

COMMUNITY VISITOR PROGRAM



Annual Report
2012-2013

**The Hon Robyn Lambley MLA
Minister for Health
Parliament House
State Square
DARWIN NT 0800**

Dear Minister

In accordance with Part 14, section 115 (1) of the *Mental Health and Related Services Act*, and Part 6, section 66 (1) of the *Disability Services Act*, I submit the Annual Report on the operations of the Community Visitor Program for the period 1 July 2012 to 30 June 2013.

Yours sincerely

SALLY SIEVERS
PRINCIPAL COMMUNITY VISITOR

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Introduction



From the Principal Community Visitor

It gives me great pleasure to introduce the twelfth Annual Report for the Community Visitor Program (CVP) under the *Mental Health and Related Services Act* and the very first under the *Disability Services Act*. The Annual report details for the Minister for Health the activities of the CVP, Community Visitors and Community Visitors Panels in the 2012-2013 financial year. It is also my first report as Principal Community Visitor (PCV).

I took up my appointment as Anti-Discrimination Commissioner in January 2013 and was appointed as Principal Community Visitor on 19 February 2013. It has been a particularly busy year for the CVP as we have prepared for and commenced visits to residential facilities as required under the *Disability Services Act* (DSA).

CVP staff continued to visit and receive complaints and queries from people accessing mental health facilities and co-ordinated Community Visitors Panel visits whilst familiarising themselves with a new client group - those with Complex Cognitive Impairment. Staff also liaised with the Aged & Disability Program, and as required by the DSA, prepared appropriate materials for the expanded program. The CVP consulted with and received education and training from those with expertise in this specialised field to best meet the legislative requirements.

In mid April 2013 the PCV was approached to provide a visitor program under the new Alcohol Mandatory Treatment scheme. After consulting with stakeholders and negotiation with the Department of Health the CVP agreed to provide the program under the new legislation.

The program has also expanded to include employees in Alice Springs, which has meant locating and establishing an office in Alice Springs, first a temporary office in the Court precinct, for which we thank in particular Sarah McNamara, and then a permanent home in the Health Development Unit.

During the five months I have been in the role I have taken the opportunity to meet with stakeholders, sessional Community Visitors and Panel members. Two visits to Alice Springs in April and May 2013 have enabled me to become familiar with both Central Australia and the Top End including visiting both Secure Care Facilities and touring the renovated Alice Springs Mental Health Unit (MHU).

I also had the opportunity to meet and discuss the CVP with the Minister for Health, Ms Robyn Lambley MLA on 1 May 2013. I met with the CEO of the Department of Health, Mr Jeffrey Moffet on 9 February 2013 and subsequently have had numerous contacts with him to discuss concerns raised by the CVP.

The CVP plays a crucial role in protecting the human rights of the most vulnerable groups in our community, and does this through three tiers which will be explained in detail in this report and briefly here. The Community Visitors take calls, queries and complaints, and visit mental health facilities on a weekly basis. They are able to assist people with problems and issues as they arise and resolve them as quickly as possible and with little formality. The Community Visitors Panels perform the very important work of systemic advocacy.

In the coming year we will be focussing on working closely with the Northern Territory Mental Health Services (NTMHS) to work towards closing the numerous outstanding recommendations.

As you will see as you take the time to read the Annual Report it is a very long journey, many crucial recommendations have been outstanding for a substantial period. The challenge next year will be to move these forward, monitoring and setting out milestones on the way to ensure momentum is maintained. Together the Department of Health and CVP need to be clear what is to be achieved and can agree when recommendations have been completed.

A snapshot of the Community Visitor Program's achievements 2012 – 2013

- Expanded CVP responsibilities by initiating a visitor program under the DSA.
- Accepted the responsibility to expand visitor program into Alcohol Mandatory Treatment scheme in 2013-2014.
- Opened a new office in Alice Springs.
- Handled 388 complaints and enquiries resulting in 261 complaints and enquiries resolved in 2012-2013.
- Fulfilled all legislative requirements under the MHRSA and DSA, including closing 228 files in this period (see 'About the CVP' for statistics on the CVP's performance).
- Maintained strong and respectful working relationships with the NTMHS, despite staff changes and the complexities of the mental health space.

A personal achievement for me was in May 2013 when I attended and presented a paper at the Australian Institute of Interpreters and Translators Mini Conference, titled 'Do you hear me? Closing the Gap in Communication'.

In closing, I would like to acknowledge the clients, who are vulnerable by the nature of their illnesses and impairment. It takes courage to complain and to push for a resolution of a matter. Many say they do this so “it doesn’t happen to anyone else”.

I would also like to thank the dedicated CVP team, staff, sessional CVs and Panel members, and ADC staff who support the program. All of whom are passionate about their work and dedicated to the best outcome for clients.

Further I would like to acknowledge the work of staff of NTMHS and Disability Services. They continuously work in a challenging and often unpredictable environment with many competing demands and changing priorities. Their care and professionalism for clients on all levels is to be commended.

The CVP thanks the staff of the services for their cooperation with the CVP to ensure that together the best outcomes for clients can be achieved.

I look forward to the challenges of the coming year across all the programs including working with the Department of Health as it moves into its new structure and the progress towards the implementation of Disability Care in the Northern Territory. There is still so much to do.

SALLY SIEVERS

PRINCIPAL COMMUNITY VISITOR

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Significant Issues in Mental Health

The issues described in this section are seen as priority issues for the CVP. This means that the CV and CV Panels will focus on finalising and progressing these matters in the coming year. All issues described in this section have a significant and often lasting impact on the life of the person receiving treatment, and their families and carers. They relate to basic human rights, upholding the principles of least restrictive treatments and prevention of more severe and chronic impacts of mental illness and system improvements. Some aspects are repeated throughout other sections of this report.

Case examples are used to illustrate specific issues throughout 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 2012 - 2013 are not detailed in this report because to do so would identify the person affected.

Impact of Lack of Housing and Support Options

Sections 104(1)(f) and 111(2)(h) of the MHRSA empower the CVP to inquire into any matter considered 'appropriate having regard to the principles and objectives' of MHRSA.

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 and 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.

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.¹ A holistic approach is needed that considers every aspect of the person's life to ensure that a person with a mental illness experiences stability and can contribute to our community.²

It is the view of the CVP that accommodating people in restrictive environments, such as the mental health ward, may also contribute to a loss of independent living skills, and therefore contradicts section 8 (c) of MHRSA.

People with complex disabilities, such as co-morbidity of mental health disorders and cognitive disabilities are particularly disadvantaged. Because accommodation with the appropriate level of support is limited in the community, both in urban centres and remote

¹ Manu-Preston C.L., *Home & Help...What Works*, 2011, Churchill Fellowship Report, accessible at: <http://www.mhaca.org.au/2012/Churchill%20web%20final%20report.pdf>

² Allan Fels, National Press Club address on mental health and suicide prevention, August 2012, accessible at: <http://theconversation.com/national-press-club-address-allan-fels-on-mental-health-and-suicide-prevention-8567>

communities, they experience homelessness, stay in undignified or unsafe places, or are itinerant. It also places unreasonable strain on family relationships.

In the context of treatment, people may have multiple admissions to hospital, remain in hospital for periods extending over many months to over a year, or are kept in the criminal justice system for lack of better options.

The 2010 report on housing and accommodation for people with psychosocial disability living in Alice Springs 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'.³ To date, the CVP has not been advised if funding has been allocated for such a facility.

In April 2012 the Secure Care Facility under Department of Health, Disability Services, commenced operation in Central Australia (see 'Disability Services – Secure Care'). This has provided long-term options for people with complex cognitive impairment, although this option is not permanent accommodation.

In the Top End the facility built for the same purpose is now being used for other clients, resulting in a continued gap in the Top End for this group of people. While there are a number other places operated by Disability Services and NGOs to accommodate individuals, this does not meet the current level of needs.

Case Example

Rhonda's experience: lack of appropriate accommodation

Rhonda is an Indigenous woman with complex needs due to her mental illness and cognitive impairment. Her understanding of social situations is limited, English is not her first language and her memory is impaired. She has poor impulse control due to frontal lobe damage possibly from childhood abuse. She had been increasingly ostracised from her family for several years due to her challenging behaviour and very limited language and social skills. Over the last decade she has been in prison repeatedly, but has been found unfit to plea. After the last time in prison she was transferred to the psychiatric ward, because her community refused to accommodate her in any way. Despite no need for acute psychiatric care she remained in the ward with extremely limited community access for several months. She is now temporarily being housed in the care of an NGO.

The CVP has been informed that the Mental Health Program is opening six sub-acute beds in Alice Springs in October, 2013. Additional supported accommodation established in Darwin in the past year comprises three beds in a house at Virginia, funded by the NT Government and one additional bed in a TEAMHealth facility, funded under the National Partnership Agreement Supporting Mental Health Reform (NPA). A new eight bed facility is due to open early 2014 in Darwin, also funded under the NPA.

³ Mental Health Association of Central Australia, *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, 2010*, p.9, accessible at: <http://www.mhaca.org.au/reportsectionhtml>
Community Visitor Program

The CVP welcomes the sub-acute facility and additional supported accommodation. However, the CVP reiterates, as in previous Annual Reports, that a needs-analysis be undertaken for the Top End. The CVP believes it is important to assess the housing and support needs for people with mental illness and complex needs against the range of options available. A proactive, evidence-based approach to determine whether the level of need is being met should be applied to develop housing and support options.

Case Example

Evan's experience **Lack of appropriate accommodation**

Evan is a man in his 50s with a deteriorating physical and neurological condition, which also causes psychiatric symptoms. He had lived in housing supported by an NGO, but his health care needs and behaviour management became too complex for the level of care provided. Evan was admitted to the psychiatric ward and remained there for approximately 6 months due to lack of other options. He is now housed in a small group home auspiced by an NGO.

The CVP continues to raise these fundamental rights as a matter of urgency.

Cultural Awareness

The term cultural safety refers to the importance of providing accessible services catering for a client's individual cultural context. Given the high number of Indigenous people accessing services from NTMHS, including the Inpatient Units, the CVP regards that culturally safe and appropriate practices be a high priority. Standard 4 of the National Mental Health Standards specifically addresses this importance, and section 11 of the MHRSA sets out specific principles to underpin the admission, care and treatment of people of Aboriginal and Torres Strait Islander descent.

The CVP expects that service providers follow best practice in consideration of the diversity of cultural backgrounds of their clients.

Use of Interpreters

The use of interpreters is a pivotal tool to ensure that clients understand and can have input into the processes around their treatment. Without the person being able to comfortably understand the language being used, such processes have the potential to further alienate the client. The CVP is concerned that inconsistent or ineffectual use of interpreters may result in these processes being a threat to a person's rights, rather than being the intended layer of protection. Furthermore, difficulties providing interpreters can result in longer stays at an inpatient facility than are necessary, which is inconsistent with the principles of the least restrictive alternative that underpin the MHRSA.

Interpreters are also crucial during the assessment period. Mental health assessments depend largely on communication with the patient, ascertaining their perceptions, cognitive processes and emotional state. In addition to being able to understand each other's language,

it is critical that there is an awareness and acknowledgement of differences in behaviour, thinking and expressions, which may be due to the different cultural background of the people involved.

Case Example

A CV spoke with a client with the assistance of an interpreter, who said that he had trouble understanding the doctor, who spoke too quickly to him in English.

The CVP is pleased to report that TEMHS Inpatient unit is now using interpreters on a regular basis for assessments and Tribunal hearings. According to the Aboriginal Interpreter Service, the Inpatient Unit is the ward with the highest use of interpreters in the RDH.

It is acknowledged that the first assessment for an involuntary admission cannot always be undertaken with an interpreter due to emergency circumstances. The CVP suggests that interpreters could be booked in advance for second assessments or when the pending admission is known due to arrangements of transport from remote communities.

Access to interpreters continued to be a challenge for CAMHS staff in 2012-2013. These challenges included difficulties around determining the need for an interpreter, limitations of service areas for hospital-based interpreters and non-attendance of requested interpreter. The CVP acknowledges that these challenges have been expressed by CAMHS staff and that there is a commitment from the service to improve processes in this area.

When an Aboriginal person is admitted to the Mental Health Unit in Alice Springs, nursing staff record his or her first language. Staff maintain a record of times when an interpreter is requested, and is either not available or is booked but fails to attend. This record is monitored by the CVP, 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.

While interpreters are used regularly as described above, interactions on the ward remain a challenge. Although many clients have some understanding of English, it cannot be assumed that they are able to understand all decisions being made about them, nor that staff necessarily understand their needs.

Case Example

A CV tried to speak with a woman who clearly required an Aboriginal interpreter. The CV enquired to the nursing staff about the client having access to an interpreter. The nurse stated that when they wanted to have a conversation with the client they would try and get a hospital-based interpreter to attend, but the hospital-based interpreters consistently failed to attend. The reason for this appeared to be that the ward was not within the hospital areas they service.

The CV liaised with the Chief Nursing Manager about why the ward is not included within the areas serviced by the hospital-based interpreters and why interpreters are not requested more regularly. The CV arranged for an interpreter to attend the next visit, and was able to communicate with the woman, who relayed that she was mostly feeling good, but that she would like to do more activities, sit outside more often and that she had not had much contact with family.

To make interpreters more readily available on the ward, the CVP has suggested that interpreters rostered by the hospitals could also be utilised for inpatients of the mental health wards. For example, RDH has a weekly changing roster of interpreters who are available during the day and can be called upon at any time. This roster could also be made available to mental health clients. Equally it might encourage staff to use interpreters more regularly, such as to explain processes on the ward.

Cultural Awareness

Many Indigenous people feel isolated and vulnerable when they are alone away from people they know and language they preferably speak and in an environment that is severely restricted and can be confronting. Aboriginal Mental Health Workers (AMHW), culturally competent staff and other cultural brokers are imperative for the assessment, treatment and recovery of Indigenous people in the mental health system.

AMHWs in the Top End are available during business hours and have been observed to build close and supportive relationships with clients with complex needs, who in some cases had been on the ward for several months due to lack of housing options.

In Central Australia, CAMHS have employed an Aboriginal Mental Health Liaison worker. It is of great importance to the CVP that this position receives appropriate recognition within the mental health system. In June, the CV Panel asked for clarification about the responsibility of the position, and to what extent it contributes to the support of Aboriginal clients on the ward. This will continue to be monitored in 2013-2014.

The presence of family members can be reassuring and at times they also act as cultural brokers and it is encouraging that the NTMHS Inpatient Units readily accommodates boarders.

Case Example

Helen's experience **Observing interactions between Aboriginal clients and staff**

Helen is an Indigenous woman from a remote community, who speaks English and in her community is recognised as a leader and a person who is comfortable in interacting with a 'whitefella system'. When speaking to the CV she did not have any complaints about her own treatment, but stated that she was saddened by the treatment of other Indigenous patients. She felt that they were often 'brushed aside' and it appeared that 'the staff on the ward have not got any cultural awareness training and that maybe things would be better if they had'.

In the Top End, for new staff on the ward, cultural awareness is briefly discussed at orientation to RDH. There is also online two-hour training available and RDH provides further cultural awareness training. Additionally, AMHWs undertake discussions especially with new staff.

A client's understanding of their illness assists in better long-term outcomes. Successful treatment, especially ongoing maintenance of good mental health, is based on a number of factors. Regular compliance with appropriate medication is only one aspect.

The CVP acknowledges the general challenges of low levels of mental health literacy in remote communities, together with complex social and individual factors that impact on a person's capacity to maintain their mental health. The CVP also acknowledges the patience shown by many staff explaining to clients their diagnosis, treatment and reasons for admission.

However, the number of Indigenous clients who express to the CVP that they do not understand why they are in treatment, especially when being treated in the very restrictive environment of JRU, remains concerning. Comments as quoted below are common and seem to indicate that many do not understand the concept of treatment in hospital. Failing rates of compliance with treatment after admission and frequent re-admissions may be partly attributable to these circumstances.

"I am ok now. I know I was bad before, but I am ok now. Why can't I go?"
 "I ran away because I wanted to go shopping and I didn't know how long I have to stay here."

With the amount of clients unclear about their diagnosis and treatment, there appears to be a gap of effective communication with these clients and the CVP will continue to monitor this in 2013 - 2014.

Information for Aboriginal Clients in TEMHS Inpatient Service

In the last Annual Report the CVP commented on the lack of progress in providing information in local languages in regard to client rights in the form of 'Talking Posters'. These are available to clients in CAMHS, and are also available about the CVP.

The recommendation by the Panel has been open since 2004 and given the difficulties around effective cross-cultural communication, the importance of this recommendation remains.

In February 2012, the PCV wrote to the CEO of the Department of Health to urge that the recommendation be implemented. In response, the CVP was assured that the posters would be available by November 2012. To date this has not occurred. However, the CVP has been informed that delays occurred due to quality assurance issues and the Talking Posters are expected to be available in November 2013.

Data Management

As part of monitoring NTMHS compliance with the requirements of the MHRSA, the CVP regularly reviews the paper-based and occasionally electronic evidence of client records in accordance with section 107(c) of the MHRSA. The review of admission papers, hospital client paper files or electronic records reveal that the first or preferred language of clients is rarely recorded.

As part of an involuntary admission, APPs are required to fill out the 'Form 10' in which the need for an interpreter at Tribunal Hearings needs to be identified. In 2012-2013, this section of the form was only filled out on 34% of the forms and the preferred language spoken identified only in 7.5% of cases.

Restrictive Practices

Contemporary and best practice in mental health service provision is underpinned by the principle of least restrictive treatment. The concept of least restriction entails that a person is treated in an environment that places the least restrictions on them, and that such action is taken only as a measure of last resort. The National Standards for Mental Health Services refer to least restrictive practice in the standards 1.9, 6.5, 10.5(5), and the key principles.

The CVP recognises that there are instances when practices of mechanical restraint and seclusion, are considered appropriate to achieve a therapeutic benefit for the client. The fundamental liberties and rights of a person are particularly critical in instances of restrictive practice. For this reason, the CVP regard restrictive practices as a significant issue.

The MHRSA section 62 provides guidelines around seclusion episodes. A function of the CVP is to review the associated documentation to ensure that practices are in accordance with the legislation and associated standards.

'The Inspection of Seclusion and Restraint Registers' section of this report details the CVP's findings from the routine inspections of these registers. The issues of particular significance to the CVP are:

- **Length of seclusion episodes:** Instances of seclusion should last only as long as the expressed behaviour meets the legislated criteria, and the CVP has noted a trend of clients spending increased time in seclusion even without signs of agitation. The CVP is also concerned about the impact of restrictive practices on young people.
- **Cultural safety:** Culturally safe practices must be employed to lessen the negative impact of crisis situations. Practices include use of AMHWs, interpreters, and other actions that take a person's cultural context into account.
- **Pre- and post-interventions around seclusion and use of restraint:** the CVP reiterates the importance of pre- and post-interventions to facilitate de-escalation, client comfort and reassurance around potentially confronting situations.
- **Involvement of carers and family:** In accordance with legislation and Approved Procedures, families, carers and guardians should be notified of seclusions and involved in critical aspects of client care.

- Data management: it is imperative that the Seclusion and Restraint Registers accurately reflect all necessary details around a seclusion or restraint incident in order to be compliant with section 62 (12) of the MHRSA.

Early Intervention

The CVP has previously raised the need for a comprehensive model of early intervention in NTMHS.⁴ Early intervention is recognised widely as an effective way of preventing future episodes of mental illness, and reducing the severity of the impact of such episodes, especially for young people experiencing their first episodes of mental illness.

In 2010-2011, the CVP stated 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 interventions 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.'⁵ Information released by the Early Psychosis Prevention and Intervention Centre stresses the importance of the right intervention at the right time.⁶

When the CVP visited the TEMHS community teams in 2011-2012, it was apparent that while individual staff may have undergone training and have relevant skills, there was no specific focus on intervention for early psychosis in the Community Team. However, it must be acknowledged that the team is not specifically resourced to provide this service.

Some improvement has been made for the Katherine region, where a permanent position for Child and Adolescent Mental Health has now been established. Furthermore, in 2012-2013, the TEMHS Manager informed the CVP that staff have been provided with Early Psychosis Training through Orygen Youth Health.

The Forensic team reported that there are difficulties for clients under 18 receiving youth-specialised mental health services due to their complex issues relating to the criminal justice system. As a Forensic team their expertise is not in treating youth.

The Child and Adolescent Team in Central Australia reported significant challenges in servicing young people in remote areas, where early intervention is almost impossible due to lack of local presence of specialised clinicians.

While the difficulties in providing early intervention is compounded in the remote context, the lack of an overarching framework of early intervention with young people in the mental health

⁴ Community Visitor Program, *Annual Report 2011-12*, Department of Justice, accessible at <http://www.cvp.nt.gov.au/resources/index.html#publications>

⁵ Community Visitor Program, *Annual Report 2010-11*, Department of Justice, accessed at: <http://www.cvp.nt.gov.au/documents/Publications/annualreports/CVP%20Annual%20Report%202010%20-%202011.pdf>

⁶ Early Psychosis Prevention and Intervention Centre, *Factsheet 2: Getting Help Early*, accessed at: http://oyh.org.au/sites/oyh.org.au/files/factsheets/fact2_gettinghelp.pdf

space is equally concerning in urban areas. Urban centres of Darwin and Alice Springs have high rates of young people, with 35% of the population aged 25 and under.⁷

The CVP has been informed by NTMHS that in 2011, the NT Government submitted an expression of interest to establish a youth specific early psychosis service in the NT as part of the Australian Government's Early Psychosis Youth Centre (EPYC) initiative. Despite an initial announcement that the NT was successful, the Australian Government made a subsequent announcement that the funding was allocated to Headspace. The CVP believes that an Early Psychosis Team is an imperative in the NT.

Final Special Panel Report

In 2011–2012 the PCV established the first Special Community Visitors Panel to investigate issues of concern about documentation and cross service communication in the Community Team in Alice Springs. Three visits took place over an 18 month period.

The process and collaboration between the CV Panel and CAMHS demonstrates that much can be achieved when there is a focus and impetus in service reform. The CVP commends the work of the CAMHS to have enacted all 17 recommendations in a timely manner. A full copy of the report is included in Appendix 2.

⁷ Australian Bureau of Statistics, 2011 Census Quick Stats, accessed at:
http://www.censusdata.abs.gov.au/census_services/getproduct/census/2011/quickstat/UCL712001?opendocument&nvpos=220
Community Visitor Program

1.1 Vision and Mission Statement



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 in accordance with requirements of the *Disability Services Act*.
3. Improve CVP governance.
4. Increase recognition of the CVP throughout the Territory.

1.2 CVP Overview

The CVP is established under Part 14 of the *Mental Health and Related Services Act* (MHRSA) and Part 6 of the *Disability Services Act* (DSA). 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 NT Mental Health Services and Disability Services in the NT. It is also one of the mechanisms in place to ensure that quality mental health and disability services are provided. The CVP is located in the Anti-Discrimination Commission to guarantee its independence from mental health and disability services.

1.2.1 Jurisdiction

The jurisdiction of the Community Visitor Program in Mental Health and Disability Services includes a range of treatment facilities approved under the two Acts.

Mental Health

The treatment facilities consist of inpatient psychiatric units and treatment agencies (outpatient services). 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, the Joan Ridley Unit (JRU) and the Contained Assessment Unit (CAU). The Approved Treatment Facility for CAMHS is the Mental Health Unit (MHU) located in Alice Springs Hospital.

Disability Services

The treatment facility currently consists of one inpatient residential facility (Secure Care) Kwiyernepe House and is located in Alice Springs.

There are a further two 'Appropriate Places', one in Darwin and one in Alice Springs. An Appropriate Place is a residential facility where a client resides pursuant to a Supervision Order made under the Criminal Code.

1.2.2 Principal Community Visitor

The Principal Community Visitor has overall responsibility for the CVP and has a range of responsibilities under the two Acts. 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.

1.2.3 Manager Community Visitor Program

The CVP Manager is part of a three-person team made up of two full-time and one part-time employees. The role itself does not have a statutory function, although the Manager is an 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.

1.2.4 Community Visitors Panels

A Community Visitors Panel (the Panel) is established for each Approved Treatment Facility under the MHRSA, 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.

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 clients, 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 2011-2012, conducting a visit to the Community Team in Alice Springs. The reason this Panel was established and the findings from their investigation are briefly outlined in the 'Significant Issues' section of this 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.

The DSA has also established a Community Visitors Panel to visit the Secure Care Facility at least once every 6 months. The scheme is very similar to that set out above.

1.2.5 Community Visitors

Community Visitors (CV) 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 MHRSA, the Mental Health Review Tribunal or Part 7 of the DSA, the Review Panel.

Community Visitors visit the Mental Health inpatient units on a weekly basis so that as many clients as possible have access to a Community Visitor. Visits to Kwiyeirpe House occur on a monthly basis as clients have longer inpatient stays in this residential facility. The Community Visitors respond quickly, within the same day if possible, to complaints and requests from clients. The legal obligation is to respond at the end of the next working day.

While visiting an Approved Treatment Facility or Agency, or a Secure Care Facility, a Community Visitor also has an inquiry function. Visitors may inquire into the adequacy of standard of services and Facilities, the possible failure of persons employed in Facilities or Agencies to comply with the Acts, 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.

1.3 Staff of the Community Visitor Program

Organisational Chart



The Community Visitor Program team is as follows:

1. The Anti-Discrimination Commissioner is appointed Principal Community Visitor.
2. At 30 June 2013, five staff of the Anti-Discrimination Commission, employed under the *Public Sector Employment and Management Act*, were appointed as Community Visitors.
3. Community Visitors (except those employed by the ADC) and all Community Visitors Panel members receive fees under the Determination of Remuneration, Allowances and Expenses under the *Remuneration (Statutory Bodies) Act* for 'Other Member' Expert High Impact Panels and are referred to as sessional members.

Community Visitors & Panel Members

2012 -2013



Sally Sievers
Principal Community Visitor



Claudia Manu-Preston
CVP Manager



Carly Ingles



Mark O'Reilly



Shanna Satya



Maya Cifali
Chair



Kate Lloyd



Tessie Reinsch



Teja Lipold



Ken Lechleitner



Alison Hanley
Chair



Garry Halliday



Pamela Trotman



Hiltrud Kivelitz



Traci Keys



Sarah Giles



Phil Dempster



Karyn Jessop



Georgia McMaster

1.4 Performance of the Community Visitor Program

Performance of the CVP is measured against its legislative requirements and is reported under ADC in the Department of Attorney General & Justice Annual Report.

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 2012-2013 related to *Mental Health and Related Services Act*.

There is minimal data collected for the *Disability Services Act* as CVP visits have only occurred since April 2013. Where relevant, comparison is made across financial years.

Table 1
Comparison of the Achievements of CVP 2010/2011 - 2012/2013

	Legislative Requirements	Alice Springs			Darwin		
		2010/ 2011	2011/ 2012	2012/ 2013	2010/ 2011	2011/ 2012	2012/ 2013
Visits¹	In response to requests/ inspection	43	41	46	93	109	81
Panel Visits	2 (At least once every 6 months)	2	2	3	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	97%	92%	99 ² %	99%	95%	100%

Note 1:

Visits include visits to inspect the Approved Treatment Agencies.

Note 2:

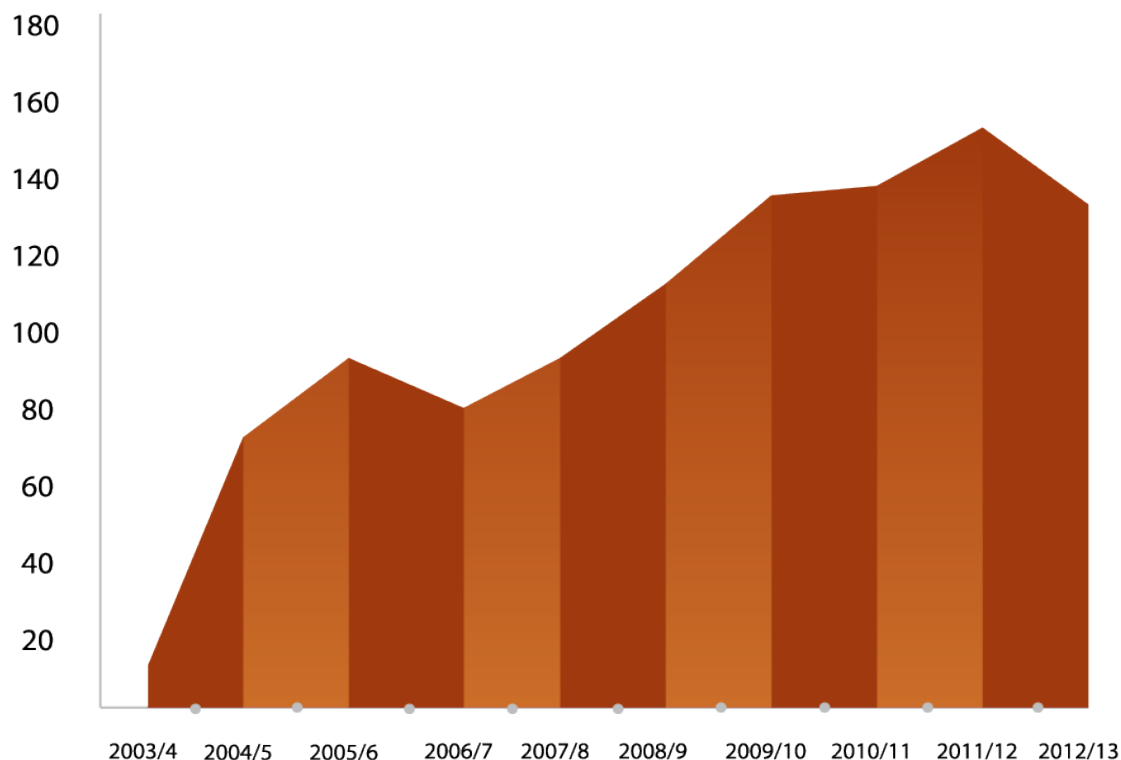
One person in Alice Springs was not contacted within one working day of request due to technical phone issue. The small number of requests from Alice Springs inflates the impact.

CVP visited the TEMHS Inpatient Facility and CAMHS Mental Health Unit once each week. Most people who are admitted to an inpatient facility in the NT will have the opportunity to see a Community Visitor. Enquiries and complaints can usually be resolved quickly with minimal formality.

1.4.1 Mental Health Visits and Inspections

Figure 1

Number of Visits to Approved Treatment Facilities and Agencies 2004 – 2013



Number of Visits

Figure 1 provides a pictorial representation of the growth in the number of visits from 2003 – 2013. 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 CAMHS MHU were introduced.

The CVP is also required to visit an Approved Treatment Agency or Facility. In 2012-2013 the CVP made 137 such visits, including visits to the Barkly Region Mental Health Team, the Katherine Mental Health Team, the CAMHS Remote Team, CAMHS Child and Youth Team, and the TEMHS Forensic Team.⁸

In 2012-2013 there was a small increase in requests in Alice Springs and this may be associated with the increased visits to the MHU from January 2012 to a weekly visit.

There was a fall in the number of requested visits this year in Darwin. The reasons are unclear and the CVP will continue to monitor this development.

⁸ Reports from the CAMHS Remote Team and CAMHS Child and Youth Team visits were not finalised at the time of writing.

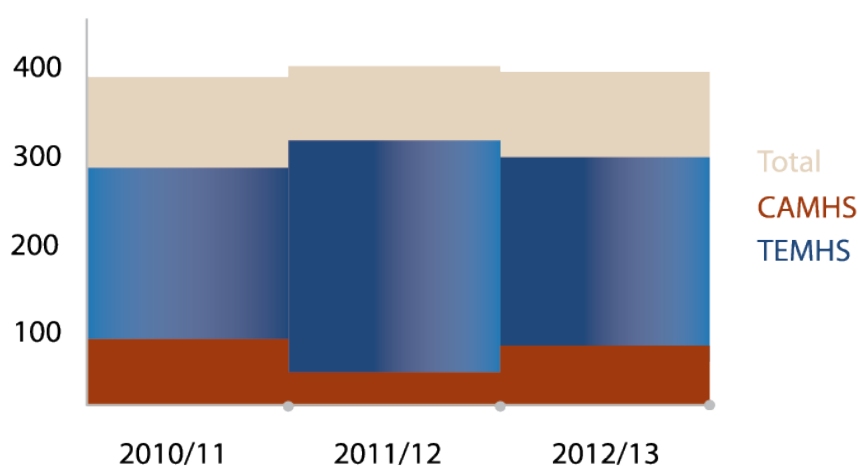
1.4.2 Complaints and Enquiries

Table 2
Complaints and Enquiries Received

Complaints & Enquiries Received	Alice Springs			Darwin		
	2010/11	2011/12	2012/13	2010/11	2011/12	2012/13
	98	62	87	285	333	301

Table 2 shows a 10% decrease in complaints and enquiries managed by the CVP in Darwin with a 40% increase in Alice Springs.

Figure 2
Complaints and Enquiries Alice Springs & Darwin 2009 - 2013



Complaints and Enquiries Alice Springs & Darwin 2010 - 2013

Complaint or Enquiry?

Clients, carers and service providers contact the CVP or speak to a CV for many reasons. Often, the contact may involve a request for information or a request for a CV to support the client during interactions with the NTMHS (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 recorded as enquiries.

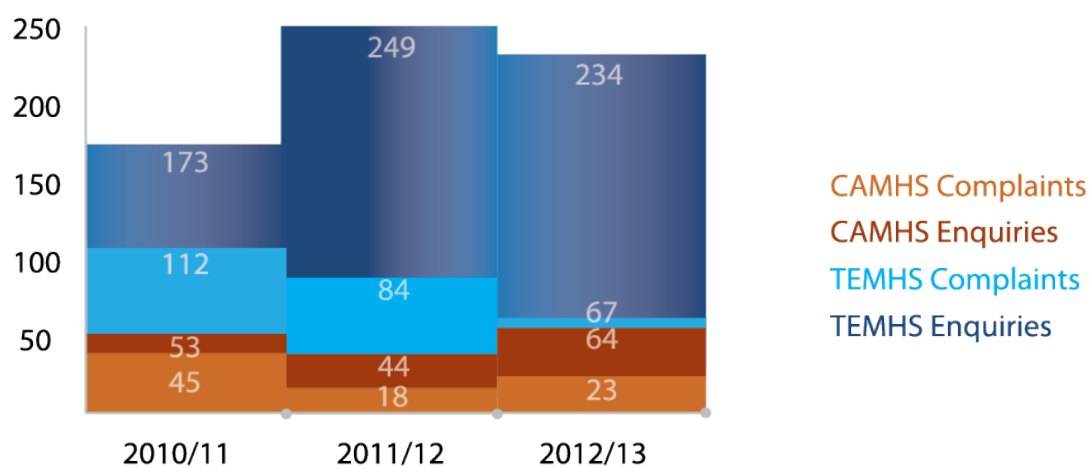
Complaints are generally of a more serious nature. They may be verbal or in writing and occur when the person contacting the CVP has a grievance with the NTMHS, is really unhappy with their situation and/or specifically describes their contact as a complaint.

Table 3
Complaints and Enquiries Received 2010 – 2013

	Alice Springs			Darwin		
	Complaints	Enquiries	Total	Complaints	Enquiries	Total
2010/11	45	53	98	112	173	285
2011/12	18	44	62	84	249	333
2012/13	23	64	87	67	234	301

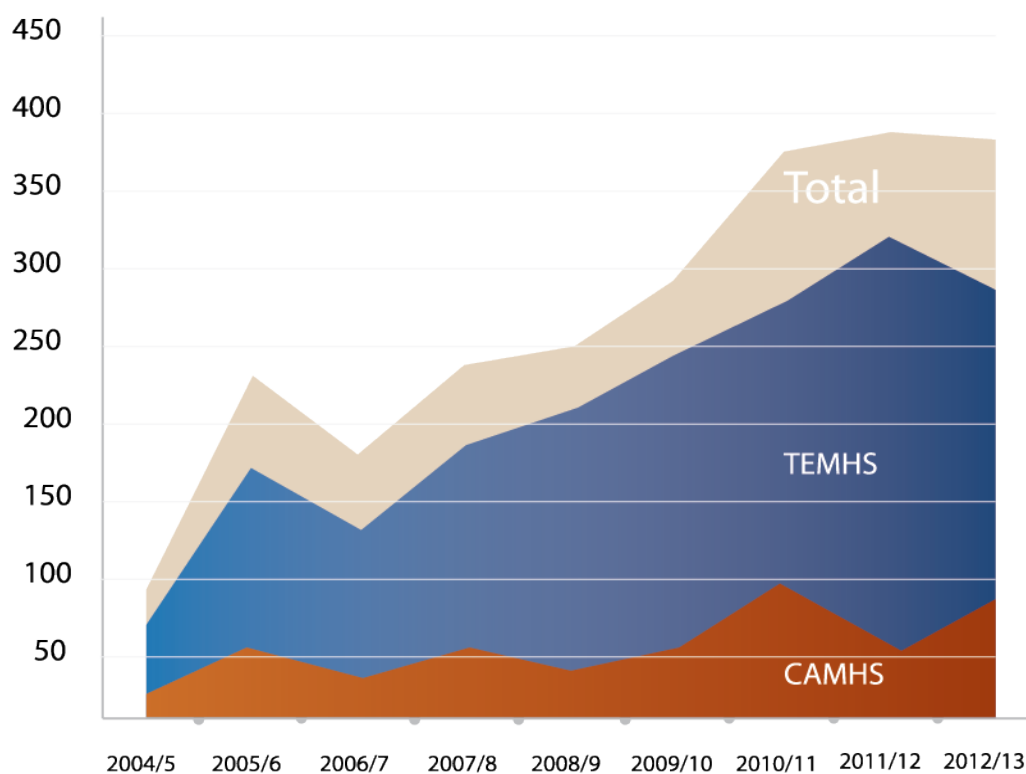
In Darwin the number of complaints and enquiries fell in 2012 - 2013, while in Alice Springs the number of both complaints and enquiries rose considerably over the previous year. This was probably due to the increased number of visits in Alice Springs in 2012-2013.

Figure 3
Complaints and Enquiries Alice Springs & Darwin 2010 - 2013



Complaints and Enquiries Alice Springs & Darwin 2010 - 2013

Figure 4
Number of Complaints and Enquiries 2004 – 2013



Number of Complaints & Enquiries 2004 -2013

Figure 4 demonstrates a slight decrease in the total complaints and enquiries managed by the CVP. In 2011-2012, the CVP received a total 395 complaints and enquiries and in 2012-2013 there was a moderate decrease of 388 complaints and enquiries received.

Categories of Complaints and Enquiries

The broad categories of complaints correspond with the inquiry functions of the CVP defined in s104 of the MHRSA; 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 MHRSA and any other matter having regard to the principles and objectives of the MHRSA. 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 2012 - 2013

		CAMHS	TEMHS	TOTAL
Advocacy		6	73	79
	Access to files		3	3
	Protection of private info		5	5
Information	Provided to clients/carer/ service providers by CVP		41	41
	Interpreters/ cultural safety	2		2
Medication		3	7	10
Miscellaneous		1	10	11
	Activities	3		3
	Assessment & Treatment	21	25	46
	Consultation Client/Carers		3	3
Quality of Service Provision	Discharge Planning	1	2	3
	Facilities	1	16	17
	Management Plan		1	1
	Procedures		7	7
	Relationship with staff	9	5	14
	Accommodation	4	10	14
	Detention	1	16	17
	Least Restrictive Alternative	10	14	24
Rights	Legal	5	10	15
	Respect for Dignity		1	1
	Safety	1	1	2
	Transport by Police		1	1
	Voluntary/Involuntary	5	10	15
Smoking		11	7	18
Visit	Request/Support	3	33	36
	Total	87	301	388

Table 4 shows that in 2012-2013, 42% of all complaints and enquiries involved actions such as advocacy, providing information or visiting/support (for example joining a person during an appointment with mental health staff). 47% of the visits related to quality of service provision and rights, while 5% related to the issue of smoking.

1.4.3 Other Complaints and Enquiries

In addition to complaints and enquiries about NTMHS, 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 NTMHS, but may assist a client by providing relevant information, referral and advocacy. The CVP in Darwin has also assisted in an advocacy role with clients lodging a complaint with the Health and Community Services Complaints Commission.

Figures 5 and 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 2012-2013 is 388.

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 NGO mental health organisation, Legal Aid and other government and non-government organisations.

Figure 5
Source of Complaints and Enquiries Top End

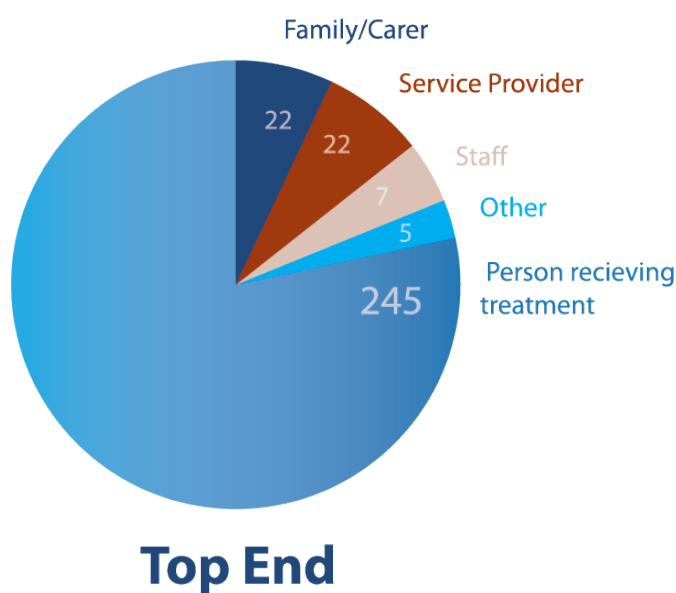
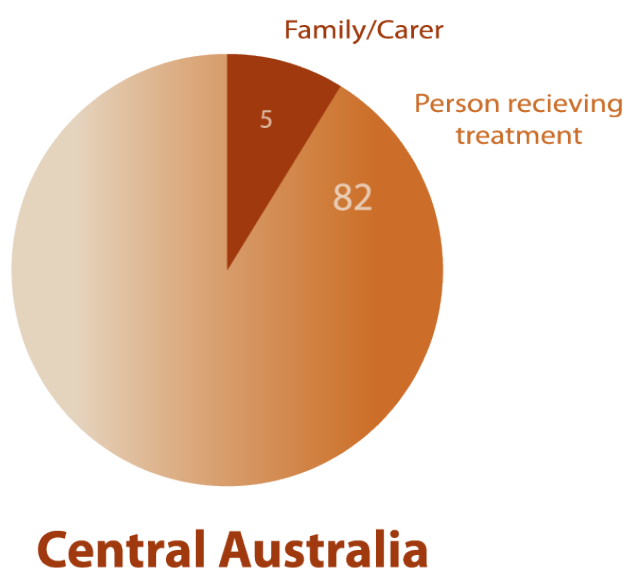


Figure 6
Source of Complaints and Enquiries Central Australia

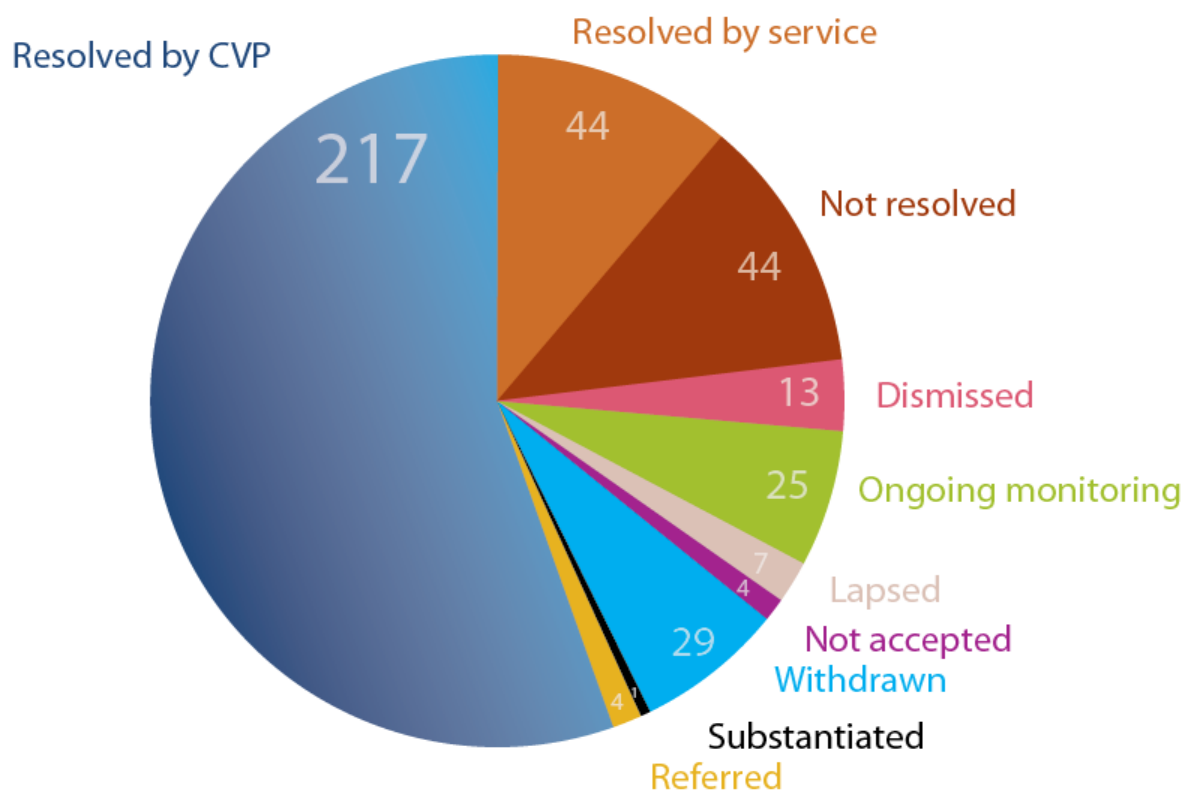


Outcomes of Complaints and Enquiries

The CVP provides quarterly reports to TEMHS and CAMHS on complaints and their outcomes. If the CVP 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 to another complaints organisation such as the Health and Community Services Complaints Commission.

Figure 7

Outcomes of Complaints and Enquiries NT



The CVP closed 228 out of 388 complaints and enquiries received in 2012-2013. This is much lower than in 2011-2012 (514), but more in line with 2010-2011 (347).

1.5 Other CVP Activities

The expansion of the CVP role into the Disability Service, together with the ongoing high level of complaints and enquiries work has impacted on the capacity of the CVP to become involved in other activities.

As the program has expanded all staff are involved in continuing the important work of increasing the profile of the CVP and community engagement. The Manager continues to meet with key agencies such as Mental Illness Fellowship Australia NT (MIFANT) and the Mental Health Association of Central Australia (MHACA).

1.5.1 Involvement with NT Mental Health Services

The CVP views the opportunity to work collaboratively with NTMHS as critical in improving quality service on issues that affect people with mental health problems in the Territory. The Manager CVP meets with the Director of Mental Health when an issue arises. The Manager CVP and CVs are also able to contact all team managers and staff and their willingness to work with the CVP is both acknowledged and appreciated. The ongoing communication is facilitated through the following regular mechanisms:

- Bimonthly meetings with TEMHS & CAMHS General Manager.
- Principal Community Visitor meets with the Chief Executive of Health.
- Regular Approved Procedure & Quality Assurance Committee (APQAC).
- NT Police & Mental Health Top End Regional Advisory Group.

Unfortunately, the meetings of APQAC and NTMHS with NT Police have only taken place infrequently. APQAC has only met twice and NTMHS and NT Police only once this year.

1.5.2 Involvement with Disability Services

The CVP has undertaken substantial preparation for the implementation of the new jurisdiction for people with complex cognitive impairment, this includes close liaison with senior staff in Disability Services and contribution to the development of legislation and policies and training as highlighted in the section 'Disability Services – Secure Care'.

1.5.3 Involvement with other Key Government Agencies

- Health and Community Services Complaints Commission (HCSCC): the Manager CVP has met with the Health Complaints Commissioner and intends to further strengthen the relationship and referral pathways in the coming year.
- CVP, HCSCC and Darwin Community Legal Service hosted and facilitated a public forum on complaints and rights during Disability Awareness Week 2012.
- The Principal Community Visitor has met with the President of the Mental Health Review Tribunal.
- Meetings with Principal Community Visitor and CVP with staff of Office of Public Guardian.

1.5.4 Submissions and Policy Review

Input into the Department of Health Policy, 'Hospital Inpatient Restraint, Patient Restraint and Providing Treatment Where Adult Patient Consent Cannot Be Obtained'.

1.5.5 Involvement with Community Agencies/Activities

Membership

The CVP is a member of the Mental Health Coalition.

Networks and Meetings

- Mental Health Professional Network meetings.
- Top End Mental Health Service Provider Network meetings.
- Involvement with Community/Official Visitor Programs from other states and territories attendance at the 2012 NSW Official Visitor Conference.
- Participation in Course Advisory Group for Social Work at Charles Darwin University (CDU).

Conference Presentation

May 2013 – Principal Community Visitor – Ausit (Australian Institute of Interpreters and Translators Inc.) mini conference; 'Do You Hear me? Closing the Gap in Communication'.

Other Presentations

- CDU Presentation to social work students on 'Legal issues and Social Work with regards to the Mental Health Related Services Act and Disability Services Act'.
- Headspace consultation regarding approaches to address early psychosis.
- Service presentation to Health Development Unit and MHACA in Alice Springs on CVP role.
- Service presentation to clients of Top End Mental Health Consumer Organisation (TEMHCO) and Support Worker Forum in Darwin on CVP role.

Other Involvements and Visits

- Training to all CVs and Panel members on 'Working with people with Complex Cognitive Impairment' by Daryl Murdock.
- Attendance at two forums on Disability Care/NDIS.
- Attendance at International Nurses Conference, Darwin.
- Participation in Community Awareness event during Disability Awareness Week and Mental Health Week.
- Supervised social work student.
- Ongoing training for mediators by CJC.
- Attendance at presentation on 'Crime and Mental Health': by the Australian and New Zealand Association of Psychiatry, Psychology and Law, Social Policy Forum.
- Happiness Forum by Carers NT.

2.1 Quality of Service Provision

In this section of the Annual Report, the work of the CVP over the past twelve months, and issues raised by people receiving treatment as well as those arising from inspections of facilities and agencies are discussed under the headings Assessment and Treatment, Facilities and Procedures.

2.1.1 Assessment and Treatment

Involvement of clients in treatment

The National Mental Health Standards clearly set out the importance of client involvement in their own treatment, as evidenced under standard 6.7: 'Clients are partners in the management of all aspects of their treatment, care and recovery planning'.⁹ Furthermore, the associated Principles of Recovery oriented mental health practice state that such practice:

*...acknowledges each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them.*¹⁰

In the NT, some clients have complained to the CVP about the lack of input they have into treatment decisions. Clients may be considered unable to give consent to treatment. However, their lived experience of managing their illness must be acknowledged, respected and considered. A number of clients also have experience of treatment in other jurisdictions and some have stated that they are 'treated more as equals', given more responsibility for managing their illness and allowed to take risks.

One of the roles of the CVP is to inform clients about their rights. One way to exercise these rights is to ask questions about treatment and decisions made by the NTMHS.

Case Example

Yvonne's experience: Communication regarding treatment

Yvonne is a young Indigenous woman from a remote community. She has been in JRU for several days and does not understand why she is there or when she can go home. She has a basic command of English, but she has been too scared to ask any questions of staff. The CV attended the next assessment with the client. The doctor asked a number of questions and then briefly explained that the medication should reduce her symptoms. The doctor then asked if Yvonne had any questions, but she said no. After the assessment the CV asked Yvonne if she understood what she had been told. She said no. The CV asked Yvonne's nurse to explain all of this to her again, which was done slowly and in basic English in a way Yvonne understood.

Clients respond to predictability and an understanding of why the level of restriction is necessary. If a person is forgetful or has problems understanding information due to lack of English or lack of

⁹ Australian Government; *National Standards for Mental Health Services*, 2010, p.14, accessed at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-servst10>

¹⁰ *ibid*, p.43

cognitive capacity, the onus is on the NTMHS to find appropriate ways of ensuring that the client has understood their treatment.

Involvement of Carers

In the NT the MHRSA and the *Carers Recognition Act*, make reference to the Northern Territory Carers Charter (the Charter) these provide the legal framework for the involvement of carers. The National Mental Health Standards also state the importance of carer participation.¹¹

The Charter 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.

In the Top End, 11% of all complaints and enquiries received were raised by carers or family members, and in Central Australia the percentage was 9%. The issues fall into three main categories: lack of timely responsive treatment for their family members, the lack of acknowledgement of their caring role and needs, and the lack of information related to treatment, mainly ECT.

As evidenced in the report *From Adversity to Advocacy - The Life and Hopes of Mental Health Carers in Australia*, the issues listed above are among the top seven priorities of mental health carers around Australia.¹²

The CVP reinforces the view that the involvement of carers is pivotal to the long-term success of any care and treatment. Carers generally have a detailed and long-term knowledge of the person receiving treatment, their strengths and their limitations and often detect changes in their behaviours before anybody else. However some carers feel that this knowledge is undervalued when it comes to decision-making in the clients' interest.

Case Example

Terry's experience – assessment and communication issues

Terry called the CVP to express his frustration and concerns. Terry was separated from his wife Carmen, but with her agreement remained listed as her carer with NTMHS.

Terry believed his wife's mental health had deteriorated, probably through non-compliance with her medication. He alerted the Crisis Assessment Treatment Team (CATT) to describe the symptoms he had observed. The CATT visited Carmen, but saw no need for further follow-up and did not give feedback to Terry. A couple of days later Terry called the CATT again after complaints by neighbours and the involvement of the police. The case manager of the adult team performed an assessment and gave feedback to Terry that Carmen 'was fine' and they saw no need for further involvement at this point.

The situation continued to deteriorate. Terry called CATT again a couple of days later and stated to the CVP that he had found the person on the phone unhelpful and 'talking down' to him. He contacted the adult team the following day and spoke to a different person, who he felt was more receptive to his concerns. The team followed up with another assessment and subsequently his wife was admitted to the inpatient ward. When Terry visited his wife, the staff were reluctant to allow him to speak to her as the information about him as her carer had not been passed on.

¹¹ Ibid, p.16

¹² Mental Health Council of Australia, *From Adversity to Advocacy - The Life and Hopes of Mental Health Carers in Australia*, 2009, accessed at www.mhca.org.au

This example highlights the importance of information sharing between teams. The importance of including information about carers/family members should be a mandatory and obvious field in the electronic file, as previously recommended by the CV Panel. Terry's experience also alerts to the need to acknowledge the in-depth knowledge the carer usually has of the client and to follow-up on the carers' concerns.

The CVP acknowledges the difficulty in balancing the requirements in the inpatient facilities for effective treatment in the least restrictive manner, and often the wish of the client for the shortest period of admission. The timing of information sharing can be as important as the content. Allowing time for clients and their families to consider options or prepare for changes is crucial and demonstrates respect.

It is also acknowledged that the NTMHS staff face complex circumstances and at times different perspectives and wishes from clients and their carers that they are expected to consider.

Case Example

Violet's experience – discharge planning

Violet's son Kyle was in the inpatient unit and he asked his doctor on Friday afternoon for weekend leave which was granted. Consequently, Kyle called his mother and said he wanted to be picked up. Violet had no prior knowledge of any potential leave and had to re-arrange a number of other commitments. She would have appreciated a phone call from the doctor to discuss the weekend leave with her. Violet also reported a similar lack of communication regarding the pending discharge of her son, which was simply a phone call in the morning for discharge the same day.

It is important to carers that their own needs and limitations are acknowledged and understood by the treatment team and that they are met with a non-judgmental attitude. Time and attention given to carers and families is an investment in improving client outcomes.

Relationship with Staff

There have been a significant number of clients who, usually unprompted, state that they are very happy with the treatment and the way staff interact with them. Staff have been described as 'caring', 'fabulous', 'excellent', 'helpful', and 'good to talk to'. The CVP has often observed warm and respectful interactions between staff and clients and acknowledges the often trying and challenging situations in which staff remain professional and patient. In comments made by staff about clients, the CVP mostly detects care and concern for the wellbeing of clients.

Case Example

While the CV was conducting a visit a client whom the CV had met on several occasions, was engrossed in telling a story to a staff member who appeared genuinely interested and did not appear in a hurry to return to another task. This observation was noteworthy as the CV remembered this client expressing her disappointment about staff in the past, mainly due to what she perceived as staff being too busy to give the clients any time.

However, occasional complaints are made to the CVP regarding the perceived lack of respect and acknowledgement from staff towards clients and carers.

Case Example

Rebecca's experience – acknowledge carer stress

Rebecca's daughter Sunny, who has been in treatment for several years, had recently been admitted to hospital. Rebecca had been dealing with a number of personal and professional issues recently and was exhausted and very emotional. During the first few days of Sunny's admission she yelled at a nurse and a doctor while visiting Sunny, and consequently she felt that the staff were reluctant to engage with her. She told the CV that she was hesitant to contact the doctors herself because she felt guilty and thought that they were too busy anyway. The CV arranged for a meeting between Rebecca and the treating doctors, which restored some of the broken-down communication. However, Rebecca felt the doctors didn't really understand the constant stress of caring for her daughter, or the impact of other stressors in her life.

The CVP stresses the importance of observing the dignity of clients and families, regardless of their state of health or behaviour, which may be due to the stressful situations they experience. This needs to be expressed in all actions and communication.

Case Example

Jonathan was admitted as an involuntary patient and visited by his parents, who were not happy about treatment decisions. A staff member attempted to explain the decision, however the parents called the CVP to complain about the language used and noted that "we are not anybody's 'darl' and don't want to be treated like children".

Unfortunately, staff at times are described as 'not listening' and 'not taking seriously' the views of clients and families. Clients at times feel that it is disrespectful to them that in their view, decisions and diagnoses are made after only very brief interactions.

Case Example

Anthony stated to the CVP, "the doctor only saw me for about 5 minutes. How can he make a decision about me so quickly? He doesn't know me, he has never seen me before and doesn't know anything about my life. I think it's ridiculous that he thinks he knows what's wrong with me".

Case Example

A CV was present at an assessment where a client had asked for a second opinion. The assessment took about 2-3 minutes and the manner of the doctor appeared dismissive and rushed.

Access to Other Allied Health Services

Access to other health care while in psychiatric inpatient units is an important component of holistic treatment, especially considering the often poor physical health of people living with mental illness.

The following example shows the need to address access to other health services in the hospital such as a dietician.

A client complained to the CVP that the hospital dietician was refusing to come and assist him whilst he was in the psychiatric ward despite numerous requests from the mental health staff. He had previously had access to the hospital dietician when on other wards of the hospital.

The CV liaised with NTMHS staff about how the client's restricted diet and his inability to eat much of the food that was available and as such was purchasing other food. The client felt discriminated against, primarily because he had received support from the hospital dietician whilst being a patient of other wards.

The CV was told that access to the dietician was restricted based on capacity of the dietician and the hospital policy at the time was to service hospital wards as the priority. This will be addressed from July 1st 2013 when the inpatient facility becomes part of the new hospital network. Although the matter was not resolved, the client appreciated being able to convey his concerns to both the CVP and Mental Health staff.

Activities

Regular programs and activities in mental health wards are recognised as an important part of the treatment, support and rehabilitation process. Inpatient facilities must balance the range of activities on offer whilst recognising the current mental health status of the client. This is noted in the National Standards of Mental Health Services.¹³

TEMHS

The TEMHS Inpatient Unit is comprised of three areas: Cowdy Ward, Joan Ridley Unit (JRU) and Contained Assessment Unit (CAU).

The Cowdy Activity Centre provides the greatest number and variety of recreational activities and therapeutic interventions in a relaxed atmosphere. The CVP repeatedly receives good feedback from clients about the Centre.

The collaboration of staff and clients during Mental Health Week 2012 in running a 'café' together was positive in fostering a partnership environment and raising funds for equipment and activities.

The CVP commends the Cowdy Activity Centre for the range of activities on offer and the interaction between staff and clients.

CAU clients appear to occasionally use the Activity Centre. However, as mentioned in previous reports, the CVP notes that JRU clients have very limited access to the Activity Centre or any other structured

¹³ National Mental Health Standards, Standard 10.5.12, p.27

activities, and they repeatedly state that they are bored, because 'there is nothing to do'. A sensory room has been set up and can be accessed by clients in JRU accompanied by staff.

Because of the assumption that some JRU clients are at a high risk of absconding, these clients often spend considerable amounts of time in an extremely confined space. Given that JRU is a highly restrictive environment, it is important to ensure access to a structured activity program.

In regard to therapies on offer, the CVP has received positive feedback from clients about Cognitive Behaviour Therapy (CBT) sessions, which assist them to develop self-management strategies. Several clients have mentioned this as 'the best thing' they have experienced during admission.

Case Example

Walter's experience (CBT)

Walter had contact with the CVP about a year after his admission and stated, 'working with K (one of the nurse consultants providing CBT) has been one of the best things I ever learned. She taught me how to manage my stress. I never knew about the breathing and all of that. Every time I get stressed I do the things she taught me and it really works. I am so grateful for that.'

The CVP supports the provision of a range of therapies such as CBT, as a tool to self-manage stress and to control unhelpful patterns. These types of tools encourage clients to contribute to and direct their own treatment, and should be utilised more extensively.

The allied health staff of the unit deals with a wide range of issues addressing the often complex psychosocial needs of clients, are instrumental in care coordination, behaviour management, often may contribute to non-clinical emotional support through reliable relationships and cooperate with families and carers.

CAMHS

The renovation of the activity room at CAMHS has meant that the space for a variety of programs and activities has expanded. The CVP commends CAMHS for finalising this area.

Unfortunately access to regular programs and activities remained reduced throughout the year. This was the subject of a number of complaints during the year.

Due to staffing issues no structured activities have been available since January 2013. The CVP has suggested that CAMHS have a contingency plan in place to ensure that activities continue irrespective of individual staff availability.

One client reported to the CVP that he was very bored on the ward, and in his opinion the main activities were eating, sleeping and watching television. He requested more structured, practical activities. He indicated he would appreciate the opportunity to share chores or do basic life skills activities more often, such as cooking.

The CVP notes that there were other occasions where clients provided positive feedback on the responsiveness of staff to their requests for activities.

One client had wished to attend an external activity and had done so before her admission with the support of a local non-Government organisation (NGO). CAMHS staff had developed an activity plan for the client in conjunction with the Guardian and another NGO to enable this to take place.

CAMHS has stated that a part-time Occupational Therapist in the MHU will be appointed. The CVP expects that this will allow for more comprehensive functional assessments of clients and possibly expand the range of activities.

The position of Social Worker is an important role in the inpatient facility context, as it facilitates client access to other social services and provides non-clinical therapeutic outcomes.

During 2012-2013 the Social Worker provided assistance to clients to access Centrelink, Territory Housing, and liaised with families.

During the second quarter of 2012-2013, the CVP was advised that Centrelink officers were unable to continue to visit the MHU as previously had. This is seen as an essential service for clients, it was thought that the lack of the outreach service would add to the stress already experienced by clients in the ward. The Social Worker resolved this by negotiating for a Centrelink officer to attend every Tuesday. This was a positive outcome.

At the end of the review period there had not been a Social Worker on staff at MHU for some month. The CV Panel has recommended that the position of Social Worker of the MHU be made permanent as it complements that of the 0.5 FTE Occupational Therapist.

2.1.2 Facilities

The CVP inquires into and makes recommendations relating to the standard and appropriateness of facilities for the accommodation, physical wellbeing and welfare of persons receiving treatment or care at Approved Treatment Facilities or by Approved Treatment Agencies pursuant with (section 104) of the MHRSA. Further, the CVP has the power to inspect any part of the facilities or the premises (section 107(a)).

TEMHS

Cowdy Ward

Cowdy Ward has remained a locked ward.

The common area of the ward provides a friendly space for clients. Information is displayed throughout this area to inform clients on a range of topics including the CVP Talking Posters.

In the 'lounge room' a whiteboard displays which nurse is allocated to which client for the day and also the leave status of the client. The CVP considers this to be useful information, firstly for people to know who their 'first point of call' is for the day and secondly if they have leave or not, because many client questions revolve around this. The CVP encourages TEMHS to consistently provide this information on the whiteboard.

The CV Panel again noted the low level of cleanliness in the bathrooms and showers in Cowdy Ward, although some improvements have been made in the second half of 2012-2013. Again the CVP reiterates the importance of a high standard of hygiene when people are sharing facilities and where

the standard may impact on the physical health and wellbeing of inpatients. Several clients mentioned dirty showers and bathrooms and one client undertook cleaning her own bathroom, because she felt uncomfortable with the standard of cleaning.

The CVP has raised the issue with the CNM repeatedly, who has addressed this with the cleaning contractor. She expects that the contract arrangement will change under the new hospital governance.

The High Dependency Unit (HDU) is an area accessible from the general ward, but has a higher degree of privacy and separation and has a private courtyard. Its function is mainly to accommodate the special needs of mothers with babies and young clients (under 18 years).

The CV Panel has repeatedly commented on the poor appearance of the area and described it as bleak and shabby.

Joan Ridley Unit (JRU)

JRU is a high security unit with double-locked doors, the seclusion room and the nursing station fully enclosed. The appearance of this unit is prison-like, and the CVP notes that the areas remain bleak and uninviting. The large courtyard is unchanged from previous years. A new courtyard has been completed during 2012-2013.

Equipment for exercising or other activities is hardly ever seen, although occasionally clients have a soft ball that is being kicked around in the large courtyard. Considering the large number of young people, especially young men in JRU with some of them remaining for several weeks due to an assumed risk of absconding, the lack of options for meaningful activity remains a concern.

It is acknowledged that there is a need for differing levels of security. However the CVP suggests that greater therapeutic benefit will be achieved with a more pleasant environment that does not appear like a restrictive institution.

The CVP commends JRU on the sensory room, which is believed to have been initiated by the OT. It has some equipment which is known to have a calming, relaxing effect and clients can also sit and listen to music. They have to be accompanied by a staff member, therefore the access depends on staff availability. However, the CV has the impression that the room is being used frequently.

As in Cowdy Ward, there are also issues around cleanliness in JRU. Both the CV and the Panel have commented on the lack of cleanliness, and numerous clients have complained about the lack of hygiene and the compounding effect of this on their mental health.

Case Example

A client described his stay in JRU as very challenging, because he found the low level of hygiene confronting.

Another client stated that having to remain in this environment made her feel low and undignified and was compounding the effect of her mental health.

Someone had scrawled on the wall of a toilet in JRU "This toilet is disgusting".

The CNM and TEMHS manager have expressed their disappointment with the lack of resources to upgrade the facility, especially since some of the surfaces remain looking untidy even if they have just been cleaned.

Contained Assessment Unit

The CAU is a new, secure unit, which was built to accommodate both young clients and people with complex cognitive impairment assessed under Part 6 Division 4 of the MHRSA.

The unit has 5 beds and has a calm and friendly atmosphere. However, it is similarly restricted as JRU with double locked doors and high fences and a fully enclosed nurses station. The furniture and fittings are new, colourful and friendly. Clients have access to a courtyard in company of staff only and it is frequently used. There is also a covered, very spacious courtyard, which can be accessed freely by clients.

Although a number of clients with MHDCD have been admitted, no client has been admitted under the above-mentioned legislation. A number of clients have been admitted under section 39 or 42 of the MHRSA, but they are not only nursed in CAU.

Over the last year the unit has been used as an 'overflow' ward for both Cowdy and JRU.

Depending on availability, it appears that clients 'graduate' from JRU to CAU. It is also used for clients who might benefit from a quieter or less volatile environment.

CAMHS

The MHU has consistently received positive feedback on the ambience, cleanliness and aesthetics of the ward. CVP has observed clients making use of all the facilities provided. The renovations caused major disruptions whilst they were underway, however since completion the facility is an attractive, functional environment. Information is freely available and clearly displayed both in English and local Indigenous languages.

The newly refurbished Low Stimulus Area (LSA) is a secure part of the unit. It was designed for the purpose of accommodating people with complex cognitive impairment assessed under Part 6 Division 4 of the MHRSA. As in the Top End, no clients have been admitted under the above-mentioned legislation. The LSA is also used as an overflow for the main MHU and for clients who are considered to be 'at risk' or for whom seclusion is necessary.

During the renovations clients repeatedly raised the issue of lack of access to the outside area, especially in conjunction with smoking restrictions. Since the second quarter of 2012-2013 the outside area is accessible again.

In 2012-2013, some incidences occurred that raised issues around client safety in individual bedrooms. In response to this, CAMHS proposes a swipe card system for access to bedrooms. This system would ensure that only staff and each client could access their individual bedrooms. The CVP welcomes this commitment to client safety and will continue to monitor the issues around client safety.

2.1.3 Clinical Plans and Discharge Plans

In 2012-2013 the CVP noted that a number of clients with complex needs had behaviour management plans developed by the OT. Katherine Mental Health team reported that more Indigenous clients than in the past have 'Stay Strong Plans', a tool developed for goal setting and relapse prevention for Indigenous people.

Although continuous treatment plans are found throughout the notes in client files, there is little evidence that clients or carers make active contributions to the treatment planning.

The MHRSA requires that a discharge plan is prepared prior to discharge (section 89 (1)), and must contain arrangements for accommodation, psychosocial wellbeing and ongoing psychiatric treatment and must be capable of being implemented (section 89 (2)), clients and their families must be consulted (section 89 (3) & (4)). The plan must be recorded in the client file.

The CV Panel has commented on the lack of evidence of understanding of the client's bio-psychosocial situation forming the basis for discharge planning. The Panel and CVs also noted that there is lack of evidence that clients and carers have been consulted or had any active contribution into discharge plans.

2.1.4 Procedures

Communication and Data Management

Communication of client information is a critical component to enable informed decision-making. The CVP has been told that electronic information systems with the NTMHS are not as compatible as one would expect. It is important that the NTMHS ensure that communication systems have robust policy frameworks, which include practices to integrate information from a variety of sources, and are not reliant upon individuals.

Case Example

Lorraine's experience – Communication issues

Lorraine is the adult daughter of Mark and lives interstate. Leading up to and during the admission of her father, Lorraine had repeatedly contacted the NTMHS about her concerns for her father's deteriorating mental health and stressed the importance of close follow-up and the need for a CMO. Mark was discharged on a CMO. He gave a temporary address and phone number to the services and reluctantly agreed to accept medication. When Lorraine contacted the services four weeks later, she found that the community team had no knowledge of her father's CMO and the need for follow-up. It became apparent that the usual information-sharing between Inpatient and Community team had not taken place due to staff being on leave. There was no reliable system between the inpatient treatment team and the community team in circumstances when clients require follow-up of new CMO.

After intervention by the CVP, the NTMHS responded immediately and a new procedure was implemented whereby, irrespective of staff absences, client follow-up would occur particularly when a CMO is in place.

Following on from the 2011-2012 visits, there was a special inquiry into communication processes of the CAMHS Community Team during 2012-2013 (see also 'Significant Issues' and Appendix 2). The Panel was pleased to find major improvements in accuracy and consistency in the use of the Community Care Information System (CCIS). Unfortunately, hospital hand-written notes are still not routinely transferred to CCIS.

New inpatient assessment and management templates are soon to be incorporated into CCIS. These templates incorporate identification of carer, language and GP/PHC, early planning for discharge as well as bio-psychosocial and longitudinal risk assessment. When implemented the CVP considers this as a significant improvement on the previous documentation standards.

Accuracy of information

It is critical that information is accurate and not based on hearsay or assumptions, as it directly affects decision-making.

A client complained that information provided to the Mental Health Review Tribunal was not correct. Although this information was not used as the basis for the decision to make an involuntary order, it was viewed by the client as untrue and hurtful. The CV reviewed her file notes and liaised with her consultant. The consultant acknowledged the reference to the client's risk of intoxication might have been included in the Tribunal documents in error and agreed with the client that this was an issue of concern.

Although medical records are legal documents and great care is taken to ensure information is correct, it should be acknowledged that inaccuracies in records do occur and that they are able to be rectified.

Electroconvulsive Therapy (ECT)

In the NT only the Inpatient Unit in Darwin has an ECT facility.

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

The use of ECT needs to be approved by the Mental Health Review Tribunal under section 66 (2)(a) and further in the 'Guidelines for Acceptable Standards for the Practice of Electro-Convulsive Therapy in the Northern Territory' (the ECT Guidelines) and the NTMHS Approved Procedures.¹⁴

The CVP hears concerns about ECT more than any other treatment. The MHRSA provides guidelines in section 66 that ensure the use of ECT is approved by the person receiving treatment and/or the carer's consent, where possible. Timely and sufficient consultation and provision of information about the treatment is essential.

Case Example

Eva's experience – Quality of Information

Eva's son Jacob had been in treatment for several weeks. While Eva and her family were happy overall with the treatment and their contact with the staff, they became very concerned when ECT was suggested as a treatment option. Eva had heard bad things about ECT and the family was worried because they felt that this decision has been taken too quickly and they wondered if all other options had been explored.

The CVP arranged for a meeting in which the family could raise their concerns with the treating consultant. The consultant acknowledged the fears and explained in depth the reasons for ECT for Jacob, the potential outcome, side effects and procedure. The family was also given a tour of the ECT facilities.

The meeting concluded with the decision that ECT would not commence for the time being. After the meeting Eva and her family felt much more assured that ECT could help Jacob and next week she indicated that the family was happy to go ahead. The family appreciated the opportunity to gain more information about the treatment and time to consult with the extended family.

TEMHS have available a DVD that explains the procedure to clients and families. A special DVD was made within the unit, which is available in several local Aboriginal languages. TEMHS reports that the DVDs are regularly used to educate clients and their families and carers.

¹⁴ The NTMHS Approved Procedures provide 'guidance to the legislative requirements relating to the performance of ECT (including licensing, consent, authorisation, reporting and notification) Department of Health, *Approved Procedures to the Mental Health and Related Services Act, 2009*, 2nd Edition, Part 12: ECT.

This year the TEMHS CV Panel enquired into ECT at the practices and facility for the first time, which included a review of the ECT Guidelines. The findings and recommendations are described in the 'Recommendations' section.

Enquiries and complaints about ECT are not common at the MHU, as the procedure is not conducted in Alice Springs. Clients who require ECT are sent to Darwin for the procedure. However the need to travel can cause additional issues for Central Australian clients requiring ECT.

A client complained that he thought his consultant was punishing him by making him have ECT. The client was very unhappy about this and he was afraid of the unknown side effects. He was also unhappy about travelling to Darwin and being away from his family. The CV liaised with the visiting consultant about these concerns. The consultant believed it was the next 'therapeutic step' as the client was not responding well to the current treatment and thought that ECT would be of benefit to him.

This consultant left the service and was replaced by another locum consultant who, within one week of treating the client, decided against ECT. It was explained to the CV that the locum consultant was had decided on a different medication regime and the client was responding positively to this. The client was subsequently discharged without the need to be sent to Darwin for the treatment.

The CVP acknowledge the expertise and authority of the treating doctor in treatment decisions. However, the CVP suggest that better information about the treatment options and the basis for the decisions would assist the client in their understanding of the benefits and may dispel concerns about the treatment.

Procedures around Involuntary Admission

Section 39 & 42 of the MHRSA deliver the legal framework for involuntary admissions. The NTMHS Approved Procedures provides guidance as to how this should be undertaken. The 'Form 10' provides evidence of this procedure, and is sent to the Principal Community Visitor pursuant to sections 41(1)(e)(i) and 43(1)(e)(i).

The CVP also receives the lists of the weekly Tribunal hearings, which includes also people who have been discharged or have become voluntary patients since their involuntary admission. The CVP checks the numbers of people listed in these documents against the number of Forms 10 and thereby establishes the rate of compliance of NTMHS with the requirement of sections 41(1)(e)(i) and 43(1)(e)(i).

Because of the low compliance rate in 2011-2012, the CVP had recommended that procedures be put in place to ensure that CAMHS meets its legal obligation in this regard. A swift response was received from CAMHS with a commitment to improve. Notification processes have improved significantly in 2012-2013, beginning with a 22% rate of notification in the first quarter, to a 75% rate of notification in the last quarter.

For TEMHS, the overall rate of compliance in 2012-2013 has been 76% with a steady increase over the four quarters (87% in the fourth quarter). The CVP welcomes the improvement of both services in this area.

Whilst the overall compliance to notify has improved, the different parts of the form, relating to different requirements of the MHRSA, are often not at all or only partially filled out.

An involuntary admission must be authorised by two APPs. The second assessment must be undertaken within 24 hours for people with mental illness and 72 hours for people with mental disturbance. In a number of cases Form 10 does not evidence that a second APP has authorised the admission and in some cases the second assessment was not within the timeframe or no time was noted on the form.

The following sections are very rarely filled out completely.

Part C consists of four parts:

- The confirmation of the detention and the relevant section of the MHRSA
- The predicted date of the tribunal hearing
- The possible need for an interpreter
- The person's right to apply for an early tribunal hearing pursuant to section 41(4)(c) and section 43(4) (c), and possible need for an interpreter at the hearing.

Given that the Form 10 is the mechanism, which evidences the process of communicating the rights of clients and determining their need for an interpreter, this is an essential component of the form. In many cases it remains unclear if the client's need for an interpreter was identified, if the assessment took place with an interpreter, and whether or not their rights were communicated to them.

Form 10 is currently under review to improve parts of the form that are ambiguous and the CVP expects that an improvement in the form and compliance rate will occur in 2013-2014.

Security Staff and Other Uniformed Officers

Security Staff

Clinical staff are employed in the inpatient units because they have specialist knowledge and skills in mental health treatment and care.

Throughout 2012-2013, the CVP raised concerns about the presence of uniformed security officers, both in TEMHS and CAMH. The CVP requested that the ongoing role of security guards be clarified, particularly in relation to their role in managing client behaviours. The CVP also enquired what mental health training was provided for security personnel.

In TEMHS the CV Panel was informed in 2012 that the employment of the Security Personnel would be reviewed after six months. In 2013 the CVP was informed that security staff would remain on the ward ongoing.

In CAMHS the High Dependency Unit (HDU, now LSA) was out of use for the first quarter of 2012-2013. This resulted in the increased use of security guards in the management of clients. While the CVP acknowledges the need for client and staff safety and the role that security guards have in these instances, this was a matter of concern during CVP visits.

The General Manager of CAMHS provided a response to the CVP acknowledging concerns and explained that the security guards did receive basic mental health training and that in the future there would be less security guards at the MHU because the HDU would be operational.

Case Example

A CV was present when there was an incident with a client who was aggressive. A security guard and staff member restrained the client, and in the course of this the security guard spoke to the client in a manner, which could be seen as threatening.

It seemed inappropriate to the CV that the security guard spoke to the client in such a way. It was the CV's view that the clinical staff member who was present should have been the person to speak to the client instead.

The CVP will continue to monitor the use of security guards and the appropriateness of the policy.

Other Uniformed Officers

In the last report the CVP raised concerns about the presence of uniformed staff of Correctional Services or Serco (for refugees from detention centres) in JRU. Especially when there are more than two, their presence can be perceived as intimidating, and officers were frequently seen in the nursing station by the CVP. Concerns were raised that confidentiality of client information could be compromised.

This year the CVP noticed a significant improvement and reported that officers of Correctional Services or Serco were rarely seen in the nursing station. The CVP acknowledges this improvement.

During one CVP visit, two groups of approximately 12-15 staff each of Correctional Services entered CAU and later JRU in the company of the administration officer of the ward. Although they only remained for a short period of time, there had been no forewarning to the clients, nor any form of explanation. The CV noted that their presence felt intimidating. When the CV enquired about this visit, she was told that it was part of the orientation for new staff of Correctional Services. The CV raised the issue with the CNM, who stated that she had no knowledge of the visit and had not been approached by Correctional Services. The CNM did not approve this visit and stated that she would raise the issue with the relevant department.

The CVP emphasises the importance of ensuring client privacy and questions that orientation of staff outside of mental health staff should be clarified and managed.

2.2 Rights

The protection of the rights of people receiving treatment from NTMHS is one of the CVP's core functions. Section 104(1) and 111(2) of the MHRSA allow CVs and the Panel to monitor the adequacy of services for assessment and treatment of persons receiving treatment under the MHRSA. The CVP also monitors non-compliance with the MHRSA of any person employed by NTMHS.

2.2.1 Least Restrictive Alternative

The first object of the MHRSA 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 section 8(a). It states that the least restrictive or least intrusive treatment should be provided in the least restrictive environment.

This may have different applications in different scenarios. The MHRSA provides for involuntary treatment in the community, because this is seen as less restrictive than involuntary admission and treatment in hospital. In case of an admission an open ward is considered less restrictive than a locked ward and voluntary admission is less restrictive than involuntary admission. If 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'* (section 14(c)).

CVs and CV Panel members are obliged to review policies and practices which are likely to limit the freedom of people receiving care and monitor whether the treatment is in fact the least restrictive option.

Involuntary Admissions

A number of clients and family members have commented on the level of restriction they experienced by being admitted as involuntary patients. This is particularly concerning when clients are actively seeking help from NTMHS and want to be admitted as voluntary patients, but then find themselves admitted involuntarily. On occasion people have specifically asked not to follow this up with their doctors for fear of further restrictions, despite reassurance from CVs that this was not likely. It might indicate the level of mistrust and fear those restrictions have on client's perceptions of their treatment team.

Case Example

**Samuel's experience
Admitted involuntarily despite wish to be voluntary**

Samuel has had a difficult time in the last few months due to multiple stressors in his personal and work life. He has recently smoked increasing amounts of marijuana and felt mentally fragile. He talked to his mother Amanda about this and, after several intensive talks, was convinced to seek professional help. Samuel had never had contact with NTMHS before and went to the emergency department of the hospital. After several hours waiting time, he was assessed by an APP. Samuel described some of his recent symptoms and stated that he was looking for help and would feel safer being in hospital for a while. The APP stated that he would be involuntarily admitted.

He became very upset. His mother visited him the next day and stated that he was worse off than before, that she had never seen him this hopeless and that she was really worried about him. She spoke to the treating doctor and asked why Samuel was an involuntary patient, despite his own wish for admission. The doctor stated that he had been concerned about her son's possible suicidal ideation. Samuel was discharged a few days later with no further follow-up. Amanda stated that she thought that her son would be very unlikely to ever seek professional help again. His trust in mental health professionals had been broken and it had also impacted on their relationship. They did not want to follow up any complaints once Samuel was discharged, because they did not want to have anything to do with the services anymore.

The MHRSA states that a person can be voluntarily admitted if the APP considers that the person is able to give informed consent (section 25(7)). The CVP has repeatedly raised concerns about the levels of restriction used by NTMHS. The CVP acknowledge the expertise and authority of the treating team in treatment decisions however it remains unclear in some cases as to why APPs choose a more restrictive practice when the client explicitly asks for, and consents to, an admission.

Case Example

Patricia's story: change from voluntary to involuntary status

Patricia was a client who had recently been discharged and had returned voluntarily to the inpatient unit. Upon voluntary admission, she was heavily medicated and slept through the night. The next morning, Patricia discovered that her status had been changed to involuntary. She did not remember being assessed to have her status changed and felt powerless and distressed. Upon review of the file, the CVP found that there were questions in relation to section 9(m), 10 and 14 in regard to the appropriateness of the action by the consultant in undertaking an assessment in which Patricia could not participate because she was asleep. This matter was raised with the consultant.

It is of critical importance to a person's rights that the legislated procedures are followed when decisions are made about the status of any person receiving treatment.

Level of Restriction in Facilities

The level of restriction for clients in Inpatient treatment is largely determined by the ease of access in and out of the facility particularly in relation to the doors of the wards being locked or unlocked.

TEMHS

Although TEMHS management has stated again in 2012-2013 their commitment to re-opening Cowdy Ward, no steps towards this have been noted by the CVP. The Panel has requested to be advised which steps are undertaken towards re-opening of the ward. No information in this regard has been communicated.

CAMHS

During 2012-2013 CAMHS changed the name of the High Dependency Unit (HDU) to the Low Stimulus Area (LSA).

During renovations, the doors to the MHU were frequently found locked during visits of the CVP. The ward has been consistently unlocked since the second quarter of 2012-2013 when renovations were completed and the LSA made operational. The locked status of the ward, coupled with the hospital-wide non-smoking policy, was the topic of a number of enquiries and complaints to the CVP, particularly in the first quarter of 2012-2013. The CVP commend the CAMHS for maintaining an unlocked ward for most of 2012-2013.

Rights of Voluntary Clients

The NTMHS policy states that voluntary clients are not permitted leave for 48 hours after their admission, however this does not appear to comply with the principles of the MHRSA.

The CVP was told that if the client wanted to leave within this time that nursing staff were to prevent them and contact the relevant psychiatrist who then assesses them for involuntary admission. It is believed that the initial introduction of the policy was in response to a sentinel event. However the blanket approach penalises all clients and does not allow for the consideration of individual circumstances and factors based on the level of need.

2.2.2 Legal Representation

Section 41(1)(c) and 43(1)(c) of the MHRSA require that a legal practitioner prepared to act for the person must be notified of their 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 2011-2012 Annual Report, the CVP commented on the change in the practice of legal representation and the resulting disadvantages for clients. 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. The Tribunal is now responsible for rostering legal

practitioners for Tribunal Hearings. Those lawyers represent their client only on the day of the Hearing.

Seth was aware of the processes around the hearing and his right to legal representation. The hearing for a CMO was a week later and he wanted to prepare for it with his legal representative. It was impossible to get in contact with a Tribunal-appointed lawyer any earlier than the afternoon before the hearing: apart from not knowing who would represent him, the Tribunal also stated that the report from the APP would not be available until the day before. Seth found this unacceptable and found other ways of getting a private lawyer.

With this arrangement, TEMHS cannot comply with sections 41(1)(c) and 43(1)(c) of the MHRSA because no legal representative is appointed until the afternoon before the Tribunal Hearing. In 2012-2013 the PCV wrote to the Department of Attorney General and Justice to query whether the issue of legal representation was being reconsidered and to raise the question of who was going to legally represent those before the Local Court for proposed treatment orders under the DSA. No response has been received to date.

2.2.3 NT Hospitals Non-Smoking Policy

The CVP does not argue for or against a smoking policy. However, the CVP must draw attention to the client feedback received on how those policies affect them. In particular, the CVP is concerned that the policy might lead to an increase in restrictive practices due to the additional stress clients feel.

Although some clients have stated that they understand the rationale of the policy, or have experienced the restriction as positive and were proud of the achievement of not having smoked for a certain period of time, the majority of clients describe the restriction as an unnecessary stress. Although nicotine replacements are readily available to all clients, many state that they do not feel much relief from them and continue to be stressed about the fact they cannot smoke.

As Cowdy Ward has remained locked, clients are restricted in their ability to leave the premises. Clients who have permission to leave the ward in company of staff have set times during the day when they are taken for walks and can smoke.

Nurses remind clients regularly in morning meetings that they cannot smoke on the ward and they might be fined. On one occasion a client had been found smoking in a toilet. Following this clients were told that they might incur the cost of over \$1000 if fire services were called due to smoke alarms going off.

Clients who are involuntarily detained under the MHRSA do not have a choice of leaving the ward when they want to smoke, nor are they considered able to make an informed choice whether to get treatment or not. The CVP does not think it appropriate that threats are made or that fines are imposed.

In Alice Springs, the lack of a LSA for part of the year further reduced staff ability to manage the escalation in behaviour associated with the client's addiction needs. It was noted by staff at MHU that while assaults on staff by consumers are infrequent, they are often related to smoking. Previously, when consumers were able to smoke in a courtyard attached to the ward, there were fewer assaults.

Robert is a consumer with a nicotine addiction. During an involuntary admission Robert was placed in seclusion on a number of occasions due to his expressions of aggressive behaviour. Staff indicated that this behaviour, and related seclusion events, may be related to his nicotine addiction, as the restriction to smoke was a recurring stress factor for Robert.

The CVP would like to see innovative, constructive ways considered by NTMHS to respond to client stress due to the policy.

2.3 Information

2.3.1 Access to Records Related to the Mental Health Review Tribunal

Section 132 of the MHRSA 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. Instead they must apply to the Tribunal and the Tribunal will decide if access will be given.

Since 2009 the CVP has raised the lack of procedural fairness. At present, the APP provides a report to the MHRT as evidence for the application of involuntary treatment. The client is not given access to this report until the day of the Tribunal Hearing, usually through the legal representative. There is little or no time to prepare a response.

The CVP repeats that this is not a fair process and expects that the policy around this matter will be reviewed. TEMHS has stated that policies and processes related to this were in progress and to be released in 2012-2013.

However the CVP has not been advised of any changes and the practice of not providing clients with any information prior to the hearing continues.

Case Example

Mick's experience - Access to reports

Leading up to the Tribunal hearing, Mick had asked the CVP about his rights in the process. A CV had explained that he could ask for a copy of the report to be given to him the day before the hearing. Mick also asked the CV to attend the hearing as his support. When the CV met him in the morning before the hearing, he stated that he had asked to be given the report, but it was refused.

During the hearing a number of events were described that were used as evidence to prove that a further involuntary admission was justified. Mick was angry that events he was able to explain rationally from his point of view were 'twisted' in a way that 'speak against me'. He stated that if he had seen the document at least the day before, he would have been able to prepare for the hearing in a fair way. As it stood, he 'had to think on my feet' and he felt severely disadvantaged.

When the CV asked the doctors why the report had not been given to the client as requested the answer was that this normally doesn't happen, because some of what is in the report would jeopardise the trusting relationship with clients.

2.4 Inspection of Seclusion and Restraint Registers

Section 62 of the MHRSA provides the legal framework for the seclusion of people in Approved Treatment Facilities. The MHRSA defines seclusion 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'*.

Seclusion is one of the most coercive and restrictive practices undertaken by a mental health service under the MHRSA. Under the principle of least restrictive treatment, seclusion should only be applied as a measure of last resort to prevent harm to the person or others, to prevent continuous destruction of property, or to prevent absconding.

The MHRSA outlines the criteria, which must be met before a person can be secluded, and the checks and balances in place to ensure the person's safety, which include regular medical and psychiatric reviews while the person is in seclusion. A senior nurse, medical practitioner or APP must cease the seclusion without delay if the criteria ceases to be met.

Mechanical restraint is regulated at section 61 and the MHRSA defines it as the *'application of a device (including a belt, harness, manacle, sheet and strap) on a person's body to restrict the person's movement'*. It is only to be applied if no less restrictive method of control is applicable or appropriate. The form of restraint, reasons, time and the person making the decision, have to be recorded in the Seclusion and Restraint Register (the Register) and the client file (section 61(12)).

Section 61(14) and 62(14) require that the CVP inspects the Register at least every six months. This is a crucial function of the CVP.

2.4.1 Seclusion and Restraint - CAMHS

In 2012-2013 the CVP inspected the Seclusion Register of CAMHS in January and June 2013 for the periods 16 July 2012 to 25 January 2013 and 26 January to 26 June 2013.

As in the previous Annual Report there were no seclusion events registered in the first review period due to the seclusion room being affected by renovations. Staff reported that clients who might ordinarily have been secluded were specialled in a low stimulus environment with access to their bedroom, but away from other clients and as soon as possible re-integrated into the open ward.

While the general trend of successfully employing other strategies to disperse potential risk situations continued in the second review period, the CVP also found a number of seclusion events. These affected one client who was secluded repeatedly and for some extended periods (up to 11 hours). The seclusion register did not reflect the number and other details of the events and is therefore not in compliance with section 62(12) of MHRSA.

Three clients were recorded in the Register as experiencing restraint, but the type of restraint was not noted. Two of the clients were people with co-morbidity of complex cognitive impairment and mental illness. The CVP has recommended that the requirements of the MHRSA be followed up with more diligence and will continue to monitor similar cases.

2.4.2 Seclusion and Restraint - TEMHS

During the 13 months from 1 June 2012 to 30 June 2013, there were two reviews done by the CVP. The Registers were reviewed on 11 and 14 January 2013 for the period June 2012 to November 2012, and 9 July 2013 for the second period from December 2012 to June 2013.

Ten individual client files were also reviewed. There were a total of 198 seclusion events. In calculating the rates of seclusion, the month of June 2013 was excluded to ensure that rates could be compared with previous review periods.

The first review period had a significantly higher number (131 from June - November 2012) then 59 in the second review period (excluding the month of June 2013). Compared to the previous period the number of events has decreased by 13% from 243 events in 2011-2012 to 198 in 2012-2013.

Length of Seclusions

The trend indicated in the Annual Report 2011-2012 of a decrease in the length in time of seclusions has not continued this year. With 29% of seclusions being over four hours the CVP has noted an increase. Some of the events extended over several days with the longest one being over 166 hours. Six other seclusions were recorded over 48 hours. In the second review period two men under 25 years were subjected to the longest and most repeated seclusions (14 seclusions over one month).

The CVP also noted that a significant number of seclusions continued despite no apparent signs of agitation in the client over extended periods. The reasons for these are unclear. Some file notes indicate that staff wanted to await the commencement of the day shift, or were concerned about possible aggression by the client, despite them showing no sign of agitation over several hours.

The CVP has raised concerns about these practices and will continue to monitor this.

Case Example

During a night shift an APP described a patient as '*asleep but rousable*' and decided to continue the seclusion because nurses felt that it was unsafe to release the person given the level of aggression during the day.

In recent months the CVP noted some attempts to reduce the time spent in seclusion by keeping individuals isolated in other areas of the Joan Ridley Unit to ensure client and staff safety or to break the seclusions and re-seclude only if this was seen as necessary.

Interventions around seclusions

In this reporting period the CVP paid attention to pre- and post-interventions, which are recorded in the forms used to record details of seclusions. The use of pre-interventions demonstrate attempts to de-escalate potentially hazardous situations and with the aim of avoiding the use of seclusions. Post-interventions give a sense of the care after a potentially confronting and negative experience for the client. They may also indicate strategies to prevent further escalation and potential further seclusions.

More than one intervention can be employed prior to or after the event. In 57% of the seclusion events in 2012-2013, de-escalation strategies were employed before the seclusion, in about half of the events PRN was used to contain the situation. Just over a quarter of clients who were subsequently secluded received one-on-one attention before the seclusion.

In the post interventions 19.5% received PRN after the seclusion and 41% of clients were debriefed.

Section 62(9)(g) of the MHRSA states that the person in seclusion must be provided with any 'psychological or physical care appropriate to the patient's needs. The CVP has raised concerns about the apparent lack of any other interventions to facilitate client comfort or reassurance especially during extended periods of isolation.

Case Example

Marilyn's experience

Marilyn complained to the CV that she had been placed in seclusion. She was assessed in the Emergency ward, and placed in seclusion overnight. According to her reports she was not really spoken to by anybody until the next morning when she was being assessed by an APP. She stated that 'I felt horrible, because all I needed was someone to talk to and not to be left alone in a bleak and cold room with no contact and comfort.' She was discharged on the same day because she was not assessed as being at risk.

Cultural Safety

An intervention option that is considered useful for Indigenous clients is to involve an Aboriginal Mental Health Worker (AMHW) or interpreters. The CVP acknowledges that they are not always available, that a crisis situation does not always allow to provide such interventions and that the involvement of additional people might be contra-indicated. However, AMHWs and/or interpreters can be involved in managing clients during (especially if prolonged) or after seclusion. According to the register and reviewed files, their involvement in 2012-2013 remained minimal.

Just over half (51%) of all seclusion events in this period involved Indigenous people. The involvement of AMHW around seclusions was recorded on eight occasions, three of them in the last month reviewed, June 2013. The CVP could not find any involvement of interpreters at the medical reviews.

Given the high number of Indigenous clients on the ward and the extensive body of local evidence-based knowledge of culturally safe practices, the CVP is concerned about the lack of culturally safe practices around the highly volatile crisis situations.

Case Example

Simon

Simon, a young Indigenous man had been an inpatient for about one month and was nursed on Cowdy Ward. He had been granted accompanied leave and was described as 'settled, bright and reactive, with no overt psychosis'. After one such outing he was agitated. Staff raised concerns that a conflict with another Indigenous client on the ward could emerge. Simon was moved to JRU to avoid a possible escalation. Simon showed signs of frustration which led to a seclusion of four hours and another one over nine hours the next day. Although he was asleep he remained in seclusion. The CVP could not find any evidence that the move to JRU had been explained to Simon, or that any other attempts of cultural intervention or involvement of an AMHW or interpreter had been undertaken.

Other culturally and linguistically diverse (CALD) clients and their possible needs for interpreters are currently not identified on the forms related to seclusion.

Observations and Medical Reviews

Section 62(8)(b) of the MHRSA and Approved Procedures require that a person in seclusion is to be observed by nursing staff every 15 minutes, and a medical review by an Approved Psychiatric Practitioner is to be conducted every four hours.

The observations are generally recorded within the time frames, occasionally more frequently. The medical reviews were late on 13 occasions; on another four occasions the APP did not note the time of the review. On 11 occasions the medical reviews have been missed altogether; including three occurring during one extended seclusion period of 44 hours.

Case Example

A medical review was 1 hour and 15 minutes late, but the client was released from seclusion at the review. It raises the question of whether the seclusion could have ceased earlier had the review been on time.

There appears to be a tendency to delay the cessation of seclusion of individuals until the APP who is generally responsible for the treatment is on the ward.

Notification of Carers and Guardians

Section 62(15) of the MHRSA requires notification of a person's adult guardian (as defined in Section 3(1) of the *Adult Guardianship Act*) as soon as possible after the seclusion. The Approved Procedures state that it is expected that family members or carers be notified of seclusions, however there has been limited evidence that this takes place. In the 2012-2013 reporting period, family members were notified twice and there is evidence that a guardian was notified once. Although not a legislative requirement, the CVP believes that advising family members or carers of seclusion events and offering support, such as debriefing opportunities, is good practice.

Other restrictive practices

In recent years the practice of removing clothes from any client going into seclusion has changed to this only occurring if concerns for client's safety were evident. The CVP welcomes this change, because it helps to preserve the client's dignity as much as possible. In this review period the removal of clothes was recorded four (4) times due to the individuals attempting to hang or strangle themselves.

In file reviews the CVP found three (3) references to other restrictive practices, but details were not recorded, nor were they found in the Register.

Transport of Clients

Patient transport from remote communities is routinely undertaken by sedating clients. On occasion mechanical restraints such as handcuffs are also used. It is difficult to measure the degree to which misunderstandings based on language and culture contributes to more restrictive practices is difficult to measure. The anecdotal evidence the CVP has gathered is enough to raise concerns.

The intubation of mental health clients when transported via chartered air travel to a treatment facility has been accepted practice because of the perceived risk associated with the air travel. The CV enquired why different levels of restriction are not considered such as mechanical restraint and the use of PRN. The CV raised concerns associated with the practice and requested clarification about the necessity to intubate clients as a mandatory measure. The CV further queried what the guidelines are in relation to patient travel.

The NTMHS provided the Safety & Travel Guidelines and met to discuss the issues. The NTMHS highlighted that it was not the policy of Department of Health but of the air charter company. The NTMHS made a commitment to raise the issue of the air carrier policy to ensure that the client's rights, dignity and care was based on the principles of the 'least restrictive in the least restrictive environment'.

The CVP will continue to advocate for a practice orientated at the principle of least restrictive options and more individual assessments of needs.

3.1 Secure Care

A New Legislation and Model of Care

The *Disability Services Act* provides the legislative framework to enable the operation of Secure Care Facilities in the NT. Secure Care Facilities provide involuntary therapeutic treatment to adults with complex cognitive impairment who are engaging in repetitive high-risk behaviours which are likely to result in harm to themselves or to other people. To be assessed for admission to a Secure Care Facility, people must meet these criteria and be likely to benefit from involuntary therapeutic treatment.¹⁵

The objective of the Secure Care Model is to provide a safe, structured and stable environment in which clients are encouraged to learn new daily living, social and communication skills and manage their reactions to triggers for their high-risk behaviour.¹⁶ It provides one option in a range of therapeutic, treatment and accommodation responses for clients who require high levels of support.

The principles that underpin the care and treatment are based on the least restrictive option as is possible in the circumstances and to ensure that the client continues to obtain therapeutic benefit. The jurisdiction of the CVP includes the Secure Care Facilities (of which there is presently one) and Appropriate Places where people are held under supervision orders.

In this early stage of implementation there has been an incomplete rollout of the two-tier Secure Care Model. The stabilisation and assessment stage has not been utilised and the reintegration component to support clients' transition to less restrictive community options is yet to be implemented. Furthermore, the related service components and pathways are yet to be articulated.

The change in policy to not establish a Secure Care Facility in Darwin and have only one facility, Kwiernpe House in Alice Springs, represents a significant reduction in treatment options in the Top End. It potentially means that clients from areas outside of Central Australia have to be located away from their familiar environment, social and cultural supports, or to not have the benefit of Secure Care available at all. It is the view of the CVP that the need for such an option in Darwin has not diminished and the lack of options for clients with complex needs remains unaddressed (see also Significant Issues- Lack of Housing and Support Options).

3.2 The Community Visitor Program in Secure Care

Sections 55, 56 and 63(1)(2)&(3) of the DSA articulate the role of CVs and CV Panels in Secure Care Facilities and Approved Places. The CVP inquires and makes recommendations about the adequacy of information relating to rights of the residents, the effectiveness of complaint procedures and any matter relating to the treatment and care. The Principal Community Visitor is responsible for ensuring that the CVP meets its obligations as set out in the DSA.

The CVP visit Kwiernpe House at least once each month and each of the Appropriate Places at least once every three months. The CVP may also make additional, unannounced visits or visits in response to a request from a resident.¹⁷

¹⁵ The MHRSA defines a person with a cognitive impairment in Section 6A(1) and (2)

¹⁶ Department of Health, Aged and Disability Secure Care Progress Update June 2012, accessed at:

http://www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=other/74/96.docx&siteID=1&str_title=Secure%20Care%20Progress%20Update.docx

¹⁷ Community Visitor Program and Aged & Disability Protocol, April 2013, internal document.

If serious matters arise the CVs and CV Panel may refer them to the Principal Community Visitor who may notify the CEO of the Department of Health, or to the CV Panel for immediate investigation, or specific consideration during the next scheduled visit. The CV Panel established for the Secure Care Facility of Kwiernpe House, visit at least once every six months.

No visit by the CV Panel has taken place in the review period, because Kwiernpe House had been operational less than six months.

3.2.1 Establishing the Community Visitor Role

The CVP has undertaken substantial preparation towards the implementation of the new jurisdiction for people in Secure Care Facilities. In this period the CVP liaised closely with senior staff in Aged and Disabilities Services, non-disability services and contributed to the development of legislation, policies and procedures.

The CVP has existing systems and expertise from its role in NTMHS. This has enabled the CVP to establish the relevant mechanisms for the additional legislative functions quickly. While there are similarities in operation of the CVP, it is also important to note the Secure Care monitoring function is distinctly different in its operation and objectives.

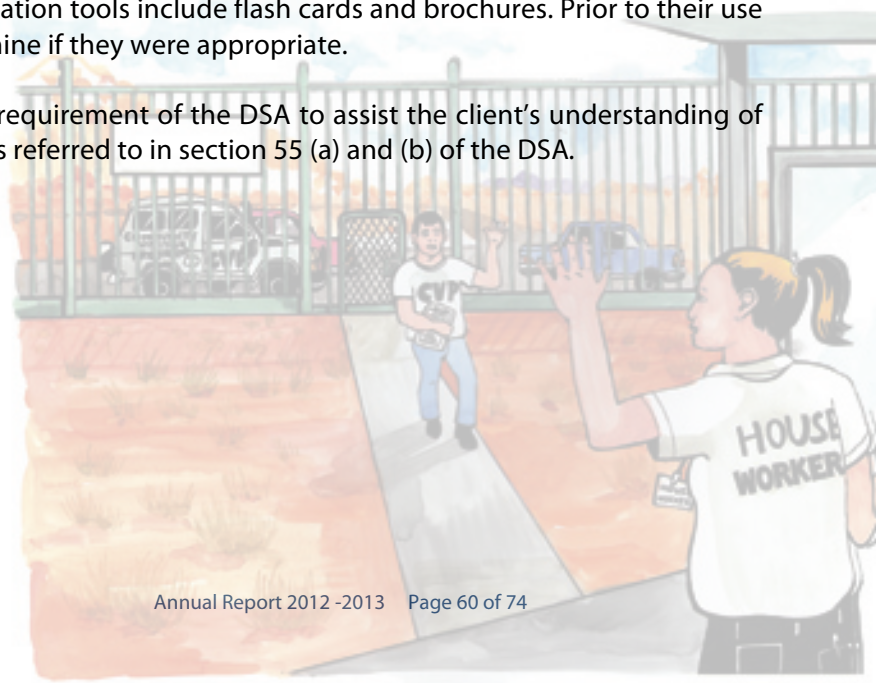
A protocol was developed by both organisations. It is the first such protocol, developed to guide the relationship between the two agencies detailing the role and responsibility of both the Community Visitor Program and the Aged and Disability Program.

The CVP engaged a specialist in the area of complex cognitive impairment to expand the knowledge within the CVP and to assist in developing contemporary tools to assess the adequacy and standard of the practices and processes employed. The CVP recruited an Indigenous male as a CV to assist in building relationships with clients.

Disability Services provided training on the legislation and associated policies and procedures to CVP in Alice Springs and Darwin. In turn, the CVP training was provided to staff at Kwiernpe House in Alice Springs and Yirra House in Darwin.

The CVP developed culturally and linguistically appropriate communication tools about the CVP to inform clients of the role of the CVP and how it can assist them during their admission as shown throughout this section. The communication tools include flash cards and brochures. Prior to their use they were trialled with clients to determine if they were appropriate.

Whilst this is good practice, it is also a requirement of the DSA to assist the client's understanding of their rights and the complaint processes referred to in section 55 (a) and (b) of the DSA.



3.2.2 CVP Activities since Commencement of Service Provision

Kwiernpe House was opened on 3 April 2013. Two visits pursuant to the legislation were undertaken from April to June 2013. There was one client in the facility at the start date. Another client was being gradually oriented to the facility. The findings of the CVP are fairly limited at this stage, because only two visits have taken place in the review period.

Staffing of the Secure Care Facilities

The CVP acknowledges that Disability Services have made a commitment to recruit people who demonstrate not only appropriate qualifications, but also their commitment to values around person-centred services which contribute to maximum choice and participation for clients.

The recruitment of staff proved a greater challenge than anticipated. This resulted in a delay for the opening of the facility. Key positions such as an occupational therapist remain unfilled, which impacts on the capacity of the service to provide functional assessments.

Assessment and Treatment

Following the negotiated procedure, the CVP received all relevant documents, detailing a copy of the Behaviour Management Plan with the client history, and associated order.

The review of those documents showed that although risk behaviours were identified, there is limited evidence about how the risk behaviours were being addressed and how those strategies were being measured to ameliorate the behaviour. The CVP views this as a necessary strategy to support future transition to the least restrictive environment, as is the objective of the admission. The CVP will continue to monitor and provide advice to the facility as well as refer any issues associated to the Review Panel.¹⁸

Activities

The CVP commends the Kwiernpe House staff in offering the diverse range of activities for the clients, but also hopes that a comprehensive cultural safety strategy will be developed to support extensive community activities.

Facilities and Procedures

The building of Kwiernpe House was purpose-built and has an open plan layout with a view to outside areas and the living areas. The CVP was pleased to see that there is a large area in the back of the building for which gardening and outdoor recreational activities are planned. The building is locked and there are varying levels of security access in the different parts of the facility.

¹⁸ Section 40 Review of behaviour support plan – review panel, DSA

Indoors consists of the entrance area, offices and assessment rooms, an enclosed staff area with windows all around, a shared kitchen and living areas. The bedrooms have en suite amenities and each has a private outdoor patio. There is a seclusion room.

On both visits the CV observed that the building was clean and orderly, the atmosphere was relaxed and interaction between staff and clients was amiable and attentive.

Given that the Secure Care model only commenced in April 2013, and the Disability Program is continuing to refine and develop this new service, it is too early to draw any conclusive findings from the initial visits. To date care and treatment has been provided in line with the relevant legislation and NT Disability Standards.

The CVP looks forward to continuing to work together with the clients, Disability Services and other key stakeholders to achieve improved service quality for people living in the Secure Care Facilities and Appropriate Places.



The core business of the CVP is receiving, investigating and resolving complaints and enquiries, visiting and carrying out the inspection and monitoring functions of these facilities. The priorities of the CVP over the next twelve months will aim to continue improving the program's capacity to meet its core functions.

In 2013-2014, the CVP will expand its role to provide enquiry, complaints resolution, advocacy and visiting functions for people detained in Mandatory Alcohol Rehabilitation Facilities under the *Alcohol Mandatory Treatment Act (AMTA)*.

4.1 Focus of Community Visitors and Panels

- Monitor and progress all open recommendations (see appendix 1).
- Monitor compliance of services in regard to the three Acts.
- Maintaining regular visits to all Approved Treatment Places and Facilities and places under each Acts.
- Monitor workload capacity and CVP processes to ensure best outcomes for clients.
- Advocacy in relation to appropriate accommodation, particularly for those with complex needs
- Advocacy in relation to restrictive practices.
- Advocacy in relation to cultural safety, particularly in relation to Aboriginal people.
- Advocacy in relation to early intervention, particularly in the context of early psychosis interventions.

4.2 Internal Processes of the Community Visitor Program

- Continue to develop structures and processes to consolidate the expanded role into DSA and AMT.
- Review strategic and business planning.
- Review and improve internal information systems.
- Review and update the CVP Handbook.
- Manage expansion of CVP.

4.3 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 in the areas of mental health, disability service provision, and alcohol rehabilitation, relevant to the CVP role and practice frameworks in these areas.
- 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 in NSW.
- Encourage staff to utilise clinical supervision as a means of ongoing reflective practice and professional development.

Community Visitors and CV 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 NTMHS management. If this is unsuccessful, and the matter remains unresolved over time (generally about six months), the Panel or CVP is likely to make a recommendation.

The CV 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.

Open Recommendations

CAMHS

Recommendations	By	Date	Status
<p>1 It is recommended that discussions between CAMHS and AIS management and training officers resume in order to develop a training package assisting interpreters in their understanding of mental health issues.</p>	CV Panel	June 2013	OPEN
<p>2 The recommendation of April 2012 (closed in Nov 2012) about the non-smoking policy be revisited as follows: It is recommended that CAMHS doctors and management give further consideration to the exemption from the hospital non-smoking policy when appropriate to inpatient’s clinical outcomes, and to allow doctors to use their professional judgement case-by-case in this respect.</p>	CV Panel	June 2013	OPEN
<p>3 It is recommended that the MHU address the lack of physical movement and activity programs for clients, including contingency plans to ensure that activities continue irrespective of individual staff availability.</p>	CVP Quarterly report	Apr – June 2013	OPEN

(Cont.) CAMHS open recommendations

Recommendations	By	Date	Status
4 It is recommended that the position of the Social Worker of the MHU be made permanent as it complements that of the 0.5 FTE Occupational Therapist.	CV Panel	Nov 2012	OPEN
5 It is recommended that procedures be put in place to ensure that CAMHS meets its legal obligation to notify the Principal Community Visitor pursuant to s.s 41 and 43 of the MHRSA.	CVP Quarterly Report	Jan - March 2012	OPEN
6 It is recommended that there be close monitoring of the new referral process between the On-Call and Child and Youth Teams.	CVP Child & Youth Team inspection	2011-12	OPEN
7 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.	CVP inspection	June 2007	OPEN

TEMHS

Recommendations	By	Date	Status
1 It is recommended that an ECT committee be convened and that ECT ward rounds be commenced as per ECT Guidelines 2006 (p14 and 31).	CV Panel	April 2013	OPEN
2 As the ECT guidelines are being reviewed, the Panel recommends that the group reviewing the ECT Guidelines should contain an expert, external to the NT	CV Panel	April 2013	OPEN
3 It is recommended that management request a report from the director of ECT on evidence of quality activities, demographics of clients receiving ECT, the nature of consent and key clinical indicators for ECT across the patient population (p.18 ECT Guidelines 2006)	CV Panel	April 2013	OPEN

(Cont.) TEMHS open recommendations

Recommendations	By	Date	Status
<p>4 It is recommended that TEMHS seriously considers implementing an Early Psychosis Service based on the Australian Clinical Guidelines developed by Orygen Youth Health (2010).</p>	CVP Inspection Tamarind Centre	May 2012	OPEN
<p>5 It is recommended that APPs, 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.</p>	CV Panel	Nov 2011	OPEN
<p>6 It is recommended that all clients who are admitted voluntarily to the TEMHS Inpatient Unit are provided with:</p> <ul style="list-style-type: none"> • 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 client during the admission. 	CVP Quarterly Report	2010– 2011 Second Quarter	OPEN
<p>7 It is recommended that there are systems to ensure that AMHWs are integrated into the clinical care of all Aboriginal clients. There should be documented evidence of their role in individual client care.</p>	CV Panel	May 2008	OPEN
<p>8 It is recommended that for those under 18 admissions to the inpatient unit that are unavoidable, TEMHS develop with urgency a comprehensive framework for a 'youth friendly' inpatient service which also ensures youth under 16 have access to expert assessment and management.</p>	CV Panel	Nov 2007	OPEN
<p>9 It is recommended that the NTMHS ensure that interpreters are present at assessment for all clients whose first language is not English.</p> <p>It is further recommended that interpreter assistance be then arranged for all further assessments and to assist the client at any hearing before the Mental Health Review Tribunal.</p>	CV Panel	May 2007	OPEN

(Cont.) TEMHS open recommendations

Recommendations	By	Date	Status
<p>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 clients in the NT, and is developed collaboratively with client groups and mental health professionals.</p>	CV Panel	Nov 2006	OPEN
<p>It is recommended that discharge planning procedures be improved by identifying and referring to preferred ongoing General Practitioners</p>	CV Panel	October 2004	OPEN
<p>It is recommended that information services to Aboriginal clients be improved by providing greater access to AMHW including when admitted out of hours, advocating for improvements to the interpreter service and providing appropriate visual information material.</p>	CV Panel	October 2004	OPEN

Recommendations Closed in 2012-2013

CAMHS

Recommendations	By	Date	Status
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.	CV Panel	April 2012	CLOSED 2012-2013
2 It is recommended that the MHU arrange a meeting with the Aboriginal Interpreter Service (AIS) 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.	CV Panel	April 2012	CLOSED 2012-2013
3 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).	Community Visitor Remote Team Inspection	2011-12	CLOSED 2012-2013
4 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.	CV Panel	Nov 2011	CLOSED 2012-2013

TEMHS

Recommendations	By	Date	Status
1 It is recommended that funding is made available for the major works required to enable clients in JRU to spend some time outside each day.	CV Panel	Nov 2006	CLOSED 2012-2013
2 It is recommended that procedures to ensure TEMHS' legal obligations to notify the CVP pursuant to section 41 and section 43 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.	CVP Quarterly Report	2005-2006 Third Quarter	CLOSED 2012-2013

ALICE SPRINGS
COMMUNITY VISITORS PANEL

REPORT TO PRINCIPAL COMMUNITY VISITOR

Special Visit to
Central Australian Mental Health Service Community Team
June 6th, 2013

1. Introduction

The Community Visitors Panel (CVP) conducted a special visit to the community team of the Central Australian Mental Health Services (CAMHS) on **6th June 2013**. The visit was undertaken at the request of the Principal Community Visitor as a follow up of the previous visits of March and November 2012 in order to assess progress.

The CVP members conducting the visit were:

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

This third 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 purpose of the CVP visit was to gauge the response of the service to the outstanding recommendations. More specifically the CVP was tasked with undertaking an audit of documentation that help ensure client safety in the community and determine the progress made over the last six months in response to the findings of the November 2012 visit and its two recommendations which read:

The CVP ...recommends that by June 2013

- *A report on the implementation of the outstanding recommendations be compiled detailing the reasons for any delay.*
- *CCIS be used by all doctors, details in all sections of CCIS be completed including clear identification of current medication.*

This visit occurred over a half day and consisted in an audit of notes on CCIS cross-referenced against the hand written and/or hard copy notes of the Alice Springs Hospital (ASH) as well as an informative meeting with CAMHS Management, informal discussions with some staff members and mapping of the organisational chart and locations of services.

For the purpose of the audit, the CVP was provided with a list of all CAMHS clients referenced by case manager. A total of 370 clients are currently on CAMHS list, client names were cancelled and the CVP was given access to CCIS on two computers. The Panel members reviewed the joint CCIS and ASH hospital paper notes of 12 consumers who have been managed by the community team in the last 6

months. These clients were chosen randomly by choosing the first name from the top of each of 12 pages of listed clients. Coincidentally this meant that the notes of most of the case managers and doctors involved in outpatient care were represented in the selection. Alice Springs Hospital records were given the 12 numbers in advance and access to the corresponding notes raised no difficulty.

2. Findings

As a result of the visit, the CVP was satisfied that, since the last visit, improvements had been made in systems that ensure accrued safety and in the areas of communication and documentation within CAMHS.

The Panel met with senior management: the A/g General Manager Peter Thornton, the Clinical Director Dr Jo Holdaway, Dr Chris Turnbull (Consultant), Bronwyn Diahli (Community Team Manager). The Panel was pleased by the fact that CAMHS seems to have found some working balance. The Clinical Director and Doctors of the community teams are also providing hands on services within the MH Unit. The Panel appreciated the efforts made to maintain systemic lines of communication between all members of the team and to work in collaboration with the Mental Health Unit at the Hospital.

Staff Turn-Over Issue

There was no basic change to the Community Team structure. However the resignation of the General Manager (in March 2013?) resulted in the appointment of the CNM of the MH Unit as acting General Manager, waiting for the position to be filled. The double workload led to the very recent appointment of an Acting CNM. It is imperative to hasten the appointment of a separate General Manager so that CAMHS operations and organisation structure be restored with some basic stability.

The position of the Clinical Director (CD) established in early 2012 in answer to the first recommendation of the review has finally be made permanent. The CD's input in the systemic operations of the Service has been very successful. Unfortunately Dr Holdaway, Clinical Director, will be leaving the position after 2 years. She is confident that quality and communication systems are in place and the changes that have been made while in the position are sustainable.

Since last summer it seems that there has been no staff deficit in the Community team.

Case Management

The client list sometimes indicates the consultant psychiatrist as case manager, possibly in the case of outpatients only. But the detailed notes are clear in identifying who is responsible for the follow-up of each client in the community. Although psychiatrist may be listed as case managers, this is a reflection of CCIS rather than of doctors case managing clients. When doctors are listed as case managers this Panel is relatively confident that the client does not require case management.

Recommendations Implementation

Dr Jo Holdaway indicated that a written report on the progress of the implementation of the outstanding recommendations could have been prepared for the Panel but implementation of the recommendations was addressed for all 17 recommendations, one by one.

The Panel understood from Management that:

Recommendation 1. Actioned

The Director of Clinical Services position is established and made permanent.

Recommendation 2. Actioned

2013 Draft business rules for CCIS are on the Intranet, and will be finalized.

Recommendation 3. Actioned

The inclusion of new mental health risk and clinical assessment templates in the CCIS is close to being finalised.

Recommendation 4. Actioned

Risk Man: the quality audit tool is used by staff and regularly reviewed by the Management team

Recommendation 5. Actioned

Although CCIS is unchanged in this respect the new templates, which are being trialled allow for comprehensive bio-psycho-social assessment. Management is committed to continue to support use of the forms, through the Clinical Leadership Group.

Recommendation 6. Actioned

Doctors undertake a patient review every 3 months, and community team meet ½ hour daily

Recommendation 7. Actioned

Brief Community Team meetings are held daily and in the view of Management this has increased *Recovery* for some clients. Overall communication has improved. The ward discharge planner is responsible for notifying case managers about discharge meetings by email. Once a week there is a formal meeting.

Recommendation 8 & 9. Actioned

There is a whiteboard list of clients showing depot dates and 'overdue' events in the office. This is reviewed at each morning meeting. However, there is no reminder system on CCIS.

Recommendation 10. Actioned

For high risk clients only: discussed at multidisciplinary morning meetings and recorded. Risk fields in CCIS are used.

Recommendation 11. Actioned

All CAMHS clients cases are reviewed at regular clinical meetings; there is a rolling formal audit of cases. This has increased the number of 'up to date' case reviews in notes. High risk cases are more evenly distributed among Case Managers than in the past.

Recommendation 12. Actioned

There have been a series of meetings between CAMHS Management and MHACA .The complementary role of each was reviewed but the new MoU is not yet signed off.

Management reports a good working relationship with the association and Acting General Manager, Peter Thornton, meets with MHACA management monthly. Management says that the discharge planner also has a good working relationship with MHACA, and there is a sense of dual case management with the community team, and that they have excellent staff.

Recommendation 13. Actioned

There is a monthly audit of documentation with a series of simple question. It is a quantitative audit and similar to the New Zealand (RANZCP) clinical review programme. There is a cross-jurisdictional audit of notes. TEMHS audited CAMHS notes and vice-versa. In 2012 this was conducted on notes from the Community team and in 2013 a similar audit was conducted on Inpatient Unit notes.

Recommendation 14. Actioned

Outpatient cases are reviewed 3 monthly in the rolling review at clinical meetings. On CCIS doctors are still recorded as case managers as this field is required by the CCIS system. However these clients do not require case management.

Recommendation 15. Actioned

Video-conferencing is used, with the Barkley as a project site. The un-reliability of technology is still a barrier to expand this system of review.

Recommendation 16. Actioned

Unreliable clients are referred to the case management team.

Recommendation 17. Actioned

A Critical Incident Protocol has been established. Breach of standards are reported and discussed at the weekly management meetings, and monthly reviews of RiskMan.

Systems are not optional anymore, there is clinical leadership, and new staff have a four hour orientation to systems.

The Panel was satisfied that all recommendations have been complied with, some with greater success than others. The Panel's recommendation of November 2012 can be closed.

3. Case Note Audit

The CVP's main objective was to evaluate the relation between client safety and documentation, and how extensively the CCIS system is being used over hand written notes on the Alice Springs Hospital (ASH) files.

The Panel noted that CCIS documentation is increasingly used by case-managers as well as doctors and reflected improved team-work, involvement of other services and identification of PHC services or GP with copies of referral or discharge letters indicating a high level of care. Medications are recorded in progress notes (there is nowhere else in CCIS which is appropriate). Dispensing medication only happens from the ward and from the Depot Clinic. A hospital standard dispensing system is in place. In only one case, a prescription photocopy was included into notes. In another there was evidence on only one occasion in the last six months that the doctor did not use CCIS for outpatient recording. Within the hard-copy case notes of the ASH, psychiatric entries are in one separate section of the notes.

Notwithstanding major improvements and accuracy in CCIS notes, the hospital hand written notes are still providing a second set of information not automatically transferred to CCIS.

- It was among the case manager's progress notes that one could retrieve information about the psycho-social history or general background of a client. However, the new templates developed by the Quality team may provide an improvement.
- Language is identified mostly as 'English'. It is in the view of the Panel that interpreters should be offered for all assessments for mental health clients whose *first language* is not English.
- There is no clarity in finding risk assessment, except in progress notes. CCIS risk field refers to medication or medical risk.
- There is little evidence in CCIS of any attention to physical health. However, potential risks of physical complications of psychiatric medication are now clearly mentioned on 'risk assessment' section of CCIS notes.

4. Recommendations

It is the opinion of the Panel that the recommendations of November 2012 can now be closed, and that there is no longer need for another Special CVP Visit of CAMHS, as the team seems to be on the right track in their systemic guidelines.

P.S. With reference to recommendation 12: - it is now confirmed that the MoU between CAMHS and MHACA was signed by both parties on 3rd July 2013.

ADC	Anti-Discrimination Commission
AIS	Aboriginal Interpreter Service
AMHW	Aboriginal Mental Health Worker
APP	Approved Psychiatric Practitioner
ASH	Alice Springs Hospital
CAALAS	Central Australian Aboriginal Legal Aid Service
CALD	Cultural and Linguistically Diverse
CAMHS	Central Australian Mental Health Services
CATT	Crisis Assessment Treatment Team
CCIS	Community Care Information System
CNM	Clinical Nurse Manager
CVP	Community Visitor Program
DSA	Disability Services Act
ED	Emergency Department
GP	General Practitioner
HCSCC	Health and Community Services Complaints Commission
HDU	High Dependency Unit
JRU	Joan Ridley Unit
LSA	Low Stimulus Area
MHACA	Mental Health Association of Central Australia
MHDCCD	Mental Health Disorders and Cognitive Disorders
MHRSA	Mental Health and Related Services Act
MHS	Mental Health Service
MOU	Memorandum of Understanding
NAAJA	North Australian Aboriginal Justice Agency
NT	Northern Territory
NTMHS	Northern Territory Mental Health Service
PHC	Primary Health Care
PRN	'Pro Re Nata', medication used due to circumstances or as need arises
RDH	Royal Darwin Hospital
TEMHS	Top End Mental Health Services
Tribunal	Mental Health Review Tribunal