;
 - Disability Advocacy Service (Alice Springs);
 - Central Australian Aboriginal Legal Aid Service (CAALAS);
 - Office of the Public Guardian, Alice Springs;
 - Life Without Barriers;
 - Health and Community Complaints Commission;
 - Northern Territory Council of Social Services;
 - Pete’s Place;
 - Mental Health Coalition;
 - Resolve in Nhulunbuy;
 - TEAM Health Katherine;
 - Carers NT Katherine;
 - NT Legal Aid; and
 - Mental Health Association of Central Australia.
-

PART 4

PRIORITIES 2009 – 2010

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.

- Focus of Community Visitors:
 - In 2008 – 2009 Community Visitors audited legal forms of consumers detained to the Approved Treatment Facilities. These audits will continue in 2009 – 2010 to ensure compliance with the Act.
 - Community Visitors will continue to visit the Mental Health Unit in Alice Springs fortnightly and the TEMHS Inpatient Unit in Darwin weekly. During visits, Community Visitors will speak to inpatients to ensure they understand their rights pursuant to the Act, including their right to early review of their detention.
 - Community Visitors will also monitor particular issues during the 2009–2010 year. At this stage, these issues are identified as: JRU facilities (in particular safety of consumers), the right to be treated with dignity and respect, transport to hospital, mechanical restraint, monitoring seclusion, the provision of information about rights and inpatient client support and management plans.
- Improving internal CVP processes:
 - The appointment of a new Principal Community Visitor has provided the opportunity to review internal CVP procedures. Reporting between Community Visitors and Community Visitors Panels and the Principal Community Visitor will be reviewed and revamped over the next twelve months.
 - The CVP has only one permanent staff member. A manual needs to be in place to enable the CVP to continue should the Manager be absent or resign from the program.
- Training for Community Visitors and Panel Members: The following opportunities for professional development would enhance CVP:
 - Mediation training for all Community Visitors to improve the ability to resolve complaints through conciliation.
 - The development and delivery of investigations training for Community Visitors and Community Visitors Panel members.

APPENDIX 1

NEW RECOMMENDATIONS 2008 - 2009

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 CAMHS or 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 2009 Community Visitors Panel Visit

1. It is recommended that the Mental Health Unit create an action plan to improve the use of interpreters on the Unit in line with Approved Procedure 27 of the Mental Health and Related Services Act.
2. It is recommended that the Mental Health Unit significantly reduce the number of days the ward is locked.

DARWIN

TEMHS Inpatient Unit

May 2009 Community Visitors Panel Visit

1. It is recommended that TEMHS investigates ways of ensuring that hot water is available for showers for consumers admitted to the TEMHS Inpatient Unit.

APPENDIX 2

RECOMMENDATIONS CLOSED 2008 – 2009

ALICE SPRINGS

Mental Health Unit

No recommendations were closed in the 2008 – 2009 reporting period. With two new recommendations in the May 2009 visit, five recommendations are now outstanding.

CAMHS Community Teams

The two recommendations below were made by the Alice Springs Community Visitors Panel during their visit to the CAMHS Community Teams in March 2006. As the Panel no longer visits the approved treatment agency in Alice Springs, there has 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 have remained outstanding. In the absence of any ability to review these recommendations, they have been closed.

1. It is recommended that CAMHS establish protocols with NT Correctional Services and prison management to facilitate timely assessment of inmates and ease of contact between mental health workers and their clients.
2. It is recommended that the Department of Health and Families meet with the Department of Justice and establish a set of protocols to ensure that all prison inmates who are consumers of CAMHS are housed and treated within the prison system in a manner consistent with their mental health treatment and provided with a rehabilitation program.

DARWIN

TEMHS Inpatient Unit

During a visit to the TEMHS Inpatient Unit in November 2006, the Darwin Community Visitors recommended that a complaints system be put in place to allow consumers to access and lodge forms independently of staff.

The Panel closed this recommendation after their visit in November 2008. They found that the TEMHS client information booklet is clear that there is a complaints process. A suggestion box on the wall opposite the reception desk is cleared once each week. A sign on the box reads 'Compliments, Comments or Criticisms'. A form which provides for suggestions, complaints or complements is freely and confidentially available.

Tamarind Centre

Fourth Quarterly Report 2008 - 2009

In the third quarterly report of 2007-2008, the Community Visitor 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.

In the fourth quarterly report 2008–2009, the recommendation was closed for the following reasons:

- no complaints about treatment of young people with early psychosis had been received since the recommendation was first made;
- the CVP had been informed that a policy will be developed post restructure of the Adult Community Mental Health Team and the On Call Team – this means it is unlikely that the recommendation can or will be met in the near future;
- the report "A Healthier Future for all Australians"¹ recommends the institution of specialist clinical services for prevention of, and intervention for, early psychosis throughout Australia. It is possible that this national focus will provide the necessary impetus including funding and support for a specialist service; and
- monitoring this recommendation through the system of quarterly reporting is difficult because the community visitor makes very few visits to the approved treatment agency.

Services for people with early psychosis will be monitored through annual/bi-annual community visits to the Approved Treatment Agency.

¹ A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission – June 2009 Commonwealth of Australia

In the third quarterly report 2007–2008, the Community Visitor also 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 were easily accessible on CCIS. It was 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.

In the fourth quarterly report 2008–2009, the Community Visitor noted that recovery workshops had been held with staff of the mental health service earlier in 2008. The Manager TEMHS had reported that a recovery plan was being trialled by TEMHS. These initiatives were supported by the adoption of the Tidal model in the Inpatient Unit. Accordingly, the recommendation was closed.

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). For example, Recommendation 2 from the Darwin Panel regarding the development of systems to ensure AMHW involvement in clinical care remains open pending the Panel sighting AMHW documentation in clinical 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.

Progress may also have been made since the close of the 2008 – 2009 reporting year. It is possible that some aspects of the recommendations still open in this section of the report have been addressed. For example, the CVP is aware that a three month project to consult with Indigenous people with a view to developing appropriate information has just been completed at the time of writing this report. This would partially address Recommendation 4 made by the Alice Springs Panel and Recommendation 11(a) made by the Darwin Panel.

ALICE SPRINGS

Mental Health Unit

May 2009 Community Visitors Panel Visit

1. It is recommended that the Mental Health Unit create an action plan to improve the use of interpreters on the Unit in line with Approved Procedure 27 of the *Mental Health and Related Services Act*.
2. It is recommended that the Mental Health Unit significantly reduce the number of days the ward is locked.

May 2008 Community Visitors Panel Visit

3. It is recommended that there be a general upgrading of amenities as follows:
 - (a) Provision of facilities to store personal items
 - (b) Refurbishment of the recreation room
 - (c) Improvements to lighting, heating and courtyard HDU
 - (d) Improvements to garden and paving in main courtyard
 - (e) Continued improvement in quiet room
 - (f) Repairs to Venetian blinds
 - (g) Dining seating

March 2004 Community Visitors Panel Visit

4. 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.
5. 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

6. 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.

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 2009 Community Visitors Panel Visit

1. It is recommended that TEMHS investigates ways of ensuring that hot water is available for showers for consumers admitted to the TEMHS Inpatient Unit.

May 2008 Community Visitors Panel Visit

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

November 2007 Community Visitors Panel Visit

3. 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 Community Visitors Panel Visit

4. It is recommended that the Mental Health Service ensure that Interpreters are present at assessment for all consumers whose first language is not English.
5. 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.
6. It is recommended that if a consumer must be transported to an approved treatment facility by police, then all efforts are made to transport the consumer in the car rather than in the cage of the vehicle.

November 2006 Community Visitors Panel Visit

7. 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.

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 Community Visitors Panel 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 are 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.