NT COMMUNITY VISITOR PROGRAM

ANNUAL REPORT
2010 - 2011

COMMUNITY VISITOR PROGRAM
NORTHERN TERRITORY

The Hon Kon Vatskalis MLA
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 2010 to 30 June 2011.

Yours sincerely

EDDIE CUBILLO
PRINCIPAL COMMUNITY VISITOR

30 September 2011

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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
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

INTRODUCTION

PRINCIPAL COMMUNITY VISITOR

I am pleased to present the tenth Annual Report for the Community Visitor Program (CVP) in which I report to the Minister of Health on the activities of the CVP, community visitors and community visitors panels in 2010/2011. I also report on how people affected by mental illness experience mental health services in the Territory.

The Annual Report is presented in four parts. This introduction and a brief outline of the way the CVP operates form Part 1 of the report. In Part 2 I describe the issues reported to me by community visitors and panels. The outcomes of inspections of seclusion registers undertaken in 2010/2011 are described in Part 3, and finally, the activities and performance of the CVP are detailed in Part 4.

Program statistics in Part 4 demonstrate the growth of the work of the program since the 2003/2004 reporting period. In the past twelve months alone, complaints and enquiries received by the CVP have increased by 27%. Capacity to action and close complaints and enquiries has diminished accordingly. At the end of the 2010/2011 financial year, 11% of files were open compared with 6% in 2009/2010.

The role the CVP plays in monitoring the rights of people receiving mental health treatment is likely to change over the next twelve months. If it is properly resourced, the CVP will provide a service to clients admitted to the new Stabilisation and Assessment Services in Darwin and Alice Springs at the same level as the existing service to clients admitted to the psychiatric inpatient units. There is also a possibility that the CVP will be asked to monitor the rights of people receiving treatment in the two new Secure Care Units being built, one in the Top End and the second in Central Australia.

We continue to find ways to manage the CVP more efficiently. As foreshadowed in my previous Annual Report, complex complaints which involve mental health staff are referred to the other Independent Officers for investigation. This of course only happens with the agreement of the person lodging the complaint. In 2010/2011, two serious complaints about mental health staff were referred to the Health and Community Services Complaints Commission and a third complaint, which could not be resolved at point of service, was referred to the Office of the Information Commissioner.

Some longstanding recommendations have been closed over the past twelve months. Some will close in the near future with structural changes to the Top End Mental Health Service (TEMHS) Inpatient Unit. At the time this report is published, the fishbowl in Cowdy Ward is finally gone. Its replacement has a much more open feel; however from the clients' side it unfortunately still gives a very strong message of separation of staff from clients. There is better news in the Joan Ridley Unit where an outside area for people in the unit has been developed and should be in use soon.

Other longstanding issues have not been addressed. While there is evidence that interpreters are being used more often in the TEMHS Inpatient Unit, they are still not used routinely for Indigenous people whose first language is not English. Recently, and anecdotally, I heard the story of an Indigenous person who, when asked, told his treating team he was hearing voices. On another day when an interpreter was present, the same person was able to say that he did hear voices – the voices of the doctors asking if he was hearing voices! He thought they were checking his hearing. This is the type of misunderstanding which can occur when people are asked questions which include unfamiliar concepts in what might be their fourth, fifth or even sixth language.

The CVP is established to uphold the rights of people receiving mental health treatment in the Territory and to monitor the quality of services offered. Its focus is therefore on problems with the delivery of mental health services and this is reflected in this Annual Report.

We 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, and continue to provide a service sometimes in extraordinarily difficult circumstances. They do so because they are committed to working with people with mental illness. For some, it is a vocation and this is evident in their work.

Finally, I take this opportunity to thank community visitors and community visitors panel members across the Territory for their excellent reports, hard work and commitment throughout 2010/2011. Without their dedication, the service provided by the CVP would not be possible. In addition, I thank the staff at the Anti-Discrimination Commission, some of whom contribute as community visitors and all of whom contribute valuable practical support and expertise. Without their help, the CVP could not continue to operate.

EDDIE CUBILLO
PRINCIPAL COMMUNITY VISITOR

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 (TEMHS) and Central Australian Mental Health Service (CAMHS), are responsible for 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 located in Alice Springs Hospital.

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 its activities to the Minister for Health. The Principal Community Visitor's role is primarily a management role.

Manager Community Visitor Program

The CVP Manager is the only full-time employee of the program. The role itself does not have a statutory function, although the Manager is appointed community visitor and is responsible for most visits in the Top End. The CVP Manager works with the Principal Community Visitor to determine the strategic direction and positioning of the CVP. In addition to complaints resolution and advocacy functions, the Manager is responsible for managing and implementing the CVP on a day to day basis.

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 to which they are appointed 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. No special community visitors panel has been convened in the period covered by this report, although both the Darwin and Alice Springs Panels reviewed the files of community clients while investigating quality of continuity of care from hospital to community.

After every visit to a facility or agency, the Chair of the panel must forward a report detailing the outcomes of the visit to the Principal Community Visitor. The report is then forwarded to the person-in-charge of the facility or agency visited.

Community Visitors

Community visitors are appointed by the Minister for Health for a three year term. They have complaints resolution and advocacy functions. Visitors may help a person 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 the person 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 people as possible have access to a community visitor. They also respond quickly, within the same day if possible, to complaints and requests from consumers for a visit.

While visiting an approved treatment facility or agency, a community visitor also has an inquiry function. Visitors 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. A summary of these reports is forwarded to the person-in-charge of the facility and/or agency every quarter.

PART 2: ISSUES IN MENTAL HEALTH

Case examples are used to illustrate specific issues throughout Part 2 and Part 3 of the CVP Annual Report. In all cases details such as gender, diagnosis and/or location are changed to protect confidentiality with a view to protecting both the vulnerable person and staff. It is the intent that the person who is the subject of the case example would not recognise him or herself. In such a small jurisdiction, this means that some significant work of the program, and unfortunately significant issues arising in 2010/2011 are not detailed in this report because to do so would identify the person affected.

SIGNIFICANT ISSUES

Level of Restriction in the TEMHS Inpatient Unit

The first object of the *Mental Health and Related Services Act* ('the Act') in section 3(a) is to balance the obligation *to provide for the care, treatment and protection of people with mental illness while at the same time protecting their civil rights*. The principle by which this balance is achieved is the principle of the least restrictive alternative. It states that the least restrictive or least intrusive treatment should be provided in the least restrictive environment. It recognises that while the state has an obligation to intervene in people's lives, it must do so in as narrow a way as possible.

The principle of the least restrictive alternative is evident throughout the Act. Section 8, *Interpretation of the Act*, gives direction on how the Act is to be exercised or performed. Section 8(a) provides that mental health treatment and care should be provided in the least restrictive and least intrusive environment. Section 14(c) provides that where a person is to be admitted to an inpatient facility on the grounds of mental illness, *there must be no less restrictive means of ensuring that the person receives the treatment*.

Community visitors and community visitors panel members are obliged to pay attention to practices and policies that are most likely to limit the freedom of people receiving care in the inpatient units. There are indications that the provision of mental health treatment in Darwin is becoming increasingly restrictive. Indications of increased restriction include locking Cowdy Ward, treating an increased number of clients in the Joan Ridley Unit, treating increasing numbers of clients as involuntary clients and restricting leave arrangements for the few clients who are admitted voluntarily.

The TEMHS Inpatient Unit was locked in February 2010. In 2009/2010, the Darwin community visitors panel reported that TEMHS Management was apparently committed to returning Cowdy to its former functioning as an open ward. TEMHS intended to evaluate the effects of closing the ward in September 2010. The panel recommended that consumers play an active part in this evaluation.

No evaluation has taken place. At the time of writing this report, Cowdy Ward remains locked. The reality appears to be that Cowdy Ward will remain a closed ward.

During eight (8) visits to the TEMHS Inpatient Unit in October/November 2010, the community visitor for the Top End recorded the ratio of voluntary to involuntary clients and the leave status of voluntary clients. During a further four visits in April 2011, the community visitor recorded the number of people admitted to the unit, which part of the unit they were admitted to (ie Cowdy Ward or the more secure JRU), their voluntary/involuntary status and what leave was permitted for clients admitted as voluntary clients. These snapshots are not discrete. Some clients have been counted twice during the same admission and so the picture below can be seen only as an indication of a trend to an increased level of restriction.

In October/November 2010:

- 9% of people admitted to the ward were voluntary; and
- 30% of voluntary clients were free to come and go, 10% were on leave (no bed had been kept), 55% were permitted leave with conditions only (conditions include length of leave, time of leave and leave with staff or others), and 5% (one person) was not permitted any leave at all.

In April 2011:

- 33% admissions were to JRU despite Cowdy Ward being a closed ward;
- Less than 1% of people admitted to the ward in April were voluntary; and
- Not one voluntary client was permitted unrestricted leave. 100% were permitted leave with conditions only.

The snapshot supports community visitor observations throughout the 2010/2011 reporting period that the delivery of care in the Top End is becoming more restrictive with few voluntary admissions, and with very few people admitted to the unit being allowed to leave at will, irrespective of their voluntary/involuntary status. There may be valid reasons for this, including increased acuity of people admitted to the unit. Given the very clear requirement that care is delivered in the least restrictive manner, these observations are cause for some disquiet.

Accommodation with Support in Alice Springs

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.

Two people who require 24 hour supported accommodation have had long stays in the Mental Health Unit in Alice Springs over the past twelve months. One of these people remained in the unit for 8 months despite already having funding for a support package. The second consumer, admitted in August 2010 remains in the unit one year later. It has been assessed that he cannot be discharged without the funding he needs to live independently.

Safe, secure housing with appropriate levels of support is the cornerstone of recovery. It provides the basis for rehabilitation and for the development of consistent support, treatment, relationships and activities. Some people with psychiatric disability, while not needing secure care, do require 24 hour supported accommodation; at least in the short term. The difficulty is that it is prohibitively expensive and people with psychiatric disability are competing with the disability sector for scarce resources.

Delayed admission can have devastating effects on people's lives, including in some cases loss of employment, loss of accommodation and delayed recovery from the acute episode. The Mental Health Unit in Alice Springs is an acute unit for people experiencing acute episodes of mental illness. It has eight beds (which can extend to ten), with plans for six more beds when the new Stabilisation and Assessment Unit comes on line. People who are admitted to the unit long term reduce its capacity to admit and treat other people who need acute care. The situation has been exacerbated since renovations to the facility commenced early 2011, limiting the number of beds in the inpatient unit.

The 2010 report on housing and accommodation for people with psychosocial disability living in Alice Springs[1] recommends that *24 hour supported accommodation in community housing be provided for six people with severe psychiatric disabilities requiring long-term specialised supervision and support* (p.9). To date, no funding has been granted for such a facility. For the client who has been in the ward for the past twelve months, there is no prospect of discharge because there is nowhere for him to go. This is a situation which is unconscionable and must be addressed.

[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.*

Range of Mental Health Services in the Northern Territory

The Northern Territory is a small jurisdiction, and economies of scale result in largely generic services being offered. Over time, this is gradually changing, and in 2010/2011 there were three new initiatives. A Perinatal Mental Health Team/Project is leading the introduction of universal screening for depression for pregnant women shortly before and after birth. The team is also providing training to relevant health workers as well as a specialist consultation service for women with complex mental health presentations. Mental Health Services recently concluded a 12 month project in partnership with Territory Palliative Care Services. By the end of 2010/2011, Crisis Assessment Teams with a dedicated phone number (1800 NTCATT) were providing a 24 hour/day mental health crisis assessment and intervention service for all people living in the Territory.

The Manager of TEMHS has informed the CVP that staff in TEMHS will be trained to provide a service for people who suffer Post Traumatic Stress Disorder (PTSD), as part of the services' commitment to 'trauma informed care'. Initially and starting in 2011/2012, staff at the Tamarind Centre will offer a twice weekly clinic for people who have experienced trauma. Other specific mental health services are desperately needed.

Early Psychosis

There is no dedicated early psychosis team in the Territory. An early psychosis team has the specialist skills and knowledge necessary to work with young people (generally under 25 years) with first episode psychosis. Information from the Early Psychosis Prevention and Information Centre (EPPIC) website[2] demonstrates the importance of the right intervention at the right time. A young person is most likely to experience psychosis in adolescence at a time when they are becoming independent; leaving school, starting work and developing relationships independent from the family. It is a crucial time with developmental tasks that can be adversely affected if the young person experiences mental illness. Specialist intervention addressing the biological, social and psychological needs of the young person is seen as being key to recovery from psychosis and improved long term outcomes.

The CVP is aware that the Commonwealth has announced that 16 Early Psychosis Centres will be established around Australia using a competitive tendering process with a minimum 50% State or Territory contribution. The CVP strongly supports the establishment of EPPIC in the Northern Territory.

Assertive Community Treatment (ACT)

In the late 1990s, most other jurisdictions in Australia introduced assertive community case management for people with severe mental illness and enduring disability. Assertive case management is team case management available seven days/week, and delivered in the client's home. It is an intensive model of management with case managers having a case load of about 10 - 12 clients, and assertive because follow up is maintained. It is also expensive.

[2] http://www.eppic.org.au

Some case managers working with the TEMHS Adult Community Team have case loads of more than 30 people. The community visitor in the Top End conducted a brief review of the number and quality of contacts that case managers were having with clients to determine whether or not the size of case loads was adversely affecting client care. The community visitor found that on the whole, case managers maintain regular contact with their clients, and that in most cases this contact is sufficient for the person to remain well. For many clients, it is restricted to medication management and monitoring mental state.

The community visitor noted that the Adult Community Team case manages a number of clients who would meet the criteria for Assertive Community Treatment. These clients have frequent hospital admissions, have difficulty maintaining housing and relationships, and often have a co-morbid issue such as alcohol or other drug misuse. Some need daily follow up in order to remain well. Some have contact with the criminal justice system. The community visitor was impressed with the ability of case managers in the Adult Team to maintain contact with their clients, and recognises the workload stress that they must be experiencing given the size and nature of their case load. A small Assertive Community Treatment Team in the Top End would provide a valuable service for clients likely to benefit from this model of case management (including young people with early psychosis), and free up case managers to provide an holistic service to clients who do not need intensive intervention.

Peer Support

A peer support program in mental health services refers to the paid employment of people with lived experience of mental illness. This lived experience may be as the person with the illness, or as the carer or family member of the person with mental illness. Peer support workers are able to share their journey and their own learning with people who are just embarking on their own journey.

Peers are employed in non-government mental health services in the Northern Territory. They should be employed in government mental health services. In this, the Territory is well behind mental health services in all other jurisdictions. The benefits of a peer support program are many. Mental health clinicians and people with lived experience have the opportunity to learn from each other. Peer workers offer hope of recovery to the person with illness and their family. Peers work in all areas of mental health. They visit clients with case managers, visit hospitals and help facilitate groups. They offer ideas and suggestions to people with lived experience and can talk about what has worked for them or their family member as the person learns to self-manage their illness. The CVP sees the institution of a peer support program as the next step forward in the development of mental health services in the Territory.

PART 2: ISSUES IN MENTAL HEALTH

INFORMATION

Access to Reports Prepared for the Mental Health Review Tribunal

Section 132 of the Act provides that a person who is to appear before the Mental Health Review Tribunal (the Tribunal) review must, subject to harm considerations, be given access to the medical records and reports that are before the Tribunal. The Act implies that it should be normal practice to show medical records and reports to the person appearing before the Tribunal. If there is a likelihood that doing so might cause the person or someone else harm, the Mental Health Service should apply to the Tribunal to withhold the harmful information. The Tribunal may then make orders about who has access to this information.

Corey chose to represent himself at a hearing before the Tribunal. The community visitor asked the medical team whether Corey could be given a copy of the report written about him so he could prepare for hearing. In the end, the community visitor was provided with a copy to show Corey.

In the Territory, people appearing before the Tribunal do not see the reports written about them until they meet with their legal representative, often on the day of the hearing. This issue was raised in the 2009/2010 Annual Report. It is raised again in this report and the CVP has already received a formal complaint about this issue in 2011/2012.

The CVP is of the view that this is a matter of procedural justice that needs to be addressed for all people appearing before the Tribunal. Processes should be in place to protect what are sometimes competing rights; the person and his or her right to know what is written in the Tribunal report, and the rights and safety of the people who provide information to mental health service. In the Northern Territory, no formal processes are in place. The matter will be raised with the President of the Mental Health Review Tribunal with a view to its resolution in 2011/2012.

Confidentiality in a Small Jurisdiction

David had a significant working relationship with John, a staff member who worked in the ward where David was to be admitted. It was important to David that John not know that he was being admitted to hospital. To address this issue the hospital arranged for David to be transferred to a different state for treatment. Meanwhile, the Manager of the Unit contacted John, told him about David's admission and asked him not to come to work the next day (in case David was still in the ward).

Optimum treatment occurs when a range of health professionals; doctors, nurses, social workers and occupational therapists are able to contribute their skills and knowledge to the treatment plan. Confidentiality is therefore seen as "team confidentiality", which means that information is shared within the team, and is confidential to mental health services rather than to individual holders of information.

The Manager of the inpatient service believed that John needed to know that he should not attend work, and in an environment where all information is shared within the team, could see no problem in sharing information about David's admission. David complained because it was his view that in his circumstances, information regarding his admission should not have been passed on to his friend and that the decision to pass it on should have been delayed, pending the outcome of negotiations for treatment interstate.

This is not an unusual situation in a small jurisdiction like the Northern Territory where it is likely that staff will have had social interactions with people who are current and future clients of the mental health service. As part of the resolution of his complaint, David was given the opportunity to comment on information policies for NT Mental Health Services. The CVP is of the view that a specific policy should be developed to protect the privacy of individuals who find themselves in this or similar situations.

Guardian's Access to Files

Section 92 of the Act provides that a person's adult guardian may apply in writing to an authorised psychiatric practitioner of an approved treatment facility or agency for access to the person's records. The practitioner may approve access without conditions, or on the condition that the practitioner or someone able to interpret the information is present during access. The application may be refused if, on reasonable grounds, there is a belief that there may be some harm to self or others associated with access to the file. In effect, the same conditions apply as if the person was applying for the file him/herself.

Carol had been admitted to the inpatient unit. Her guardian wished to see her record, and was advised by the community visitor to apply to her psychiatrist as required by s92 of the Act. The initial application was refused, and the psychiatrist advised the guardian to apply to Medical Records at the hospital.

There is a lack of understanding throughout the Territory about how people receiving mental health services are able to access their information. Section 92 of the Act details an administrative process which is designed to make access easier than it would be if the person had to apply using Freedom of Information legislation. In the case example above, access to the file was granted after it was understood that the guardian would appeal the decision to refuse access to the Mental Health Review Tribunal.

PART 2: ISSUES IN MENTAL HEALTH

QUALITY OF SERVICE PROVISION

Sections 104(a) and (b) and 111(2)(c) and (d) of the Act state that community visitors and community visitors panels, as part of their inquiry functions, may inquire into and make recommendations about the adequacy of services of assessment and treatment, the standard and appropriateness of facilities, the adequacy of information relating to rights provided to people, and the accessibility and effectiveness of complaint procedures. Community visitors also inquire into these matters in approved treatment agencies (ie outpatient services). In this section of the Annual Report, issues raised by people receiving treatment as well as those arising from inspections of facilities and agencies are discussed.

Assessment and Treatment

APP Reviews and Management Planning - CAMHS Community Team

Community visitors conduct inspections of community teams once yearly when possible. The community visitor in Alice Springs conducted two inspections of the Community Team in 2010/2011. During both visits, she reviewed a recommendation which has been outstanding since June 2007 and reported in every CVP Annual Report since that time.

This recommendation refers to the situation where notes from some outpatient appointments in Alice Springs are recorded on the hospital file rather than on the community based electronic file known as the Community Care Information System (CCIS). Every time the case manager sees the client, the contact is documented in CCIS. If the doctor has not checked CCIS, s/he will not have access to recent information about the client. Similarly, if the doctor decides to change medication and does not document this in CCIS, the case manager will not necessarily know of the change because the case manager does not see the hospital file.

For the system to work, case managers must be available to attend outpatient appointments with the client. If for any reason they are unable to do so, there is the risk of miscommunication between doctor and case manager and an increased risk there will be a mistake. This is a serious issue which the CVP believes should be addressed. After visiting the inpatient team in June 2011, the community visitor reported that all staff are now trained in the use of CCIS, and she was informed that the situation is beginning to improve. The CVP will continue to monitor this issue over 2011/2012.

Information for Indigenous People Admitted to Inpatient Units

In 2004, the community visitors panels in both Darwin and Alice Springs recommended that Indigenous people admitted to the inpatient units in the Territory should have access to appropriate information about their rights. The Alice Springs Panel was able to close their recommendation in 2010/2011 when interactive poster boards were installed in the Mental Health Unit. These boards use push button technology to provide information about the rights of involuntary clients. There are six posters installed, providing information in English and in five local Indigenous languages.

Unfortunately, the Darwin panel was unable to close its recommendation. Community visitors are aware from speaking to Indigenous people from remote areas that they do not understand their rights. This includes the right to request early review of admission and the right to ask for a second opinion. There have even been occasions when family members, staying in the Unit as a boarder, have not known that they were able to leave the facility.

The Darwin community visitors panel, in its report of each of the two visits to the TEMHS Inpatient Facility conducted in 2010/2011, stated that no further work had been done to provide appropriate information about rights to Indigenous people admitted to the Unit. This needs to be addressed.

Interpreters

Through its objects, interpretation and fundamental principles, the Act provides that interpreters should be used for people whose first language is not English. For example, s8(f) *Interpretion of Act,* provides that a person who has a mental illness and who needs language or interpreter services to assist with communication, should have access to those services. In a multicultural community like Darwin, interpreters should be used routinely. It is especially important to Indigenous people receiving treatment in what to some must be a strange, and very threatening environment.

In May 2007, the Darwin community visitors panel recommended that TEMHS should ensure that interpreters are present at assessment for all consumers whose first language is not English. The panel suggested that the first step to achieving this is to record the client's first language clearly on their file. In each report on the two visits conducted in 2010/2011, the panel noted some evidence that interpreters are used occasionally, and that they are used for clients from remote areas during ward rounds. However in their May 2011 report, the panel commented that there is still an absence of documented language group in both paper notes and CCIS, despite CCIS having a designated field for language identification. The recommendation remains open.

Anna was the boarder for an Indigenous man. She told the community visitor that she was being used as an interpreter and that this was not appropriate given their relationship. The community visitor was also concerned that an entry in case notes stated that the man had good English. When trying to address his concerns she became aware that this was clearly not the case.

Community visitors for the TEMHS Inpatient Unit have also documented instances when interpreters had not been used, or when family members have been used as interpreters as in the case of Anna, above. Community visitors report to the Principal Community Visitor, and feedback from people like Anna is conveyed to the service through quarterly reporting.

On another occasion, an Interpreter was prevented from interpreting for an Indigenous client in JRU when booked by the service for a doctor's interview. The reason given was that this Interpreter usually accompanied the community visitor on routine visits to the TEMHS Inpatient Unit. The doctor told the Interpreter it was a "conflict of interest". The interview went ahead without an interpreter present. Later, the doctor said that the client really did not need an interpreter.

The Interpreter had been talking to the client before the doctor came into the unit, and it was his professional assessment that the client would have been better able to communicate with an interpreter present. Even if a client from a remote region has reasonable English, there are differences and shades in meaning that an Interpreter will understand and be able to convey.

In the Mental Health Unit in Alice Springs, the patient's first language is identified on admission and the medical record is stamped to indicate that an interpreter is needed. There is no reason that a similar process could not be put in place in the Top End, as the Darwin community visitors panel has suggested over a number of years.

Involvement in Treatment Planning

Section 9(g) of the Act provides that as far as possible, a person is to be involved in the development of any ongoing treatment or discharge plan. This applies to all people receiving mental health treatment irrespective of their legal status.

Jack's nurse contacted a community visitor because Jack was unhappy about a proposal to administer depot medication. Jack had just been admitted to the inpatient unit. He reported a history of side effects to this medication, including feelings of extreme tiredness. His doctor had researched his notes and found no indication that Jack had complained about this medication in the past. His nurse told Jack that they would administer a very low dose of the medication, but would wait until after he had seen a community visitor.

The community visitor spent some time chatting to Jack about his options in this situation. He understood that the dose being offered was very low, and felt that his concerns had been heard. His remaining request that the injection be administered in his arm was addressed with his nurse and Jack agreed to his medication. The community visitor reported that the excellent work done by the nurse in this case contributed to Jack feeling included in his treatment plan and subsequently to his decision to agree to his medication.

Jack's inclusion in treatment planning, while good practice, was managed informally. There is often little overt evidence of client involvement in planning, and in the inpatient unit, while notes often refer to a "Management Plan", there is often no such document on file and the client may not even necessarily be aware that a plan exists.

In their visit to the TEMHS Inpatient Facility in May 2011, the Darwin community visitors panel reviewed the management plans of clients receiving treatment in hospital and in the community. Although there are times when the plan is discussed with consumers or carers, the panel reported finding no evidence that consumers or carers are central to planning, that is, that they are involved right from the very start of planning.

In 2010/2011, the CVP received two complaints from people admitted to a psychiatric inpatient unit for the first time. These complaints both related to lack of involvement in treatment and indeed, lack of information about the treatment itself or why it was being offered. One of these complaints is detailed below.

Kay was living and working in remote NT and became aware that something was not quite right. She went to see a doctor for help, and was offered a ride to hospital with the Royal Flying Doctor. She accepted, and was sedated, placed in a safety blanket and strapped onto a stretcher. She was not permitted to go home and lock up, or pack any clothes or toiletries.

Once in hospital, Kay says she was not involved in her treatment. For example, she was booked for some tests which are routinely conducted for people with first episode psychosis, although Kay didn't know this. She told the community visitor that she didn't even know what tests she was booked into, until an orderly told her. She also said she was not informed about her medication.

Kay did not wish to lodge a formal complaint with the CVP, however she asked that staff be made aware of her experience. She said that admission is a "scary reality" for people not yet diagnosed with mental illness, and that the experience of being tied down and sedated without information as to why and without the opportunity to collect essential items makes the reality even scarier. Kay felt that these issues were addressed later in her admission, however she asked that clients be properly informed as to all aspects of their care and treatment during transport and admission.

Medical Treatment in Psychiatric Inpatient Units

It is standard practice throughout Australia to conduct a brief physical examination before admitting a person to a psychiatric ward. In the Territory, people being admitted to a psychiatric inpatient unit are assessed in the Emergency Department (ED) of either Alice Springs Hospital (ASH) or Royal Darwin Hospital (RDH).

During a visit to the TEMHS Inpatient Unit, the community visitor was informed that Georgie had two "Code Blues" called, yet still was not admitted to a medical ward at RDH. The Code Blues were called because staff had not been able to rouse her.

On investigation, the community visitor found that after the first incident, Georgie was treated in RDH, but returned to the TEMHS Inpatient Unit after she had recovered. The following day, Georgie was found to be unresponsive in the morning. She was medically reviewed and plans made to move her to a medical ward at RDH later that day. By evening, Georgie was reviewed in her room and again found to be unresponsive. A second "Code Blue" was called. In the end, she was assessed in the ED at RDH and then returned to TEMHS Inpatient Unit for treatment because there were no beds available in the medical ward. Arrangements were made to monitor her, and to transfer her to RDH the following day if necessary.

The community visitor asked the Authorised Psychiatric Practitioner (APP) whether Georgie would have been better off medically had she remained in RDH after her transfer when the first Code Blue was called. The APP felt that the transfer back to the psychiatric unit was reasonable in the circumstances, and that consultation between RDH and TEMHS had been effective and followed existing protocols. The major problem was confusion when the plan had been to transfer Georgie to a medical ward on the second day, and the transfer had not taken place. This was verified when the community visitor reviewed the case file. The community visitor was satisfied that this was a "one-off" occurrence and did not indicate a systemic problem between RDH and TEMHS.

The Community Visitor investigated incidents where two emergency medical calls had been necessary for two consumers admitted to the Mental Health Unit (MHU) within a very short period of time.

1. Mandy was assessed as having high blood pressure in ED, which settled and she was subsequently transferred to the MHU. She was transferred back to ED when she became unconscious and unresponsive.

2. Nani was sedated in the MHU and subsequently suffered respiratory depression. She was transferred to the Rapid Assessment and Discharge Unit for observation.

The community visitor was satisfied on investigation that the medical situations with both Mandy and Nani were well handled by nursing and medical staff in the MHU. She was informed by the Acting Director of Psychiatry that staff have the expertise and experience necessary to safely manage sedated clients in the Unit.

Staff were concerned for Oliver who was admitted to the MHU with high blood pressure. They were concerned that notes from his admission had not been transferred to the MHU when he was transferred from ED.

NT Mental Health protocols do not require a physical examination of clients who are being re-admitted to an inpatient facility within a week of discharge. On investigation, it turned out that a medical examination of Oliver was not undertaken in ED because he had been discharged from the unit less than a week previously.

The Acting Director of Psychiatry told the community visitor that triage and admission protocols were being reviewed at the time with a view to fine tuning and improving processes between ED and the MHU. The community visitor determined that the matter would be considered resolved when the outcome of the review of processes between ED and the MHU was forwarded to the CVP. At the time of writing this report, it has not been received. There have been no similar incidents in either Darwin or Alice Springs in the past six months.

Removal of Clothes in Seclusion in the TEMHS Inpatient Unit

People are secluded when they are placed alone in an area which they can't leave. It happens when they are so agitated or unwell that they are a risk to self or others, and there appears no other safe way of managing the risky behaviours. Concerns have been expressed in the past two Annual Reports about the practice of removing the clothes of all people who are secluded in the TEMHS Inpatient Unit. Routinely, the policy has been that the person being secluded is covered by a blanket and clothes are removed. The person is then placed in a "non-tear" gown. The CVP has been informed that the reason for this is to prevent harm to the person being secluded. If this is the reason, the CVP has maintained that there should not be a wholesale policy and that only those people who are assessed as being at risk of self harm should have their clothes removed.

The need to minimise risks to the person being secluded is acknowledged. However there are other risks inherent in removing the person's clothes which should also be taken into account. For example, there may be risk to cultural safety – in some cultures removing a woman's clothes in the presence of men can cause significant trauma. Similarly, removing the clothes of a person who has a background of trauma, including sexual abuse, in the presence of people from the opposite gender can exacerbate the original trauma. In 2010/2011, the CVP followed up a significant complaint from a minor with a background of trauma. The young person was secluded and clothes removed in the presence of four people of the opposite gender. In this case, the young person had vomited while being restrained and the blanket was used to prevent the person's face lying in the vomit. Clothes were removed quickly, however the young person was not covered by a blanket.

There has now been a change in policy so that clothes are removed only from people assessed as being at moderate to high risk of self harm. Factors other than risk of self harm should be considered in addition to the self harm risk, including the age of the person involved and factors such as previous trauma and cultural safety. The need to preserve individual dignity requires that any decision to remove the person's clothes and the reason for this decision should be clearly documented in the person's medical record.

Facilities- TEMHS Inpatient Unit

JRU Environment

Outside Area

JRU is the more secure of the two locked wards which comprise the TEMHS Inpatient Unit. People at high risk of harm or who are assessed as high risk of absconding are nursed in JRU. At times, JRU is quite full with up to ten people being nursed in the unit at a time. It is a reasonably small space, not well equipped for managing an inpatient group this large. When full, it is not unusual for the atmosphere in the unit to be highly emotionally charged.

For several years now, the CVP has been advocating for an outside area for clients in JRU. It is seen as a human right for the people who may be nursed in JRU for weeks at a time, and who are not able to go outside at all during that time. It has also been seen as particularly important for Indigenous clients, and for those people who relax outside in fresh surroundings.

Jane, admitted to the TEMHS Inpatient Unit for the first time, asked the community visitor whether she would get hurt while in the unit. She said she felt as if she was in jail and being punished becauses she had been in there three days and still had not been able to go outside.

The CVP was able to report twelve months ago that money had been allocated for the work to develop an outside area for JRU. It is pleasing to report that this work was just commencing at the close of 2010/2011 and appears almost completed at the time of finishing this report. Once the grass has regrown and trees and hopefully some plants returned to the area, the Panel recommendation that has been outstanding since November 2006 will be closed.

JRU Toilets

John told the Community Visitor that he couldn't understand how he could be expected to use the toilet in JRU.

The toilets in JRU are stainless steel toilets without seats. The Darwin community visitors panel has consistently described the toilets as "prison style" toilets, with comments on how they contribute to the person's sense of being in prison. They lack dignity. The community visitor couldn't help John, other than to pass his comments on to TEMHS.

Apparently, porcelain toilets and plastic seats are potentially extremely dangerous when a person is behaviourally out of control. Those instances are rare in the inpatient unit, and could be managed by retaining one stainless steel toilet and replacing all other toilets in JRU with the same toilets available for use by inpatients in other hospital wards.

Cowdy Ward

The outside courtyard area of Cowdy Ward has been redeveloped, and staff, who undertook this project largely in their own time, should be congratulated. The luxurious plants dotted around the courtyard, along with the bright decor result in a pleasant and relaxing environment.

Showers

There has been an ongoing issue with the showers in Cowdy Ward. Over many years now, the CVP has been receiving complaints about the temperature of the showers and the poor water flow from them. The community visitors panel tests the showers during each visit to the ward, and over the past twelve months, has reported that flow and temperature have improved slightly.

Jane, a young woman who had been admitted to Cowdy Ward with depression, told the community visitor that it didn't help that she was unable to have a shower. She said the water was heating after some time, but that the flow was so sparse that by the time it reached her, it was cold. Jane was having problems with her hair and needed to wash it every day. She couldn't do so because it took so long and it was just too hard for her.

The community visitor contacted the Unit Manager who followed up immediately. She responded to the visitor the same day, indicating that the hose to the shower was blocked and had been cleaned. While the shower was still not good, the problem was addressed sufficiently to allow Jane to wash her hair.

Jane appreciated the immediate response she received from the Unit Manager. It seems a minor issue for her to report to the CVP, and for the CVP to then report in this Annual Report. However it is not minor for people who have been admitted to the TEMHS Inpatient Unit. They are in hospital because they are unwell; they are vulnerable, hurt and frightened. People admitted to hospital should be able to enjoy a hot shower with reasonable water pressure. The problem with the plumbing in the TEMHS Inpatient Unit has been known about for years, yet it has not been fixed.

Facilities – CAMHS

CAMHS Community House

The Adult and Remote Teams are housed in CAMHS Community House, situated next to the Royal Flying Doctor Services in Alice Springs. While it is an attractive building, its design makes it difficult to provide a modern mental health service, and its size and heritage listing makes expansion impossible.

There appears to be one interview room in the facility which meets the safety standards that are expected of a mental health service. This room is used primarily by the Community Team, however it is available for use by the Forensic and Remote Teams as well.

The interview room requires a booking to secure it. If a client attends CAMHS without an appointment, as often happens with clients of the Remote Team, there may be no place to meet with a staff member.

A room formerly available to the Remote and Adult Teams has since been taken over by Administration. The Remote team will occasionally use the Team Manager's office to meet with clients, however this is not always available and is not an appropriate or safe setting.

CAMHS – Child and Adolescent Team

The CAMHS Child and Adolescent Team is situated in a building close to Alice Springs Central Business District. The rooms are bright and colourful, and provide a welcome and non-stigmatising environment for clients of the service.

When the Manager of the CVP visited this office in March 2011, it was very clear that confidentiality would be almost impossible to maintain in this office. There are several offices and interviewing rooms, and conversations held in rooms at one end of the office could clearly be heard in rooms furthest away.

In June 2011, the community visitor in Alice Springs conducted an inspection of the Child and Adolescent Team. She reported that the consultation and therapy rooms had both been sound-proofed, and that this promoted the confidentiality of young consumers and their families when meeting with the psychiatrist and clinicians in these rooms.

Procedures

NT Mental Health Service 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.

Since 2008/2009, the CVP has been reporting that there appears to be no system in place to ensure that reports are made to the CVP as required by s100(9) of the Act. Despite receiving a report in April 2011 as detailed below, the systemic failure to report every six months does not yet appear to have been addressed.

In April 2011, after a meeting with the TEMHS Manager, the CVP was sent a copy of a report detailing all complaints and feedback received by the Quality Co-ordinators in the NT for the period July to December 2010. This report, covering Darwin and Alice Springs, detailed five complaints registered in Riskman, the incidents database used in the Territory, and two comments/compliments received as feedback. No report has been received for the period January to June 2011.

Notification

Notification of Involuntary Admission to CVP

Sections 41(1)(c) and 43(1)(c) of the Act require that the person-in-charge of an approved treatment facility notifies the Principal Community Visitor if a person is involuntarily admitted for 14 days on the grounds of mental illness or seven days on the grounds of mental disturbance. In every quarterly report since the third quarter in 2005/2006, the CVP has commented on TEMHS' failure to notify the Principal Community Visitor of involuntary admissions to hospital as required by the Act. A recommendation that this notification is improved has been outstanding since November 2007.

The Manager of the CVP is now aware that TEMHS has put systems in place to improve the rate of notification, and by the final quarter in 2010/2011, the rate had improved from 7% in 2007 to 81%. Even so, the recommendation will remain open until the Principal Community Visitor is notified of all involuntary admissions to hospital.

Notification of Legal Practitioners

As stated above, sections 41(1)(c) and 43(1)(c) of the Act also require that a legal practitioner prepared to act for the person must be notified of involuntary admission for 14 days on the grounds of mental illness and seven days on the grounds of mental disturbance. Further, the legal practitioner must be notified of the involuntary admission within one working day. Notification is made by faxing the required form (Form 10) to the legal practitioner.

The Darwin community visitors panel reviewed 11 case notes during their visit to the TEMHS Inpatient Facility in May 2011. None of the 11 forms reviewed indicated that a legal practitioner had been notified (ie the relevant part of the form was not completed).

This is most likely an unintended consequence of decisions by both the North Australian Aboriginal Justice Agency (NAAJA) and NT Legal Aid Commission (NTLAC) to withdraw their services to clients in the TEMHS Inpatient Unit. As a result, the Mental Health Review Tribunal has engaged solicitors from private firms to represent clients appearing before the Tribunal. Unfortunately they are available on the day of hearing only. Clients therefore do not have access to legal advice on admission to the facilities, and the mental health service is unable to comply with the requirements of the Act because no legal practitioner is available to notify of the admission.

The CVP sees access to legal advice at the time a person is involuntarily admitted to hospital as a basic human right. Accordingly, in 2010/2011, the Principal Community Visitor met with key people in NAAJA and NTLAC to advocate for a change in policy to allow people with mental illness to have legal advice when they are admitted to hospital. The CVP will continue to advocate for change in 2011/2012.

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 visitors and community visitors panels to look into the adequacy of services for assessment and treatment of persons receiving treatment under the Act, as well as any failure of a person employed by mental health services to comply with the Act. Issues of people's rights that have arisen in 2010/2011 are reported in this section of the Annual Report.

Least Restrictive Alternative

The principle of the least restrictive alternative requires that people admitted to the inpatient facility are treated voluntarily whenever possible. It also requires that they are treated in the least restrictive environment. This means the person should be treated in the community if possible (even involuntarily) and when admitted to the inpatient unit, receive treatment in open rather than locked environments. While this is no longer possible in the Top End, Cowdy Ward is a less restrictive environment than JRU.

It was Jake's first admission to a psychiatric inpatient facility. He was admitted to JRU, and due to his build and a history of violence, he was accompanied at all times by security guards. Jake remained in JRU for the entirety of his admission, despite no overt displays of aggression. He became increasingly frustrated because he saw that other people, who had been aggressive while in JRU, were transferred to Cowdy Ward.

The community visitor spoke to Jake in JRU throughout his admission, seeing him for the final time four weeks after he was first admitted. By the final visit, the security guards were no longer seen as necessary. The community visitor spoke to the TEMHS Manager, the Director of Psychiatry, the Clinical Nurse Manager and treating APPs about Jake's situation to no avail. Jake was discharged from involuntary status in JRU direct to the community, five weeks after he was first admitted.

Legal Rights

Section 104(e) of the Act provides that a community visitor may inquire into the failure of persons employed in the approved treatment facility to comply with the Act. At regular intervals, community visitors review medical records during visits to the inpatient facilities to ensure that the legal and human rights of people are observed. Unfortunately, it is not unusual for the community visitor to find instances where the requirements of the Act have not been met.

APP Review of Involuntary Clients Every Three Days

Section 40(1) of the Act requires that all people admitted involuntarily must be reviewed by an APP at least once every 72 hours. This is a requirement for two reasons. Firstly, it is good practice to regularly review a person who is so unwell that he or she needs to be involuntarily admitted to an approved treatment facility. Secondly, a person should become voluntary as soon as he or she no longer meets the conditions for involuntary admission.

In a review of medical records of involuntary clients in the TEMHS Inpatient Unit on 12 November 2010, the community visitor noted that three involuntary clients had not been reviewed by an APP every three days as required. The TEMHS Director of Psychiatry was notified.

In a second review on 31 December 2011, the community visitor found that APP reviews were conducted out of time on eight occasions over the Christmas and New Year period. This affected six people admitted involuntarily to the Unit, with three reviews conducted three days late.

When notified of the outcomes of the second review, the Director of Psychiatry advised that delays in reviewing involuntary clients occurred due to a shortage of medical staff over the Christmas period. A new process, requiring on call medical registrars or hospital medical officers to attend the morning ward review with the Senior Shift Nurse, has been instituted. This is an appropriate response. It is also an effective response - community visitors continued to monitor compliance with s40(1) of the Act and were aware of no other times when it was not met prior to the end of 2010/2011.

APP Review of Involuntary Admission for Mental Illness Within 24 Hours

A person involuntarily admitted to an approved treatment facility on the grounds of mental illness pursuant to s39(1) of the Act must have the admission reviewed by a second, independent APP within 24 hours. This provides some protection for the person, ensuring that at least two doctors believe that the person meets the criteria in the Act necessary for involuntary admission. The community visitor, when inspecting medical records, checks admission documentation to ensure that the APP review takes place in time. The visitor inspects the medical record which is generally, but not always, written at the same time.

Bob’s status was changed to involuntary (and back to voluntary) four times in the one admission. On three occasions the review, which was due within 24 hours, was conducted out of time.

The community visitor notified the Director of Psychiatry that this had occurred. Of some concern was finding two instances where there were discrepancies between the times recorded on the Form 10, the form used to record involuntary admissions and times recorded in the medical record. One instance is recorded below.

The Form 10 indicated that Ann's first review by an APP and the decision to admit her to the inpatient facility involuntarily took place at 12 noon. The corresponding entry in Ann's medical record appeared to be contradictory because it indicated that she was admitted involuntarily at 10.30 am. Ann's admission was reviewed the following day. The Form 10 indicated that the review took place exactly 24 hours later at 10.30 am. The corresponding entry in the medical record was made at 2.30 pm, four hours out of time.

The Community Visitor reported these discrepancies to the Director of Psychiatry. The Acting Director responded as follows: "The forms are not always written at the exact time that we review the patients as it is sometimes more time effective in a busy ward to write them at another time."

This explains the first discrepancy, that is, the time on the Form 10 being later than the entry in the medical record. There is a second explanation. The APP may have started the assessment interview with Ann at 10.30 am and finished it 90 minutes later at 12 noon when the decision was made to admit her involuntarily and the Form 10 was filled in.

It does not explain the second discrepancy. The time on the Form 10 is earlier than the time in case notes, indicating that it must have been case notes that were completed later on this occasion. There was no indication in the medical record that it was a retrospective entry. The CVP suggested to TEMHS that the time of actual assessment and review should be written on the Form 10, and that if notes in the medical record are retrospective, that this is recorded in the medical record.

Notifying the Client of the Right of Early Review of the Admission

Section 41(1) of the Act provides that a person who is involuntarily admitted to an approved treatment facility for up to 14 days on the grounds of mental illness, must be notified of the right to have the admission reviewed by the Tribunal within seven days. Similarly, s43(1) states that a person involuntarily admitted to an approved treatment facility for seven days on the grounds of mental disturbance must be provided with the same information.

Form 10 (see Appendix 4) is the form used to document involuntary admission and to notify the Tribunal, the Principal Community Visitor and the legal practitioner of the involuntary admission. By completing Part C of Form 10, the APP is stating that he or she has informed the person of the right to ask for an early Tribunal review of his or her involuntary admission.

This section of Form 10 was completed properly in only four of the eleven case-notes reviewed by the Darwin community visitors panel during their visit in May 2011.

This indicates that people who are admitted to the TEMHS Inpatient Facility involuntarily may not being adequately advised of their right to early Tribunal review of their involuntary admission. It is a critical issue, given that consumer groups agreed to the extension of the period for Tribunal review of decisions for involuntary admission on the proviso that there would be a corresponding right of early review. This right does not exist if people, unhappy with involuntary admission, are not properly informed.

Right to Use a Phone, Send Letters and Receive Visitors

Section 13(c) of the Act stipulates the right of all persons admitted to hospital to communicate with others by phone or by mail and to receive visitors. These rights are further detailed in s95 *Letters and Postal Articles*, s96 *Access to Telephone* and s97 *Visitors*. There are times when the treating team thinks contact by mail, phone or in person may be harmful for the person or others and in these instances, s98 of the Act outlines the process by which an order may be made to restrict these rights. Essentially, it states that an order may be made to restrict the right of communication by phone, mail or to receive visitors, but the order must be reviewed daily. The person also must be informed of his or her right to ask the Tribunal to review this decision.

Ways of communicating with other people have changed considerably since the Act was first passed in 1998. People now use rapidly changing technology including mobile phones and laptops to communicate via social media such as facebook. The problem is that these devices are likely to have cameras installed, cameras which potentially violate the privacy of other people admitted to hospital.

To protect the privacy of all, people admitted to the Mental Health Unit in Alice Springs are not allowed to keep their mobile phones with them. The use of laptops is restricted in the TEMHS Inpatient Facility. The CVP believes that the reason for removing these items is valid, however at the same time, because people now communicate using these devices, their removal denies the right of communication with others contained in s13 of the Act.

Recently, the Manager of TEMHS facilitated a workshop on the use of technology in inpatient units in a national conference of mental health nurses. There does need to be discussion at a national level across all disciplines and sectors, and the outcomes of these discussions should be reflected in mental health legislation which is outdated.

Jasmine told the community visitor that when she was made involuntary, the doctor told her that if there was a risk of harm to her reputation, her right to use her telephone could be taken away.

In fact, s98(1) of the Act states that the right to access a telephone can be restricted or denied if there is a *serious likelihood of the person suffering serious physical or mental deterioration or that the safety or well-being of other persons* is at risk. It is questionable whether a possible risk to reputation constitutes serious physical or mental deterioration.

A person who is unwell may make phone calls or contact others in a way that interferes with friendships and even future work. This is a problem which is not necessarily covered by s98(1) of the Act. The CVP has contacted NT Mental Health Services with an informal recommendation that sections 95, 96 and 97 are reviewed and updated, and s98 of the Act is amended to include a harm provision not limited to physical or mental deterioration.

Jarrod told the community visitor that his phone had been removed. He said he wanted to speak to his children. He was also worried because he thought his mother wouldn't be able to contact him.

Jarrod's phone had been removed because he was so unwell that he kept worrying about his children. As a result, he kept calling them. The order was put in place to stop this because Jarrod's children were upset by it. The community visitor helped Jarrod apply to the Tribunal for a review of the order.

What can happen with orders such as these is that a person can be prevented from contacting everyone. An alternative is to write the order to prevent contact with particular people if this contact is likely to be harmful for them or the person who is unwell, but to allow contact with others. In Jarrod's case, this would have meant stopping the phone calls to his children, while still making sure that other family like his mother were able to phone him. The doctor made sure that Jarrod's mother was given the phone number for Cowdy Ward so she could contact Jarrod if she needed to. Jarrod was happy with this solution

Jerry told the community visitor that Alison, a counsellor, with whom he had a long standing therapeutic relationship, was not permitted to visit him in hospital despite an agreement that the counsellor would act as support person only. Jerry's doctor believed this might be harmful, and asked the counsellor not to visit Jerry.

The decision to prevent Alison from visiting was a clinical decision, and as such rightfully a decision to be made by the clinical team. The Manager of the CVP thought that Jerry's entitlement to receive visitors pursuant to s97 of the Act was being restricted, and an order should be in place. This would give Jerry the right to appeal his doctor's decision to the Tribunal. After checking with policy in the NT Mental Health Program, the Manager CVP contacted the Clinical Nurse Manager to inform him that any decision to restrict visitors should take place in accordance with s98 of the Act. The CVP Manager offered to contact the Consultant to discuss this matter and was told this would not be necessary.

Later that week, the CVP contacted the Unit to find out whether a s98 order had been put in place. It had not. The CVP Manager asked whether the counsellor could attend the ward, and was informed that he could, although Jerry had not been told that this was the case. The next day, Jerry said a nurse had spoken to him about the situation the day previously, but he did not really understand what the nurse had been saying. It had apparently been agreed that the matter would be discussed in ward round that day. Later, Jerry told the community visitor that during ward round he had been asked to wait until the following week when his usual doctor would have returned from leave. Still no order under s98 had been put in place, yet Alison was still not allowed to visit.

The community visitor told Jerry that he could talk about this during a Tribunal hearing already due the next day. The Tribunal was asked to rule on whether a s98 denial of entitlement would be upheld. In the end, no ruling was necessary because the doctor agreed that Alison could visit that day and over the weekend.

The real issue in this case was that the locum doctor did not know the Act as well as he should. Section 98 orders are not difficult to enact, they require completion of Form 49 which is then faxed to the Tribunal and Adult Guardian if appropriate. The order is reviewed daily and documented in the medical record and the subject of the order informed of the right to appeal to the Tribunal.

Rights of Voluntary Clients

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.

As can be seen from all the case studies below, managing voluntary admissions to an acute psychiatric facility is about balancing the rights of the person being admitted with risk. It involves complex decision-making that should be clearly documented in case notes and clear and transparent communication between the APP and client.

Gina approached the community visitor stating that her human rights were being violated. Gina had been admitted to the inpatient facility as a voluntary patient and said that she was being prevented from leaving. She told the community visitor that she was likely to try to harm herself if she left the facility.

The community visitor told Gina that her best option at that time would be involuntary status because this would give her the right to appeal the admission to the Tribunal. Gina's life circumstances meant that it was important for her to remain voluntary. Given this situation, the community visitor formed the view that the treating team was acting in accordance with the principle of the least restrictive alternative and that there was an over-riding obligation to keep Gina safe, while at the same time respecting her clear wish for voluntary admission. The community visitor told Gina that she believed her human rights were being respected.

At the same time, this situation can become problematic for the service if it continues because it places the treating team in danger of contravening s29 of the Act. Gina continued to refuse to guarantee her safety while at the same time asking to leave the facility and her status was appropriately changed to involuntary over the next week. In circumstances like this, the APP should clearly document the risk issues for the client as a rationale for an advance decision to require APP review in the event the person asks to leave the facility. A rationale for voluntary as opposed to involuntary admission should also be clearly documented in the medical record.

Jo had been admitted to the inpatient facility involuntarily on the grounds of mental illness, and later had her status changed to voluntary. When checking medical records, the community visitor found a case note entry by the APP at the time Jo became voluntary which read: *if she insists on leave → nursing staff can put on her section and the psych reg on call can section her*. When Jo tried to leave the ward two days later, she was sectioned.

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.

In Darwin, the Mental Health Review Tribunal convenes every week on Wednesday. This means that if a person is admitted on a Tuesday, and must be reviewed by the Tribunal within 14 days, s/he must appear before the Tribunal in the week following the admission. In this case, there was a mistake and Jo did not appear before the Tribunal, and so her involuntary admission expired. On the day the order expired, she was reviewed by the APP and assessed as meeting the criteria for voluntary admission, despite not being allowed to leave the facility. When she tried to leave two days later, she was admitted involuntarily.

The community visitor reported a possible breach of s29(1) of the Act to the Principal Community Visitor who reported to the Chief Executive (CE) Department of Health as required by s116 of the Act. The outcomes of a comprehensive investigation undertaken by staff from the Mental Health Program demonstrated that the APPs involved with Jo's voluntary admission were not aware that the time frames for review by the Tribunal had expired. The APPs involved stated that the decision to admit Jo voluntarily on the day her detention expired was a genuine coincidence. Further, the intention in the clinical notation which read that nursing staff should detain Jo if she tried to leave, was directed at ensuring that she was assessed by an APP to see whether her mental state had deteriorated. The report stated that the Consultant responsible for Jo's management, who was not responsible for the entry in her medical record, felt that the decision to change her status to voluntary was reasonable given some improvement in her presentation at that time.

The CVP agrees with the conclusion that staff acted in good faith. The reality is that this is almost always the case – however even people acting from the best of intentions can act in a way that results in an abuse of rights. Nonetheless, the investigation report identified systems issues for follow up, including problems related to weekly Tribunal meetings and problems with orientation of new APPs.

Colin contacted the CVP after he was admitted to Cowdy Ward as a voluntary patient. At the time, he hadn't realised that the ward was locked. He said he had problems with the Cowdy environment and asked to be able to go outside. When he wasn't able to do so, he asked to leave. Later he was reviewed by an APP and his status changed to involuntary.

The community visitor reviewed Colin's case notes. The APP reviewing Colin assessed him as no longer having the capacity to give informed consent to treatment, and on that basis admitted him involuntarily. It was documented that Colin was told that it was his responsibility to abide by his Management Plan. The community visitor could find no such plan in the file and asked for a copy, however none has been forthcoming. It appears that either there was no management plan, or it constituted a verbal agreement that Colin would abide by the policy that people admitted voluntarily agree to remain in the ward for 48 hours.

A week later, Colin became voluntary again. He approached the community visitor asking whether he had the right to leave the facility. He stated that he did not want to ask staff in light of what had happened the week previously. The community visitor was not able to provide the consumer with advice about any rights he might have as a voluntary client.

This is the difficulty that arises when people are admitted voluntarily when they do not really meet the criteria for voluntary admission, and is the reason for clear documentation and communication being so important. The community visitor contacted the NT Legal Aid Commission and asked that they provide advice to Colin. The lawyer rang Colin and his doctor, and he was discharged later that day.

In February 2011, the community visitor recommended that:

1. The NT Mental Health Service report to the CVP detailing how the status and rights of consumers admitted voluntarily to the inpatient units differ from those of consumers admitted involuntarily; and

2. All consumers admitted voluntarily to the TEMHS Inpatient Unit be provided with:

   (a) a copy of the guidelines for voluntary admission, with these guidelines detailing current policy with respect to leave and discharge from the Unit as well as the individual's rights as a voluntary patient; and

   (b) a copy of an Inpatient Management plan which is developed in consultation with the consumer during the admission.

At the time of writing this report, no response has been received.

PART 3

INSPECTION OF SECLUSION REGISTERS

Seclusion is defined in s62(16) of the Act as *the confinement of the person at any time of the day or night alone in a room or area from which free exit is prevented*. Section 62 of the Act provides the legal framework for the seclusion of people in the approved treatment facilities. It outlines the criteria which must be met before a person can be secluded, and the checks and balances in place which include regular medical and psychiatric review while the person is in seclusion. Section 62(14) states that the *principal community visitor must ensure that a record kept under subsection (2) is inspected by a community visitor at intervals not longer than six months*. Inspection of the seclusion register is a crucial function of the CVP because seclusion is one of the most coercive and restrictive practices undertaken by a mental health service.

CAMHS Mental Health Unit

The community visitor in Alice Springs reviewed the Seclusion Register held in the Mental Health Unit in January 2011 and again in June 2011. There were 15 seclusion episodes in 2010/2011, on par with the number of seclusions in 2009/2010. In the second part of the reporting period, that is from February to June 2011, there was only one seclusion incident.

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. One person was secluded for a total 27 hours and 25 minutes. The first medical review was conducted one hour and 15 minutes out of time. All other medical reviews complied with legislated time frames.

TEMHS Inpatient Unit

Seclusion Registers in the TEMHS Inpatient Unit were inspected in December 2010 and June 2011. 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 2010 and the 30th November 2010. In this Annual Report the CVP is reporting on review of seclusion episodes from 1st June 2010 until 30th May 2011.

A total 185 episodes of seclusion were reviewed in this period. This compares with 243 episodes for the same period the previous year, representing a 24% decrease in the incidence of seclusion for the year overall. It represents a remarkable 72% reduction in seclusion episodes in comparison with the 653 seclusions for the same period in 2008/2009.

At the same time, there is the possibility that periods of seclusion are getting longer. In 2010/2011, 43% seclusions lasted longer than three hours, and 21% lasted longer than four hours. The CVP will continue to monitor the period of seclusion over the next twelve months.

Some issues were identified during the reviews and are detailed below. Minor issues include the occasional incident where the medical review did not occur in time, where seclusion episodes were not included in the seclusion register and there were minor problems with documentation at times.

The Principal Community Visitor is required by s116 of the Act to report any suspected offence against the Act to the CE of the Department of Health. In 2010/2011, there were two episodes of seclusion which prompted a report to the CE of Health. One report was made after the close of the 2010/2011 reporting period. The incidents which led to these reports are not detailed in this Annual Report because it is not possible to disguise the identity of the people involved.

Issues Identified During Reviews of the Seclusion Register for TEMHS

Cultural Safety

The form used to document the seclusion details the post-seclusion interventions that might be used. For Indigenous people, debriefing with an Aboriginal Mental Health Worker (AMHW) is one such intervention, and documentation indicates that unfortunately it is rarely used. The case study below illustrates the importance of appropriate intervention, how hard it can be to organise and how effective it can be once in place.

Adrian had been secluded 11 times over two weeks, with 10 of those seclusions taking place in nine days. During the admission, spasmodic attention was paid to Adrian's language needs. His records indicate that an interpreter was not available on admission, but that interpreters were used occasionally, including once for a medical review while he was in seclusion. Case notes document one time when Adrian was crying, and nursing staff tried unsuccessfully to locate an interpreter for him.

There was however, no evidence of AMHW involvement at any time in the period in which Adrian was being repeatedly secluded.

On admission, it was documented that an AMHW was either not available or refused to see Adrian. There was no record of AMHW involvement in debriefing after seclusion. The inpatient team also considered it might be helpful for Adrian to have a boarder, yet it was a further six days before any attempt to organise a boarder was made. A further week later, that is two weeks after his last seclusion episode, a plan in Adrian's case notes indicated that an AMHW should speak with him. He was seen with an AMHW and an interpreter and a "Stay Strong Plan" developed with him. The CVP advocates for quality interventions such as this to take place at the beginning of the admission rather than towards the end.

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 2010/2011, the community visitor found three instances of medical reviews being conducted out of time as follows:

1. Sophie was secluded for a period of 20 hours and 15 minutes. The final medical review was conducted one hour out of time.

2. Rob was secluded for 40 hours and 30 minutes. One medical review on the second day of seclusion was conducted 45 minutes out of time. The observation sheet in the seclusion register recorded that the medical review was late because security were not available at the time. The APP recorded in the medical record that the delay was due to the prolonged restraint of another patient (presumably security were involved).

3. Warren was secluded for 21 hours and 30 minutes. A medical review due overnight was conducted one hour and 15 minutes out of time. The APP documented that there had been a delay in conducting the review “due to urgent clinical duties elsewhere”.

TEMHS is to be commended on the continued improvement in ensuring that medical reviews are timely. Documentation is also much improved. In 2010/2011, on two of the three occasions when medical reviews were conducted outside the times mandated by s62 of the Act and the Approved Procedures, the reason was documented in the medical record.

Removal of Clothes

The CVP is pleased to be able to report that in 2010/2011 there has been a change in policy so that only people who are assessed as being at a moderate to high risk of self harm have their clothes removed when being secluded. All others remain in their own clothes, and only have items such as belts, shoelaces and chains removed.

The CVP has informally recommended that decisions to remove a person’s clothes when secluded should be documented in the person’s record, along with the reason that the decision is made. Doing so underlines the importance of preserving the dignity of people receiving mental health services.

In 2011/2012, community visitors will, when checking the seclusion register, check medical records to ensure that this documentation is taking place.

Mechanical Restraint

Section 61(1) of the Act defines mechanical restraint as *the application of a device (including a belt, harness, manacle, sheet and strap) on a person's body to restrict the person's movement but does not include the use of furniture (including a bed with cot sides and a chair with a table fitted on its arms) that restricts the person's capacity to get off the furniture.* Sections 61(2) to (15) provides for the conditions under which mechanical restraint might occur, how it should occur and the responsibilities of the service if mechanical restraint is used. It is not routinely used in the Northern Territory, however there were two incidents where it might be said to have occurred between January and June 2011.

Case notes record that while in the ED at RDH, Bruce spat at staff. He was restrained and placed in a face mask. It is not clear whether Bruce was a client of RDH or TEMHS at the time this took place.

The CVP will need to seek advice on whether a face mask constitutes mechanical restraint. While ED, as a department of RDH, is an approved treatment facility for the purposes of the Act, this does not mean that any mechanical restraint in ED necessarily activates section 61 of the Act. This applies only to people receiving mental health treatment. In the past, the CVP has suggested that a register should be kept of any mental health client who is mechanically restrained while in ED. This will be monitored further in 2011/2012.

Byron was a prisoner who was admitted to JRU when he became unwell. The protocols are that all prisoners are accompanied by two prison officers when they are admitted to the TEMHS Inpatient Unit.

Byron was so unwell that there were two occasions when he was delirious and unable to manage his behaviour and was handcuffed by the prison officers. The community visitor only became aware of this when reviewing Byron's Management Plan.

The only record of the restraint on Byron's hard copy medical record was a nurse's entry which stated that he had required restraint and handcuffs and was given sedation. A case note entry by the APP did not mention the restraint, nor did a later case note entry by nursing staff that day.

The community visitor contacted the Clinical Nurse Manager who stated that nursing staff do not use restraints on the unit and indeed they did not. Byron was nonetheless restrained. The restraint occurred at the intersection between mental health and prison services and it is not clear whether it should trigger s61 of the Act. At this stage, the CVP is flagging this as a matter to be explored further.

Other Seclusion Matters

Two other seclusion episodes reviewed in 2010/2011 triggered community visitor concerns.

Jason has a known history of serious assault in the context of personality disorder and substance misuse. When admitted to JRU, he threatened nursing staff. Given his history, he was placed in seclusion. The question is whether the use of admission and seclusion to an inpatient psychiatric facility to manage out of control behaviour associated with substance use is appropriate.

In a medical review conducted while Jason was in seclusion, the APP recorded his impression that he was not suffering acute mental illness. He stated Jason was not safe out of seclusion due to impulsivity and his anger that he was in JRU, and that he should be discharged from hospital as soon as possible.

People are admitted to an approved treatment facility for treatment of mental illness. While the Act allows for admission on the grounds of mental disturbance, this is for the purposes of assessment only. It seems that admission may not be appropriate for people such as this fellow for whom the underlying issue is assessed and documented as volatile substance use. Seclusion is one of the more coercive interventions used in mental health, yet to maintain their own safety and the safety of clients admitted to the approved treatment facility, medical and nursing staff are placed in the situation of having to impose this intervention on a client who does not necessarily meet the criteria for admission to the facility. This makes the use of seclusion to manage people such as Jason dubious at best. Certainly, it cannot be deemed to be therapeutic for the client, and yet surely this is the purpose of admission and treatment.

Wayne was secluded for 60 hours and five minutes after he had unpredictably and seriously assaulted a client in Cowdy Ward. He had done so because he was unwell, but he was not obviously unwell. There was no apparent change in his presentation as documented soon after he was secluded, to what was documented more than two and a half days later.

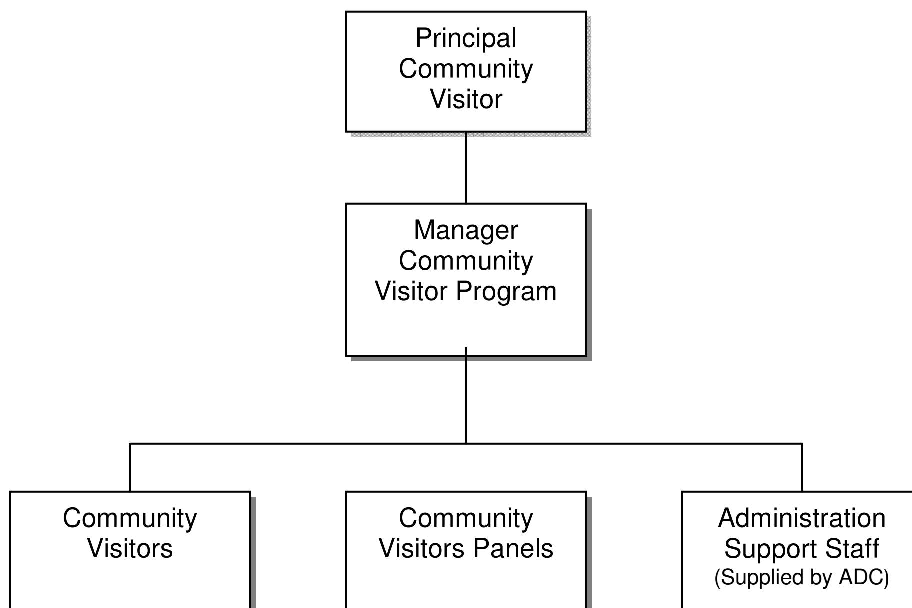
At face value, the client did not appear to meet the criteria required for seclusion as contained in s62 of the Act from very soon after seclusion commenced, and a rationale for his continued seclusion was not documented in the hard copy medical record, nor was there a rationale for ceasing seclusion.

The community visitor is prepared to accept the likelihood that Wayne was assessed as too unwell to be discharged from seclusion, and that the decision to maintain him in seclusion came about from clinical discussion in the ward. This was not documented in the notes, and the CVP has therefore asked TEMHS to provide a response regarding his continued seclusion.

PART 4: ADMINISTRATION OF THE CVP

STAFF OF THE CVP

Organisational Chart



Staffing

The CVP team is as follows:

1. The Anti-Discrimination Commissioner is appointed Principal Community Visitor.

2. At 30 June 2011, three staff of the Anti-Discrimination Commission, employed under the *Public Sector Employment and Management Act*, were appointed as Community Visitors.

3. Community Visitors (except those employed by the ADC) and all Community Visitors Panel members receive fees consistent with the Determination of Remuneration, Allowances and Expenses under the *Remuneration (Statutory Bodies) Act* for “Other Member” Expert High Impact Panels.

Principal Community Visitor 2010 - 2011

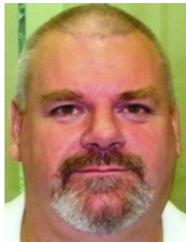
Eddie Cubillo

Community Visitors and Panel Members 2010 - 2011

Judy Clisby
Manager CVP

Karyn Jessop

Traci Keys



Phil Dempster

Pamela Trotman

Carly Ingles

Teja Lipold

Georgia McMaster

Garry Halliday

Alison Hanley

Sarah Giles (Chair)

Mark O'Reilly

Jessica Kneebone

Susan Wearne

Maya Cifali (Chair)

PART 4: PERFORMANCE OF THE CVP 2010 - 2011

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. Where relevant, comparison is made across financial years.

Visits and Inspections

Table 1: Comparison of the Achievements of the CVP 2008/2009 – 2010/2011

		Alice Springs			Darwin		
	Legislative Requirements	**2008/ 2009**	**2009/ 2010**	**2010/ 2011**	**2008/ 2009**	**2009/ 2010**	**2010/ 2011**
Visits[1]	In response to requests/ inspection	24	44	43	85	88	93
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%	97%	100%	100%	99%

Note: Visits include visits to inspect the approved treatment agencies.

Community visitors visit the TEMHS Inpatient Facility once each week and the Mental Health Unit fortnightly. Most people who are admitted to an inpatient facility in the Northern Territory therefore have access to a community visitor.

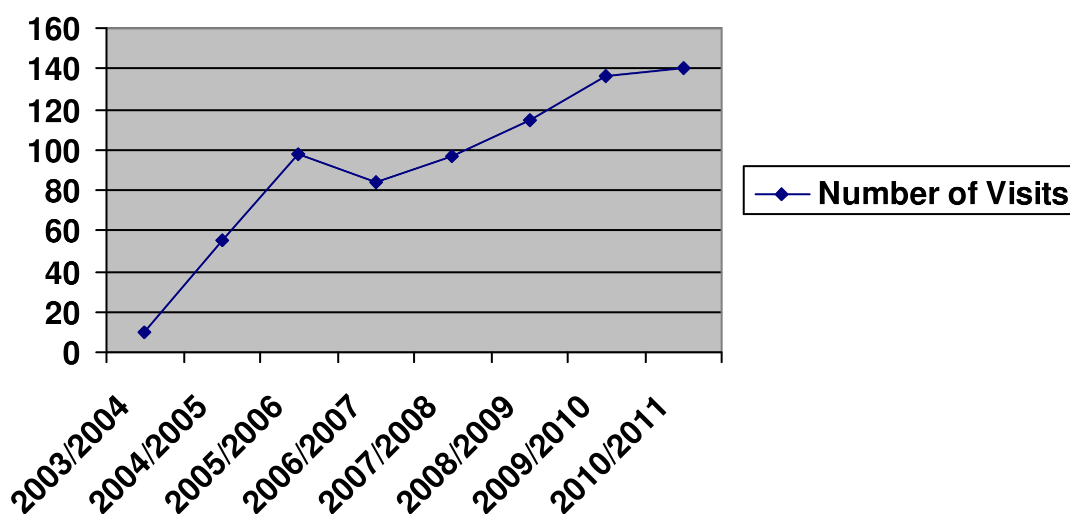
The number of visits also includes community visitor inspections of the approved treatment agencies. In 2010/2011, Teja Lipold, one of the community visitors in Alice Springs, visited the Adult Community Team, the Forensic Team and the Remote Team twice. She also visited the Child and Adolescent Team once. Judy Clisby, the Manager of the CVP and the community visitor in the Top End visited the Forensic Team in 2010/2011. No visits were made to teams in Nhulunbuy, Katherine or Tennant Creek in 2010/2011.

Number of Visits

Figure 1 below details the number of visits conducted to approved treatment facilities and agencies from 2003 – 2011. The graph indicates a steep rise between 2003/2004 and 2005/2006 when weekly visits to the TEMHS Inpatient Unit and fortnightly visits to the Mental Health Unit were introduced.

Community visitors are also required to visit an approved treatment agency or facility when a person receiving treatment asks for a visit. The increased rate of visits since 2005/2006 reflects an increased number of requests from people receiving treatment. This indicates that the CVP is becoming better known to people who are admitted to the inpatient facilities.

Figure 1: No. of Visits to Approved Treatment Facilities and Agencies 2003 - 2011



Complaints and Enquiries

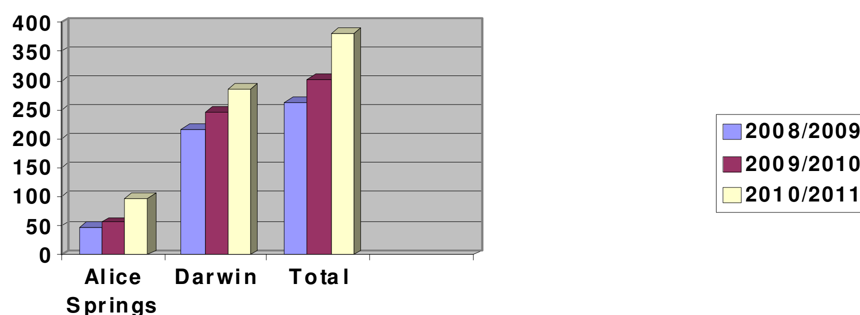
Table 2 below shows a 75% increase in complaints and enquiries managed by the community visitor in Alice Springs, while the number of visits to the Mental Health Unit remained the same. In Darwin, there was a 15% increase in complaints and enquiries from a 6% increase in the number of visits. This demonstrates that the number of complaints and enquiries is not directly related to the number of visits conducted, although it is fair to say that over the time the CVP has been operating, the overall trend is that an increase in visits has corresponded to an increase in complaints and enquiries.

The other variable which is not accounted for but which is referred to above is the effect of increased visibility and hence knowledge of CVP services by staff and clients. Many people admitted to an inpatient unit have previous experience of a community visitor and now make contact as soon as they are admitted.

Table 2: Complaints and Enquiries Received

	Alice Springs			Darwin		
	2008/09	2009/10	2010/11	2008/09	2009/10	2010/11
Complaints & Enquiries Received	47	56	98	216	247	285

Figure 2: Complaints and Enquiries Alice Springs & Darwin 2008 - 2011



Complaint or Enquiry?

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

Whether a contact is defined as a complaint or enquiry does not reflect the time taken to resolution. One of the most time consuming matters handled by the CVP to date, a matter which involved advocating with mental health staff, management and lawyers over 18 months was counted as one enquiry.

Complaints are generally contacts of a more serious nature. They may be verbal or in writing and occur when the person contacting the CVP has a grievance with the mental health service, and/or specifically describes their contact as a complaint.

In 2010/11, the CVP received a total 383 complaints and enquiries. 112 complaints and 173 enquiries were received regarding services provided by TEMHS, and 45 complaints and 53 enquiries about services received from CAMHS.

Table 3: Complaints vs Enquiries Received 2008 - 2011

	Alice Springs			Darwin		
	Complaints	Enquiries	Total	Complaints	Enquiries	Total
2008/09	27	17	**44**	86	130	**216**
2009/10	25	31	**56**	70	177	**247**
2010/11	45	53	**98**	112	173	**285**

Figure 3: Complaints vs Enquiries Alice Springs & Darwin 2008 - 2011

The graph below shows that the ratio of complaints to enquiries has remained relatively constant in Central Australia even while the number of complaints and enquiries has increased. In the Top End, there appears to have been an increased proportion of complaints to enquiries in 2010/2011.

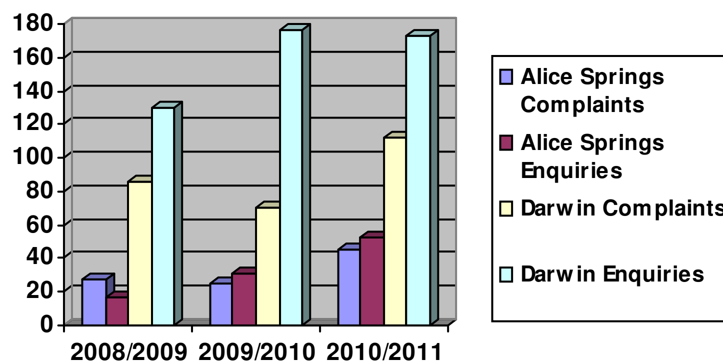
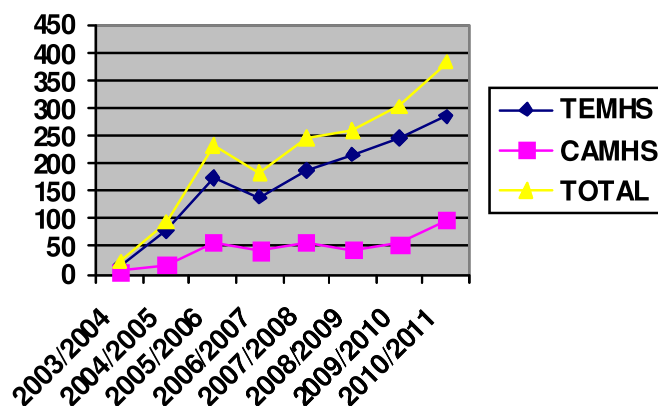


Figure 4: Number of Complaints and Enquiries 2003 – 2011

Figure 4 demonstrates increasing trends in the total complaints and enquiries managed each year by the CVP.



Categories of Complaints and Enquiries

The broad categories of complaints correspond with the inquiry functions of community visitors defined in s104 of the Act; that is, to inquire into the adequacy of services for assessment and treatment, the standard and appropriateness of facilities, the adequacy of information, the accessibility and effectiveness of complaints procedures, failure to abide by the Act and any other matter having regard to the principles and objectives of the Act. The sub-categories (ie access to files, activities etc) have generated from the types of complaints and enquiries handled by the CVP.

Table 4: Categories of Complaints and Enquiries 2010 - 2011

Category of Complaint/Enquiry		CAMHS	TEMHS	Total
Advocacy		21	75	**96**
Information	Access to Files	2	7	**9**
	Inaccurate information on file	1	2	**3**
	Provided to Consumer/Carers/ Service Providers by CVP	6	28	**34**
Medication		7	9	**16**
Miscellaneous		2	8	**10**
Quality of Service Provision	Activities	1	1	**2**
	Assessment & Treatment	8	33	**41**
	Consultation Consumer/Carers	9	16	**25**
	Discharge Planning	6	5	**11**
	Facilities	1	18	**19**
	Procedures	7	5	**12**
	Relationship with Staff	2	6	**8**
Rights	Detention	1	16	**17**
	Least Restrictive Alternative	3	16	**19**
	Legal	12	8	**20**
	Miscellaneous	5	11	**16**
	Respect for Dignity		3	**3**
	Safety		3	**3**
	Seclusion		4	**4**
	Transport by Police	2	2	**4**
Visit	Request/Support	2	9	**11**
TOTAL		**98**	**285**	**383**

Other Complaints and Enquiries

In addition to complaints and enquiries about mental health services in the NT, the CVP received a total three (3) complaints and 22 enquiries about matters not directly related to the provision of mental health services by TEMHS or CAMHS. These enquiries have included requests for advocacy with non-government mental health organisations. The most common enquiry is a request for information from the CVP.

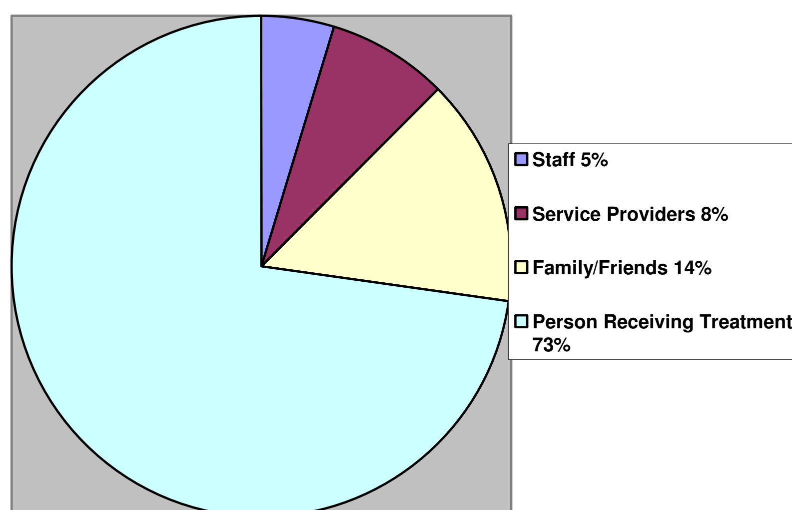
The CVP has no role in investigating complaints against organisations external to mental health services, but may assist a consumer by providing relevant information, referral and advocacy. The community visitor in Darwin has also assisted in an advocacy role with consumers lodging a complaint with the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

Sources of Complaints and Enquiries

Complaints and enquiries are received from multiple sources, as illustrated in the figure below. The term “staff” refers to any person employed by the mental health service. Service providers refer to organisations such as the non-government mental health bodies, legal aid and other government and non-government organisations.

Figure 5 below includes the 25 complaints and enquiries received about facilities other than CAMHS and TEMHS. The total number of complaints and enquiries for 2010/2011 is N = 405.

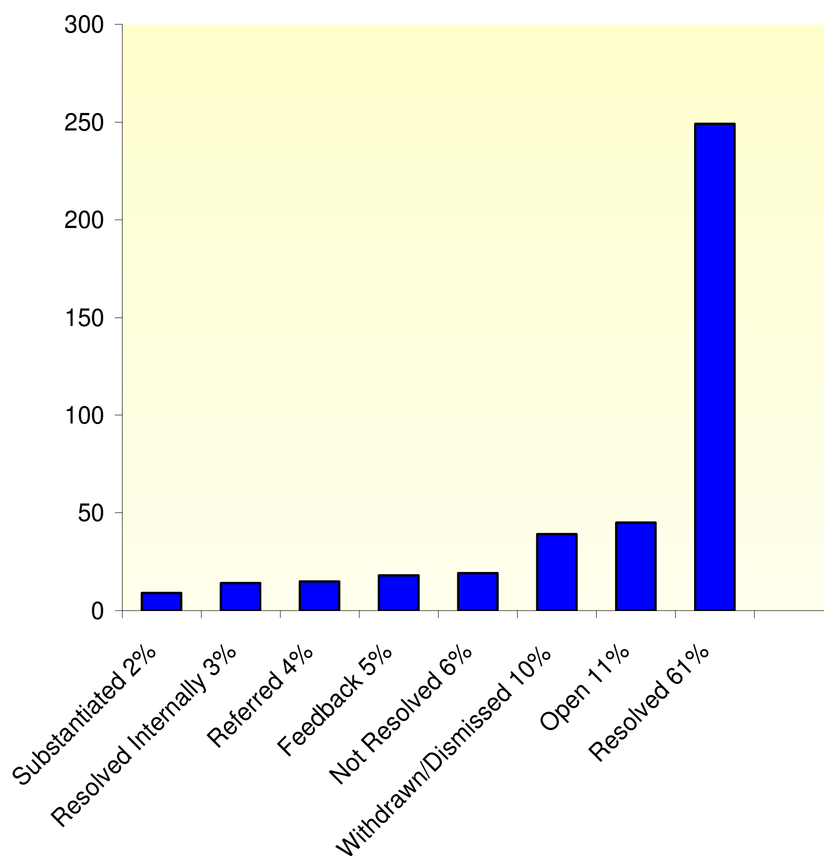
Figure 5: Source of Complaints and Enquiries NT 2010 - 2011



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 to another complaints organisation such as the Health and Community Services Complaints Commission.

Figure 6: Outcomes of Complaints and Enquiries NT 2010 - 2011



PART 4

OTHER CVP ACTIVITIES 2010 - 2011

As can be seen from this report, the number of complaints and enquiries managed by the CVP continue to increase each year. The increase in 2010/2011 was unexpected because community visitors have reported ongoing improvements in culture in the inpatient units. 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. In the past, the Manager of the CVP attended individual agencies, talking about the role of the CVP in the network of mental health services. This is no longer possible, and the CVP Manager now attends network meetings like the Mental Health Coalition and the Mental Health Network when possible. The Manager still meets regularly with key agencies like Mental Health Carers NT and the Mental Health Association of Central Australia (MHACA).

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 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.

Involvement with other Key Government Agencies

- Health and Community Services Complaints Commission: the Manager CVP meets quarterly with a staff member from Health Complaints. The Manager CVP has also met with the Health Complaints Commissioner.
- The Principal Community Visitor and Manager CVP have met with the President of the Mental Health Review Tribunal, and will continue to meet with him quarterly through 2011/2012.
- For a short period of time, the Manager CVP sat on the Reference Group for the development of procedures from amendments to Part IIA of the Criminal Code.
- The Principal Community Visitor and CVP Manager met with the Children's Commissioner;
- The Principal Community Visitor met with NTLAC and NAAJA.
- The Manager CVP has represented both the ADC and the CVP on the Information Sharing and Legislative Reform (ISLR) Reference Group.

Submissions

In 2010/2011, the CVP has prepared a submission on the consultation for secure care facilities in August 2010. The CVP has also submitted comments on four separate cabinet submissions in areas related to the CVP's role in the Territory.

Involvement with Community Agencies/Activities

One mechanism for promoting the purpose of the CVP is involvement in community activities. In the 2010/2011 financial year, the CVP contributed to the following:

- The Manager of the CVP was a member of the Chronic Disease Network Conference Organising Committee;
- The CVP is now a member of the Mental Health Coalition;
- The CVP Manager gave a single lecture on mental health legislation and the Anti-Discrimination Act for the Social Work legal studies subject;
- By agreement with the Community Justice Centre (CJC), community visitors and panel members who wish to gain training as a mediator can do so with the CJC at no cost in return for an agreement to act as a mediator for the CJC;
- The CVP has continued to work with AIS during 2010/2011 so that interpreters can accompany community visitors on visits to the inpatient facilities.

PART 4

PRIORITIES 2011 - 2012

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 improve the program's capacity to meet its core functions.

In 2011/2012 the CVP may have an enhanced role in monitoring the rights of vulnerable people and their families once the new Stabilisation and Assessment Units are opened. There may also be a role with the Secure Care Facilities, at least with facilities for adults with cognitive disability and challenging behaviours. At the time of writing this report, these changes are not definite. The priorities for the program outlined below therefore exclude any possible changes in 2011/2012.

- Focus of Community Visitors and Community Visitors Panels:
  - The audit of legal forms of consumers admitted involuntarily will continue in 2011/12 to ensure compliance with the Act. Community visitors will continue to pay particular attention to the management of consumers admitted voluntarily to TEMHS Inpatient Unit.
  - Community visitors will continue to respond to requests for visits from the Mental Health Unit in Alice Springs and the TEMHS Inpatient Unit in Darwin weekly.
  - The practice of weekly visits to the TEMHS Inpatient Unit in Darwin and fortnightly visits to the Mental Health Unit will be reviewed after the first six months of 2011/2012. While this has increased access to the CVP, the workload is now so high that it cannot be managed within existing resources. Reducing access will reduce the number of complaints and enquiries the CVP will need to manage.
  - Community visitors will also monitor particular issues during 2011/2012. At this stage, these issues are identified as trauma informed care, level of restrictiveness in the TEMHS Inpatient Unit, the rights of people admitted voluntarily to approved treatment facilities, documentation for use of non-tear gowns for those in seclusion and the provision of information about rights to Indigenous people admitted to the TEMHS Inpatient Unit.
  - From 1 September 2011, both inpatient facilities in the Territory are non-smoking facilities. Community visitors and panels will monitor the impact of this policy on inpatient experience.

- Improving internal CVP processes:
  - Strategic and business planning – there has been no opportunity for the CVP to include visitors and panel members in planning. If the CVP is expected to take on additional roles in 2011/2012, a meeting of all community visitors and panel members will be necessary.
  - Succession planning - the CVP has only one permanent staff member and this presents a risk to the program from loss of corporate knowledge. In 2009/2010 and 2010/2011 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.
  - In 2011/2012 the CVP will become a "paperless service". Not only is this environmentally responsible, it will save administrative time for the Manager of the program.
  - The CVP will examine ways of improving its efficiency, including referral of more complex complaints which require investigation to the Health and Community Services Complaints Commission.
- Training for community visitors and panel members: The following opportunities for professional development will improve the capacity of the CVP:
  - The CVP will liaise with interstate programs to develop accredited training for community visitors.
  - Community visitors and panel members will continue to have access to mediation training from the Community Justice Centre.
  - The CVP will formally approach NT Mental Health Services for training with their electronic information systems.
  - Two community visitors and panel members will be offered the opportunity to attend the National Official Visitors Conference to be held in Sydney in August 2011.
  - Dummy mental health files will be compiled to enhance training in inspecting case note records.

APPENDIX 1

NEW RECOMMENDATIONS 2010 - 2011

Community visitors and community visitors panels are able to make recommendations to either CAMHS or TEMHS based on observations made during visits and inspections. Recommendations might also arise from complaints managed by the CVP. Generally, before a recommendation is made, an attempt will be made to resolve the issue with mental health management. If this is unsuccessful, and the matter remains unresolved over time (generally about six months), the panel or visitor is likely to make a recommendation.

ALICE SPRINGS

Mental Health Unit

May 2011 Community Visitors Panel Visit

1. *It is recommended that the position of Diversion Therapist become a permanent position on the Unit.*

2. *It is recommended that the position of Social Worker become a permanent position on the Unit.*

DARWIN

TEMHS Inpatient Unit

May 2011 Community Visitors Panel Visit

1. *The panel recommends that the Principal Community Visitor advise the Tribunal of its concerns regarding:*

   - *whether proper notification of involuntary admission is taking place as required by the Act, and in particular, notification of the Tribunal, the Principal Community Visitor and a Legal Practitioner; and*

   - *failure to advise consumers of the right of early review of involuntary admission.*

2. *The panel recommends that the Principal Community Visitor write to the Chief Executive Officer Department of Health advising of its concerns regarding a possible breach of s62 of the Act.*

Community Visitors Second Quarterly Report

3. *It is recommended that the NT Mental Health Service reports to the CVP detailing how the status and rights of consumers admitted voluntarily to the inpatient units differ from those of consumers admitted involuntarily.*

4. *It is recommended that all consumers who are admitted voluntarily to the TEMHS Inpatient Unit are provided with:*

   - *a copy of the guidelines for voluntary admission, with these guidelines detailing current policy with respect to leave and discharge from the Unit as well as the individual's rights as a voluntary patient; and*
   - *a copy of an Inpatient Management plan which is developed in consultation with the consumer during the admission.*

Community Visitors Fourth Quarterly Report

5. *It is recommended that approved psychiatric practitioners, when involuntarily admitting a person to the TEMHS Inpatient Unit, complete Parts C and D on the Form 10 to ensure that interpreters are used where required, that the person is informed of his/her right to early review of the admission and that primary carers are notified of the admission where appropriate.*

APPENDIX 2

RECOMMENDATIONS CLOSED 2010 – 2011

ALICE SPRINGS

Mental Health Unit

July 2004 Community Visitors Panel Visit

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.

The Alice Springs Community Visitors Panel closed this recommendation once interactive boards, providing information about rights in local Indigenous languages, were installed in the Mental Health Unit. They are now being used by Indigenous clients admitted to the Mental Health Unit.

November 2009 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 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.

The Panel was advised during their visits in 2010/2011 that there were no problems accessing allied health services. This recommendation came into being as a result of concerns raised by the medical staff and management of the Unit in response to their frustrations. Because those concerns are no longer being raised, the recommendation was closed.

CAMHS Community Teams

May 2005 Community Visitors Panel Visit

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.

The community visitor found during an inspection visit in June 2011 that clinicians in the Adult Team are aware of the need to use an interpreter and that this was evidenced by entries in notes in CCIS. The Team Leader reported that there had not been a huge demand for interpreters, although problems occasionally arise after hours when clinicians are called to assess people in the Emergency Department of Alice Springs hospital. The recommendation is closed, however the community visitor will continue to monitor the use of interpreters by clinicians in the CATT and Adult Mental Health Teams.

DARWIN

TEMHS Inpatient Unit

No recommendations were closed for the Top End Mental Health Service in 2010/2011.

APPENDIX 3

OPEN RECOMMENDATIONS AS AT 30 JUNE 2011

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 suitable evidence for closure being provided. Even though a recommendation is not closed, there may still be progress towards its completion.

ALICE SPRINGS

Mental Health Unit

May 2011 Community Visitors Panel Visit – New Recommendation

1. *It is recommended that the position of Diversion Therapist become a permanent position on the Unit.*
2. *It is recommended that the position of Social Worker become a permanent position on the Unit.*

CAMHS Community Teams

June 2007 Community Visitor Inspection

1. *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

The community visitor was informed that all medical staff have now been trained on CCIS and are beginning to use it to document outpatient appointments.

Doctors and case managers can only communicate in writing if they are using the same system for documentation. If they all use CCIS, the doctor who is seeing a client in an outpatient clinic can look at the case manager's notes to see how well the client has been. After the appointment, the case manager can check the doctor's notes to see whether medication has been changed, or to check any recommendations the doctor might make about the client's ongoing management.

If CCIS is not used by doctors, the only way to be sure that the case manager and doctor communicate is if the case manager attends the outpatient appointment. The community visitor has noted that when this happens, the case manager documents what happened in the appointment in CCIS. If the case manager cannot attend the appointment and the doctor does not document what happened in CCIS, there is the possibility that a mistake can be made.

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

The Darwin community visitors panel noted that they should be able to close this recommendation in 2011/2012. At the time of writing this report, the 'fishbowl' has been replaced. Unfortunately, while there is now a private and secure area for staff to write notes and make phone calls, there is no open counter area. The new area maintains and underlines the separation of staff from clients. It is bounded on three sides by a high counter, with glass three quarters of the way to the ceiling.

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

Progress

During both visits in 2010/2011, the Darwin community visitors panel commented that they have found no evidence of progress with this recommendation in case note audits undertaken during visits to the facility.

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 Darwin community visitors panel will close this recommendation once appropriate information is available for Indigenous people admitted to the inpatient unit. They report that there has been no progress with this aspect of Recommendation 3 in 2010/2011.

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

There has been considerable progress with this recommendation. The CVP was informed by the TEMHS Manager that a training program has been developed and that police training is ongoing with a positive relationship established between training providers in NT Police and NT Mental Health Service. It is anticipated that this recommendation will be closed in 2011/2012.

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 Darwin community visitors panel notes that housing is a significant component of recovery for people with severe mental illness. It can also have economic benefits with potential savings when repeated and lengthy hospital admissions are avoided. The accommodation and support needs of people with complex needs (ie cognitive disability and challenging behaviours) are being addressed to some degree through the provision of secure care services. However, there is still a lack of services for people with co-morbid issues like mental illness and substance use disorder who do not need secure accommodation services. The recommendation will remain open until adequate assessment and planning for accommodation support services in the Top End has taken place.

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

In the report of their visit to the TEMHS Inpatient Facility in May 2011, the Darwin community visitors panel reported that work to convert the garden outside the JRU to a courtyard for JRU consumers was expected to start very soon. Once this has been completed and is being used by people admitted to JRU, the recommendation will be closed. This will be a wonderful change of service provision to clients in JRU.

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

The Darwin community visitors panel reported that a review of case notes showed that consumers from remote Indigenous communities did not have their language needs assessed on admission and use of interpreters was inadequate. There has been progress - interpreters are used at times, and are being used regularly during ward rounds with Indigenous patients from remote areas. There have been indications that one barrier to using interpreters is their availability. It was proposed that a small project be undertaken to identify the factors that interfere with access to interpreters, however in May 2011 the panel reported that this project had not progressed.

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 CVP has been informed that the proposed formal Memorandum of Understanding (MOU) between NT Mental Health Services and NT Police will be replaced by a formal protocol. It is now three years since the CVP was involved in the initial negotiations between Mental Health Services and Police. The protocol has still not been signed off.

The panel is aware of significant improvements in the way people are transported to hospital. They will be pleased to close this recommendation once formal agreement between NT Police and NT Mental Health Services has been reached.

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 18 have access to expert assessment and management.*

Progress

In the report of its visit in May 2011, the Darwin community visitors panel stated that it appears that a youth friendly framework has been put on hold until the new five bed unit is open. A male youth worker has been employed in Cowdy ward, with an "evolving" role. The panel described the High Dependency Unit (HDU) area where

youth sleep as “bleak”. At an informal level, nursing staff do their best, sometimes bringing in equipment from home. However, the only difference between formal procedures for the management of adults and young people seems to be the allocation of a staff member, usually a Patient Care Assistant, to remain with the young person at all times.

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 commented that there does seem to be increasing involvement of AMHWs into clinical care, yet there is limited evidence of this in case note documentation. As this becomes more frequent, the panel will have the evidence needed to close this recommendation.

May 2011 Community Visitors Panel Visit

12. *The panel recommends that the Principal Community Visitor advise the Tribunal of its concerns regarding:*

    - *Whether proper notification of involuntary admission is taking place as required by the Act, and in particular, notification of the Tribunal, the Principal Community Visitor and a Legal Practitioner; and*
    - *Failure to advise consumers of the right of early review of involuntary admission.*

Progress

Matters raised by the community visitors panel were referred to the President of the Mental Health Review Tribunal via e-mail on 6 July 2011. The recommendation will accordingly be closed in 2011/2012.

13. *The panel recommends that the Principal Community Visitor write to the Chief Executive Officer Department of Health advising of its concerns regarding a possible breach of s62 of the Act.*

Progress

The Principal Community Visitor wrote to the CE Department of Health advising of the possible breach of s62 of the Act on 30 August 2011. The recommendation will accordingly be closed in 2011/2012.

Quarterly Reports

2005 - 2006 Third Quarterly Report

14. It is recommended that procedures to ensure TEMHS' legal obligations to notify the CVP pursuant to s41 and s43 of the Mental Health and Related Services Act are put in place forthwith and that the CVP is formally notified of these procedures in writing.

The notification rate for the final quarter 2010 – 2011 is estimated at about 81%. Compared to the 7% of notifications received by the CVP when this recommendation was first made in 2005/2006, this is a substantial improvement. Nevertheless, the recommendation will remain open until the notification rate is 100%.

2010 – 2011 Second Quarterly Report

15. It is recommended that the NT Mental Health Service reports to the CVP detailing how the status and rights of consumers admitted voluntarily to the inpatient units differ from those of consumers admitted involuntarily.

16. It is recommended that all consumers who are admitted voluntarily to the TEMHS Inpatient Unit are provided with:

- *a copy of the guidelines for voluntary admission, with these guidelines detailing current policy with respect to leave and discharge from the Unit as well as the individual's rights as a voluntary patient; and*
- *a copy of an Inpatient Management Plan which is developed in consultation with the consumer during the admission.*

Progress

No response was received to either recommendation in 2010 – 2011.

2010 – 2011 Fourth Quarterly Report

17. It is recommended that approved psychiatric practitioners, when involuntarily admitting a person to the TEMHS Inpatient Unit, complete Parts C and D on the Form 10 to ensure that interpreters are used where required, that the person is informed of his/her right to early review of the admission and that primary carers are notified of the admission where appropriate.

Progress

This is a new recommendation, received by TEMHS after the close of the reporting period.

APPENDIX 4

FORM 10

Client details		
HRN:	Family name:	Given name:
DOB:	Also known as:	Male/Female

PART A

First APP Examination

(Do not complete where an APP has made the Recommendation for Psychiatric Examination)

I,
Title Given name Family name of Authorised Psychiatric Practitioner

have examined
Given name Family name of person

currently detained at under section of the Act.
Name of Approved Treatment Facility

The outcome of my examination is that the person is to be:

- ☐ Admitted as an Involuntary Patient on the Grounds of Mental Illness pursuant to s39 *(for a period of up to 24 hours from the time of examination)*
- ☐ Admitted as an Involuntary Patient on the Grounds of Mental Disturbance pursuant to s42 *(for a period of up to 72 hours from the time of examination)*
- ☐ Managed on an Interim Community Management Order pursuant to s45 *(for a period of up to 24 hours from the time of examination)*
- ☐ Discharged from the Approved Treatment Facility

Signature of 1st Authorised Psychiatric Practitioner Date Time of examination

PART B

Second APP Examination

I,
Title Given name Family name of Authorised Psychiatric Practitioner

have conducted a second examination on the above mentioned person.

The outcome of my examination is that the person is to be:

- ☐ Admitted as a Voluntary Patient pursuant to s25
- ☐ Admitted as an Involuntary Patient on the Grounds of Mental Illness pursuant to s39 *(for a period of up to 14 days from the time of 1st examination)*
- ☐ Admitted as an Involuntary Patient on the Grounds of Mental Disturbance pursuant to s42 *(for a period of up to 7 days from the time of 1st examination)*
- ☐ Managed on an Interim Community Management Order pursuant to s45 *(for a period of up to 14 days from the time of 1st examination)*
- ☐ Released from detention

Treatment provided since involuntary admission:

Signature of 2nd Authorised Psychiatric Practitioner Date Time of examination

Page 1 of 2

Mental Health and Related Services Act
Approved Procedures

10 Examination at an Approved Treatment Facility and Involuntary Admission

Form 10
Section 38,39,42,55

PART C

Notification of Right to Apply for Review

I,
Title Given name Family name of Authorised Psychiatric Practitioner

have detained
Given name Family name of patient

at from on on the grounds of Mental Illness/Mental Disturbance
Approved Treatment Facility Time Day / Month / Year

It is likely that the Tribunal will review this admission on:

at
Day / Month / Year Address where Tribunal hearing is being held

I advise that an interpreter was required/not required to conduct the assessment.

I confirm that the above named person has been informed of their right to make an application for an early review and that the person has/has not requested an early review and requires/does not require an interpreter at the Tribunal hearing.

Language Required:

Signature of Authorised Psychiatric Practitioner Date

Any further information regarding this admission should be sought from on
Contact Name Phone number

PART D

Report of notification not provided to primary carer of involuntary admission

I,
Title Given name Family name of Authorised Psychiatric Practitioner

have decided not to notify
Given name Family name of person not notified

of the admission of
Given name Family name of Patient

as an involuntary patient on the grounds of Mental Illness/Mental Disturbance for the following reason/s

PART E

Authorisation

Signature of Authorised Psychiatric Practitioner Date

- ☐ *Copy sent to the Tribunal and Principal Community Visitor - for admissions under 39(1)(b), 39(3)(a) or 42(2)*
- ☐ *Copy sent to Legal Practitioner acting or prepared to act for the person*
- ☐ *Form placed on clinical file*