Northern Territory
COMMUNITY VISITOR PROGRAM

ANNUAL REPORT
2009 - 2010

COMMUNITY VISITOR PROGRAM
NORTHERN TERRITORY

The Hon Kon Vatskalis
Minister for Health
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 2009 to 30 June 2010.

Yours sincerely

EDDIE CUBILLO
PRINCIPAL COMMUNITY VISITOR

24 September 2010

CONTACT DETAILS

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

Location:	Darwin:	7th Floor 9-11 Cavenagh Street, Darwin NT 0800
Postal Address:	LMB 22 GPO Darwin NT 0801	
General Enquiries:	Telephone: Freecall: TTY:	(08) 8999 1451 1800 021 919 (08) 8999 1466
	Facsimile:	(08) 8981 3812
	Email:	CVPProgram.ADC@nt.gov.au
	Website:	www.cvp.nt.gov.au

CONTENTS

Page

Page

PART 3

PART 4

ADMINISTRATION OF THE CVP

Page

TABLES

FIGURES

LIST OF ACRONYMS AND ABBREVIATIONS

ADC	Anti-Discrimination Commission
AIS	Aboriginal Interpreter Service
AMHW	Aboriginal Mental Health Worker
APP	Approved Psychiatric Practitioner
ASH	Alice Springs Hospital
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
GP	General Practitioner
HDU	High Dependency Unit
JRU	Joan Ridley Unit
MHACA	Mental Health Association of Central Australia
MHU	Mental Health Unit
MoU	Memorandum of Understanding
NAAJA	North Australian Aboriginal Justice Agency
NT	Northern Territory
RDH	Royal Darwin Hospital
TEMHS	Top End Mental Health Services
The Act	The Mental Health and Related Services Act
Tribunal	Mental Health Review Tribunal

PART 1 - OVERVIEW

MESSAGE FROM THE PRINCIPAL COMMUNITY VISITOR

I am pleased to present the ninth Annual Report for the Community Visitor Program (CVP). I look forward to continuing the hard work of my predecessors in this role and I hope to highlight the importance of the CVP to the wider community to help break down the stigma attached to mental health.

The 2009 - 2010 financial year has been a busy year for the CVP. Community visitors have conducted 134 visits to the inpatient units and community agencies, and responded to 303 complaints and enquiries from consumers, carers, staff and service providers about mental health services in the Northern Territory. The two community visitors panels have conducted two visits to the inpatient facility in their area, each providing two substantial reports detailing the outcomes of their inquiries.

The graphs in Part 4 of this Annual Report demonstrate how the work of the program has increased since the 2003 – 2004 reporting period. It is now at capacity.

As a result, the CVP will need to look at ways of managing more efficiently, so that community visitors can continue to respond quickly to consumer requests. To save time, the CVP Manager reduced contact with individual community organisations. Instead, the CVP is now involved with two networks, the Mental Health Coalition and the Darwin Mental Health Network hosted by Carers NT. Further efficiencies will most likely include a reduction in the style of complaints investigated, and increased referral of more complex complaints to the Health and Community Services Complaints Commission.

There have been some innovations in 2009 – 2010. A liaison between the Aboriginal Interpreter Service and the CVP has enabled community visitors to attend the inpatient units with interpreters during their regular visits. Interpreters have two roles during these visits; interpreting and acting as a cultural broker. This has made a real difference to the ability of community visitors to provide a service that is relevant to all consumers. It has already led to an increase in enquiries from Indigenous consumers.

The CVP continues to engage constructively with Northern Territory Mental Health Services. Regular meetings are held with the Director Mental Health Services. The CVP Manager meets with the Manager of Central Australian Mental Health Services (CAMHS) during six monthly trips to Alice Springs and monthly with the Manager Top End Mental Health Services (TEMHS).

In previous Annual Reports, the CVP reported on its concerns that people with mental illness are often transported to hospital in the cage of police vehicles. Last year we reported significant progress. The CVP looks forward to the time when this progress is ratified by a formal Memorandum of Understanding between NT Mental Health Services and NT Police. Over the next twelve months, the CVP will be monitoring how people are transported to hospital after hours.

Last year, the CVP reported some optimism about the future of supported accommodation for people with psychiatric disability and people with complex issues. Supported accommodation remains a major issue for Territorians who do not require secure care, yet need accommodation with varying degrees of support. Without action, people who need accommodation and support in order to live in the community are still likely to languish in acute inpatient units or even prison.

Other longstanding issues also remain unresolved. The Darwin community visitors panel has written to me regarding the failure of mental health services to implement two recommendations about services for Aboriginal consumers. The first recommendation dates back to 2004 and concerns the lack of appropriate information for Indigenous people about their rights on admission to the TEMHS Inpatient Unit. I understand that the Manager of the CVP is currently working with TEMHS to address this issue, and expect to see this recommendation resolved over the next twelve months. The second recommendation, outstanding since May 2007, concerns TEMHS' failure to record Aboriginal consumers' first language in their medical records and to always use, or seek to use, interpreters for the initial assessment.

A new issue for the CVP to monitor in 2010 – 2011 is the locking of Cowdy Ward, formerly the open ward of the TEMHS Inpatient Unit. When a ward is locked, it is more likely that the distinction between the way voluntary and involuntary consumers are managed becomes blurred, and this has been the case in Cowdy Ward. The CVP has been informed that Cowdy is locked only as a temporary measure, to be evaluated once new risk management processes are established. Community visitors will continue to monitor the locked ward and its effect on consumers and the rights of consumers.

It is also of concern to the CVP that in 2009 - 2010, the North Australian Aboriginal Justice Agency ('NAAJA') ceased representing people who are involuntarily detained and appearing before the Mental Health Review Tribunal ('the Tribunal'). Legal representatives perform an important function in the Tribunal process as they assist consumers to articulate their views and concerns and ensure a balance between their views and the information which is provided by the medical practitioners. NAAJA brings a special expertise with Indigenous consumers, being known and trusted. They make sure that interpreters are used at Tribunal hearings.

While there are provisions in the Act for the appointment and reimbursement of legal representatives assisting consumers, it is desirable for reasons of continuity and expertise that they are represented by one of the two legal aid services. The CVP will continue to monitor and advocate for Mental Health consumers to receive the best ongoing legal representation.

In its Annual Report, the CVP focuses on issues of concern connected with the delivery of mental health services. This is its role. 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. There has been significant improvement in the way inpatient services are delivered in the Territory. In 2009 – 2010, the community visitors panel in Alice Springs was able to close three outstanding recommendations, one of which had been open since 2004. In the same period, the use of seclusion Territory wide has reduced by an impressive 63%. Some of this reduction may be due to the nature and number of admissions to the inpatient units, however the outcomes of the Territory's focus on reducing the use of seclusion has been remarkably effective.

Finally, I would like to take this opportunity to thank community visitors and community visitors panel members for their excellent reports, hard work and commitment in 2009 - 2010. Without their dedication the CVP couldn't provide a complaints resolution and advocacy service for people receiving treatment from NT Mental Health Services. In particular, I thank Lisa Coffey who was Principal Community Visitor from March 2009 until she resigned in August 2010. The CVP was fortunate to have a Principal Community Visitor with Lisa's expertise and commitment to the rights of people with mental illness. Finally, I thank the staff at the Anti-Discrimination Commission for their practical support and expertise.

CVP OVERVIEW

The CVP is established pursuant to Part 14 of the *Mental Health and Related Services Act* (the Act). The program is an essential component of a system of checks and balances designed to protect the legal and human rights of people receiving treatment from Mental Health Services in the NT. It is also one of the mechanisms in place to ensure that a quality mental health service is provided. The CVP is located in the Anti-Discrimination Commission to guarantee its independence from mental health services.

Jurisdiction

The jurisdiction of the Community Visitor Program includes all treatment facilities (inpatient psychiatric units) and treatment agencies (outpatient services) approved under the Act. Two major entities, Top End Mental Health Service and Central Australian Mental Health Service, are responsible delivering 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. The approved treatment facility for TEMHS is the TEMHS Inpatient Unit, comprising Cowdy Ward and the Joan Ridley Unit (JRU). The approved treatment facility for CAMHS is the Mental Health Unit.

Principal Community Visitor

The Principal Community Visitor has overall responsibility for the CVP and has a range of responsibilities under the Act. These include establishing standards, principles and protocols for the program, circulating information about the program and reporting on the activities of the CVP to the Minister for Health. The Principal Community Visitor's role is primarily a management role and the Principal Community Visitor does not personally undertake any visits to facilities, agencies or consumers.

Community Visitors Panels

A community visitors panel is established for each approved treatment facility, with members appointed by the Minister for Health. Panels have three members; a medical practitioner, a legal practitioner and a community member. The role of the community member is to represent the interests of consumers. 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.

Panel members are required to visit the inpatient facility at least once every six months. During visits they inquire into 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.

The Principal Community Visitor may establish a special community visitors panel to investigate and report on the overall operation of an approved treatment agency. The special community visitors panel might be convened, for example, 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

Community isitors are appointed by the Minister for Health for a three year term. They respond to enquiries and complaints from consumers of mental health services, and may help a consumer 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 help a consumer use the review mechanisms set out in Part 15 of the Act (Mental Health Review Tribunal).

Community visitors visit the inpatient units regularly so that as many consumers as possible have access to a community visitor. Visitors also respond 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 of 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 location are changed to protect confidentiality. It is the intent that the person who is the subject of the case example would not recognise him or herself.

SIGNIFICANT ISSUES

Supported Accommodation

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 they "consider appropriate having regard to the principles and objectives" of the Act. The principle of the least restrictive alternative, which states that the least restrictive treatment should be provided in the least restrictive environment, is explicitly outlined in section 8 of the Act and is implicit in sections 9(b) and 9(c) 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.

Supported Housing for People with Mental Illness and Psychiatric Disability

A key component of stabilising a person's mental illness is stabilising accommodation. In the Territory, the acute shortage of affordable accommodation, and the lack of adequate support means that too often people with mental illness are admitted unnecessarily to hospital or are managed through the criminal justice system.

Most people who experience problems with their mental health recover between acute episodes of illness and are able to return to normal living. A few experience varying levels of disability associated with their illness. Symptoms associated with mental illness may interfere with a person's ability to apply for and maintain accommodation. A person who does not have housing with the right level of support may become more unwell, because without a routine, they are less likely to take their medication regularly. In addition, the stress of being homeless may lead to the person becoming more unwell. People with mental illness living in the Territory are too often caught in this cycle.

Central Australia

A consumer told his story about being homeless at the launch of "There's No Place Like Home - There Is No Place", the report of findings of an accommodation project auspiced by the Mental Health Association of Central Australia (MHACA). Jay told his story to illustrate the relationship between stable accommodation and mental health.

Jay had been homeless, and sleeping in the Todd. He would not take any medication at night because it was sedating, and he felt unsafe if he could not wake easily. As a result, his mental health deteriorated until he was so unwell that he could not manage, even when he was in a safe place like a motel. MHACA took a chance, and when housing became available, placed him in it. Jay started taking his medication and improved from there. The CVP has been informed that Jay has now returned home to live near his family and is working.

The MHACA study found that of all the people directly included in the study, either by survey or attending a focus group, a third live in accommodation such as caravans, hostels, shelters or camps. Slightly more than a third of the others are in unstable accommodation. Data from CAMHS in the second quarter of the 2008 – 2009 reporting year indicated that 36 people receiving mental health services were homeless and a further 58 people were at risk of homelessness. This data did not include people living in remote areas.

It was recommended that urgent action needs to be taken. This action should include providing six places in 24 hour supported accommodation (ie a group home), 10 additional units of housing, support packages for 15 people, the purchase of four respite beds and finally, housing and support for three people already in contact with the criminal justice system[1].

Jay's story illustrates how important stable housing and the right amount of support can be to assist with people's recovery. This support needs to be timely.

There needs to be some way of ensuring that the right help is available when it is needed, not twelve months later as is the case with the consumer described below.

The CVP reported in the 2008 – 2009 Annual Report that an Indigenous woman with a severe psychotic disorder had been treated involuntarily in inpatient units for three months. There was some optimism that an accommodation/support package would be available to ensure that the gains made in hospital could be consolidated in the community. One year later, this package is still not available, although Aged and Disability Services has agreed to fund the support.

Potentially, the stabilisation of this person's illness achieved while she was in hospital could have been lost. She was fortunate that staff in the Mental Health Unit continued to support her after her discharge from hospital and the community team continued this high level support. It is a credit to CAMHS that she has remained well.

[1] Mental Health Association of Central Australia (2010) *There's No Place Like Home – There Is No Place. A Report on Housing and Support for People with Psychiatric Disability living in Alice Springs*. http://www.mhaca.org.au/2010housing/Housing%20Report%20Executive%20Summary%20final.pdf

The Top End

TEAM Health provides a substantial amount of accommodation for people with mental illness living in Darwin. There is still a critical shortage of supported accommodation beds for people with mental illness. About one person every two weeks is discharged from the TEMHS Inpatient Unit with no accommodation. Most often these are people with dual diagnosis; mental illness and substance use, or mental illness and challenging behaviours, who have worn out their options in standard accommodation. They are discharged with payment for three night's accommodation. This is less than ideal.

The community visitors panel in Darwin believes this issue is of critical importance and that one option in the short term would be to commission a study similar to that carried out in Alice Springs. At the very least, the study would provide information about the level of need for supported accommodation in the Top End, with recommendations about the most appropriate accommodation and support models to meet this need.

Supported Housing for People with Complex Needs

Jane is a young woman with multiple issues resulting in quite profound intellectual and psychiatric disability. Her disabilities mean that she cannot live independently without 24 hour care. Jane was admitted to an inpatient unit on a short term basis for respite for her carers. She suffers chronic mental illness, but was not assessed as being acutely unwell at the time of her admission. Three weeks later, the organisation responsible for providing care had withdrawn its services and there is no short term solution. It looks as if she may remain in the ward for several months. This is not an unusual circumstance.

Work is well underway to develop secure care units in Alice Springs and Darwin regions for adults who have permanent and significant intellectual or cognitive impairment with severely challenging behaviours that might place themselves and others at risk. This group may include people who also experience mental illness. Some people may require long term secure care, others may be able to move to less restrictive accommodation once behaviours are stabilised.

Not all people who need high level support require secure care. Additional and sufficient supported accommodation places must be developed to ensure that secure care is used only for those who pose a risk to themselves and others, and only as long as they are assessed as continuing to need this level of restriction. There is a danger that if there are not enough supported community accommodation places, people will still be inappropriately managed in the psychiatric inpatient units and by the criminal justice system. There needs to be a way of quickly responding to the needs of people such as Jane so she receives the right care in the right environment.

Locking Cowdy Ward

The Objects and Fundamental Principles of the Act provide that mental health treatment and care should be provided with the minimum restriction possible on people's rights and liberties. Community visitors and community visitors panel members therefore pay particular attention to practices and policies that are most likely to limit the freedom of people receiving care in the inpatient units. The locking of Cowdy Ward is one such practice.

The TEMHS Inpatient Unit has two separate wards, the Joan Ridley Unit (JRU) which is a secure ward used as an Intensive Care Unit for acutely ill people and Cowdy Ward, which has traditionally been an open ward. In February 2010 the doors of Cowdy Ward were locked, that is, Cowdy was closed. People admitted to, and visiting Cowdy Ward can only leave when a staff person unlocks the door for them.

Section 104(2) of the Act states that a community visitor must refer any matter that he or she considers should be investigated by a panel to the Principal Community Visitor. One of the panel's duties, outlined in s111(2)(b) of the act is to inquire into the extent to which persons receive treatment and care in the least restrictive and least intrusive environment. Accordingly, the Principal Community Visitor referred the locking of Cowdy Ward to the Darwin community visitors panel for inquiry during their inspection of the ward in May 2010.

The panel reported that the ward was locked in response to a series of incidents with consumers. The idea is that the ward will remain locked until a new system for managing leave from the unit has been introduced and well established.

This new system involves coding access to leave. If a person is assessed as being at too much risk to have any leave from the ward, the access code is red. If leave is permitted, but only with an escort, the code is orange and full access to leave is coded green. The risk assessment, and hence the coding, applies to all activities, including the morning walk.

The panel reported that the coding system for leave needs to be consistent with the consumer's status on the ward. A person whose status is voluntary should be able to leave the ward at any time. CVP concerns about the effect of locking Cowdy ward on the ability of voluntary consumers to leave the ward are outlined, with examples, on pages 16 - 18 of this Annual Report.

Panel members spoke to consumers about their experience of the locked ward, finding that on the whole, most consumers did not have a problem with it. One person told the panel it was distressing and said it was like punishing everyone for the problems of a few.

The community visitor has also found that most consumers do not complain about the ward being locked. Some, however, have reported that they find it very confining.

While the system is supposed to account for individual differences via individual risk assessments which are reviewed daily, a problem for people admitted involuntarily is that the new system is a “one size fits all” approach, which lacks the flexibility to cope with individual needs.

One person told a community visitor that during previous admissions to hospital, even when involuntary, she was able to leave the ward and go for a short walk. She has no history of harming herself or others. She said that this is one way she manages her admission to hospital, because being able to “get away” is very important for her.

The CVP believes an individual approach, developed in consultation with the consumer, is more appropriate in these circumstances.

Apart from concerns about leave arrangements for people admitted to the ward on a voluntary basis, the Panel did not report any real concerns regarding Cowdy being locked. They did report that TEMHS Management is apparently committed to returning Cowdy to its former functioning as an open ward and intends to evaluate the effects of closing the ward in September 2010. The panel recommended that consumers play an active part in this evaluation. The CVP will continue to monitor the effect of the locking of Cowdy Ward on consumers’ inpatient experience in 2010 – 2011.

PART 2: ISSUES IN MENTAL HEALTH

RIGHTS

The protection of the rights of people receiving treatment from mental health services is one of the CVP's core functions. Sections 104(1) and 111(2) of the Act allow community visitor 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. This section of the Annual Report will look at rights issues that have arisen in the 2009 - 2010 reporting period.

Right to Review

Independent Review of Involuntary Admission

Because involuntary admission involves a loss of freedom, the Act provides a number of protections. The first protection is that the involuntary admission must be reviewed independently by two Authorised Psychiatric Practitioners (APPs). This happens within 24 hours if the involuntary admission is on the basis of mental illness, and within 72 hours if the admission is on the basis of mental disturbance. Community visitors in Darwin and Alice Springs review medical records at regular intervals to check whether reviews have been conducted within appropriate time frames and documented appropriately.

The community visitor for the TEMHS Inpatient Unit noticed while reviewing medical records that on one occasion, the Registrar who admitted a person involuntarily also took notes when the Consultant reviewed the detention the following day. This meant that the initial assessment and its review were all documented in the same hand writing.

The visitor reported this to TEMHS Management, noting that this practice, if repeated, could give the impression that the review of the decision to admit the person involuntarily was not conducted independently.

While reviewing notes at another time, the community visitor noted two instances where the assessment by the APP for involuntary admission and the review of the admission by a second APP were conducted at the same time.

There is no doubt that the intention of the legislation, that the second review should be an independent assessment of the consumer, is undermined if the initial

assessment is conducted at the same time as its review. Accordingly, the community visitor contacted the TEMHS Director of Psychiatry advising of these concerns. The visitor was informed that APP reviews are independent, even when they are conducted at the same time.

The CVP does not agree. In the Top End, the practice is that the two processes, the initial assessment and its review, are conducted by a Psychiatric Registrar and the Consultant Psychiatrist responsible for supervising the Registrar. This relationship alone means that independence is compromised either by fact or by perception. The perception of lack of independence is underlined if the Consultant and Registrar assess, and review the person's involuntary admission at the same time.

It was later acknowledged that this is not best practice but there are times when it might happen again if the ward is busy. The CVP believes that processes should be put in place to make sure it does not happen again.

Timely Review of Involuntary Admission

While visiting the TEMHS Inpatient Unit in July 2009, the community visitor noted that a consumer was admitted involuntarily on the grounds of mental illness at 9:30 am on 22 July 2009 was not reviewed until 10:15 am on 23 July 2009. Because she was admitted on the grounds of mental illness, the review should have been conducted within 24 hours. It was conducted 45 minutes out of time.

It is pleasing to be able to report that this happens far less often than it has in the past, however once the order has gone over time, it is possible that the person would have the right to leave the facility should they choose to do so.

In her report, the community visitor suggested that a system should be in place to track when reviews are required for each consumer so that prescribed timeframes are not inadvertently breached. She suggested that the whiteboard on the wall in each nurses station, which records patients names, attending doctor and nurse and other information, could include another column for review dates and times. This would assist staff make sure that reviews are always conducted in time.

While the community visitor was in JRU on another occasion, the Psychiatric Registrar informed the Consultant, in the community visitor's presence, that the second APP review of the consumer's detention had not been conducted, ie it was out of time. The Consultant stated in that case the consumer was voluntary. His Registrar reminded him that he had seen the consumer in time that morning, suggesting that he had formed an opinion at that time and could record that time as the time at which the detention was reviewed. The Consultant stated the consumer had appeared quite well to him that morning, and he was not prepared to sign the form until he had spoken to nurses about the consumer's presentation. He spoke to nursing staff, signed the form and dated it for that morning (within 24 hours of the previous APP review).

This was reported to TEMHS as an abuse of process. Not only was the review of detention out of time, at the time the review was due, the Consultant had not formed the opinion that the detention should be confirmed. It would have been more appropriate to document the actual time the decision was made to confirm the detention, even though this was outside the time frames prescribed by the Act.

Right to Request Early Tribunal Review of Admission

A second protection for people admitted involuntarily to an approved treatment facility is that their admission is automatically reviewed by the Mental Health Review Tribunal (the Tribunal). Before the Act was changed in March 2009, the admission was reviewed within seven days for people detained on the grounds of mental illness, and 10 days if detained on the grounds of mental disturbance. Now, the admission is reviewed within 14 days for people detained on the grounds of mental illness. The time for review of an admission on the grounds of mental disturbance has not been changed. Everyone, no matter the grounds for their admission can apply to the Tribunal to have their detention reviewed within 7 days of their involuntary admission.

Problems can arise at three stages in this process. Firstly, the person has to be informed of their right to request an early review of his or her admission, secondly, the appropriate paperwork must be forwarded to the Tribunal in time (there is a closing time) and finally, the Tribunal has to agree to review the involuntary admission. There have been problems at each stage over the past twelve months. The case example below illustrates some of the issues that have arisen.

Jane, who had been involuntarily admitted to the Mental Health Unit, told the community visitor she was unhappy with her involuntary admission. The community visitor advised Jane of her right to apply for an early review of detention. Nursing staff advised the community visitor that Jane would be reviewed by a doctor the next day, and the decision whether to detain her for a further 14 days would be made at that time. At this stage, the community visitor had been unable to review the consumer's notes and was not aware that the consumer's detention for a further 14 days had already been confirmed. The next day, the community visitor made several attempts to contact Jane's doctor, finally making contact at 2.30 pm (the day before the Tribunal was due to sit). It was at this time the community visitor became aware that the second APP review had already taken place.

Around 3 pm, the Registrar who reviewed Jane phoned the community visitor, and when asked whether Jane was advised of her right to an early review and what her response to this information was, the Registrar stated that he had not provided this information to her because he was new to the Territory and was unaware of this process. The Registrar further stated he would not support the consumer going to Tribunal the next day because they were changing Jane's medication and it would take several days to know if it was working.

The Registrar later informed the community visitor that he did not have the time to complete the necessary paperwork for the consumer's early review, that he was doing the work of other psychiatrists on the ward, in addition to his own, and that he still had to see two clients appearing before the Tribunal the next day.

The CVP Manager advised the Acting Manager CAMHS of the situation asking that the necessary paperwork be completed. She also contacted the Tribunal to find out whether they would conduct a hearing given that the application would be submitted well after the closing time stipulated in the Tribunal's Practice Directions. The Tribunal advised that they would not hear the case the next day because paperwork was submitted too late.

This complaint illustrates a number of issues. Firstly, the APP responsible for conducting the second review was not aware of his obligation to inform the consumer of her right to apply to the Tribunal for early review, nor was he aware of his obligation to complete the Form 12. This form prompts the APP to inform the consumer of the right to apply for early review of the admission. Finally, the APP appeared not to understand the role of an external body like the Tribunal and the importance of observing the consumer's right to have an intervention like involuntary admission and enforced treatment reviewed externally.

The CVP accepts that the Tribunal must set a closing time for hearing applications, and that this should allow for the time needed for the Tribunal to be convened and for Tribunal members to receive and read the paperwork. In the case outlined above, it was too late for any of these processes to occur.

There does however need to be some flexibility built in to the system to ensure that that focus is on the rights of the person whose freedom has, after all, been curtailed. At present, the person admitted involuntarily may not be informed of the right to have his or her admission reviewed and the mental health service may fail to notify the Tribunal in time of a request for a review. If the application for early review is received after the closing time, it is likely that it will not be reviewed, despite this not being the fault of the person involved.

The only person who suffers adversely in this situation is the consumer – there is no sanction against either the mental health service or staff who do not observe the consumer's rights.

Right to Review of Restriction or Denial of Entitlement

Section 98 of the Act provides that under some circumstances, an APP may order that the right of a person to write and receive letters, or to make and receive phone calls or to see visitors in reasonable privacy may be restricted or denied. An APP must review this order daily, and the person has the right to apply to the Tribunal to review the APP's decision to impose the order.

Joe contacted the CVP because he had been placed on an order which restricted his entitlement to visitors pursuant to s97 of the Act. The order had been put in place to protect Joe's reputation after he had been abusive to his employer during a visit.

The community visitor found three problems with the way the order was put into place. Firstly, the rationale for the order did not appear to comply with requirements of s98 (1) of the Act, which states that:

An authorised psychiatric practitioner may order that a right of a person under section 95, 96 or 97 be restricted or denied if the authorised psychiatric practitioner reasonably believes that unless the right of the person is restricted or denied there is a serious likelihood of the person suffering serious physical or mental deterioration or that the safety or well-being of other persons, another person or the general community is at risk.

It appears that the only rationale for restriction of entitlement is harm to others or the risk of deterioration of mental health. In this case, the rationale was protection of reputation. There appeared to be no assessment that the consumer was likely to suffer serious physical or mental deterioration or that any other person might be placed at risk.

Secondly, the scope of the order needed to be more clearly defined, that is, the degree of restriction was not specified in the order. The reason given for placing the consumer on the s98 order was to prevent contact with people from his workplace. This however was not specified in the order, and until the community visitor intervened, it appeared that Joe's family would be prevented from visiting him.

Finally, access to external review of the order via the Tribunal proved problematic. Because the Tribunal only sits once each week, an order under s98 is likely to be reviewed by the Tribunal only if it is in place for several days (up to a week or more) or if it is put in place the day before the Tribunal hearing. This means that the right to review contained in the Act is not really a right that can be claimed.

Rights of People Admitted Voluntarily to an Approved Treatment Facility

The Act provides that every effort should be made to admit a person to an approved treatment facility on a voluntary basis if at all possible. At the same time, Section 29 of the Act: "Discharge of voluntary patients" provides:

(1) Subject to section 30, a person admitted as a voluntary patient may leave the facility at any time.

(2) A person must be informed of his or her right to leave the approved treatment facility on being admitted as a voluntary patient.

Approved Procedure Five 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.

Jessica told the community visitor that earlier that week she had cut herself superficially, and presented to the On Call Team. She was assessed and sent home. She said the next morning, a worker from the On Call Team phoned her and told her she had to go to hospital. Jessica wanted to know whether she had to stay in hospital and whether she had to take medication. When reviewing the consumer's case notes, the community visitor found the following entry from the APP: "Doctor on duty to be informed in case of attempt to abscond/non compliance with ward rules/risk of self harm - may be sectioned in such case". Documentation from a nurse the next day stated that the consumer was asking to go home. She was "Advised that she needed to stay and be reviewed tomorrow and sectioning was a possibility if she left".

Working in the least restrictive way means that consumers are admitted to the inpatient unit voluntarily whenever possible. How this is managed if a person changes his or her mind about staying in the unit is hard for community visitors and staff alike. There are times when a person who is so unwell that he or she lacks the capacity to give informed consent, agrees to an admission and manages the admission better if it is voluntary, even though he or she is too unwell to be discharged. In these circumstances, a community visitor will not get involved unless the person makes a clear statement that he or she wants to leave the facility. The Act is unambiguous in these circumstances. A person who is admitted voluntarily must be allowed to go, or admitted involuntarily if the criteria for involuntary admission are met.

Risk Management in Cowdy Ward

The boundaries between voluntary and involuntary admissions in the TEMHS Inpatient Unit have been blurred since Cowdy Ward was closed and the new risk management system put in place. Essentially, the policy is that all consumers are not permitted leave in the first 24 hours after admission, despite the requirement that a person admitted voluntarily must be informed of the right to leave the facility at any time. After the first 24 hours, risks are assessed daily by staff, at the very least during handover. On the basis of this risk assessment, the consumer is either able to leave the ward alone, granted leave with conditions, or is unable to leave the ward.

Jock, who had been admitted to the ward voluntarily, told the community visitor he wanted to be able to sit in the garden area out the front of Cowdy Ward so he could sit outside without being around cigarette smoke. Despite his voluntary status, Jock was not permitted to leave the ward without an escort.

Jock was feeling caged. The community visitor spoke to his nurse about the situation, pointing out that Jock was voluntary and could therefore leave at any time. She stated that Jock had understood and agreed to the plan.

During a visit to the ward a few days later, the community visitor was approached by Michael, who was very distressed and repeatedly stating that he wanted to go home. He had been admitted voluntarily and wanted to leave. The Consultant was reluctant to detain him, yet wanted him to remain in hospital for a few hours to get some much needed rest, with a view to going home later that day.

There is no doubt that the Consultant was concerned for Michael's welfare and was acting in his best interests. One problem with a closed ward is that these situations are much more likely to arise. A person can be clearly expressing a wish to leave, but not be able to do so because they need a person to physically unlock the door. Delays, refusal to unlock the door and requiring a doctor to review the person who wishes to leave are all ways of protecting the person. Used improperly, they may also contravene the spirit of the Act.

Due to concerns arising from these, and other similar complaints from consumers, the community visitor checked the voluntary/involuntary status of consumers admitted to Cowdy Ward against their leave status during visits to the ward on 18/6/10 and 25/6/10.

On 18/6/10, 18 consumers had been admitted to Cowdy Ward, five of whom were voluntary. Two were permitted unescorted leave, two were allowed escorted leave, and one appeared to be not permitted leave at all. The community visitor reviewed this consumer's case notes. She had been admitted to the ward on the grounds of mental disturbance, and admitted voluntarily two days later. A doctor's plan on that day stated that she was to be admitted as a voluntary patient and that she was not to have any leave until reviewed by the treating team.

On 25/6/10, 14 consumers had been admitted to Cowdy Ward, one of whom was voluntary. Two consumers were not permitted any leave and twelve were permitted escorted leave only, including the consumer who was voluntary.

This is strong evidence that a person's legal status, ie whether he or she is voluntary or involuntary, appears to be irrelevant to the ability to leave the ward.

In one case the voluntary nature of the admission was conveyed and understood by a consumer. Jill told the community visitor during one visit that she was voluntary, and this meant she could leave at any time. She said she didn't want to leave, she only wanted to go out with other people. Jill's status was indeed voluntary, and she was assessed as being able to have escorted leave only. It is questionable as to why it was necessary to place conditions on Jill leaving the ward, given that she had already decided she would not leave the ward alone.

The voluntary nature of the admission was not managed in the case of the voluntary consumer who wanted to go into the front garden but was not permitted to do so, nor was it the case with the voluntary consumer who was repeatedly asking to go home.

While understanding the need for a comprehensive risk management system, the system must be framed within the confines of the legislation designed to regulate the admission of people to psychiatric inpatient units. The cases outlined above demonstrate that this is not the case. The Manager TEMHS, in response to reports from the CVP, suggested that the CVP Manager meet regularly with APPs from TEMHS in an attempt to discuss and resolve these issues as they arise.

Right to a Fair Tribunal Hearing

APPs must apply to the Tribunal in a number of circumstances, including an application of involuntary admission for more than 10 days on the grounds of mental disturbance or 14 days on the grounds of mental illness. When making these applications, the APP is responsible for writing a report which details the person's social, medical and psychiatric history and reasons for the application. It is not unusual for the CVP to receive a complaint that some of the information in the report is untrue, or that the consumer did not see the report until just before the Tribunal hearing.

Content of Reports Prepared for Tribunal

Joel had only one previous admission to a psychiatric inpatient unit, and while it appeared he might have a mental illness, the situation was sufficiently ambiguous to require a comprehensive assessment. A family member, who was concerned about Joel, was the major source of information for the mental health service. Joel complained that a number of statements in two reports prepared for the Tribunal were untrue.

Permission was given for the community visitor to contact Joel's GP and other persons and agencies so that an independent investigation could be conducted. The community visitor found the following:

- On the whole, hearsay evidence was acknowledged in the reports as hearsay, although at least one hearsay statement was demonstrably wrong;
- Joel stated that other hearsay statements were wrong, although it was not possible to find any proof either way;
- The fact that Joel's partner had denied some of the information provided to the service and subsequently contained in the Tribunal Report was not mentioned in the report, ie there was not a fair representation of two opposing views;
- There was no evidence to support some of the conclusions reached in the application;
- Statements about some suspected behaviours were vague, not supported and seemed very unlikely; and
- Results from a urine drug screen were misrepresented.

The mental health service is often reliant on hearsay, and there is no problem with this if it is acknowledged as such. If the person preparing the report is aware the

person, or people close to the person disagree, then this should also be included. For the sake of fairness, information must be tested before it is included as factual, particularly when it is of a prejudicial nature. Finally, it is important that language is careful and non emotive.

Access to Reports Prepared for Tribunal

Section 132 of the Act provides that a person who is the subject of a review must, subject to harm considerations, be given access to the medical records and reports that are before the Tribunal. The implied process is that the person who is the subject of the review must be given access to medical records and reports to be considered by the Tribunal. If there is a likelihood of harm, the Mental Health Service should apply to the Tribunal to withhold the harmful information. The Tribunal may then make orders about who should be given access to the information.

The reality is that only the legal representative is provided with a copy of the application to the Tribunal, generally the day before the Tribunal hearing. The community visitor is not aware that an application has ever been made to the Tribunal to prevent a person who is appearing before a Tribunal being given access to reports to be considered by the Tribunal. As a rule, access is just not provided. The person who is the subject of the review is only ever provided with a copy of the application by their legal representative, generally after the Tribunal hearing has taken place.

The application to the Tribunal for a further period of involuntary admission for Joel was 21 pages long. It contained a previous medical report that he knew existed, but had never seen. Joel had approximately an hour with his partner and his lawyer to examine the application before the Tribunal hearing. He was unwell at the time, and had problems absorbing the information.

The Consultant overseeing Joel stated that he did not want Joel to see the entire report for two reasons; firstly it contained information about the sources of information in the report, and secondly, Joel was assessed as being too unwell to understand what was in the report. It appears that the Consultant did not realise that it is standard practice for the legal representative to send a copy of the report after the Tribunal hearing.

The community visitor found that the content of the report was not shared with Joel or his partner prior to hearing, except by their lawyer and that this is consistent with everyday ward practice. It is procedurally unfair and a denial of natural justice.

Other jurisdictions have legislative provisions similar to the NT to ensure that consumers know what is contained in reports to Tribunals. Information from Tribunal/Board websites in South Australia, Western Australia, Victoria, Queensland and Tasmania, indicates that people who are subject of application are either provided with a copy of the application or have it discussed with them. There is no clear direction from NSW and the ACT.

The CVP is of the view that this is an issue that needs to be addressed for all consumers who appear before the Tribunal. Processes should be in place to protect what are sometimes opposing rights; the consumer's right to know what is written about him or her in the Tribunal report, and the rights and safety of the people who provide information to the mental health service.

Right to Understandable Information

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.

Mental Health Unit, Central Australia

In Alice Springs, information for consumers is available in written form in two local languages. The panel reported in both 2009 – 2010 reports that the Mental Health Unit was looking at using *One Talk* technology to develop posters with oral information about rights available in six languages at the push of a button. The panel decided that the recommendation would remain open until the next visit, in the hope that the posters would be up in the Unit and being used.

TEMHS Inpatient Unit, Top End

The Darwin community visitors panel reported in April 2010 that, since 2004, they had been advised of at least three different TEMHS strategies to address the issue of how information is given to Aboriginal consumers. During their last visit, the panel was advised that CAMHS would be developing the information material using *One Talk* technology, and that this would then be rolled out across the NT.

Given the delay since their first recommendation (ie 2004), the panel was not satisfied with this. In the report of their visit to the Principal Community Visitor, the panel expressed the opinion that the mental health service should identify when the information for Aboriginal consumers would be ready for use in the inpatient unit. The panel then wrote to the Principal Community Visitor regarding future CVP action with respect to this outstanding recommendation.

At the time of writing this Annual Report, the Manager of the CVP is in a working group with the Senior Policy Officer Mental Health Services and the Manager TEMHS to urgently address this issue. The CVP hopes to be able to report that this recommendation has been closed in both Central Australia and the Top End in the 2010 – 2011 Annual Report.

Right to Interpreter Assistance

The Guidelines to Approved Procedure 27 state 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. At the beginning of the 2009 – 2010 reporting period, there were outstanding recommendations about the need to improve the use of interpreters in both the Mental Health Unit and the TEMHS Inpatient Unit.

Mental Health Unit, Central Australia

The recommendation for the Mental Health Unit was closed in 2009/10 after the Alice Springs community visitors panel reported that significant steps had been taken to improve the use of interpreters, including the use of a “sign in” book for interpreters. There has been closer collaboration with the Aboriginal Interpreter Service (AIS), with the AIS attending the Mental Health Unit to train staff in how to use interpreters. The Mental Health Unit has also designated one staff member to act as a contact point for the AIS to ensure that issues with interpreters can be followed up.

TEMHS Inpatient Unit, Top End

The Northern Territory is a multicultural community, and interpreters are needed for many people who do not speak English as their first language.

The community visitor witnessed what can happen when treatment is discussed without an interpreter present while attending the TEMHS Inpatient Unit to see a consumer in the company of another service provider. Doctors met with the consumer without an interpreter present to discuss her treatment. TEMHS had contacted the telephone interpreter service and were informed that no interpreters

were available at that time. After the doctors left, it became apparent to the service provider that the consumer was not happy with the outcome of the meeting with her doctors. The service provider arranged a telephone interpreter and the doctor agreed to meet again with the consumer. The outcome was a completely different treatment plan.

During a visit to the TEMHS Inpatient Unit on 7 May 2010, the community visitor reviewed four medical records of consumers whose first language is not English to determine whether Interpreters were present during interviews with their doctor.

Two consumers were interviewed without interpreters at any time. Case notes indicated that their English was strong enough for assessment purposes.

The initial assessment of the third consumer was undertaken without an interpreter present. The doctor commented in the assessment that the consumer appeared to have difficulty understanding her. The consumer was reviewed with an interpreter present during his next two interviews with a doctor, and without an interpreter for his final review.

No interpreter was present for the initial assessment of the fourth consumer and there was no documented evidence of effort to find an interpreter. The assessing doctor noted that the consumer would not answer questions. No interpreter was present for the second and third reviews. The Registrar noted in the fourth review that he had tried to arrange for an interpreter twice but none were available. The consumer was interviewed with an interpreter present twice, and on three further occasions there was no evidence of any attempt to use an interpreter.

In May 2007, the community visitors panel for the TEMHS Inpatient Unit recommended that interpreters be present at the assessment of all consumers whose first language is not English. Interpreters shoud then be arranged for all further assessments and for any subsequent Tribunal hearing.

During their visit in April 2010, the panel reviewed the case notes of two consumers who required an interpreter. The panel noted that there was no record of either person's first language on the medical record.

The panel later spoke to a family member of one consumer about interpreter use. She stated that an interpreter had been used during a previous admission to the inpatient ward, but not this time. She advised that medical staff and others had asked her to act as an informal interpreter. She said she was not happy that she had been asked to interpret, as it was culturally inappropriate for her to speak to the consumer in the way she was being required to. Further, she said that her family relationship to the consumer was a barrier to open, unbiased communication.

The panel acknowledged that it may be difficult to locate an interpreter after hours, or when there are not enough consistently available accredited interpreters for a particular language group. Nevertheless, because this is such an important gap in service, the panel wrote to the Principal Community Visitor requesting future CVP action with respect to this outstanding recommendation.

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, described in section 111(2)(a) of the Act, 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

Bathrooms in the TEMHS Inpatient Unit

Consumers have been complaining about the showers in the TEMHS Inpatient Unit for some years now, and their complaints have not been adequately addressed. The community visitor attends the consumer meeting every Friday morning. Every week, consumers complain about the showers in the Unit.

Apparently, the flow is very poor, and the water, if it heats at all, can take between five and 10 minutes to heat up.

The CVP is aware that TEMHS has made numerous attempts to address this issue.

In April 2010 the Darwin community visitors panel indicated that the issue had been rectified to some extent after Royal Darwin Hospital (RDH) resumed its landlord responsibility for the inpatient unit. The panel felt that the water was slightly warmer than on previous visits and took less time to heat. They concluded however that there needed to be greater improvement, particularly with the onset of the dry season.

One bathroom, in the main bedroom wing of Cowdy ward, is shared by visitors and consumers from three bedrooms. In the report of their visit to Cowdy in December 2009, the panel reported that the plaster on the wall was peeling, the corners were grubby, there were substantial water stains and the walls had holes in them where railings had been removed.

One panel member, on closer inspection, found that the floor of this bathroom was slippery with built up grime. This finding was repeated in the panel's second visit in April 2010. The panel was informed by TEMHS Management that all the bathrooms

would be upgraded as part of the refurbishment happening with the building of the new Stabilisation and Assessment Unit. It is hoped that the CVP will be able to report in 2010 – 2011 that consumers in the TEMHS Inpatient Unit are able to have hot showers in clean, well maintained bathrooms.

Privacy in Cowdy Ward

Joan told the community visitor that she felt frightened getting changed in her room because there is a clear glass panel in the door which people can easily see through. Jane said she placed a towel over the panel at night so she could have some privacy.

The room is in the area set aside for vulnerable people like adolescents or mothers with young babies who may need to stay in a separate area. The community visitor spoke to the Clinical Nurse Manager (CNM) who stated it might be possible to place curtains on the corridor side of the glass panel. This would be safe for the consumer, it would ensure privacy, and nurses could still check the consumer during rounds. The CNM has since confirmed that she will ensure that curtains are placed on these windows.

Fishbowl in Cowdy Ward

In October 2004, the Darwin community visitors panel recommended that a physical upgrade take place in Cowdy Ward to provide a private secure area for staff to undertake the administrative tasks associated with consumer care so that there would no longer be any need for the glassed in nurses station commonly known as 'the fishbowl'.

All consumers who have been admitted to the inpatient unit, as well as many visitors know what it is like to stand outside the window of the fishbowl waiting for a staff member to first notice, and then acknowledge their presence. It is a shared experience that is universally disliked.

TEMHS management informed the panel that the 'fishbowl' will have gone by June 2011. Similar promises have been made in the past, although this time it appears that minor works money has already been received to convert the seclusion room behind the nursing station to an office and to convert the fishbowl into a nursing station.

JRU Environment

In previous annual reports, the CVP has commented on the environment of JRU, a secure ward for people who are acutely unwell and who are at risk of absconding or who pose a risk of harm either to themselves or others. A key issue consistently raised by the CVP is the fact that there is no external courtyard with access to fresh air.

Jacinta, a young Indigenous woman who was acutely unwell and being nursed in JRU, asked to see the community visitor. She told the visitor she wanted to leave and go home. The community visitor tried to tell her that this was not possible. Jacinta could not listen. She just kept asking to please be allowed to leave and go home.

The TEMHS Inpatient Unit is an alien environment, more so for Indigenous people from remote areas. JRU, as a secure unit, is even more alien. Without access to the outside, people feel trapped. TEMHS Management informed the Darwin panel that minor works have been approved to create an outdoor courtyard adjacent to the dining room. Once this occurs, hopefully in 2010 – 2011, the panel recommendation regarding the need for an outdoor area, outstanding since November 2006, can be closed.

Despite the difficulties with the JRU environment, it is less austere than it used to be. In the report of their visit in April 2010, the panel stated that there have been significant improvements in the JRU environment. They drew attention to the addition of soft furnishings, new carpet, murals in the closed courtyard, repair of bathrooms, opaque window coverings and most importantly, sound dampening in the main rooms.

The sensory modulation room, a tool to help consumers relax and perhaps avoid seclusion, is another importance advance. There has also been a change in the way consumers are nursed in JRU. Activities are available in the dining room. Where once rules prevented people from having books and people could not carry a biro, it is not unusual now to see a consumer walking around with a book, a magazine, or a diary.

Much has been achieved, however there are still improvements to be made. The stainless steel toilets still look like toilets that would be found in a prison. The bathrooms need maintenance and work still has to be done to reduce the echoing in the corridor and entrance lobby.

Management reports that minor works have been approved for the 2010/11 financial year to create an outdoor area adjacent to the dining area, which will directly address this recommendation. Costing is also underway to change fixed block beds to modern safety beds and complete repairs on bathrooms.

Oleander Room

When a person comes to the Emergency Department (ED) of Royal Darwin Hospital (RDH) for a mental health assessment, he or she is brought to the Oleander room, a separate, private area within the ED.

The Oleander room is unpleasant and uncomfortable to be in. The walls are white, and marked. The lights are bright. There is no colour and there are no pictures on the walls. A grey couch lines two walls. The couches are comfortable enough, and held against the wall with strong velcro strips. The room has a real institutional feel.

Apparently colourful, comfortable chairs similar to the chairs purchased by TEMHS for the Tamarind Centre and the TEMHS Inpatient Unit were in this room. These chairs were purchased because they are designed for use in settings which need furniture which is both safe and comfortable. They were apparently removed without consultation with mental health staff.

The community visitor suggests strongly that changes are made to this room as soon as possible. Firstly a coat of paint is needed to make the room more welcoming. Laminated pictures or posters on the walls would add some colour and life to the room. For aesthetic and safety purposes, the community visitor suggests that at the very least, the couch on the wall opposite the entry is removed and two chairs of the type generally used by mental health services put in their place. It is strongly recommended that should there be any future plans to redevelop the ED, NT Mental Health Services are consulted with a view to designing a waiting area and interview room specifically suited to consumers with mental health issues and their families.

Tamarind Centre

The Tamarind Environment

A community visitor inspected the Tamarind Centre in June 2010. She found that there have been some improvements in the ambience of the waiting area, however the feeling of being 'surveilled' while in the waiting area remains. This is a perception shared by consumers.

A month prior to the inspection, the community visitor accompanied Jacqui to a meeting with her doctor at the Tamarind Centre. While waiting in the waiting room, she asked Jacqui to comment on the room. Jacqui stated that it was obvious that the windows into the waiting room were set up so that clients could be watched.

In her last report, the community visitor suggested that this could be solved by putting curtains on these windows. A recent response from the Manager TEMHS indicates that micro Venetian blinds have already been ordered and will be placed on the inside of the room facing on to the Reception Area.

Interview Rooms and Treatment Rooms

There are two interview rooms at the Tamarind Centre. They are used for appointments with doctors and with case managers. The community visitor reported that the first interview room is a good size and of pleasant ambience. Paint has been pulled off the wall at the back of the room where a vinyl chair has rubbed against it. The room has two exits. The community visitor noted that the handle on the second door (the one closest to the reception area) was stiff and needed to be fixed.

The second interview room is small and quite claustrophobic. At the time of the inspection, the green chairs in the room looked sickly against the colour of the walls, and the visitor suggested that they perhaps be swapped with chairs from the other interview room which were less likely to clash with the walls. There is only one exit from this room.

The treatment area is comprised of two small rooms which are connected through a lockable folding door. Any consumer who needs observations to be taken or who is having their medication by injection will use this room. The visitor noted paint strips hanging from the roof of the room with the guerney/bed. Each room in the treatment area has a separate exit, although the doors open into the room. The community visitor also noticed unused equipment lying around on top of cabinets and cupboards and suggested that consideration be given to installing cupboards in these two rooms so that equipment could be stored away.

In a response to the community visitor's report, the TEMHS Manager stated that repairs to the door handle in the interview room had been requested. She also stated that the treatment room would be refurbished.

CAMHS Mental Health Unit

The panel established for the Mental Health Unit in Alice Springs reported positive changes to the amenities in the Mental Health Unit after both visits to the Unit in 2009/10. The panel reported that:

- The recreation room had been painted and was being well used at the time of the visit, with nursing staff interacting with consumers and playing pool. The Panel was told that a table-top had been made for the pool table so that it could be converted into a large table for different activities. The general look of the room was improved with colourful wall hangings;
- The quiet room had been further improved with a lounge and a new bookshelf with an interesting range of reading material. The panel was advised that a decision had been made not to include literature about mental health in the quiet room. This information is available elsewhere on the ward and it was thought that the quiet room was to be a place to focus on other things. The panel reported that they were impressed by this response and the obvious thought that has gone into the use of this space;

- There were some vegetables and a scarecrow in the main courtyard attached to the Unit, and some consumers had been involved in maintaining the garden area;
- The High Dependency Unit, a lockable area in the Mental Health Unit for consumers who may be at some risk, had been repainted;
- There had been discussions amongst staff about removing the cameras and monitors within the HDU. It was felt that there was no need for them as face to face supervision was sufficient. The panel was impressed that this was "a further indication of the thought given to least restrictive practices" in the Mental Health Unit;
- There was little change to other amenities on the MHU. The common areas were being well used and were comfortable. The bedrooms were described as clean and well maintained. Keys in bedroom cupboards allow consumers to lock personal items in their rooms, although they still also have the option of leaving items in a plastic box behind the nurses' station.

Because improvements to the amenities in the Mental Health Unit were maintained across two panel visits, the panel closed a recommendation outstanding since May 2008 regarding the need to upgrade the facilities in the Mental Health Unit.

CAMHS Community House

The community visitor inspected the facilities at the CAMHS Community House during her visit to the approved treatment agency in June 2010.

The Community House is an attractive building, but is really not suited to the requirements of CAMHS. Improvements to the Community House are limited by the space available, and as it is a heritage listed building, no renovations can be undertaken. The building is owned by Alice Springs Hospital, further limiting the options available to CAMHS.

The community visitor reported that the physical facilities of CAMHS Community House remain much the same as previously, however space has been allocated for an interview room. The interview room has been freshly painted and is furnished with lounges, tub chairs and a coffee table, with plans underway to mount pictures to the walls. There are two entrances into the room addressing any safety concerns. Only a low level of outside noise is audible when the doors to the room are closed so the privacy of consumers is well protected.

PART 2: ISSUES IN MENTAL HEALTH

QUALITY

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 primary 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 2005/06, the CVP has commented on the inadequacy of notifications received from TEMHS. A recommendation that this notification is improved has been outstanding since November 2007.

In 2009/10 the Manager of the CVP decided to follow up with TEMHS whenever she was aware that a person had been detained for more than seven days but the CVP had not been notified as required. Even with this level of follow up, the notification rate improved to just 57% for the year.

Complaints Register

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.

In 2008/09 the CVP reported that 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. This situation has not been rectified. In 2009/10, TEMHS forwarded a comprehensive report on complaints for 2008/09. Despite three email reminders throughout the year, no report was received from either CAMHS or TEMHS for the 2009/10 reporting period.

At the time of writing this report, a report on complaints received and actioned by TEMHS in 2009/10 had been received.

Audit of Legal Forms in Case Notes - Darwin

The community visitor in the Top End regularly audits the paperwork on medical records to determine whether documentation and practice meets the requirements of the Act. In 2009/10, a total 44 records were reviewed over six visits to the TEMHS Inpatient Unit.

There were no problems with practice and documentation for 27 medical records checked. In all cases reviews of involuntary detention had been carried out in time. Apart from problems demonstrating independence of the first review of involuntary admission discussed in the "Rights" section of this report, only minor problems were identified. The most common issue is failure to complete the appropriate notification paperwork.

Form 12 is the form used to notify the Principal Community Visitor and the Tribunal of involuntary admission for seven days on the grounds of mental disturbance and 14 days on the grounds of mental illness. When the APP signs the Form 12, he or she also signs two additional sections. The first section affirms that the consumer has been told of the right to early review of the involuntary admission. The second section reminds the APP of the obligation to notify the primary carer of the admission.

There seems to be a problem in that parts of the form used by APPs when the person is admitted involuntarily seems to be duplicated by the Form 12. Despite the importance of informing consumers of their rights, the Form 12 is often not completed. Of the 44 records reviewed by the community visitor, the Form 12 had not been completed on 16 occasions.

The CVP is now requesting the Form 12 whenever it is not received to remind APPs of their obligations and to improve this aspect of practice in the inpatient unit.

Treatment and Care

Records of Outpatient Medical Appointments in Alice Springs

In its 2007, 2008 and 2009 Annual Reports, the CVP reported that notes from some outpatient appointments in Alice Springs were still recorded on the hospital file rather than on the community based electronic file or Community Care Information System (CCIS).

If the case manager does not attend the outpatient doctor appointment with the consumer, and if there is a breakdown in communication, the case manager may not know if medication has been changed. This increases the chance that a mistake with medication might be made.

After visiting the inpatient team in June 2010, the community visitor reported that this situation is still unsatisfactory. The General Manager CAMHS stated that he is working with relevant staff to address this issue.

Missing Purse

Jude is a young woman who was transported to hospital involuntarily by the Royal Flying Doctor Service (RFDS). She was first taken to a community clinic where she was heavily medicated for the flight. When she arrived at hospital, Jude was placed in the Intensive Care Unit. A few days later, when she was transferred to the inpatient unit, Jude reported that her purse, which had $500 in it, was missing.

The community visitor contacted Jude's mother, a nurse at the community clinic and the RFDS. She found that Jude did have her purse when she arrived at the clinic. The clinic nurse stated she placed the purse in an envelope, and put this on the plane with her.

Staff from RFDS could not locate the purse. The RFDS nurse who was with Jude on the flight said that all property must be receipted. She said there was no receipt for the purse, and she could not remember being asked to sign for an envelope. The nurse said she did remember some discussion about a purse at the time Jude was being placed on the plane, and that she had said something to the effect that she did not wish to take responsibility for the purse given that Jude was unconscious. The nurse believes the purse remained behind, either at the Clinic or with family.

The visitor spoke with the Clinic nurse a second time. The nurse said she was certain that she placed the purse in an A4 sized envelope, with Jude's nursing notes. She had since been made aware of protocols regarding property receipting, but stated that due to the critical response required in this situation, the protocol had not been followed. Jude's mother was not able to comment on whether the purse was placed on the plane, however she recalled that she was not given the purse.

Jude was transported involuntarily because she was assessed as experiencing a psychotic episode. She was unconscious at the time she was placed on the plane, having been intubated. Both factors indicate that she had no capacity to be responsible for her property.

The community visitor's investigation indicates that it is most likely that the purse was placed on the plane. It appears that protocols around receipting property had broken down at the transfer from clinic to plane, possibly due to the critical response required for Jude at the time. While the purse was not receipted when the consumer arrived at Alice Springs Hospital, this does not necessarily mean that it did not arrive.

$500 is an irreplaceable loss to a person whose only income is Centrelink benefit. The CVP believes Jude should be reimbursed for loss of her purse during transport to hospital. This issue has not been resolved. The difficulty is, given multiple agency involvement, which agency should be responsible. The CVP does not believe this

should provide an insurmountable barrier and will continue to advocate for reimbursement through NT Mental Health Services.

Contact with Family

Nicole contacted the CVP because she was concerned about her husband's mental health. They had separated recently, and she was caring for the children who appeared to be struggling with the situation. She also had concerns for the children who did not seem to be coping with the separation. She wanted to be able to discuss her concerns about her ex-husband and her children with staff from Tamarind.

The community visitor referred Nicole to Mental Health Carers NT for support and contacted the Team Leader of the Adult Team to discuss the issues raised. Within 24 hours both he and a worker from the Child and Adolescent Team had phoned Nicole. She was impressed with the immediacy and quality of the TEMHS response.

Notification of Parents Without Consent

The Act provides that the primary carer must be notified of a person's involuntary admission to hospital, unless it is not in the person's best interests to do so. A primary carer is defined as a relative who provides care and support because of a sense of responsibility, or a person who is not a relative but who nonetheless provides care and support.

The Act therefore provides for the mental health service to work with family of consumers without consent in the event that family provides support in one form or another. As stated above, Form 12 provides the opportunity for the mental health service to notify the Tribunal of a decision not to notify the primary carer of an involuntary admission.

Ben told the community visitor he was annoyed that his situation and illness had been discussed with his parents without his knowledge. He said that his mother had been diagnosed with a mental illness in in the past and he was concerned that she would have been stressed by the contact from mental health and the information given to her.

The notes showed that Ben's parents were contacted soon after his admission and his illness and diagnosis discussed with them. It was not clear from the case notes if any consideration had been given to gaining Ben's consent.

The community visitor noted that on the relevant section of the Form 12, the Psychiatric Registrar had made the statement that there was no primary carer. If this was the case, contact should not have been made with Ben's family without his express consent.

The CVP suggested that consumers should be consulted about who their primary carer might be and their wishes regarding contact. This consultation should be documented in the medical record, along with a rationale for all decisions regarding contact with the primary carer or family member.

Change of Diagnosis

Mary told the community visitor that she had been treated for a mood disorder for many years. She said she had been admitted to the Inpatient Unit a few weeks previously, and assessed by a visiting Consultant who said she did not have an mood disorder, that she was a nicotine and caffeine addict. The Consultant took her off her medication. Mary said that she later became unwell and was transported to hospital involuntarily by police and her case manager. Mary said her son witnessed this and was very upset by it.

The community visitor reviewed Mary's file. On a previous admission Mary had indeed been diagnosed with panic disorder and nicotine and caffeine dependence. She was taken off mood stabilisers.

Mary was admitted again on the grounds of mental illness about a month later. Admitting notes described her as "well known" to the mental health service with a diagnosis of a mood disorder. Mood stabilisers were re-introduced.

The community visitor was unable to speak to the psychiatrist because he had already left the NT. Nevertheless, it appears that Mary's claim about the change in treatment by the visiting psychiatrist had merit given that she relapsed soon after the removal of the mood stabiliser. The mood stabiliser was reinstated when she was re-admitted to hospital.

Both Mary and her son were adversely affected by this decision. NT Mental Health Services works with visiting Consultants often. In these circumstances, other medical staff and case managers, who know a person and his or her history well, have an obligation to ensure that treatment is not changed without consultation with other members of the treating team. The treating team includes the client, the case manager and any identified primary carer. The CVP is of the view that a policy needs to be in place to ensure this situation cannot be repeated.

Access to Allied Health Services

During its two visits in 2009/10, the Alice Springs panel looked at how easily people receiving treatment in the Mental Health Unit are able to access allied health services.

The problem is that a person who is receiving treatment in the Mental Health Unit and who needs access to allied health services such as Physiotherapy, Dietetics or Occupational Therapy, is less likely to receive this service than people in other wards in Alice Springs Hospital (ASH).

There are two reasons for this. Firstly, consumers in the Mental Health Unit are less likely to suffer an acute physical illness than patients in other wards in ASH. When resources are short, the people who are most acutely ill and who are therefore assessed as most in need of the service, are more likely to get access to it. The second reason is that the mental health service is operationally separate from the general hospital. In this circumstance, resources are much less likely to be shared.

The Alice Springs panel was advised that a Clinical Liaison Officer, half funded by the Hospital and half funded by Mental Health Services, had previously worked from the outpatient setting. The position was to be located in the Mental Health Unit, with a view that this might facilitate a more immediate liaison between the Unit and other services within the hospital. The Panel was also advised that the new General Manager of CAMHS had established a good working relationship with the hospital management and that this might have a positive effect on the ability to access Allied Health Services.

The panel has recommended that the Mental Health Unit record the outcome of requests for allied health services, with a view to providing evidence for the difficulties they experience. The panel will continue to monitor this throughout 2010/11.

Non-Smoking Facilities

Psychiatric inpatient facilities around Australia, particularly when located within general hospitals, are increasingly becoming non-smoking facilities. There are various arguments about this. In favour is the argument that psychiatric inpatient facilities are, after all, health facilities, and it is inconsistent to allow smoking when this is a known threat to health. On the other side is the argument that people admitted to a psychiatric inpatient facility do not necessarily have a choice; removing the right to smoke just adds to the stress of the admission.

The CVP can see the validity of both sides of the debate, and rather than commenting on whether facilities should, or should not allow smoking, has instead tried to monitor the effect of the change in policy.

TEMHS Inpatient Unit

The TEMHS Inpatient Unit became a non-smoking facility on 31st May 2009. Since that time, nicotine replacement via patches, chewing gum and inhalers has been offered to all consumers. Once the non-smoking policy was introduced, consumers in JRU were not able to smoke, however those admitted to Cowdy Ward could smoke if they left the ward environment. A defacto smoking area was set up in what is now a parking lot alongside Cowdy Ward.

RDH became a non-smoking campus in July 2009, and the TEMHS Inpatient Facility implemented this from 10th July. The community visitor was present at the ward meeting and witnessed the transition, which was expertly managed. No issues with the change in policy were raised by consumers at that time.

However, consumers could no longer use the parking area as a smoking area. There is an area of Crown land across the road from Cowdy Ward where consumers could legitimately smoke. Staff and consumers identified some issues with the practice of going to this area to smoke, including the risks associated with isolation and distance from the ward.

The Principal Community Visitor referred this to the panel for investigation during its visit to the TEMHS Inpatient Unit in December 2009.

The panel spoke to staff and consumers while they were in the Crown land area. They told the panel that they were concerned that alcohol drinkers also use the bush land on the other side of the creek and there had been a recent incident when police were called. One consumer thought there was a risk of being assaulted. The heat, lack of shade and seating were also a concern of smokers.

The panel concluded their report by commending TEMHS on the implementation of the Department of Health no smoking policy on the grounds that there "is no safe level of smoking or smoking exposure". The panel urged TEMHS Management to conduct a risk assessment of the practice of leaving the Unit to smoke, to clearly advise consumers of this risk and to assess the capacity of clients to safely leave the ward.

As stated earlier in this report, Cowdy Ward was locked in March 2010 and it was no longer possible for consumers to leave the ward to smoke. Accordingly, smoking has once again been permitted in the internal courtyard of Cowdy Ward. Consumers in JRU are still not able to smoke.

Mental Health Unit

During their visit in May 2010, the panel established for the Mental Health Unit in Alice Springs also enquired into the effects of the introduction of the non-smoking policy in Alice Springs Hospital. Panel members spoke to staff and consumers.

They reported that there was some diversity of opinion. It was generally agreed that the non-smoking policy was not adversely impacting the treatment of consumers. The only concern raised was that when a person who had been admitted involuntarily wanted to smoke, he or she could not be accompanied to the smoking area by a staff member. On at least one occasion, an involuntary consumer had been assessed as being able to leave the unit alone, allowed to attend the smoking area unaccompanied and had absconded. The consumer had been absent from the Unit for some days and her mental health had deteriorated during this time.

The panel reported that it was apparent that the Unit is sensitive to the issue of smoking and assesses consumers' dependence on nicotine on admission. Nicotine Replacement Therapy is given where required. As with the Darwin Panel, the Alice Springs panel made no findings regarding whether or not a no smoking policy should be in place.

PART 3

INSPECTION OF SECLUSION REGISTERS

CAMHS Mental Health Unit

The community visitor in Alice Springs reviewed the Seclusion Register held in the Mental Health Unit in December 2009 and again in June 2010. There were 13 seclusion episodes in 2009/10, representing an 87% reduction on the number of seclusions episodes in 2008/09. In the second half of the reporting period, ie from January to June 2010, there was only one seclusion incident.

The staff of the Mental Health Unit are to be congratulated on this outcome. It is an outstanding result which is indicative of a real focus on reducing restrictive practices within the unit.

TEMHS Inpatient Unit

Seclusion Registers in the TEMHS Inpatient Unit were inspected in December 2009 and June 2010. Due to the number of seclusions in the TEMHS Inpatient Unit, the community visitor typically reviews the register for the six months prior to the inspection date. In December, for example, the community visitor inspected seclusions which took place between the 1st June 2009 and the 30th November 2009. In this Annual Report the CVP is reporting on review of seclusion episodes from 1st July 2009 until 30th May 2010.

A total 231 episodes of seclusion were reviewed in this period, with only 28 episodes from December 2009 until May 2010. This compares with 637 episodes for the same period the previous year, representing a 64% decrease in the incidence of seclusion for the year overall. In the second half 2009/10 the figures are even more impressive, with a remarkable 92% reduction in seclusion episodes in comparison with the same period in the previous year.

Some issues were still identified, particularly during the first review. These are detailed below. Problems with timely medical review of seclusion reported in 2008/09 have on the whole been addressed, although there is the occasional incident where the medical review does not occur in time. A problem with documentation, identified in the first seclusion report, was addressed by TEMHS by the time the second inspection was carried out.

Issues Identified During Reviews of the Seclusion Register for TEMHS

Time Spent in Seclusion

Section 62(6)(a) provides that the time a person is kept in seclusion must be determined and noted in the record of the person being secluded. The Form 22 is used to record, amongst other things, the reasons for seclusion and how long the person will be secluded. This should be decided before the person is actually secluded. Completing the Form 22 properly makes sure that seclusion is used only as a last resort and is carried out in accordance with the Act.

The community visitor noted that from July to November 2009, the section of the form in which the period of seclusion is recorded was not completed for 25% of all seclusion episodes. It was clear that some staff never complete this section of the form.

New forms were developed to coincide with changes to the Act introduced in March 2009, and the community visitor formed the view that the major problem was most likely the design of the form. This issue was raised with the Mental Health Program, and it was agreed that a small adjustment to address the problem could easily be made.

At the same time, TEMHS addressed this issue internally. When the visitor conducted the second inspection of the seclusion register for the TEMHS Inpatient Unit in June 2010, all Form 22s were completed in full.

Medical Review of Seclusion

Section 62 (8) (b) of the Act, together with the Approved Procedures to the Act provide that a person who is in seclusion must be examined by a medical practitioner at least once every four hours.

In 2009/2010, the community visitor found four instances of medical reviews being conducted out of time as follows:

1. Sophie was secluded at 12 noon on 19 September 2009. The first medical review should have been conducted before 4 pm. It was not conducted until 5:10 pm, one hour and 10 minutes out of time.

2. Seclusion forms indicate that Rob was secluded from 10:45 pm on 17 October until 10:30 am on 18 October. Notes in the medical record showed that he had in fact been secluded at 6: 45 pm on 17 October, four hours earlier than shown on the seclusion form. What happened was that the consumer was secluded, released from seclusion, then immediately re-secluded when he tried to assault another client.

This should have been treated as one seclusion episode, but it was treated as two. As a result, the medical review due at 10:45 pm did not take place. The Psychiatric Registrar was informed by phone of the decision to re-seclude Rob, and when she attended at 1:00 am the following morning, she documented that she had attended to review the consumer as "he had been re-secluded".

If this was treated as one seclusion episode, as it should have been, the medical review was due at 10: 45 pm on 17 October. The review at 1:00 am on 18 October was therefore two hours and fifteen minutes out of time.

3. The next medical review for Rob was due at 5:00 am on 18 October. It did not take place until 6:15 am, one hour and fifteen minutes out of time.

4. Warren was placed in extended seclusion from 3:40 am on 5 May 2010 until 8:50 am on 7 May 2010. At a medical review at 9:20 am on 5 May, the doctor documented that the next medical review would be conducted at 1:00 pm. In fact, no review was conducted until 2:00 pm, 40 minutes out of time.

It is pleasing to report a vast improvement in the way medical reviews are managed and documented. This was so even during September 2009 when there were a high number of seclusion episodes (100) and the inpatient unit, and hence its staff, was operating under stress.

Removal of Clothes

The CVP reported in the 2008/09 Annual Report that as a general rule, when a person is secluded in the TEMHS Inpatient Unit, his or her clothes are removed and a non tear gown provided. The CVP has been informed that this is not the policy in the Mental Health Unit.

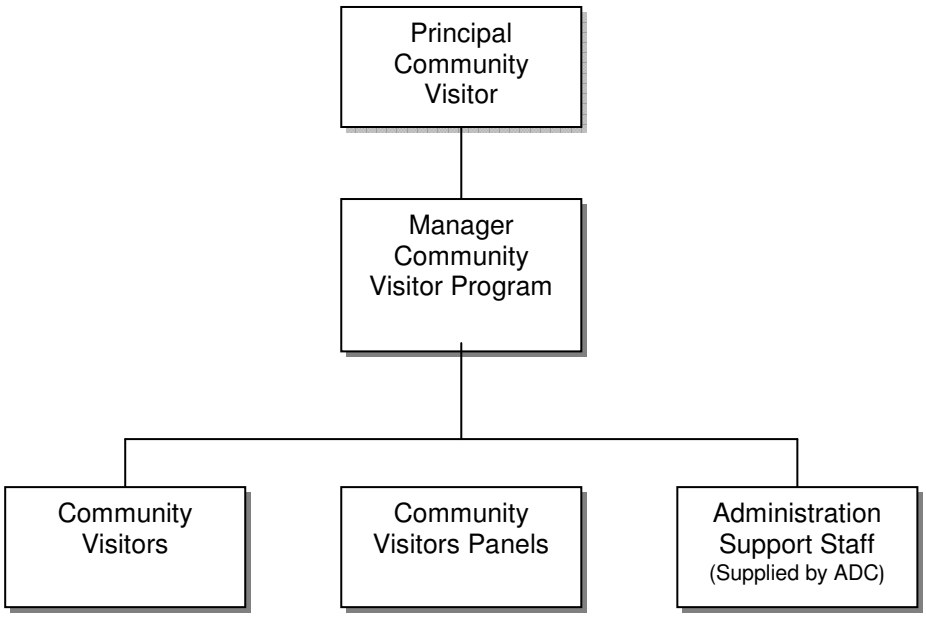
This is an issue that needs careful thought. The experience of being admitted to a psychiatric inpatient unit and possibly secluded is traumatic. Having clothes removed adds to the indignity and powerlessness experienced by the person being admitted and hence to their trauma. For some women, it is culturally inappropriate to be seen without clothes, and having them forcibly removed must add even more to the trauma experienced.

Given that the rationale for removal of clothes is risk of self harm, the CVP suggests that the decision to remove a consumer's clothes should be based on a risk assessment. Alternatively, rather than removing clothes, the safety of a consumer assessed as at risk of self harm could be protected through constant observation.

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 2010, two 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.

Lisa Coffey

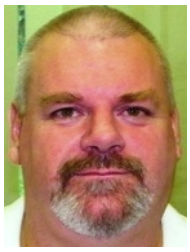
Principal Community Visitor 2009 - 2010

Community Visitors and Panel Members 2009 - 2010

Judy Clisby
Manager CVP

Rachael Dunn
Community Visitor

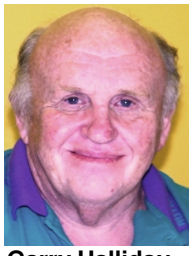
Karyn Jessop
Community Visitor



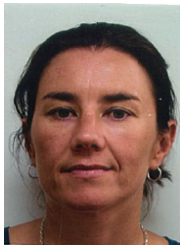
Phil Dempster
Community Visitor

Pamela Trotman
Community Visitor

Carly Ingles
Community Visitor



Garry Halliday
Community Member
Darwin Panel



Georgie Stewart
Community Member
Alice Springs Panel

Georgia McMaster
Legal Member
Darwin Panel

Alison Hanna
Legal Member
Darwin Panel

Mark O'Reilly
Community Visitor
Legal Member AS

Susan Wearne
Medical Member
Alice Springs Panel

Jessica Kneebone
Medical Member
Alice Springs Panel

Sarah Giles
Medical Member
Chair, Darwin Panel

Maya Cifali
Community Member
Chair, Alice Springs Panel

PART 4: PERFORMANCE OF THE CVP 2009 - 2010

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

Visits and Inspections

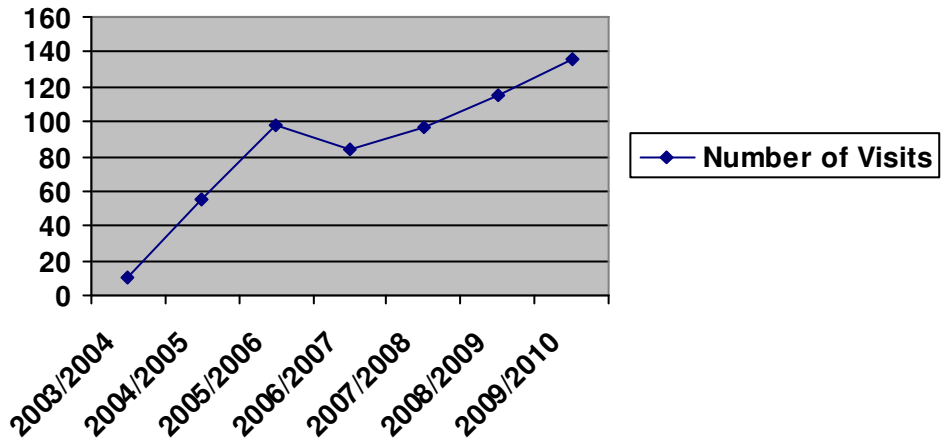
Table 1 details the number of visits to inpatient facilities by community visitors, as part of routine visits and also in response to requests for a visit. Figure 1 demonstrates how the work of the CVP has increased since 2003/04.

Table 1: Comparison of the Achievements of the CVP 2007/08 – 2009/10

		Alice Springs			Darwin		
	Legislative Requirements	2007/ 2008	2008/ 2009	2009/ 2010	2007/ 2008	2008/ 2009	2009/ 2010
Visits[1]	In response to requests/ inspection	26	24	44	63	85	88
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	Percentage contact within one working day of notification of a request	100%	100%	100%	100%	100%	100%

Notes: 1. Visits include visits to inspect the approved treatment agencies.

Figure 1: Number of Visits to Approved Treatment Facilities and Agencies 2003 - 2010



Complaints and Enquiries

Table 2 shows a 19% increase in complaints and enquiries managed by the community visitor in Alice Springs from 2008/09 until 2009/10 compared to a 120% increase in the number of visits. In Darwin, there was a 14% increase in complaints and enquiries compared to a 4% increase in the number of visits. This demonstrates that the number of complaints and enquiries is not proportionally related to the number of visits conducted, although over the time the CVP has been operating, the overall trend is that an increase in visits will lead to an increase in complaints and enquiries.

The other variable which is not accounted for is the effect of increased visibility and hence knowledge of CVP services by staff and clients. With more visits, more people are aware of the CVP and are likely to use its services. Staff are more likely to provide information about the CVP to consumers.

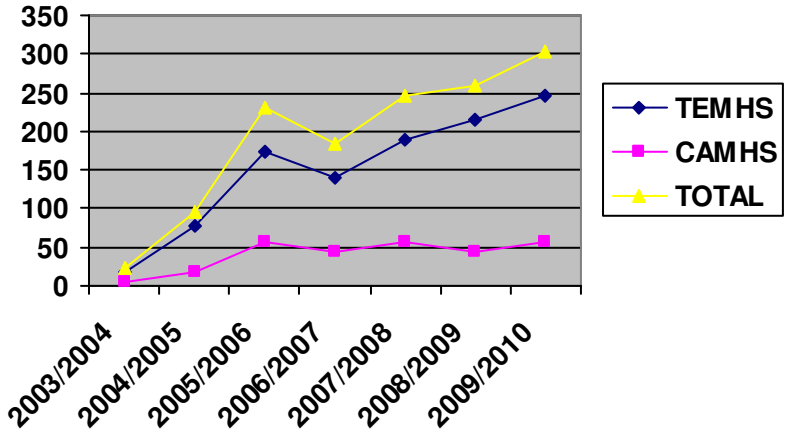
The number of visits above the expected weekly visit to the TEMHS Inpatient Unit in Darwin and fortnightly to the Mental Health Unit in Alice Springs gives some indication of the number of additional requests for visits. In the Top End, this has remained relatively constant, however there has been a significant increase in requests for visits in Alice Springs.

Table 2: Total Complaints and Enquiries 2007 - 2010

	Alice Springs			Darwin		
	2007/08	2008/09	2009/10	2007/08	2008/09	2009/10
Complaints & Enquiries	**58**	**44**	**56**	**188**	**216**	**247**

Figure 2: Complaints and Enquiries Received by the CVP 2003 - 2010

Figure 2 below demonstrates the increase in workload for the CVP from 2003/04 when 23 complaints and enquiries were actioned until 2009/10 when this had risen to 303.



Complaint or Enquiry?

Complaints and enquiries cannot be differentiated by the time taken to resolve the issue. In fact, the most time consuming matter the CVP has ever managed was a request for advocacy that is still not resolved.

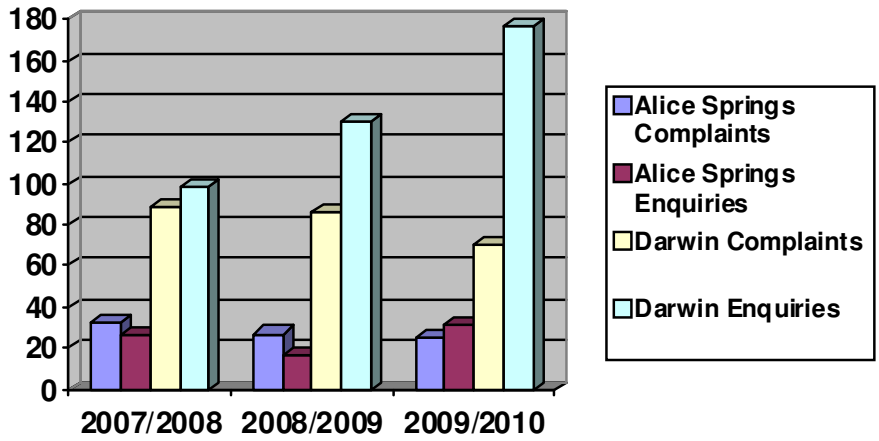
In general, contacts with the CVP that involve a request from the CVP rather than expressing a grievance about the mental health service will be classified as enquiries. At times, the person asks the CVP not to treat their issue as a complaint. These contacts are also defined as enquiries. Complaints are contacts of a more serious nature. They may be oral or in writing and occur when the person contacting the CVP has a grievance with the mental health service, and/or specifically describes their contact as a complaint.

Table 3: Complaints vs Enquiries Received 2007 - 2010

	Alice Springs			Darwin		
	Complaints	**Enquiries**	**Total**	**Complaints**	**Enquiries**	**Total**
2007/08	32	26	58	89	99	188
2008/09	27	17	44	86	130	216
2009/10	25	31	56	70	177	247

Figure 3: Complaints vs Enquiries Alice Springs & Darwin 2007 - 2010

The graph below shows that the ratio of complaints to enquiries has remained relatively constant in Central Australia. The picture in the Top End is very different. There has been a significant shift in the ratio of complaints to enquiries, with a decreasing trend in complaints and an increasing trend in enquiries. This is most likely related to an increased community visitor presence in the inpatient unit in the Top End, with consumers approaching community visitors for information and advocacy support.



Categories of Complaints and Enquiries

Table 4: Categories of Complaints and Enquiries 2009 - 2010

Category of Complaint/Enquiry		CAMHS	TEMHS	Total
Advocacy		6	80	**86**
Information	Access to Files		4	**4**
	Inaccurate information on file		4	**4**
	Provided to Consumer/Carers/ Service Providers by CVP	10	38	**48**
Medication			8	**8**
Miscellaneous		1	7	**8**
Quality of Service Provision	Activities	1		**1**
	Assessment & Treatment	7	18	**25**
	Consultation Consumer/Carers	2	4	**6**
	Discharge Planning	11	5	**16**
	Facilities	3	13	**16**
	Procedures	5	8	**13**
	Relationship with Staff	1	4	**5**
Rights	Detention		6	**6**
	Least Restrictive Alternative	1	9	**10**
	Legal	7	15	**22**
	Miscellaneous		5	**5**
	Respect for Dignity		4	**4**
	Safety	1	2	**3**
	Transport by Police		3	**3**
Visit	Request		10	**10**
TOTAL		**56**	**247**	**303**

Other Complaints and Enquiries

In addition to complaints and enquiries about mental health services in the NT, the CVP received three complaints and 26 enquiries about non mental health services. These enquiries included requests for advocacy with non-government mental health organisations. The most common enquiry is request for information from the CVP.

The CVP has no role in investigating complaints against organisations external to mental health services, but may assist a consumer by providing relevant information, referral and advocacy. The community visitor in Darwin has also assisted in an advocacy role with consumers lodging a complaint with the Anti-Discrimination Commission.

Sources of Complaints and Enquiries

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

Figure 4: Source of Complaints and Enquiries NT 2009 - 2010

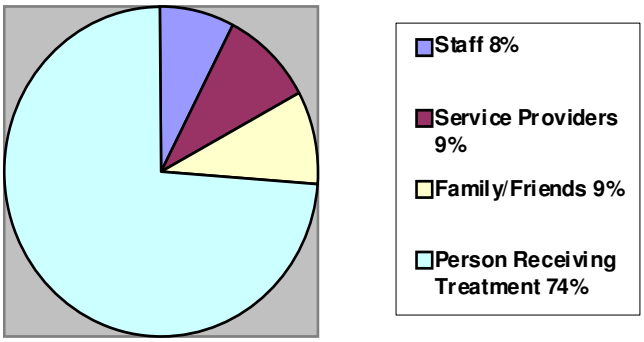
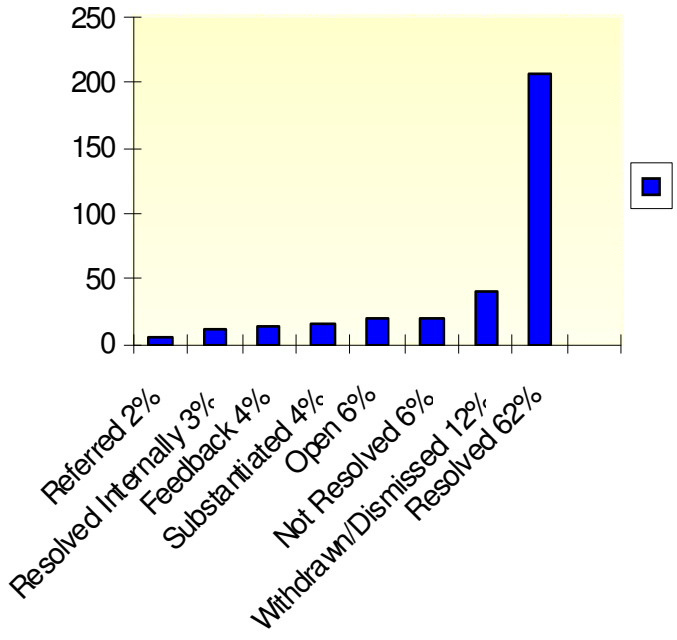


Figure 4 includes 29 complaints and enquiries received about facilities other than CAMHS and TEMHS. The total number of complaints and enquiries for 2009 - 2010 is N = 332.

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.

Figure 5: Outcomes of Complaints and Enquiries NT 2009 - 2010



PART 4

OTHER CVP ACTIVITIES 2009 - 2010

As can be seen from this report, the complaints and enquiry activities for the CVP have increased exponentially since 2003/04. Mostly, this is related to the fact that consumers seem to be more aware that a community visitor is available to them while they are in hospital. It is expected that the CVP's work will plateau at about the level it is now, but may rise again once the new Stabilisation and Assessment Units are opened.

The high level of complaints and enquiries work has impacted on the capacity of the CVP to become involved in other activities. Accordingly, the CVP has made no presentations to community groups in 2009/10 as it has in the past, and is networking not with individual organisations, but by attending network meetings like the Mental Health Coalition and the Mental Health Network auspiced by Carers NT.

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 Manager of the CVP meets with the Director of Mental Health Services every six months or when an issue arises. The TEMHS General Manager has instigated monthly meetings and the Manager CVP meets with the General Manager CAMHS during every trip to Alice Springs. In addition, the readiness of all team managers and staff to respond to contact from a community visitor is appreciated.

Submission

In 2009/10, the CVP lodged a submission into the consultation to the *Adult Guardianship Act.* This was seen as an opportunity to advocate for the NT to develop a comprehensive policy to address gaps in services and provide safeguards for people with disability living in the Territory. The CVP favours the introduction of a new Office of the Public Advocate to advocate for all people with disability, including people with psychiatric disability.

The CVP has argued for some years now that this group of people do not get access to disability services, despite the fact that mental illness can lead to sometimes chronic and incapacitating disability. In its submission, the CVP also advocated for a system which ensures protections are in place for all people with a disability who live in 24 hour supported accommodation because they are unable to care for themselves. Currently, the NT is the only jurisdiction with no system in place for protecting the rights of these sometimes very vulnerable people.

Involvement with Community Agencies/Activities

One mechanism for promoting the purpose of the CVP is involvement in community activities. In the 2009/10 financial year, the CVP contributed to the following:

- the Manager of the CVP was 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;
- the Manager CVP attended a meeting convened by the President of the Tribunal to review the Tribunal's Practice Directions;
- By agreement with the Community Justice Centre (CJC), community visitors and panel members who wish to gain training as a mediatior can do so with the CJC at no cost in return for an agreement to act as a mediatior for the CJC;
- The CVP is working with AIS so that interpreters can accompany community visitors on visits to the inpatient facilities. The Manager CVP was interviewed for a training video developed by the AIS.

Conferences

As in the past, the Manager of the CVP attended the Annual NSW Official Visitors Conference held in May 2010. This is an opportunity to meet with senior people from similar programs throughout Australia, and to catch up on current issues in Australia from a Community / Official Visitor perspective.

In October 2010, Lisa Coffey, in her dual role as Acting Anti-Discimination Commissioner and Principal Community Visitor, gave a presentation to the Seminar: "Mental Health in the Workplace" hosted by NT Mental Health Services. Lisa's presentation looked at employer obligations with respect to the employment of people with mental health issues.

The Manager CVP was also granted study leave to attend "Rights, Responsibilities, Rhetoric", a conference in Adelaide hosted by the SA Guardianship Board.

Networking

The Manager of the CVP stays in regular contact with mental health and other service providers with an interest in mental health. While reducing contact with individual organisations, the Manager has still met with people from the following groups:

- Disability Advocacy Service (Alice Springs);
- Northern Territory Council of Social Services (NTCOSS);
- Mental Health Carers NT
- Health and Community Complaints Commission;
- The HIV AIDS Council; 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:
    - The audit of legal forms of consumers admitted involuntarily will continue in 2010/11 to ensure compliance with the Act. Particular attention will be paid to the management of consumers admitted voluntarily to TEMHS Inpatient Unit;
    - 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 2010/11. At this stage, these issues are identified as: JRU facilities (in particular safety of consumers), transport to hospital (particularly after hours), monitoring seclusion and the use of non tear gowns, the provision of information about rights and inpatient client support and management plans.

- Improving internal CVP processes:
    - Strategic Planning – there has been no opportunity for the CVP to include visitors and panel members in planning. Application will be made for funding to support this in 2010/11.
    - The CVP has only one permanent staff member. In 2009/10 it was reported that a manual needs to be in place to enable the CVP to continue should the Manager be absent or resign from the program. This manual is still to be developed;
    - The CVP will examine ways of improving its efficiency, including referral of complaints to the Health & Community Services Complaints Commission.

- Training for Community Visitors and Panel Members: The following opportunities for professional development will enhance the CVP:
    - Community visitors and panel members have requested more in depth training on mental health diagnoses and treatment and on visitors programs in other jurisdictions;
    - The CVP will approach NT Mental Health Services for training with their electronic information systems.

APPENDIX 1

NEW RECOMMENDATIONS 2009 - 2010

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 the meeting. Issues not resolved are incorporated into the panel report, and will form part of its investigation during the 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 the approved treatment facility visited. In general, any new panel recommendations contained in Appendix 1 of this Annual Report refer to issues that the service has known about for at least six months.

Mental Health Unit

December Community Visitors Panel Visit

It is recommended that the Mental Health Unit provide a report to the Community Visitor Panel at the time of the next visit. This report should detail all instances where consumers have been unable to, or have had difficulty, accessing allied health services. It is also recommended that the Panel is informed of any steps taken to broker an agreement with the hospital or other service providers to resolve this problem.

APPENDIX 2

RECOMMENDATIONS CLOSED 2009 – 2010 - ALICE SPRINGS

Mental Health Unit

July 2004

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.

The Alice Springs panel reported that after reviewing files, they found there are good systems in place to record information. They stated that it is still the case that the attention to detail was not uniformly good, however they felt this was a matter for Management rather than the panel. An audit of case notes demonstrated that consumers' GPs were being identified and notified of the consumer's discharge.

May 2008

It is recommended that there be a general upgrading of amenities as follows:

- *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*
- *Dining seating*

The panel reported after their visit in November 2009 that they were pleased to see the developments in this are over the past two visits. Accordingly, the recommendation was closed.

May 2009

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.

The panel was pleased with steps taken to improve the use of interpreters. This includes the use of a sign in book for interpreters and closer collaboration with the AIS. The designation of a staff member as a contact point for the AIS will ensure any problems with interpreters are followed up. The panel decided they would continue to monitor the use of interpreters on subsequent visits.

It is recommended that the Mental Health Unit significantly reduce the number of days the ward is locked.

The panel reported that from January to May 2009, the number of days the ward was locked far exceeded the number of days it was unlocked, and accordingly, the panel recommended that there be an effort to reverse this trend. It was happy to report that from July 2009, the ward was locked six days in July, not at all in August, eighteen days in September and five days in October.

The panel was advised that at times the Unit is locked to prevent an involuntary consumer at high risk from absconding. Staff believe this is less restrictive than using the HDU, a small, locked area. In these circumstances other consumers are advised of their own rights to come and go. The Panel was satisfied with the reduced figures and the explanation provided and closed the recommendation.

CAMHS Community Teams

May 2005 Panel Visit

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

The community visitor reviewed this recommendation during her visit to the Community Teams in June 2010. She reported that the Crisis Assessment Team (CAT) is operating 24 hours a day, 7 days a week. It is expected that introduction of the 24 hour triage phone service, operating out of Top End Mental Health Services will enhance service delivery to consumers and carers. Information about the operations of CAT has been provided to community agencies, along with information about contacting ED for information. Given the introduction of the proposed new statewide response system and the lack of complaints about the CAMHS after hours service, this recommendation was closed.

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.

CAMHS has been in regular contact with Carers NTand updated them on the changes to out of hours services. There are alerts on systems and well-documented procedures for working with carers and guardians. A letter thanking the service for its quick response was recently received the guardians of a client of CAMHS.

RECOMMENDATIONS CLOSED 2009 – 2010 - DARWIN

TEMHS Inpatient Unit

October 2004

It is recommended that posters giving information about legal rights be prominently displayed in both Cowdy Ward and JRU.

The panel reported that posters giving information about legal rights are now prominently displayed in both Cowdy and JRU. They are not in plain English, however they are there. At the brief visit on 4th February a poster was seen on the glass of the fishbowl referring to rights and responsibilities with photographs of staff and consumers together. This suggests a level of communication and openness about rights under the Act. Accordingly, this recommendation was closed.

APPENDIX 3

OPEN RECOMMENDATIONS 30 JUNE 2010

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). 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.

ALICE SPRINGS

Mental Health Unit

July 2004 Community Visitors Panel Visit

1. *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.*

Progress

The Alice Springs panel hopes to be able to close this recommendation once posters using *One Talk* technology are being used in the Mental Health Unit.

November 2009 Community Visitors Panel Visit

2. *It is recommended that the Mental Health Unit provide a report to the Community Visitor Panel at the time of the next visit detailing all instances where consumers have been unable to or have had difficulty accessing allied health services and that the Panel is informed of any steps taken to broker an agreement with the hospital for a means of resolving this problem.*

Progress

No report was available for the panel at the time of their visit in May 2010. The CVP Manager has since been informed that a report will be available for the first panel visit in 2010/11.

CAMHS Community Teams

May 2005 Panel Visit

1. *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.*

Progress

The community visitor reviewed this recommendation during her visit to the approved treatment agency in June 2010. She reported that there has been some progress to its resolution, and that she would monitor further progress over the next twelve months.

June 2007 Community Visitor Visit

2. *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.*

Progress

There has been little progress with this recommendation as discussed on page 30 of this Annual Report.

DARWIN

TEMHS Inpatient Unit

October 2004 Community Visitors Panel Visit

1. *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.*

Progress

As detailed on page 24 of this report, the panel hopes to close this recommendation in 2009/10.

2. *It is recommended that discharge planning procedures are improved by identifying and referring to preferred ongoing General Practitioners ('GPs').*

Progress

The panel reviewed progress with this recommendation during their visit to the TEMHS Inpatient in April 2010. They concluded that while TEMHS reports that there have been improvements in this area, when paper and electronic files are reviewed, there is no evidence that this is the case. The panel concluded that there is little recognition of the important role that GPs play in the ongoing management of a person's health after discharge from hospital.

3. *It is recommended that 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.*

Progress

The panel referred this recommendation to the Principal Community Visitor for further action. At the time of writing this report, the CVP Manager is working with NT Mental Health Services to ensure that appropriate information is available for Aboriginal consumers.

4. *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.*

Progress

TEMHS Management informed the panel that TEMHS staff were working with NT Police to develop a training program.

At the time of writing this report, the Manager TEMHS has reported that considerable progress has been made, with TEMHS now working with the Negotiation Team Coordinator, NT Police, to provide a three day mental health training program. An online training package, to be mandatory for all NT Police, is also being developed.

November 2006 Community Visitors Panel Visit

5. *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.*

Progress

The need for more accommodation and support throughout the Territory is discussed on pages 6 – 8 of this Annual Report.

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

Progress

The Darwin community visitors panel reported that minor works money has been approved for the development of an outside courtyard area for JRU. They hope to be able to close this recommendation in 2010/11.

May 2007 Community Visitors Panel Visit

7. *It is recommended that the Mental Health Service ensure that Interpreters are present at assessment for all consumers whose first language is not English.*

8. *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.*

Progress

As discussed on pages 21 – 22 of this report, the Darwin community visitors panel will consider that progress is being made with recommendations 7 and 8 when the consumer's first language is clearly recorded in the medical record and there is an attempt to contact an interpreter for the admission interview and subsequent medical reviews.

9. *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.*

Progress

The Darwin community visitors panel reported that there has been some progress on this recommendation. National Transport Principles have been developed, and a working party of police, ambulance and mental health services developed protocols for transport to hospital as part of a Memorandum of Understanding (MoU) between NT Police and NT Mental Health Services. This MoU should be signed in the first half of 2010/11.

Staff of the inpatient unit informed the panel that people are still often transported to hospital by police, and when this is the case, they are transported in the cage of the police vehicle. On the day of the panel's visit, a consumer arrived at hospital for admission to Cowdy Ward. The consumer was transported in the cage of a police vehicle.

November 2007 Community Visitors Panel Visit

10. *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.*

Progress

In the report of their April 2010 visit, the Darwin community visitors panel reported significant progress with this recommendation. The HDU in Cowdy Ward is a space where young people can be separated from adults. The panel reported that there is evidence that expert assessment is available for young people via the community Child and Youth Team.

Young people also have access to the activity program in Cowdy Ward which has improved considerably over the past three years. There are however, no activities specifically designed for young people. The only activity available in the HDU area is a laptop, with DVDs which staff bring in for young people to use.

May 2008 Community Visitors Panel Visit

11. *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.*

Progress

The panel reported that there has been improvement in this area. Aboriginal Mental Health Workers (AMHWs) have an increasing role in consumers' clinical care. They attend ward rounds for consumers from remote areas and often are present when they are assessed for admission. There is also some evidence that AMHWs work with Aboriginal consumers to avoid seclusion, and help debrief after a seclusion. The panel stated that these improvements are sustainable, but they would like to see more evidence of AMHWs documenting their involvement in the medical records. The panel would also like to see AMHWs available out of hours.

May 2009 Community Visitors Panel Visit

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

Progress

There has been insufficient progress with this recommendation as outlined on page 23 of this report.

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.*

Progress

Even though the notification rate is not significantly different to the rate reported in the 2008/09 Annual Report, the CVP is aware that there have been genuine attempts to address this issue. As well as the CVP requesting notification forms, a staff member has been given responsibility for following up when the CVP is not notified.