ANNUAL REPORT
2011-2012

COMMUNITY VISITOR PROGRAM
NORTHERN TERRITORY

The Hon David Tollner 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 2011 to 30 June 2012.

Yours sincerely

EDDIE CUBILLO
PRINCIPAL COMMUNITY VISITOR

30 September 2012

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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
CATT	Crisis Assessment Treatment 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

This is the eleventh 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 2011/2012. It is also my third and final report as Principal Community Visitor.

The work of the CVP has continued at a frenetic pace in this past year. In 2011/12, community visitors and community visitors panels conducted a total 159 visits to the approved treatment facilities and agencies in the NT. Community visitors responded to a total 441 complaints and enquiries, an increase of 9% over the previous reporting period.

In 2011/12, for the first time, I established a special community visitors panel to visit an approved treatment agency. Generally, community visitors will be responsible for visits to the approved treatment agencies; however if it appears that there may be a serious matter which requires further investigation, the Principal Community Visitor may convene a special community visitors panel. This panel was convened to investigate issues of concern about documentation and cross service communication in the Community Team in Alice Springs. A full copy of the panel's report is included in Appendix 4 of this Report.

The CVP will be undergoing significant development and change from 2012/13. It will have oversight of secure care services for people with cognitive impairment and challenging behaviours. These services will be provided in mental health facilities and in community secure care services being set up by the Aged and Disability Program. Amendments to the *Mental Health and Related Services Act* and the *Disability Services Act* setting out the expanded CVP role have already been passed. We look forward to working constructively with staff of the Aged and Disability Program as we have with staff from NT Mental Health Services.

Because the CVP's role is expanding, it is now slightly better resourced with a full time community visitor employed in Darwin. Over the next two years, funding will become available for an additional half time community visitor position in Alice Springs and full time administrative support in Darwin. These staff will support the CVP as it provides a valuable advocacy, complaints resolution and monitoring service for people receiving services in the disability and mental health sectors.

In 2011/12, for the first time, the CVP was able to bring all its community visitors and community visitors panel members for training and strategic planning in Darwin. The first day was devoted to training, and on the second day, we were joined by representatives from government and non-government mental health and disability services as well as consumer and carer representatives. A robust and sometimes very passionate day was spent developing the new CVP strategic plan, an outline of which is included on page 4 of this report.

Some long standing recommendations were closed in 2011/12. The long awaited Protocol between NT Mental Health Services and NT Police is an impressive document and is now being implemented. It reinforces the idea that police transport to hospital should only occur as a last resort with all other less restrictive options being explored first. The Protocol also provides for professional development and mandatory training for police and mental health workers.

Other long standing recommendations will be closed in the forthcoming year. The CVP has been assured that information about rights will finally be available in Top End Aboriginal languages in Cowdy Ward and JRU by the end of 2012. I am also pleased that people admitted to JRU are able to go outside now in an area developed over the past twelve months.

Some issues have not yet been resolved. There is constructive dialogue with relevant agencies around problems with use of interpreters and with their availability. People admitted involuntarily to the inpatient units do not have legal representation on admission, and I believe this is a serious breach of their human rights. I hope this can be resolved in 2012/13.

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. This needs to be kept in mind when reading the 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. Staff in the Mental Health Unit have worked all year surrounded by renovations, with construction noise, with limitations on space. It has been stressful but they have persevered and their effort is commendable. Staff in the inpatient unit in Darwin work hard in sometimes stressful conditions. There are times when they are at risk of being assaulted, and yet they continue to come to work and provide care for their clients. They give up their weekends to work in the Unit so that it is a pleasant environment for clients.

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 2011/12. Without their dedication, the service provided by the CVP would not be possible. I am proud to have worked with this group of people over the past three years. 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.

Finally, I take this opportunity to farewell and thank Judy Clisby, who has managed the Community Visitor Program since June 2004. She has contributed significantly to the development of the program and her commitment to improve the lives of people with a mental illness is acknowledged and greatly appreciated. We wish her well in her new role as Deputy Commissioner of the Health and Community Services Complaints Commission.

I also welcome our new Manager, Claudia Manu-Preston. Claudia has managed the Mental Health Association of Central Australia (MHACA) for the past nine years. She has the right experience and knowledge to take the CVP on the next step of its journey providing services to clients in the mental health and disability sectors in the NT.

EDDIE CUBILLO
PRINCIPAL COMMUNITY VISITOR

ABOUT THE CVP

VISION

The human rights and dignity of people affected by mental illness and cognitive impairment in the NT are respected and protected.

MISSION

To be an independent and accessible service which is recognised for:

- Its response to the voice of people in the NT receiving services visited by the CVP under the MHRSA and DSA; and
- Promoting their rights through advocacy, complaints resolution, monitoring and reporting.

VALUES

Respect: We value the voice and opinion of our client group, staff and service providers by respecting knowledge and expertise, acting courteously at all times, respecting others' privacy, being inclusive and ensuring cultural safety.

Empowerment: We walk alongside the client seeing the situation from his or her point of view, appreciating that all points of view are valid, striving to understand the client's journey and maintaining hope at all times

Courage: We provide a robust service to our clients by giving frank comment, advocating for CVP clients, having the courage to communicate an outcome even if it may not be welcome or well received and challenging services which are not respectful of individual rights (including the right to high quality treatment).

Independence & Integrity: We act ethically, openly, honestly and fairly by identifying and avoiding any conflict of interest, maintaining confidentiality, resolving complaints impartially and fairly and being accountable.

Strategic Objectives

1. Operate the CVP in accordance with requirements of the *Mental Health and Related Services Act*

2. Implement the CVP's role in Disability Services in accordance with requirements of the *Disability Services Act*

3. Improve CVP governance

4. Increase recognition of the CVP throughout the Territory

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 one of two full-time employees of the program. The role itself does not have a statutory function, although the Manager is appointed community visitor. 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 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. A special community visitors panel was established for the first time in 2011/12, conducting a visit to the Community Team in Alice Springs. The reasons the panel was established and the findings from their investigation are briefly outlined in the "Significant Issues" section of this Annual Report.

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 of the CVP Annual Report. In all cases details such as gender or diagnosis and 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 identified in 2011/2012 are not detailed in this report because to do so would identity of the person affected.

SIGNIFICANT ISSUES

Accommodation with Support

Homelessness and the impact on treatment and client outcomes

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 *Mental Health and Related Services Act* ('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.

In every Annual Report since 2007/2008, the CVP has commented on the importance of accommodation to mental health outcomes for people living with mental illness in the Territory.

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. It is the human right of all people to have access to appropriate accommodation where they are able to build their lives.

A holistic approach is needed. A holistic approach considers every aspect of the person's life; from health to employment to housing to stigma and discrimination. Addressing all these aspects of a person's being is fundamental for people with mental illness to have a 'contributing life'.[1]

[1] National Press Club address: Allan Fels on mental health and suicide prevention, August 2012

The 2010 report on housing and accommodation for people with psychosocial disability living in Alice Springs[2] 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. As noted in the CVP Annual Report last year 'this is a situation which is unconscionable and must be addressed'.

The CVP has previously advocated of the importance to conduct a needs analysis on accommodation and support options available in the Top End similarly undertaken in Alice Springs to determine the issues and priority areas.

Evidence from the *Home and Help…What Works* report has shown that long term accommodation and 'wrap-around support' services improve the outcomes for people with mental illness. Further, it has positive effects on their ability to live independently with fewer hospital admissions and higher tenancy retention rates.[3]

People with difficult behaviours and complex problems are particularly disadvantaged. Because the right accommodation with the right support is not available, they experience multiple, 'revolving door' admissions to hospital. This experience is demonstrated in the three case studies below.

Shelia was discharged from hospital, and she and the case manager could not find any accommodation. Shelia has a reputation for "causing problems" in accommodation settings and is therefore difficult to place. Eventually, Shelia was given four nights accommodation at a local motel, with the possibility that the service would pay for a further four nights. The instability of this arrangement impacted on Sheila's recovery and rehabilitation. This enquiry underlies the problem with securing any accommodation for people with difficult behaviours in the NT.

Robert has limited capacity to competently and independently manage personal and domestic activities of daily living. Unfortunately he is not welcome at home and has been evicted from many residential placements. There are very few housing options for him. Apparently Robert needs a structured environment with appropriate supports for him to live in the community.

Timothy is a long-term client of TEMHS. He has multiple issues including chronic mental illness, physical illnesses, cognitive impairment and problems with substance use. His family are tired, and can no longer help look after him. Every time he leaves hospital, there is nowhere for Timothy to go. When not in hospital, Timothy has no reliable source of food, and because he is homeless, he does not take his medication as prescribed. As a result, he becomes unwell. In 2011/12, Timothy was admitted to hospital six times.

[2]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.
[3] Manu-Preston C.L, (2011), Home & Help…What Works, Churchill Fellowship Report

Unfortunately the cases detailed above are not unusual, and the significant contributing factor is the lack of secure, safe, long term accommodation with support.

Early Psychosis Service

The CVP believes an early psychosis team is an imperative in the NT because it would ensure that young people (generally under the age of 25 years) with early psychosis receive the service they need for the best possible long-term outcome for them. An early psychosis team works with young people and their families in accordance with the *Australian Clinical Guidelines for Early Psychosis (second edition)*.

Information detailed on a Fact Sheet titled "Why is it Important to get Help Early?"[4] details why it is important to have the right intervention at the right time. In 2010/11, the CVP reported that "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".

In the 2010/11 Annual Report, the CVP reported that there is no dedicated early psychosis team in the Territory. This remains the case in 2011/12, although the Manager TEMHS has informed the CVP that staff have been provided with early psychosis training through Orygen Youth Health.

When the community visitor visited the community teams in TEMHS in 2011/12, it was apparent that while individual staff may have undergone training and have relevant skills, there is no specific focus on early psychosis intervention in the Adult Team. This team is responsible for working with young people with early psychosis because they have the capacity for long term case management if necessary. A key component of responsible early psychosis intervention is work with families as individuals and in groups. There was no indication to the community visitor that this work is being done in the NT.

One reason is that the team is not specifically resourced to provide this service. Again in 2010/11, the CVP reported 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".

In a Press Release dated 11 August 2011, the Hon Mark Butler MP, Minister for Health and Ageing, announced that the Northern Territory submission for an Early Psychosis Youth Centre was "successful in the first funding round and discussions

[4] http://oyh.org.au/sites/oyh.org.au/files/factsheets/fact2_gettinghelp.pdfl

about a scaled down version are progressing"[5]. This is an exciting development, and once in place could mean a real difference in outcomes for young people with early psychosis living in the Northern Territory.

Non-Smoking Policy in Mental Health Units

Non-smoking policies have been introduced into the inpatient units in Darwin and Alice Springs, after Royal Darwin Hospital and Alice Springs Hospital were made smoke free campuses. Clients often complain to community visitors because they are not able to smoke. The CVP records very few of these complaints because there is little the community visitor can do given that it is policy.

The CVP understands that NT Mental Health Services must comply with Department of Health policy regarding the hospitals being non-smoking campuses. For a short time, an exemption was granted for clients in Cowdy Ward in the TEMHS Inpatient Unit and clients were able to smoke in the outside courtyard. This is no longer the case.

The CVP believes that the goal of making the units smoke free areas need to be overt. This would ensure the possibility to introduce procedures to achieve these goals, and then later to measure outcomes. For example, the most obvious reason for introducing a non-smoking policy is improving client health, given that the effects of smoking on physical health are well known, and that there is extensive research that demonstrates that people with mental illness are more likely to smoke cigarettes than people without a mental illness[6].

If consumer health is the primary reason for introducing the non-smoking policy, one would expect to see strategies like:

- The use of nicotine replacement therapy introduced in the inpatient unit and strategies
- The introduction of motivational interviewing and counselling in the unit and beyond
- The introduction of relapse prevention strategies
- Post discharge support for people giving up smoking and
- Evaluation of the effect of the non smoking policy and other primary health care interventions on smoking behaviour.

There is a primary health care focus. Nicotine replacement therapy (NRT) is available while the client is in hospital, and one week's free NRT is available for clients being discharged from hospital. The CVP has been informed that NT Mental Health Services ensure that inpatient staff receive "Quit" Training and that Maxie

[5] http://www.health.gov.au/internet/ministers/publishing.nsf/Content/191FB012F4DB96DBCA257A58007FF4DF/$File/MB084.pdf

[6] Eg Lawn, S. and Pols, R. (2005) Smoking bans in psychiatric inpatient settings? A review of the research *Australian and New Zealand Journal of Psychiatry* Vol 39 pp 866 – 885

Ashton, who is expert in the design of programs to help consumers of mental health services stop smoking, has been brought to the NT to train mental health staff.

A worker from Mental Illness Fellowship Australia NT attends the TEMHS Inpatient Unit once a week and conducts a brief group motivational interviewing session. There is little evidence that other strategies targeting stages of change are implemented in the inpatient units (i.e. providing information for those not contemplating change) or that the effect of non-smoking policies in the inpatient units on clients' smoking behaviours has been measured.

There is general evidence non-smoking policies in inpatient units of themselves do not affect smoking after the client has been discharged. For example, Prochaska et al (2006) state that 76% of patients discharged from a non-smoking unit smoke within five minutes of discharge, and 100% are smoking again within three months[7].

The CVP believes that NT Mental Health Services should therefore make a clear statement about how they will continue to support clients on discharge from hospital.

This is important because clients are more often than not very stressed and unhappy when admitted to the mental health inpatient units. That this stress is exacerbated when they cannot smoke.

Some clients continue to smoke irrespective of the rules, and the smoking free policy has led to other practices in the inpatient units, as described below.

During one visit to the TEMHS Inpatient Unit, clients told the community visitor that the courtyard had been shut three times during the week. Nursing staff knew that clients were still smoking in the courtyard area, and clients had been searched for lighters.

In late January 2012, after being told that the outside courtyard was being locked when clients were found smoking, the community visitor contacted the manager of the Unit to find out if any policies had been developed which would lead to the courtyard being locked. No direct response was received, however the community visitor was informed that staff in the Unit contact security at Royal Darwin Hospital (RDH) security when a client is found smoking.

[7] Prochaska, J.J., Fletcher, B.A., Hall, S.E. and Hall, S.M. (2006) Return to Smoking Following a Smoke-Free Psychiatric Hospitalization *The American Journal on Addictions* Vol 15 pp. 15 – 22

Also see: Eg El-Buebaly, N., Cathcart, J., Currie, S., Brown, D. and Gloster, S. (2002) Public Health and Therapeutic Aspects of Smoking Bans in Mental Health and Addiction Settings *Psychiatric Services* Vol 53 No 12 pp 1617 – 1622

During morning meetings in Cowdy Ward, it is now routine for clients to be informed that if they are found smoking, they will be fined by hospital security. In one meeting, the nurse said that some clients had already been fined.

Sally told the community visitor that she had been caught smoking and fined. She was not concerned about this and was grateful that nursing staff had helped by making arrangements for her to pay the fine off over time.

Sally's status was involuntary when she was fined. To be involuntary, a person must not be able to give informed consent to treatment. This means that Sally's ability to make decisions about her smoking and her legal capacity to have a fine imposed should be questioned.

Clients admitted involuntarily to hospital have no choice about remaining in the unit and no choice about smoking while in the Unit. They are also very much under stress, and the introduction of non-smoking policies has had a recognisably negative impact on their hospital experience.

The CVP does not, and has not advocated in favour of a non-smoking policy or against it. There is a risk though that the way the situation is being handled in the inpatient units is resulting in a far more restrictive hospital experience. The CVP does advocate for NT Mental Health Service to measure the effect of the bans on the inpatient units to client's smoking behaviour.

PART 2: ISSUES IN MENTAL HEALTH

INFORMATION

Procedural Fairness

"Procedural fairness" is about making sure that people are treated fairly when decisions are being made about them. When a person is admitted involuntarily to hospital, his/her liberty is removed. People who do not agree with this decision should have the opportunity to present their case to the Mental Health Review Tribunal when the admission is reviewed. When this is the case, the process would be seen to be procedurally fair.

Access to Reports Prepared for the Mental Health Review Tribunal

Section 132 of the Act provides that as long as there is no risk to the safety of the person or others, the person must be given access to his or her medical records and to any reports written by their doctor and provided as evidence to the Tribunal. If the mental health service assesses that any of the information in the medical records or reports will result in a risk to safety, they cannot refuse access. The mental health service must instead apply to the Tribunal and the Tribunal may decide that access will not be given.

Applications heard by the Tribunal generally relate to involuntary orders. An involuntary order might apply in an inpatient setting like Cowdy Ward or the Mental Health Unit. It might also apply in an outpatient setting, and mean that a person does not have to remain in hospital, but does have no choice about whether or not s/he has treatment. In the Northern Territory, outpatient involuntary treatment orders are known as Community Management Orders (CMOs).

Any involuntary treatment can only be given for a short time (maximum two weeks) before the treatment plan is reviewed by the Tribunal. The process is that the person's doctor writes a report which gives the reasons for the doctor's opinion that involuntary treatment is necessary. These reasons might be based on the way the person is presenting, as well as information received from family or friends or other health professionals. Often the person about whom the application is made does not agree with the doctor's opinion, and believes that information being given about him or her is not accurate.

Unfortunately, in the Territory, the person is not given a copy of the report written by the doctor and generally does not see it until the day of the Tribunal Hearing. There is little or no time to prepare a response for the Hearing. Given the effect of involuntary treatment and/or admission on a person's life, this is an issue that ought to be taken seriously and addressed.

Andy wrote to the CVP complaining that he had not received the doctor's report prepared for the Tribunal hearing for a proposed CMO. He said "I was supplied with the papers by the attending lawyer on the very morning of the Tribunal Hearing. This meant that I had little time to prepare the case I wanted to present, with only about 15 minutes to glance over them. This seems to me to be an unfair situation, which should be rectified for future Tribunal Hearings, for me and for others."

This issue was raised in the 2009/10 Annual Report and again in 2010/11. In 2011/12, the Principal Community Visitor wrote to the President of the Tribunal and then met with him for further discusssions regarding a change in Tribunal practice. It was agreed that there would be further discussions, and that the matter would be raised as an agenda item at the next Tribunal AGM. Unfortunately, the Tribunal President resigned soon after this meeting, and a new President was not appointed until the end of the 2011/12 financial year.

The Manager CVP also met with the Director and Senior Policy Officer Mental Health Services. It was agreed that clients should be able to see the report written about them, and that if it is assessed that this information is likely to result in any harm, application would be made to the Tribunal to withhold this information. Policies and procedures enabling a change in practice have not yet been written and this should occur in 2012/13.

Access to Medical Records when Appearing before Tribunal

The discussion above is about access to medical reports. This section is about access to medical records, and the problems that occur when this is not common practice is well demonstrated by the complaint below.

Herb was thinking about not taking his medication. Because he had spent so much time in hospital over the past twelve months, his doctor (Dr A) applied for a Community Management Order. Just before the hearing, Herb saw a second doctor (Dr B) who documented on the community record system his opinion that Herb did not need to be on a CMO. Dr B told Herb that he could ask for these notes at the Tribunal Hearing.

Unfortunately, only Dr A attended the Hearing, and Herb and his lawyer were not given access to his records. The lawyer raised this at Hearing, but unfortunately the Tribunal did not insist that the notes from Dr B be produced as evidence.

This information was not provided to Herb for several reasons. Firstly, Dr A was not aware that s132 of the Act requires that medical records are made available to persons appearing before the Tribunal. Secondly, it is standard practice that only reports for the Tribunal are provided to the client's lawyer, and the client sees the report just before hearing. Finally, since NT Legal Aid and North Australian Aboriginal Justice Agency (NAAJA) stopped representing clients at hearing, it appears that at least some lawyers do not check the medical records.

Being forced to take psychiatric medication is restrictive. It may be necessary, however, there is an indication in Herb's case that he was prepared to take his medication, and that he was assessed as not needing a CMO. If the process was fair, Herb and his lawyer would have had access to his medical record and the Tribunal would have had access to all the available evidence in order to make their decision.

The CVP would like to see changes in policy in place by 30th June 2013 so that people appearing before the Tribunal will be given a copy of the reports written about them in time to prepare a response. Further, as long as there are no safety concerns, the CVP would like to see people appearing before the Tribunal and their legal representatives being given access to the medical record as is required by s132 of the Act.

Information for Aboriginal Clients in the TEMHS Inpatient Unit

In October 2004, the Darwin community visitors panel 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.

The panel recommended that appropriate visual material should be developed because the only information available about the mental health service, treatment and any rights people might have is in written form only. All written information is in English, in a style which requires at least secondary level literacy to read. Interpreters are not necessarily used or available at the time the person is assessed and inducted into the inpatient unit, and so it is unlikely that Aboriginal people whose first language is not English will understand what is happening to them, particularly during a first admission.

The panel in Darwin is aware that the inpatient unit in Alice Springs has developed a series of 'Talking Posters' which outline rights in several local languages, and that these posters have been up in the ward for over twelve months. There were no such posters in the Top End.

The Darwin panel asked the Principal Community Visitor to write to the Chief Executive Officer (CEO) of the Department of Health pursuant to s112(5) of the Act which states:

The principal community visitor may provide the CEO with a report where he or she believes that the person-in-charge of the approved treatment facility has not taken adequate or reasonable action to implement a recommendation contained in a report of a community visitors panel.

A letter was sent to the CEO Department of Health in February 2012, reporting that there had not been adequate action to implement the recommendation made in October 2004. In response, the Principal Community Visitor was informed that Talking Posters would be in place in the TEMHS Inpatient Unit by November 2012, subject to the availability of translation services. This has been confirmed by the Manager of TEMHS.

Interpreters

Darwin

An Aboriginal woman told the community visitor that the person staying as a boarder with a client was often asked to interpret. She said that it would be better if they used an independent interpreter. The CVP has often received similar feedback to this.

In February 2012, the Principal Community Visitor wrote to the CEO of the Department of Health about TEMHS' failure to implement two recommendations about their use of interpreters. The recommendations below were made following the panel visit to the inpatient unit in May 2007:

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

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

In response, the Department of Health committed to mandating the collection of information about Indigenous status, first language and whether an interpreter is required. This information will be kept on community and hospital electronic record keeping systems. The Department has also committed to ensuring that the first language of a person being transferred from a remote language, and any interpreter requirements will be incorporated into the referral process.

Part C of Form 10, the form used to record involuntary admission to hospital, provides the opportunity to routinely identify whether an interpreter is used at assessment and therefore whether an interpreter is needed for the Tribunal Hearing. If this section is completed by the admitting doctor, it should act as a prompt for mental health staff to use interpreters. It also places an obligation on the service to

follow through with a request for an interpreter for Hearings. The Department has committed to ensuring that Part C of Form 10 is routinely completed. The CVP has been monitoring compliance, and by 30th June 2012 can report there had been some improvement.

In addition, the Department committed to establishing a single point of contact to record all requests for interpreters for Tribunal Hearings, to confirm arrangements and to monitor the use of Interpreters. This is in place, and the CVP hopes that issues with respect to interpreter availability and their use will be finally resolved in 2012/2013.

Alice Springs

When an Aboriginal person is admitted to the Mental Health Unit, nursing staff record his or her first language. Staff also maintain a record of times when an interpreter is requested, and is either not available or is booked and fails to attend. This record is monitored by community visitors, and an overall report was forwarded to the CVP Manager so that CAMHS, the CVP and the Aboriginal Interpreter Service (AIS) could work together to address this problem.

Data was collected from 3/3/12 until 30/5/12 as follows:

- There were 46 bookings, 30 of which were confirmed (AIS accepted the booking and confirmed interpreter availability).
- Of the 46 bookings, interpreters attended on 15 occasions (33%). On 31 occasions (67%) either no interpreter was available or an interpreter did not attend. On 17 occasions, the ward was notified that an interpreter was not available. On 14 occasions no notification was received.

It appears from the record maintained in the Mental Health Unit that it is difficult to actually access an interpreter when needed.

Prior to being provided with a copy of the record, staff from the CVP met with senior staff from the AIS to talk about how it might be possible to make sure that an interpreter service could be provided. A number of options were suggested, including the possibility of an interpreter attending each inpatient unit at a regular time each week or using telephone interpreters. The Clinical Director CAMHS will be contacting the AIS to discuss how these strategies might be implemented in 2012/13.

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 (i.e.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. The work of the CVP over the past twelve months, and issues about which community visitors and community visitors panels are aware, are discussed in this section of the Annual Report under the headings Assessment and Treatment, Facilities and Procedures.

Assessment and Treatment

Activities

The TEMHS Inpatient Unit has remained a closed unit during 2011/12 and, due to the renovations to the Mental Health Unit in Alice Springs for the entire reporting period, it too has remained locked. With additional stress placed on people admitted to these units by the non-smoking policy, a vibrant activities program is crucial.

TEMHS Inpatient Unit

An activities nurse is employed four days/week from Monday to Thursday in Cowdy Ward and a program is available in the gym at Cowdy Ward for those four days. In the report of their visit in May 2012, the Darwin community visitors panel stated that "the activity area (formerly the gym) is to be commended and was well attended. A variety of activities were available, suitable for different ages and interests".

Nurses will try to open the gym for a few hours on the other three days, however this is dependent on staffing and how busy the ward is. Given that Cowdy ward is locked and clients have little choice about remaining in the ward, the CVP believes it important that an activity program is offered every day.

There is no formal program for clients in JRU, the more secure area in the TEMHS Inpatient Unit. Some equipment such as art supplies is maintained in a locked cupboard in the dining area of JRU and is occasionally used by people admitted to JRU. Community visitors report that it is very rare to see this equipment being used because nursing staff need to be available to stay in the dining area with the client. Occasionally, staff will take a client in JRU to the gym after hours, or with staff support and locking the activity room, and clients are now being allowed into a new outside area when nursing staff are available. In general the only activity available for clients in JRU is watching television.

There can be up to twelve clients who are acutely unwell being nursed in JRU, all with nothing to do in a relatively small space. A structured activity program is especially important in this environment.

Mental Health Unit

Unfortunately, throughout 2011/12, the activities program in the MHU was interrupted by extensive renovations, which resulted in the activities room being unavailable for use for several months.

In the report of their visit in September 2011, the Alice Springs community visitors panel stated that there seemed to be little energy for the morning meetings which are usually held in the activities room. The panel also reported that the level of planned activity within the Unit was troubling because it seemed to have been reduced to primary-school level arts and crafts. In May 2012, Jan and Ben told the community visitor that they found the lack of structured activities in the unit frustrating. They both said that the primary activity continued to be drawing, painting and colouring in.

Some activities have continued despite the renovations and new activities put in place. For example, a volunteer from the Drovers continues to cook lunch with clients every Wednesday. Staff and visitors to the Unit are invited to join consumers for lunch every Wednesday. Other activities, including hiring a car from November 2011 for excursions were instituted to compensate to the loss in space due to the renovations.

The Activities Room is once again open, and gym equipment available to clients in the Unit. The CVP will monitor the standard of the activities program in the Mental Health Unit in 2012/13 in the hope that with consultation from clients further therapeutic and diversion activities will be on offer in the unit.

Behaviour Management Plans

Renovations to the Mental Health Unit throughout 2011/12 have resulted in there being no outside area for clients. Because the locked area of the ward was also being renovated and hence unusable, the ward has been locked for most of the year. To manage clients in a difficult environment, clients were regularly escorted out of the ward.

When reviewing files, the community visitor noticed that Wanda's leave was often cancelled or denied. Wanda had threatened and attacked staff many times throughout a long admission. A behaviour management plan was developed which involved firstly an opportunity to settle and de-escalate, and if this did not happen, she would not be able to have any leave from the ward for 24 hours.

The CVP reported its concerns with this Behavioural Management Plan, which provide negative consequences for certain behaviours rather than working through incentives for positive behaviour (even if this was just the absence of negative behaviour). When approached, management told the community visitor that the way the Behavioural Management Plan was set up was largely due to staff inexperience. He stated that staff do engage with Wanda to reward positive behaviours.

It is likely that Behaviour Management Plans will be used more often in 2012/13 when the new assessment service for people with complex mental disturbance (cognitive impairment and behavioural disturbance) commences. It is more respectful and more effective to work with adults in a way that rewards positive behaviours, and the CVP will therefore monitor the way these plans are designed accordingly throughout 2012/13.

Consultation with Carers

The rights of people who care for a person with mental illness in the NT are prescribed in law by the Act and *The Carers Recognition Act*. Unless it is not in the interests of the person with the illness, the Act provides that primary carers should be informed when:

- the person is admitted involuntarily to the inpatient unit
- application is made of involuntary treatment in the community
- the community treatment order is revoked
- the treatment given to the person in hospital or under a community management order and
- before the person they care for is discharge from hospital.

The Northern Territory Carers Charter, scheduled in *The Carers Recognition Act* recognises that the views and needs of carers must be considered when service providers make decisions which will impact on them and their role as a carer.

14% of complaints and enquiries handled by the CVP in 2011/12 were from families and friends of people receiving treatment. Some were referred from service providers and others from the mental health service.

One carer has had extensive contact with the CVP since her partner was first admitted to hospital several years ago. Zina felt that staff had lied to her during her first contact with medical staff in the TEMHS Inpatient Unit when her husband David had his first admission to hospital. Unfortunately, this had an impact on all her future contact with the mental health service.

Zina believes that her unsatisfactory experience with TEMHS is related to poor communication; specifically that she has not been consulted, but rather told what will happen in regard David and his treatment. Her impression is that staff, when questioned became defensive and less communicative.

Staff on the other hand, found her difficult to work with and they were therefore not as willing to consult with her as perhaps they should have been. As a result, the situation was made worse because there was not enough direct communication between Zina and David's case managers and doctors.

With David's permission, the community visitor arranged a meeting between Zina and David, the treating team and the Manager TEMHS. All parties had the opportunity to air grievances and plans were made to improve communication between Zina and the mental health service.

Zina later told the Community Member of the Top End Community Visitors Panel that she thought that the arrangement between herself and TEMHS should not be considered as 'special' but should be the expectation of all carers. She said she would like to think that her experience will not be repeated.

The Community Member of the panel recommended that the CVP place greater emphasis on ensuring that the rights of Carers are taken into account within the terms of the Act and the *Carer Recognition Act*. He also recommended that TEMHS be urged to provide all staff with training about the *Carer Recognition Act* and how this should be taken into account when dealing with carers.

Electroconvulsive Therapy (ECT)

The CVP has received very few complaints about ECT in the past. However, in 2011/12, five complaints about ECT were received. One complaint was about the client not being given ECT; all other complaints were because the client and/or carer were opposed to ECT being given.

The patient information handout which TEMHS gives to consumers and carers describes ECT as a therapy which involves the passing of an electrical stimulus to the brain which causes a small, controlled seizure. The person is given a light anaesthetic. ECT is used because there is strong evidence that it is an effective procedure for the treatment of depression, psychosis and bipolar disorder resistant to other forms of treatment. It is known to be safe, although the person will experience disorientation and confusion immediately after treatment. Problems with memory are often reported for a few weeks after treatment.

Jack told the community visitor that he experienced some memory problems, after he had ECT. He said he could not remember most of what had happened since his admission. He said he was not even able to say how long he had been in the ward.

The community visitor encouraged Jack to speak to his nurse and doctor and ask them to "fill in the gaps". The community visitor also suggested that TEMHS should develop a system which to help people given ECT fill in the gaps in their memory.

Prue was very distressed when told she would be treated with ECT. It turned out that she was terrified about having an anesthetic because a close family member had a bad experience with anaesthetic. Prue said that it was her body, and she should have the right to decide what to do with it.

The community visitor met with Prue and her nurse to talk about the ECT which was due the following day. Prue said she knew she was unwell, but that she would rather stay unwell than have ECT. It was apparent to the community visitor that Prue's nurse had spent a lot of time with her, giving her information about ECT, telling her exactly what would happen and how she would benefit. It was agreed that the community visitor would attend the following morning to be with Prue as she went to sleep before her treatment. It was also agreed that no preparations (other than anaesthetic tests) would take place before the anaesthetic took effect so that she would not be frightened by the equipment.

On the day of her treatment, Prue was obviously distressed, but managed to remain calm. Her nurse, who sat with her, held her hand and talked gently to her throughout all preparations is to be congratulated on her excellent nursing care.

Facilities

TEMHS Inpatient Unit

Cowdy Ward

There has been considerable work to improve the ambience of Cowdy Ward, the less secure ward in the TEMHS Inpatient Unit. A courtyard outside Cowdy Ward has been significantly improved over the past two years, with significant volunteer effort from staff and partnerships with community groups.

A second courtyard area has been updated with assistance from TEAMHealth so that people with young families have a pleasant and safe area for visiting. The nursing station in Cowdy Ward is no longer a "fishbowl". The new nursing station, while still almost enclosed, has contributed to a sense that the whole area has opened up.

The gym in Cowdy Ward is now a friendly, bustling activities area. The area outside the ECT suite has been set up so that privacy can be maintained for clients, and at the time of writing this report, nursing staff were arranging a working bee over the weekend to paint the ECT room. All staff involved in these efforts are to be congratulated on their commitment to ensuring that the ward is indeed a pleasant and therapeutic environment.

Efforts of staff to make the internal ward environment warm and inviting would benefit from funding the purchase of new furniture to replace existing furniture which is old, dirty and tattered. The Darwin Community Visitors Panel commented on the state of the furniture in the report of their November visit to the unit, and it is to be hoped that funding will be available so that furniture can be replaced in 2012/13.

Bathrooms and Showers

In the report of their November visit, the Darwin Community Visitors Panel reported that bathroom walls had been relined in Cowdy Ward. They commented however that some areas were poorly finished. On the day of the visit, the panel noticed that the main bathroom had green water staining down the wall under the shower. They approached the cleaner to ask whether the water staining could be removed and were informed that the wall had been cleaned. The panel commented that no action had been taken to remove old tape on the mirror, and that perhaps years of this being a shabby and dirty bathroom had lowered all expectations.

In the report of their visit in May 2012, the panel again reported that showers and toilets were generally grubby, and showed their age. Stained floors and dirty mirrors reported after the November visit were unchanged.

One issue that has dominated CVP reporting after panel and community visitor visits has been the fact that showers have been cold and water pressure so low that people in Cowdy ward cannot have a shower and wash their hair.

It is really pleasing to be able to report that this issue is now resolved. In the report of their visit in May 2012, the community visitors panel reported that the hot water in rooms is hot enough and is available within 15 seconds.

JRU

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. For several years, the CVP has been advocating for an outside area for clients in JRU.

It is gratifying to be able to report that a new area, outside the dining room in JRU has been developed and is being used by clients and staff in JRU.

JRU Toilets

The toilets in JRU are stainless steel toilets without seats. The Darwin community visitors panel has consistently described the toilets as "prison style" toilets, commenting that they contribute to the person's sense of being in prison. These comments were repeated in reports of their two visits in 2011/12.

Beds in JRU

Not only are the toilets stainless steel, but the beds in each room are made of solid concrete, seemingly built into the floor. There are safety issues with these beds – they cannot be moved in the event of a physical emergency if an emergency trolley needs to be used.

The CVP has been informed that replacing these beds is a priority for TEMHS, however they have not been able to do so because the cost is prohibitive.

Oleander Room

When a person with mental illness is brought to the Emergency Department at RDH, they are brought to the Oleander Room. When the panel visited in May 2012, it had recently been renovated.

The panel and a patient commented on the room's name which refers to a poisonous plant. The more pressing issue however was the starkness of the room, with harsh white light from two fluorescent lights and white walls.

The need to ensure a safe environment is acknowledged. A safe environment does not need to be a stark environment, and there are ways of ensuring that the room is not so confronting and frightening for people already feeling anxious and vulnerable. The panel has suggested that at the very least, the lighting in the room should be modified.

Facilities CAMHS

Mental Health Unit

Renovations to the Mental Health Unit have been going on for the entire year, creating an environment that at various times has been noisy, confined and from which there has been little respite. In their first visit in 2011/12, the panel commented, "(I)t was of great concern to the Panel that the impact was so apparent. All staff members and consumers spoken to were experiencing increased stress levels as a result of the difficult working and living conditions."

Staff are to be commended on continuing to work and provide a service to mental health clients in this environment.

The panel also commented on limited access to any outdoor area, with the courtyard, which was previously available for clients, remaining closed. Because the ward is locked, involuntary consumers have little or no access to outdoor areas, unless staff are able to accompany them for a walk.

Jan and Ben also told the community visitor that while they thought the ward was lovely, the facility great and the staff all very helpful, they were distressed by the lack of access to outdoor areas. Ben said that when he spoke to staff about the outside area, he was told that it could not be because it was not yet satisfactorily completed.

Ben asked whether consumers could work in the courtyard as part of a group activity, so they could improve the quality of the space together, access an outdoor area and also participate in a structured activity. In fact, this was how the vegetable garden in place before renovations commenced was developed.

This suggestion was passed on the CAMHS Management through the CVP quarterly report. Unfortunately, at the time of writing this report, the courtyard area is still not accessible to clients in the unit.

Procedures

Uniformed Officers in JRU

Prisoners who need hospital admission for reasons of mental illness are admitted to JRU. Whenever this is the case, two Correctional Services Officers are present in the ward. People living in Detention Centres are also accompanied by two uniformed officers (Serco) when admitted to JRU. When the community visitor visited JRU on 15/3/12, there were 8 people in uniform in the ward. Given that JRU is a maximum 10 bed ward, their presence in the unit was overpowering.

Community visitors have reported several concerns about the presence of uniformed officers in JRU. Firstly, community visitors consistently report that Correctional Services Officers are sitting in the nursing station when they visit. This raises privacy concerns because it means that they may hear clinical discussions about other clients in JRU.

Secondly, a community visitor reported that when she rang the ward, the phone was answered by a Correctional Services Officer. When asked why she was answering the phone, the Correctional Services Officer the community visitor was told: "Oh, we answer the phones to help people out". If uniformed officers are spending time in the station and answering the phone, it gives the appearance that they are working for the mental health service.

This second concern is important because the CVP knows that clients in JRU sometimes don't realise why they are in hospital. Many consumers don't understand why they have been admitted involuntarily, and assume it is because they have "done something wrong". The presence of so many people in uniform can just add to the confusion.

It is important that JRU is able to operate as a contained, therapeutic environment for people who are acutely unwell. It is also important that staff and clients are safe, and this is the role of Correctional Services Officers who accompany prisoners to JRU. This means that Correctional Services Officers should remain in the main ward area. It may be worth considering whether the policy that two officers must accompany each prisoner can be revised so after a certain number of prisoners have been admitted. This could result in fewer officers per prisoner in JRU.

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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 2011/12 are reported in this section of the Annual Report.

Least Restrictive Alternative

Level of Restriction in NT Mental Health Services

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.

The principle of the least restrictive alternative is evident throughout the Act. 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 involuntarily 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*.

There are varying ways of considering what the term "least restrictive" actually means. Firstly, the Act provides for involuntary treatment in the community, because this is seen as less restrictive than involuntary admission and treatment in hospital. Once a person has been admitted to hospital, admission to an open ward is considered less restrictive than a locked ward and voluntary admission (as long as it is truly voluntary) is considered less restrictive than involuntary admission.

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. They are obliged to consider whether the treatment that mental health consumers receive in the Northern Territory is in fact the least restrictive treatment.

Jared told the community visitor that he had been in JRU, the secure section in the TEMHS Inpatient Unit for a week. He said he wanted to be transferred to Cowdy Ward. Jared told the visitor that he was homeless, and so told his psychiatrist that he was suicidal so that he would be admitted to hospital. He said that he was actually far from suicidal.

Jared's Consultant Psychiatrist told the community visitor that she didn't think Jared was unwell nor that he needed to go to hospital She said that his suicide threat had to be taken seriously though because he has a past history of high lethality self harm. As a result, the Consultant felt that there was no choice but to admit Jared to hospital. Jared was admitted to JRU so he would not threaten suicide again in order to gain admission. Jared understood this, and told the community visitor he would not be making any threats again.

The Act sets out the criteria for involuntary admission and treatment which is that the person must be unwell, there must be an identifiable risk to safety and the person must lack the capacity to give informed consent to treatment. In this case, it is questionable as to whether Jared actually met these criteria. The alternative was not to admit him, however given the threat of self harm and his history, this would have involved some risk.

Mental health professionals of all disciplines share a concern about the effect of a wrong decision – on clients, clients' families and themselves. This is understandable. It is an issue in all jurisdictions, perhaps more so in the NT which is so small, where people are closer and where reputations and careers can easily be destroyed. This can result however in mental health practice which is "defensive" rather than "defensible" and which may not lead to the best outcome for people receiving mental health treatment and care.

The CVP has suggested through its quarterly reporting mechanism that this is an issue that needs to be addressed so that all mental health staff are able to practise in a risk management rather than a risk aversion environment for the benefit of clients of mental health services.

Measuring the Level of Restriction

There are indications that the provision of mental health treatment in the NT is becoming increasingly restrictive. In 2011/2012, all areas of the TEMHS Inpatient Unit and the Mental Health Unit were locked. In the TEMHS Inpatient Unit, despite Cowdy Ward being locked, a high proportion of clients were treated in JRU, the very secure section of the ward.

Restriction in the TEMHS Inpatient Unit

During 19 visits to the TEMHS Inpatient Unit throughout 2011/12, the community visitor for the Top End 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. Some clients have been counted twice during the same admission and so the picture below can be seen only as an indication of the level of restriction.

In snapshots taken throughout 2011/2012:

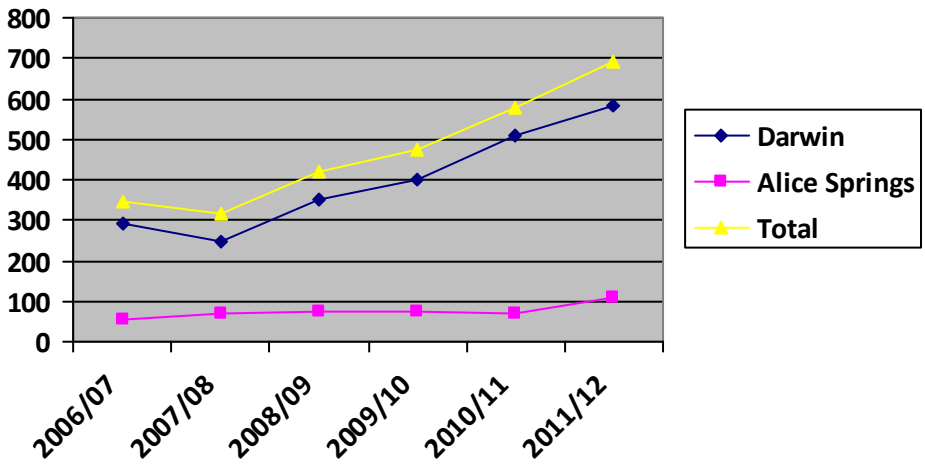
- 18% of people in the ward were voluntary; and
- When clients were admitted voluntarily, 42% were free to come and go, 20% were permitted leave with conditions only (conditions include length of leave, time of leave and leave with staff or others), and 32% were not permitted any leave. (Leave status was not recorded for 6% voluntary clients).

It is pleasing to be able to report that the proportion of people in the ward whose status was voluntary at any one time was in fact higher than that reported in the 2010/11 Annual Report. The proportion of voluntary clients permitted unrestricted leave was also higher. It indicates that while the number of involuntary admissions to hospital is increasing (see below), an increasing proportion of clients are having the status changed to voluntary. The CVP will continue to monitor this over the next reporting period.

Number of Involuntary Admissions to hospital in NT

Every week, the CVP checks the Tribunal lists for Darwin and Alice Springs. This way, community visitors know whether the CVP has been notified of all involuntary admissions to hospital and likewise, whether the Tribunal has been notified. It also enables the CVP to monitor the number of involuntary admissions. The figures used for the graph below are an estimate, based on information compiled from Tribunal lists. If anything, the number of involuntary admissions is under estimated because not all Tribunal lists are received. The trend lines in the graph below show that the number of involuntary admissions to psychiatric wards has doubled over the past five years.

Figure 1: Estimated Number of Involuntary Admissions in the NT 2006/07 – 2011/12.



There are a number of factors which might explain the large increase in involuntary admissions to hospital and the increasing trend, in Darwin at least, to admit clients involuntarily. As the population in the Territory increases, the number of people seeking or needing admission to hospital will increase, and if the number of available beds stays the same, only people who are very unwell will be admitted to hospital. It is conceivable though, given the previous discussion, that it may also relate to changes in risk management – that is the mental health service is more likely to be conservative in the way clients are managed.

Legal Rights

Tribunal Could Not Convene

On 21/6/12, the Manager CVP became aware of the risk that two clients may not be reviewed by the MHRT within legislated time frames. This was because the Mental Health Review Tribunal was unable to convene in Alice Springs.

Apparently the temporary appointment of Magistrate Birch as Acting President of the Tribunal expired prior to the Tribunal Hearing on 22 June 2012. He was therefore no longer a Tribunal member and the Tribunal no longer had a President. Magistrate Birch had been due to sit as the Tribunal's legal member on 22 June 2012 but this was no longer possible because he was no longer appointed to the Tribunal. The Tribunal could not change the roster as any change had to be approved by the Tribunal President. As there was no President, the Tribunal could not sit.

Two clients were directly affected. The first client had been admitted involuntarily on the grounds of mental illness. His detention was reviewed in time on 27 June 2012 by video link with the Tribunal sitting in Darwin on 27 June.

A second person was not reviewed in time. He was admitted on the grounds of mental disturbance (s42(1) of the Act) on 14/6/12 with this confirmed under s42(2) of the Act the same day. A s42(2) order is for 7 days only, and his admission therefore needed to be reviewed by the Tribunal on or before 21 June 2012. It was already out of time when the CVP became aware that the Tribunal would not be sitting.

This detention was reviewed by video link from Darwin on 27 June 2012 – six days out of time. The Principal Community Visitor notified the Minister of Justice that the review would be held out of time and that CAMHS staff had no choice but to hold the client involuntarily due to the delay in appointing the President of the Tribunal.

Notification of Involuntary Admission to the 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.

From January to March 2012, of 24 admissions which met the criteria for notification in Alice Springs, there was not a single correct notification to the Principal Community Visitor. On one occasion, Parts A and B of the Form 10 were completed, on three occasions, Part A only of Form 10 was completed and the CVP was not notified at all of the other 20 admissions.

The community visitor recommended that procedures be put in place to ensure that CAMHS meets its legal obligation to notify the principal community visitor pursuant to sections 41 and 43 of the Act. A swift response was received from CAMHS with a commitment to improve its notification procedures.

In Darwin the CVP has commented on TEMHS' failure to notify the Principal Community Visitor of involuntary admissions to hospital as required by the Act in every quarterly report since the third quarter in 2005/2006. From April to June 2012, TEMHS' rate of notification to the Principal Community Visitor as required was 63%.

It was reported in the 2010/11 Annual Report that TEMHS had put systems in place to improve the rate of notification, and that the rate of notification had improved to 81% in the final quarter of 2010/11. It is extremely disappointing that TEMHS has been unable to meet their legal notification requirement, and that it had decreased to 63% in the final quarter 2011/12.

Legal Practitioners

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.

In the past, the North Australian Aboriginal Justice Agency (NAAJA) and NT Legal Aid Commission (NTLAC) provided a legal service for clients admitted to the TEMHS Inpatient Unit. Both agencies withdrew their services, and the Tribunal is now responsible for rostering legal practitioners for Tribunal Hearings. Tribunal appointed solicitors represent their client only on the day of hearing.

Clients no longer have access to legal advice on admission to hospital. In the criminal justice system, access to a lawyer for people at risk of losing their liberty is seen as a basic human right. It seems discriminatory that people with mental illness do not have the same rights when their liberty is at stake.

Using Tribunal appointed lawyers has had a number of consequences. For example, TEMHS is placed in the position where it cannot comply with sections 41(1)(c) and 43(1)(c) of the Act because no legal representative is appointed until the afternoon before the Tribunal hearing.

When NAAJA was responsible for representing Indigenous people appearing before the Tribunal, they would ensure that an interpreter would be used for Indigenous people whose first language is not English. Statistics outlined in the Annual Reports of the Mental Review Tribunal indicate that the use of interpreters diminished significantly after NAAJA had withdrawn its services.

Year	2006	2007	2008	2009	2010	2011
% Hearings using Interpreter	10%	6%	17.5%	25%	21%	5%

Aboriginal people with mental illness are doubly disadvantaged. The level of disadvantage is even greater for Aboriginal people with mental illness from remote regions and greater still for those for whom English is not their first language. This is why the CVP believes that organisations like NAAJA should be involved representing Aboriginal people admitted involuntarily to hospital.

Rights of Voluntary Clients

Section 10 of the Act, "Principles relating to involuntary admission and treatment", provides that every effort should be made to admit a person to an approved treatment facility on a voluntary basis if at all possible. Sections 14 and 15 set out the grounds for involuntary admission on the grounds of mental illness and mental disturbance. These grounds include a requirement that in order to be admitted involuntarily, a person must either lack capacity to give informed consent to treatment, or must "unreasonably refuse to consent to treatment".

Three elements of informed consent are set out in Section 7 of the Act. Firstly, a person must give consent voluntarily, without any form of inducement. This means that the person should be able to refuse consent as well as give consent to treatment. Secondly, the person must have capacity to consent or refuse consent to admission and treatment, and thirdly, consent is only given when the person signs a form which signifies consent.

Yacob was admitted to the TEMHS Inpatient Unit as a voluntary patient. On his last day in hospital, he told the community visitor that he "never really felt voluntary" at any time throughout his admission.

Yacob's statement that he never really "felt voluntary" arose from the sense that he was never free to refuse consent to treatment, or that he was an equal in the development of his treatment plan. Even though Yacob was free to come and go towards the end of his admission, he could never leave without permission and it was the way permission was granted that was sometimes a problem. Once, the community visitor was with Yacob when he wanted to go outside for a walk. When he asked his nurse, Yacob was told that he could go, but only if he promised to be back in 10 minutes. The nurse was joking, however it was disempowering because Yacob knew that that the nurse could easily refuse permission for him to go out.

There were two other factors that contributed to Yacob's experience. Firstly, before he could have any leave from the unit, the service would ring his daughter and ask for her permission. This placed Yacob in the role of child rather than parent. Secondly, while staff were very caring in the way they treated Yacob, they often offered to handle situations for him rather than checking with him whether he had the confidence to do so himself.

The imperative in s10 to admit the client voluntarily whenever possible balances the individual's right to freedom with societal obligation to protect the individual and community from harm (including harms like loss of reputation, or further deterioration in physical and mental health). In the past, this has led to the situation where some people admitted to the mental health units as voluntary clients were sectioned if they tried to leave.

The CVP has consistently argued that the client who is assessed as at risk of harm meets the criteria for involuntary admission and so should be admitted involuntarily. The CVP has argued that this is in fact less restrictive than admitting a person as a voluntary patient and then not allowing them to leave.

In 2009/10, TEMHS introduced a new system whereby the rights of voluntary clients and involuntary clients were even further blurred. People admitted to the inpatient unit as "voluntary clients" have to agree not to leave the ward for 48 hours following their admission. After several complaints about this issue in 2010/11, the CVP recommended that 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.

A comprehensive response was received from the Acting Director NT Mental Health Service. The CVP was informed that in the first 48 hours following admission, there appears to be no difference in inpatient management between voluntary and involuntary clients, except that voluntary clients are seen to have given "informed consent" to admission and to remain in the ward for 48 hours. If the voluntary client changes his or her mind about admission and treatment during the first 48 hours, the client must be assessed to determine whether s/he has capacity to make that decision. Differences are more apparent after that time.

The CVP questions the "voluntary" nature of this informed consent given that the person will not be admitted if he/she does not agree to remain in the Unit for 48 hours. Nevertheless, the comprehensive response to this recommendation is appreciated. The recommendation was closed because the CVP believes that the differences between CVP and NTMHS on this issue will remain a matter of ongoing discussion.

Transport to Hospital by Police

Section 10(b) of the Act provides that *where the person needs to be taken to an approved treatment facility or into custody for assessment, the assistance of a member of the Police Force is to be sought only as a last resort and there is no other means of taking the person to the approved treatment facility or into custody.*

Abbie told the CVP that she phoned the Crisis Assessment and Treatment Team (CATT) because she was feeling anxious and had thoughts of suicide. At about 2 AM she was woken by police who told her she needed to go to hospital. At first, Abbie was told they would wait for an ambulance. Abbie lives in the rural area, and she was later told that police would take her to the Stuart Highway where they would wait for an ambulance. Abbie suffers claustrophobia, and was both horrified and terrified when she was placed in the cage of the police vehicle. After being assessed in hospital, Abbie was allowed to go home.

The Team Manager CATT told the CVP that they did not necessarily intend for Abbie to be taken to hospital, rather that NT Police should check on her because they had some concerns. The CVP was also informed that NT Police believed that they had been asked to bring Abbie into hospital for assessment. It appears that there was some confusion in the communication between CATT and NT Police.

It is pleasing to be able to report that Regional Advisory Committees are being set up as a requirement of the Protocol between NT Mental Health Services and NT Police and that TEMHS has invited the CVP to be a member of the Top End Regional Advisory Committee. These committees have many functions, including ensuring a strong working relationship at a local level between mental health services and police. Cases such as Abbie's can be brought before these committees for discussion and learning about whether the situation could have been avoided.

Abbie gave her permission for her case to be brought before the Regional Advisory Committee. The real issue though for her is that she was depressed, possibly suicidal and certainly frightened of enclosed spaces and she suffered the indignity of being put into the cage of a police vehicle. If Abbie had suffered a heart attack, an ambulance would have come to her home. The question is why she should expect less because her medical issue is a mental illness

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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 2012 and again in July 2012. There were 12 seclusion episodes in 2011/12, three less than in 2010/11. It is noteworthy that each of the seven episodes of seclusion in the first part of the year related to the same consumer.

The renovation of the Mental Health Unit throughout 2011/12 has meant that no seclusion room has been available. When necessary, the service adapted the consumer's bedroom to act as a seclusion room by locking the bathroom and removing of the door handle from the inside of the door. As the numbers of seclusion events have decreased in the review period, despite increased stress due renovations, it might be worth considering if other de-escalation strategies have been used more extensively in order to prevent escalation of events.

Section 62(8)(b) of the Act and its Approved Procedures provide that a person who is in seclusion must be examined by a medical practitioner at least once every four hours. The community visitor noted that some documentation on the register and files was not complete. It was not seen as a major issue, because it was an issue of documentation rather than practice.

TEMHS Inpatient Unit`

Seclusion Registers in the TEMHS Inpatient Unit were inspected in December 2011 and May 2012. 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 1 June 2011 and the 30 November 2011.

In this Annual Report the CVP is reporting on review of seclusion episodes from 1June 2011 until 31 May 2012. A total 243 episodes of seclusion were reviewed in this period. This compares with 185 episodes for the same period the previous year, representing a 24% increase in the incidence of seclusion for the year overall. The community visitor noted that the majority of seclusion episodes occurred in the first six months.

Period of Seclusion

The period of seclusion is the time that the consumer spends in seclusion before being released. It appears that there may be a downward trend in the time people remain secluded, with consumers secluded for shorter periods of time. In 2011/12, it appears that people are secluded for less time than they were in 2010/11. The CVP has been informed by management that there has been a policy within Mental Health Services to reduce the length of time that clients are kept in seclusion. 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. One episode lasting four hours was not authorised as required by the Act and Approved Procedures.

Issues Identified During Reviews of the Seclusion Register for TEMHS

Cultural Safety

The form used to document the seclusion episode 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 and the preparation of engaging an AMHW from admission.

This consumer was secluded 19 times in one month. He is an Aboriginal man from a remote area, and the community visitor noted that there was no evidence of AMHW involvement during pre incident interventions or post incident debriefings. A casenote entry stated that the consumer was “believed to have poor understanding of English”.

One person admitted to the inpatient unit was a refugee who could speak very little English. He needed an interpreter, and in fact problems with language were identified on one of the seclusion forms.

One client was secluded for 13 seclusions over 9 days totalling 65.5 hours. The community visitor could find no documented evidence that a interpreter was used.

Given the extensive local amount of research and knowledge about culturally secure mental health treatment, the community visitor reported her concerns that it appears that culturally appropriate strategies are not used to de-escalate tense situations for Indigenous clients and clients of linguistically and culturally diverse backgrounds.

It is critical that this issue is addressed. It is pivotal that Mental Health staff try to access and use interpreters and that interpreters are available to work with staff to de-escalate situations which might lead to seclusion.

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 2011/12, the community visitor found nine instances of medical reviews being conducted out of time.

Removal of Clothes

The CVP is pleased to be able to report that in 2011/12 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.

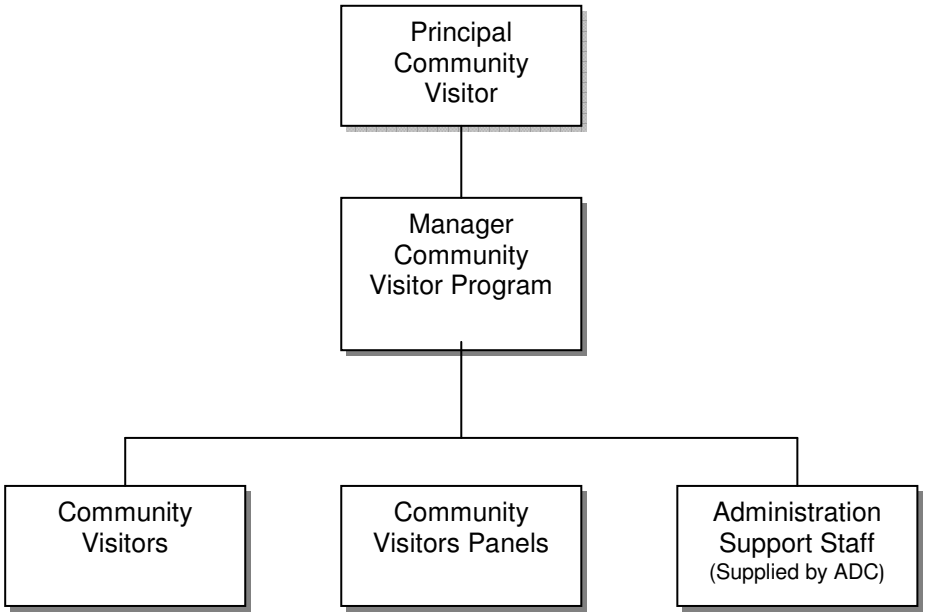
The CVP has informally recommended that decisions to remove a person's clothes when secluded should be documented in the person's record, along with the reason that the decision is made. Doing so underlines the importance of preserving the dignity of people receiving mental health services.

In 2012/13 community visitors will, when checking the seclusion register, check medical records to ensure that this documentation is taking place.

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 2011 - 2012

Eddie Cubillo

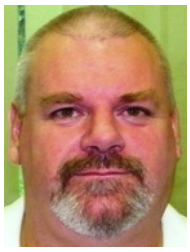
Community Visitors and Panel Members 2011 - 2012

Judy Clisby
Manager CVP

Hiltrud Kivelitz

Karyn Jessop

Traci Keys



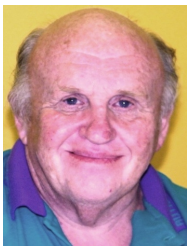
Phil Dempster

Pamela Trotman

Carly Ingles

Teja Lipold

Georgia McMaster



Garry Halliday

Alison Hanley

Sarah Giles (Chair)

Mark O'Reilly

Shanna Satya

Kate Lloyd

Maya Cifali (Chair)

PART 4: PERFORMANCE OF THE CVP 2011 – 2012

Performance for the CVP is measured against its legislative requirements and is reported in the Department of Justice Annual Report. These performance criteria will be amended in 2012/13 due to the expanded role of the CVP related to amendments to the *Mental Health and Related Services Act* and the *Disability Services Act*.

This section of the Annual Report describes the activities of the CVP, reporting on the number, categories and outcomes of complaints and enquiries received by the CVP during 2011/12. Where relevant, comparison is made across financial years.

Visits and Inspections

Table 1: Comparison of the Achievements of the CVP 2009/2010 – 2011/2012

		Alice Springs			Darwin		
	Legislative Requirements	**2009/ 2010**	**2010/ 2011**	**2011/ 2012**	**2009/ 2010**	**2010/ 2011**	**2011/ 2012**
Visits[1]	In response to requests/ inspection	44	43	41	88	93	109
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%	97%	92[2]%	100%	99%	95%

Note 1: Visits include visits to inspect the approved treatment agencies.
Note 2: One person in Alice Springs was not contacted within one working day of request. The impact is inflated by the small number of requests from Alice Springs

Community visitors visit the TEMHS Inpatient Facility once each week. From 1 January 2012 the Mental Health Unit, which was previously visited fortnightly, is now also visited weekly. Most people who are admitted to an inpatient facility in the Northern Territory will always therefore have the opportunity to see a community visitor.

The number of visits also includes community visitor inspections of the approved treatment agencies. No visits were made to teams in Nhulunbuy, Katherine or Tennant Creek in 2011/12. This will be addressed in 2012/13.

Figure 2: No. of Visits to Approved Treatment Facilities and Agencies 2003 - 2012

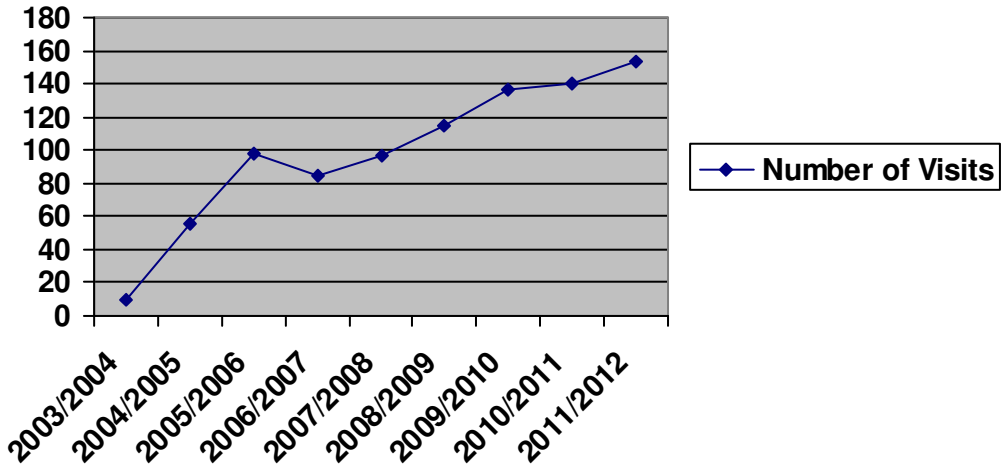


Figure 1 provides a pictorial representation of the growth in the number of visits conducted to approved treatment facilities and agencies from 2003 – 2012. The graph indicates a steep rise between 2003/04 and 2005/06 when weekly visits to the TEMHS Inpatient Unit and fortnightly visits to the Mental Health Unit were introduced. Despite the introduction of weekly visits to the Mental Health Unit in January 2012, there were fewer visits to this unit than was the case in 2010/11.

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 2005/06 reflects an increased number of requests from people receiving treatment Despite there being fewer requests for visits from people in the Mental Health Unit than had been the case the previous year, the overall growth in requests indicates that the CVP is becoming better known to people who are admitted to the inpatient facilities.

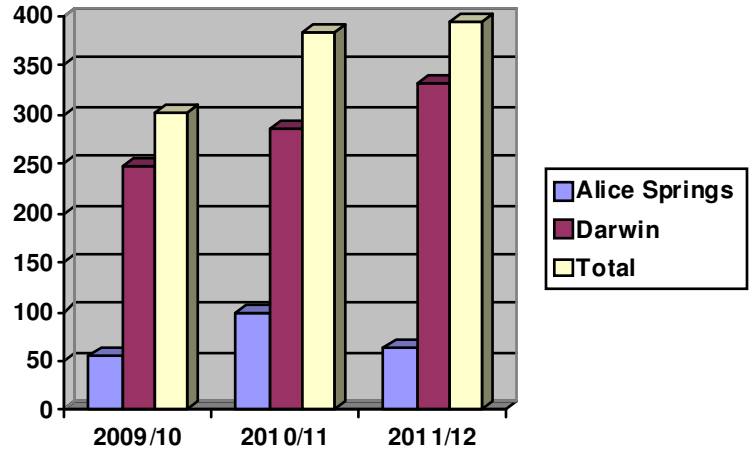
Complaints and Enquiries

Table 2: Complaints and Enquiries Received

	Alice Springs			Darwin		
	2009/10	2010/11	2011/12	2009/10	2010/11	2011/12
Complaints & Enquiries Received	56	98	62	247	285	333

Table 2 shows a 37% decrease in complaints and enquiries managed by the community visitor in Alice Springs, while the number of visits to the Mental Health Unit remained approximately the same. It is likely that the spike in 2010/11 did not indicate a trending increase in complaints and enquiries received and that the results in 2011/12 are more indicative of what can be expected from Alice Springs. The slight increase in Darwin can be attributed to increased client and staff awareness of the CVP.

Figure 3: Complaints and Enquiries Alice Springs & Darwin 2009 - 2012



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, however whether a contact is defined as a complaint or enquiry does not reflect the time taken to resolution. Some of the CVP's more complex and time consuming matters are treated as enquiries.

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, is really unhappy with their situation (for example involuntary admission and treatment) and/or specifically describes their contact as a complaint.

Table 3: Complaints vs Enquiries Received 2009 - 2012

	Alice Springs			Darwin		
	Complaints	**Enquiries**	**Total**	**Complaints**	**Enquiries**	**Total**
2009/10	25	31	**56**	70	177	**247**
2010/11	45	53	**98**	112	173	**285**
2011/12	18	44	**62**	84	249	**333**

Figure 4: Complaints vs Enquiries Alice Springs & Darwin 2009 - 2012

The graph below shows a sharp increase in the number of enquiries managed by community visitors in the Top End, while in Central Australian there are proportionally more enquiries in 2011/12, even though the overall number has decreased. Examining the categories of complaints and enquiries detailed in Table 4 demonstrates that in 2011/12, 52% of all complaints and enquiries involved community visitor action such as advocacy, providing information or visiting/support (for example joining a person during an appointment with mental health staff). It is likely therefore that the increase in enquiries is related to increased awareness of the CVP and an increasing use of community visitors to provide information, support and advocacy to people receiving inpatient mental health treatment.

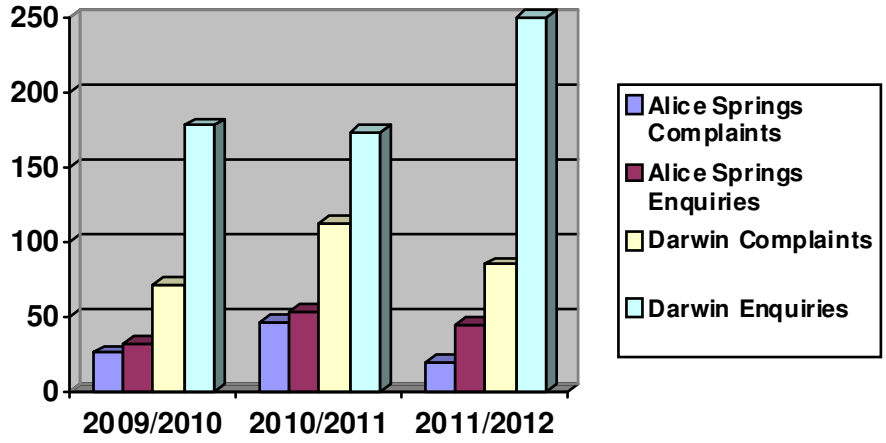
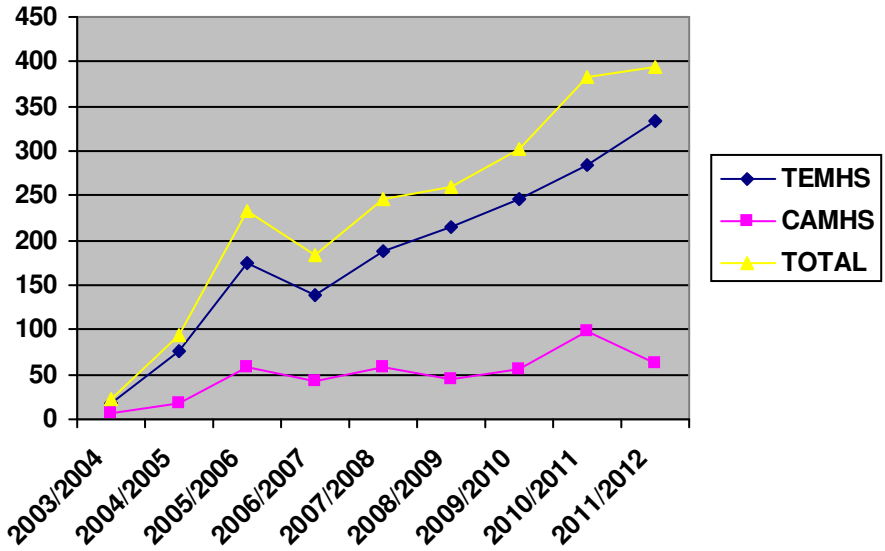


Figure 5: Number of Complaints and Enquiries 2003 – 2012

Figure 5 demonstrates increasing trends in the total complaints and enquiries managed each year by the CVP. In 2011/12, the CVP received a total 385 complaints and enquiries and the upward trend in the number of complaints and enquiries managed has slowed considerably.



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 (i.e. access to files, activities etc.) have been generated from the types of complaints and enquiries handled by the CVP.

Table 4: Categories of Complaints and Enquiries 2011 - 2012

Category of Complaint/Enquiry		CAMHS	TEMHS	Total
Advocacy		17	114	**131**
Information	Access to Files		7	**7**
	Inaccurate information on file		3	**3**
	Provided to Consumer/Carers/ Service Providers by CVP	4	42	**46**
Medication		2	10	**12**
Miscellaneous		3	10	**13**
Quality of Service Provision	Activities	2	1	**3**
	Assessment & Treatment	14	39	**53**
	Consultation Consumer/Carers	2	8	**10**
	Discharge Planning		8	**8**
	Facilities	1	2	**3**
	Management Plan		2	**2**
	Procedures	2	8	**10**
	Relationship with Staff		3	**3**
Rights	Accommodation	1	1	**2**
	Detention	4	13	**17**
	Least Restrictive Alternative		13	**13**
	Legal	2	10	**12**
	Miscellaneous	1	1	**2**
	Respect for Dignity	1	2	**3**
	Safety		1	**1**
	Transport by Police	1	2	**3**
Smoking		4	4	**8**
Visit	Request/Support	1	29	**30**
TOTAL		**62**	**333**	**395**

Other Complaints and Enquiries

In addition to complaints and enquiries about mental health services in the NT, the CVP received a total seven (7) complaints and 39 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. Some have involved referrals from mental health staff. The most common enquiry is a request for information from the CVP.

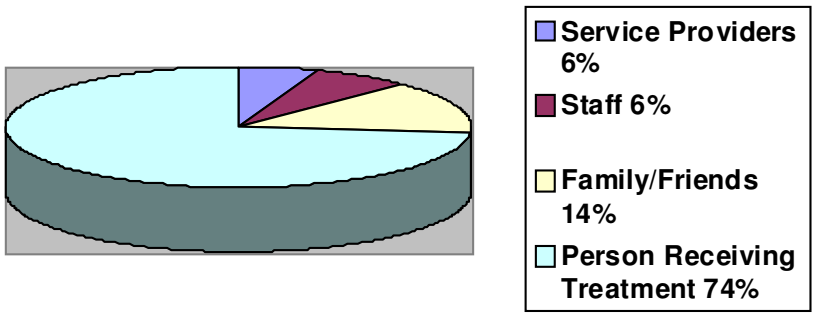
The CVP has no role in investigating complaints against organisations external to mental health services, but may assist a consumer by providing relevant information, referral and advocacy. The community visitor in Darwin has also assisted in an advocacy role with consumers lodging a complaint with the 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 6 below includes the 46 complaints and enquiries received about facilities other than CAMHS and TEMHS. The total number of complaints and enquiries managed by the CVP 2011/12 is 441.

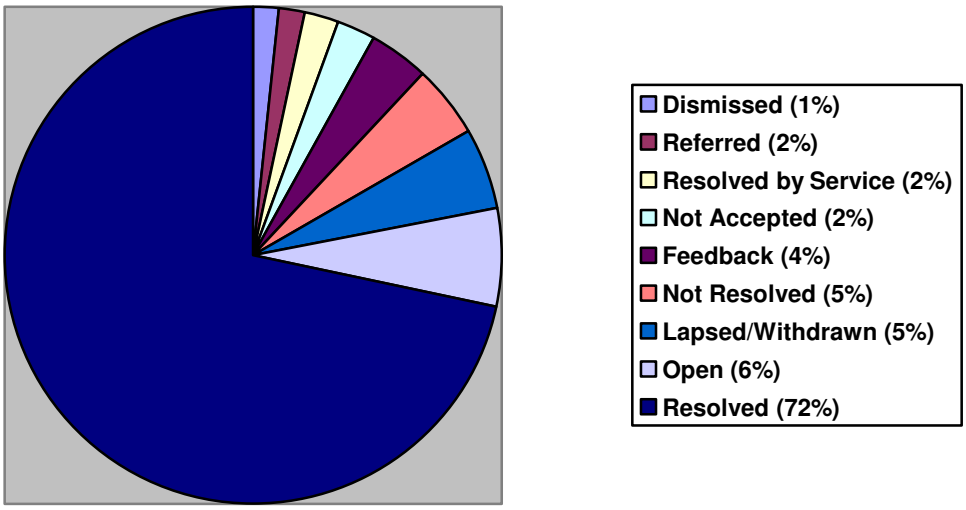
Figure 6: Source of Complaints and Enquiries NT 2011 - 2012



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 may be recorded as feedback to the service or it may be referred through the Principal Community Visitor to the Community Visitors Panel. 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 7: Outcomes of Complaints and Enquiries NT 2011 - 2012



Complaints and Enquiries Closed 2011 – 2012

Community visitors working with the CVP closed 514 complaints and enquiries in 2011/12 compared with 347 in 2010/11. This was possible because a full time community visitor was employed in the Top End and now works out of the CVP office in the Anti-Discrimination Commission.

PART 4

OTHER CVP ACTIVITIES 2011 - 2012

As can be seen from this report, the number of complaints and enquiries managed by the CVP rose again this year, but only slightly. It is likely that the workload will 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 Manager CVP meets with the General Manager TEMHS monthly whenever possible, and with the General Manager CAMHS during every trip to Alice Springs. The Manager CVP and community visitors are also able to contact all team managers and staff and their willingness to work with the CVP is both acknowledged and appreciated.

Involvement with Age and Disability Services

The CVP has undertaken substantial preparation towards the implementation of the new jurisdiction for people in Secure Facilities due to commence in 2012/13, this includes close liaison with senior staff in Age and Disabilities Services and contribution to the development of legislation and policies and procedures.

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 2012/2013.
- Children's Commissioner

Submissions

In 2011/2012, the CVP has prepared a submission on the consultation for secure care facilities in August 2011. 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:

Membership

- The CVP is a member of the Mental Health Coalition
- ISLR Reference Group

Networks & Meetings

- Mental Health Professional Network meetings (DoHA funded)
- Top End Mental Health service provider network meetings
- Attendance at forum of Mental Health in Multicultural Australia
- Chronic Disease Network
- Mental Health Carers Association
- Pete's Place
- Manse and Day2Day Living of TEAMhealth
- The Principal Community Visitor met with NTLAC and NAAJA
- National Mental Health Consumers Experience of Care Project
- NTCAG, Consumer & Carer Consultation Meeting

Conference Presentations

- At a national conference of Community / Official Visitor Programs, the Manager CVP gave three brief presentations on Smoking Policy, Least Restrictive Environment and Care and Codes of Conduct and Ethics for staff.

- The Manager CVP and the Director Policy, Conciliation and Law ADC gave a joint workshop titled: Mental Ill Health and Discrimination: It's just like having Diabetes at the "Out of the Shadows: Into the Spotlight". Chronic Disease and Mental Health. Chronic Disease Network Annual Conference

- The Manager CVP presented to a National Meeting of Disability Commissioners on the Learnings of the CVP monitoring closed environments.

Other Presentations

- Service presentation at Catholic Care.
- Presentation on *Mental Health and Related Services Act* at mental health services network meeting.
- The CVP Manager gave a single talk on working in government organisations.

PART 4

PRIORITIES 2012 - 2013

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 2012/13 the CVP will expand its role to provide enquiry, complaints resolution, advocacy and visiting functions for people with a cognitive disability and challenging behaviours. It will visit the Secure Care Facilities and approved places at least monthly.

Focus of Community Visitors and Community Visitors Panels:

- The audit of legal forms of consumers admitted involuntarily will continue in 2012/13 to ensure compliance with the Act. Community visitors will continue to pay particular attention to the management/leave status of consumers admitted voluntarily to TEMHS & CAMHS Inpatient Unit.

- 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 2012/13. While this has increased access to the CVP, the workload needs to be monitored closely in 2012/13.

- The CVP will monitor and progress the recommendations of previous panel and annual reports.

- The CVP will review the use of interpreters in all aspects of care for people who don't speak English as their first language.

- Community visitors and panels will monitor the impact of the non-smoking policy on the experience of inpatient.

- Community visitors will advocate for improvements of consumer and carer participation in treatment and decision making, monitor the application of the principles of least restrictive treatment options and cultural safety for individuals and with a view towards systemic improvements.

- The CVP will review the information provided to consumers and carers about their rights and treatment, including ECT.

- Monitor access for consumers to Mental Health Review Tribunal applications, medical files and evidence used during hearings.

Improving internal CVP processes:

- Finalise policies and procedures for CVP functions under the *Disability Services Act.*

- Strategic and business planning – finalise the strategic plan for 2012-2015 and develop annual plans.

- System development – recruit, retain and support appropriate staff for the core functions of the program in Alice Springs and Darwin and ensure use and continuous update of CVP Handbook and effective communication in expanded team of the CVP.

Training for community visitors and panel members:

The following opportunities for professional development will improve the capacity of the CVP:

- Community visitors and panel members to attend training provided by Aged and Disability Program on issues related to CVP role for people with complex cognitive impairment.

- 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.

- Attendance of community visitors at the annual conference of Official Visitors.

- Encourage staff to utilise supervision as a means of ongoing reflective practice and professional development.

APPENDIX 1

NEW RECOMMENDATIONS 2011 - 2012

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

April 2012 Community Visitors Panel Visit

1. *It is recommended that the Unit investigate whether uploading patient information to My Electronic Health Record (MEHR) may be of some benefit to patients and to report to the Panel on this issue at the next visit.*

2. *It is recommended that the Unit arrange a meeting with the Aboriginal Interpreter Service to explore ways in which to facilitate greater access to interpreters for all patients and to consider how best to provide training in Mental Health Interpreters to the AIS.*

November 2011 Community Visitors Panel Visit

It is recommended that the MHU make enquiries as to whether there is potential for the Unit to be exempt from the non-smoking policy and to consider as a Unit whether this may be beneficial.

Community Visitors Third Quarterly Report

It is recommended that procedures are put in place to ensure that CAMHS meets its legal obligation to notify the principal community visitor pursuant to sections 41 and 43 of the Mental Health and Related Services Act.

CAMHS Community Visitor Inspection Child and Youth Team

It is recommended that there be close monitoring of the new referral process between the On-Call and Child and Youth Teams.

Community Visitor Inspection Remote Team

It is recommended that the Remote Team consider having Feedback Forms translated into Aboriginal language for the commonly spoken Remote Team languages (about 7 – 8 in total).

DARWIN

TEMHS Inpatient Unit

November 2011 Community Visitors Panel Visit

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.

TEMHS Community Teams

May 2012 Community Visitor Inspection Tamarind Centre

It is recommended that TEMHS seriously considers implementing an early psychosis service based on the Australian Clinical Guidelines developed by Orygen Youth Health (2010).

APPENDIX 2

RECOMMENDATIONS CLOSED 2011 - 2012

ALICE SPRINGS

Mental Health Unit

September/November 2011 Community Visitors Panel Visit

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

In the report of its visit to the Mental Health Unit in September and November 2011, the panel reported that the position of Diversion Therapist in the Unit is now permanent. Consequently the recommendation was closed.

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

In the same report, the panel stated that it was satisfied that there is a commitment to securing a permanent social worker position on the Unit in the longer term. The recommendation was therefore closed.

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.*

The Community Visitors Panel was pleased to close this longstanding recommendation after their first visit to the TEMHS Inpatient Unit in November 2011. The panel commented that the new area contributes to the appearance of open space in Cowdy Ward.

2. *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.*

The Darwin Community Visitors Panel was prepared to close this recommendation only after sighting the protocol between NT Police and NT Mental Health Service. The Protocol provides for professional development and mandatory training for police and mental health workers. Accordingly, the recommendation has been closed.

May 2007 Community Visitors Panel Visit

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.

The Protocol between NT Police and NT Mental Health Services stipulates that police are involved in the transport of patients to hospital only as a last resort. Further, when police are involved, the protocol provides that the least restrictive intervention must apply. This means that when police are involved as a last resort, and as long as it is safe to do so, police may go in a car driven by a mental health worker, drive behind an ambulance or sit in the ambulance with the client.

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.*

The President of the Mental Health Review Tribunal was notified of the Principal Community Visitor's concerns in a meeting on 6 July 2011 and in writing the same day. Accordingly, this recommendation is closed.

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.*

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 panel closed the recommendation in the report of their visit of November 2011.

2010 – 2011 Second Quarterly Report

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.

A comprehensive response to this recommendation was received from Ms Fran Pagdin, Acting Director NT Mental Health Service. The response provides information about the reasons for current inpatient management in the TEMHS Inpatient Unit, and then explains the difference between voluntary and involuntary admission. In the first 48 hours, there appears to be no difference in inpatient management between voluntary and involuntary clients, except that voluntary clients are seen to have given "informed consent" to admission and to remain in the ward for 48 hours. Differences are more apparent after that time.

As explained earlier in this report the CVP does not agree that clients are in fact voluntary when they are not free to leave or to change their minds about admission and treatment. Nonetheless, the comprehensive response to this recommendation is appreciated.

The CVP is of the view that any remaining differences between CVP and NTMHS on this issue are unlikely to be resolved via the quarterly reporting process. The recommendation was therefore closed.

2010 – 2011 Fourth Quarterly Report

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.

This recommendation was circulated to Approved Psychiatric Practitioners throughout TEMHS in 2011/12. At this time it does not appear to have contributed to a change in practice. It is closed because it repeats a recommendation made by the Darwin Community Visitors Panel after their visit to the TEMHS Inpatient Unit in November 2011.

APPENDIX 3

OPEN RECOMMENDATIONS AS AT 30 JUNE 2012

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

April 2012 Community Visitors Panel Visit – New Recommendations

It is recommended that the Unit investigate whether uploading patient information to My Electronic Health Record (MEHR) may be of some benefit to patients and to report to the Panel on this issue at the next visit.

It is recommended that the Unit arrange a meeting with the Aboriginal Interpreter Service to explore ways in which to facilitate greater access to interpreters for all patients and to consider how best to provide training in Mental Health Interpreters to the AIS.

November 2011 Community Visitors Panel Visit

It is recommended that the MHU make enquiries as to whether there is potential for the Unit to be exempt from the non-smoking policy and to consider as a Unit whether this may be beneficial.

Progress

The purpose of this recommendation was to instigate some discussion within CAMHS and between CAMHS and the CVP. No response was received until after the reporting period.

The CVP is aware security guards escorted involuntary clients to the smoking area throughout 2011/12 while the ward was being renovated. The CVP is also aware that voluntary clients have absconded when going out for a cigarette and that denial of “smoke leave” has been used as a “behavioural

management tool". The CVP hopes there can be dialogue with CAMHS with a view to moving forward on these issues.

Community Visitors Third Quarterly Report

It is recommended that procedures are put in place to ensure that CAMHS meets its legal obligation to notify the principal community visitor pursuant to sections 41 and 43 of the Mental Health and Related Services Act.

Progress

After this recommendation was received, CAMHS immediately put procedures in place to ensure that the CVP is notified as required. This recommendation was made in the third quarterly report, and improvements in notification could not be measured meaningfully before the end of the financial year. Notifications have increased, but unfortunately not in accordance with sections 41 and 43 of the Act. Consequently, the Principal Community Visitor has referred this matter to the panel for follow up in their next visit.

CAMHS Community Teams

June 2007 Community Visitor Inspection

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

This recommendation has been outstanding since 2007. Failure to adequately address this issue led to a Special Community Visitors Panel being convened for the first time. The outcomes of this visit are referred in the Principal Community Visitor introduction and detailed in Appendix 4. A follow-up panel visit later in 2012 will report against if progress has been made from the new changes.

Community Visitor Inspection Child & Youth Team – New Recommendation

It is recommended that there be close monitoring of the new referral process between the On-Call and Child and Youth Teams.

Community Visitor Inspection Remote Team – New Recommendation

It is recommended that the Remote Team consider having Feedback Forms translated into Aboriginal language for the commonly spoken Remote Team languages (about 7 – 8 in total).

DARWIN

TEMHS Inpatient Unit

October 2004 Community Visitors Panel Visit

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

Progress

The Manager TEMHS responded to this recommendation twice in the reporting period. She states that there has been a review of current discharge planning processes and that discharge summaries are forwarded to GPs when clients indicate that they do have a GP. She also stated that the ward clerk has been trained in the use of the Primary Care Information Service (PCIS) (the health recording system used in remote areas). The panel's review of case notes during their visits to the TEMHS Inpatient Unit indicated that the name of the GP is documented at times but not at a level which allows for this recommendation to be closed. This will be a focus in 2012/13.

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 CVP has been informed that at present it is not possible to employ Aboriginal Mental Health Workers out of hours. Four Aboriginal Mental Health Workers are employed in the TEMHS Inpatient Unit, and there is a commitment to ensuring that any Aboriginal person admitted out of hours is seen by an Aboriginal Mental Health Worker as soon as possible.

In 2011/12 the Principal Community Visitor reported the failure to adequately address this recommendation to the CE of Health. The CVP has been assured that "talking posters" will be in place by December 2012. The Darwin community visitors panel will close this recommendation when they see the posters.

November 2006 Community Visitors Panel Visit

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 Manager TEMHS reported that:

- TEAMHealth accommodate up to 9 clients in Papaya, a short term accommodation option for people who are unwell to prevent hospital admission or to enable early discharge from hospital;
- Some accommodation is provided on the RDH campus for young people with complex problems;
- A three bedroom has been established in Virginia for Forensic clients needing long term help to live outside the prison environment; and
- Secure care facilities being commissioned for people with cognitive impairment and behavioural disturbance.

The discussion in the "Significant Issues" section of this Annual Report demonstrates that secure accommodation is fundamental to a person being able to recover from illness and live a "contributing life". It also demonstrates that a significant number of people with psychiatric disability and complex needs do not have appropriate housing in the Top End of the Territory. This may just mean access to accommodation in a supportive community, or it may mean accommodation with varying levels of support. The recommendation is about undertaking a needs assessment in the Top End, similar to that undertaken in Alice Springs. To date, no such action has been taken.

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

Major works have now been completed, and a garden planted outside JRU. At the time of the panel's most recent visit, the outside area was still not being used. It is anticipated that this recommendation will be closed in 2012/13.

May 2007 Community Visitors Panel Visit

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

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

In 2011/12, the Principal Community Visitor wrote to the CE of the Department of Health expressing concern about the lack of progress on this recommendation. The Department agreed that routine use of interpreters is

important, and failure to do so will be addressed as a priority. The following commitments have been made:

- The Mental Health Program will make the collection and recording of the consumer's first language mandatory and will develop systems to report on whether this is being done;
- When an Aboriginal person is being transferred to hospital from a regional or remote location, information regarding the person's first language and interpreter requirements will be included in the referral;
- Part C of Form 10, which indicates the need for an interpreter will be routinely completed by medical staff for all admissions;
- A single point of contact will be established to co-ordinate and record details of requests for interpreters; and
- TEMHS' use of interpreters will be routinely monitored.

The CVP looks forward to the receiving reports from TEMHS as above, with these reports demonstrating a commitment to use of interpreters whenever needed.

November 2007 Community Visitors Panel Visit

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 2011/12 the panel referred this recommendation to the Principal Community Visitor with the request that failure to implement it be referred to the Chief Executive of the Department of Health. This was not actioned, with the focus remaining on the need for cultural safety for Aboriginal people admitted to the TEMHS Inpatient Unit.

The Manager of TEMHS reported that as far as possible, young people admitted to the TEMHS Inpatient Unit will be admitted to the new Contained Assessment Unit. This will open in September 2012. She states that the new Unit contains two Sensory Modulation Rooms (rooms specially equipped to help the person feeling anxious and angry to manage these emotions). Preparations have also included employing a qualified youth worker and training staff in how to work with young people. Management processes and protocols for young people admitted to the unit are also being developed.

May 2008 Community Visitors Panel Visit

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. TEMHS Management state that they are being encouraged to document their interactions with clients. As this becomes more frequent, the panel will have the evidence needed to close this recommendation.

November 2011 Community Visitors Panel Visit – New Recommendation

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 recommendation replaces a former community visitor recommendation. The Department of Health has committed to ensuring that Part C of the Form 10 is completed. This section of the form documents whether an interpreter is used when the person is being assessed for admission, and whether an interpreter will be needed for the Tribunal hearing. As at June 30th 2012, only one doctor was consistently completing this section of the Form.

Quarterly Reports

2005 - 2006 Third Quarterly Report

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 last quarter in 2011/12 is an estimated 63%. The recommendation will remain open until the notification rate is 100%.

2010 – 2011 Second Quarterly Report

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

In January 2012, the Acting Director NTMHS stated that a brochure for voluntary clients was being prepared. In August 2012, the Manager TEMHS stated that fact sheets about voluntary and involuntary admission are now available for clients, however the suggestion that this be coupled with leave arrangements is a "positive suggestion" that will be auctioned.

The CVP has been informed that the current inpatient management plan is under review and that the process will be complete by October 2012.

TEMHS Community Teams

May 2012 Community Visitor Inspection Tamarind Centre – New Recommendation

It is recommended that TEMHS seriously considers implementing an early psychosis service based on the Australian Clinical Guidelines developed by Orygen Youth Health (2010).

APPENDIX 4

ALICE SPRINGS

COMMUNITY VISITORS PANEL

REPORT TO PRINCIPAL COMMUNITY VISITOR

Special Visit to
Central Australian Mental Health Service Community Team

March 2012

1. Introduction

The Community Visitor Panel (CVP) conducted a special visit to the community team of the Central Australian Mental Health Services (CAMHS) on 29 and 30 March 2012. The visit was undertaken at the request of the Principal Community Visitor.

The CVP members conducting the visit were:

Maya Cifali - Community Member and Chair
Dr Sarah Giles - Medical Member
Mark O'Reilly - Legal Member

The visit was undertaken in the knowledge that, following a critical incident in November of 2011, an external review has been conducted and recommendations have been made. The CVP were also aware of an internal audit of documentation. The CVP understands that following the critical incident there was significant staff turn-over and poor morale within the team. The purpose of the CVP visit in broad terms was to gauge the response of the service to the critical incident and the review**.** More specifically the CVP was tasked with undertaking an audit of documentation and other systems that help ensure client safety in the community.

This visit occurred over two separate days and consisted in meetings with clinical staff and management as well as an audit of notes on CCIS. For the purpose of the audit the CVP was provided with a list of all CAMHS clients referenced by case manager**.** A random sample of clients was selected and the CVP was given access to CCIS and Alice Springs Hospital notes.

2. Description of the Community Team

The Community Team is housed in easily accessible residential type premises close to the Alice Springs Hospital and other health services. Recently the Community Team has moved to the front building of the premises to facilitate easier client access to a shop front service. The Remote Team has moved to the building at the back of the property.

The Community Team, under CAMHS General Manager and Clinical Director; consists of a Team Manager, 6 Case-Managers (1 of whom is a depot medication RN), 4 Crisis Assessment and Treatment Tam (CATT) nurses, a psychiatric consultant and support staff.

Generally clients access the service through the Emergency Department (ED) at the hospital where they will be assessed by CATT and referred appropriately either to the Mental Health Unit at the hospital (MHU) or followed up by the Community Team. Clients who present directly to the CAMHS premises will also be assessed by CATT and referred to ED in appropriate cases. Clients who are admitted to the Unit will maintain contact

with the Community Team through the allocation of a case-manager. The case-manager will be involved in planning for discharge at an early time. Case-managers are required to attend ward rounds at the MHU.

3. Findings

The Panel was immediately struck by the fact that CAMHS is in a process of change. Perhaps most significant has been the appointment of a Clinical Director who now works alongside the General Manager. At the time of the visit this position had been in existence for 2 months. The Clinical Director is working with the General Manager to implement the recommendations arising out of the external review. There have been other changes in personnel. The Team Manager is currently on secondment to Aged and Disability Services for a period of 6 months. Up until the time of the visit the manager of the MHU had been acting Team Manager but the position is now filled from within the community team. Another significant innovation is the placement of a consultant psychiatrist within the Community Team.

The CVP was impressed by recent efforts to introduce systems aimed at maintaining good lines of communication between all members of the team. There are a series of regular meetings between team members. There are daily meetings between members of CATT, a daily hand-over between CATT and doctors, a daily meeting of case-managers, a weekly clinical review involving doctors, case-managers, CATT and the team manager and a monthly meeting involving the whole of the community team.

There was certainly an awareness of the need to work in close collaboration with the Mental Health Unit at the Hospital. The CVP were told that there is a strict requirement that every case-manager will attend ward rounds. This is in response to a recognition that this has not recently been a consistent practice. Ward rounds occur twice a week. Case managers have about 15 to 20 clients

Overall there appeared to be a recognition of the need to improve systems within the service and a positive, energetic commitment to the task.

4. Case Note Audit

The CVP was aware of two recent reviews of practice relating to client safety and documentation. One review was external and recommendations have been made to CAMHS. The CVP believes that the other recent internal notes review audited similar issues to the notes audit undertaken, with the notable exception of identification of the client's carer.

A primary reason for the CVP audit of case notes on CCIS was to assess how extensively the CCIS system is being used over hand written notes on the Alice Springs Hospital (ASH) file. Two different note taking systems create risk. Within the paper ASH notes psychiatric entries were in one of two sections of the notes. It is quite apparent from the notes that the practice of

using CCIS has improved dramatically since around November of 2011. Generally there is a more consistent use of this system of record keeping. There appears to more consistent use of CCIS by doctors.

It was also apparent to the CVP that the case notes indicate that there is a sense of case managers and psychiatrists knowing long-standing clients, and giving a high level of care.

Notwithstanding recent improvements the CVP was of the view that there is a general lack of consistency and care in the use of CCIS that is detrimental to the safety of clients. Safety for clients and their carers, depends on systems and documentation that is not reliant on individual relationships and local knowledge.

- CAMHS' clients live in a social context. Carers, relationships and other service providers including MHACA are rarely and inconsistently documented in CCIS. Identification of cultural background and first language is important and there is a place in CCIS for this but it does not appear to be consistently completed. It is not clear how the decision about need for interpreter is arrived at. There is little evidence of psychosocial histories in CCIS. It was also uncommon to find a summary or plan of management or to see documentation of diagnosis, formulation, or risk assessment, except in passing in progress notes.

- It appears that clients are shared with primary health care services including General Practice. This is important for the physical health of this at-risk group and GP or PHC service should be easily identified in CCIS and their role clear to CAHMS. There is little evidence in CCIS of any attention to physical health, or potential physical complications of psychiatric medication. Identification of PHC service was rare in the reviewed notes. There was no evidence of identified co-morbidity, risk factors or formal risk assessment in outpatient or "risk assessment" section of CCIS notes.

- There appears to be no clear documentation of current medication in CCIS or ASH notes. Outpatient medication appears to be prescribed by GP, by script, on CAMHS outpatient drug charts and "as needed' medication on inpatient unit drug charts when the client is not an inpatient. Medication appears to be dispensed by private pharmacies, by mental health nurses and possibly by doctors, from three different sites. On occasions this has been documented with copy of prescription but medication changes are often unclear. There was one client's case notes which referred to "not taking 600mg but 1600" of this client being offered as needed medication in addition to regular medication and of a CCIS note of **"**possible abuse of medication". In CCIS it was not clear whether clients were on depot medication. CAMHS' prescribing and dispensing need to be clear and the fewer systems the better. The use of contracts with private pharmacies, and use of doctor shopping safety net could be considered.

- In order to conduct the audit, the CVP was given lists of clients referenced by case manager. In some of these lists the case manager nominated was a treating doctor. The CVP remains unclear exactly what this means. It may be that these are clients who do not require a case manager or it may reflect actual case management by medical officers. Among these, several cases showed a large number of presentations to other members of the team. This lack of role clarity is risky. Not all clients need case management and the process of decision to case manage and allocating case manager needs to be clear. The view of the CVP is that medical officers do not have the capacity or training to case manage.

- Another perplexing issue was that some clients are referred to as "private patients". There was reluctance on the part of the service for the CVP to see their hospital notes. Private patients do appear to have CCIS notes. Documentation involving letters after each consultation, between psychiatrist and GP was sighted in one such instance. The concern of the CVP is that there is no clear delineation between access to the service for "private patients" and for other clients. CAMHS needs to be clear about the status of such patients.

- It is not clear how Did Not Attend (DNA) outpatient appointments are managed. The physical separation of outpatients and the community team may be an issue. Communication of follow up appointments is not always clear. In the past there is evidence of repeated DNA's and of several months to respond. The service needs to be responsive to client needs, case managers should be involved in assessing client DNAs and where clients are well enough, the contract should be clear.

5. Recommendations

The CVP considers that it is not appropriate to make recommendations at this point in time. The Community Team are currently working towards and making progress on the implementation of recommendations made pursuant to the external review. The CVP encourages the Community Team to continue this process. The CVP requests a report in 6 to 8 months time on the progress of the implementation of the existing recommendations. The CVP is of the view that a further visit should be conducted following receipt of the report.