



CVP

NT Community Visitor Program
2014 ANNUAL REPORT

The Community Visitor Program is located in the offices of the Anti-Discrimination Commission in Darwin and located in the offices of the Primary Health Care Outreach Unit in Alice Springs.

Location:	Darwin:	7 th Floor 9-11 Cavenagh Street, Darwin NT 0800
	Alice Springs:	55 North Stuart Highway, Alice Springs, NT 0870
Postal Address:	LMB 22 GPO Darwin NT 0801	
	PO Box 721 Alice Springs, NT 0871	
General Enquiries:	Telephone:	(08) 8999 1451
	Free call:	1800 021 919
	Facsimile:	(08) 8981 3812
	Email:	cvpprogramadc@nt.gov.au
	Website:	www.cvp.nt.gov.au

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

LMB 22 GPO Darwin NT 0801
PHONE 08 8999 1451
FREECALL 1800 021 919
FAX 08 8981 3812
EMAIL CVPProgramADC@nt.gov.au

www.cvp.nt.gov.au

Dear Minister

In accordance with Part 14, section 115 (1) of the *Mental Health and Related Services Act*, Part 6, section 66 (1) of the *Disability Services Act*, and Part 5 Division 2, section 101 (1) of the *Alcohol Mandatory Treatment Act*, I submit the Annual Report on the operations of the Community Visitor Program for the period 1 July 2013 to 30 June 2014.

Yours sincerely



SALLY SIEVERS
PRINCIPAL COMMUNITY VISITOR

30/9/2014.



Introduction from the Principal Community Visitor

It is with pleasure I present the Community Visitor Program (CVP) Annual Report, which for the first time will report under the *Alcohol Mandatory Treatment Act* (AMT Act).

The CVP Annual Report now covers three discrete areas, which illustrates just how the program has grown and how busy the program is.

The CVP even with its rapid expansion has maintained its independence and unwavering commitment to advocate for the rights of those most vulnerable in our community. Whilst there are some variations between the three pieces of legislation that give CVP its functions and jurisdiction the primary role of the CVP is advocacy, complaints resolution, inspection, monitoring and reporting.

Further, common to all areas monitored is the use of involuntary detention or restrictions on the liberty of those receiving services. The monitoring and oversight of the processes for admission, the care and treatment received, is vital when people are at their most vulnerable to ensure the protection of their human rights.

The report is comprehensive, and the challenge is for the significant issues and open recommendations in each area to be given appropriate recognition. The report outlines for each area what the CVP, from its activities over the year, views as significant issues and those that have been a focus and will be monitored over the coming year.

It has been an exceptionally busy year for the program as we have consolidated our involvement in the disability sector, visiting Kwiyrnpe House in Alice Springs and appropriate places. Also preparing for and commencing visits to the three Assessment Facilities and two Treatment Centres that deliver the Mandatory Alcohol program.

As will be set out below the number of complaints has doubled, the number of services reported on has increased considerably, requiring recruitment of staff, new panel members and sessional Community Visitors. This has also required development of systems and protocols, preparation of promotional material to explain our role and the modernising of our brand. Also to properly collate and appropriately report on the expanded services, the CVP has commissioned a new case management system.

Consistent with the approach the CVP has adopted in the past, the oversight is provided from an informed position. As was done with the expansion into disability, the CVP sought expertise and training from an alcohol specialist, as well as recruiting staff with experience and expertise in the area to inform our practice. This has assisted the CVP in identifying and providing practical recommendations on the application of national and international best practice guidelines and policies in the area of alcohol withdrawal and addiction.

It has been a very demanding year for the CVP. However, we have worked hard to create a cohesive and skilled team while also conducting the day-to-day role.

The CVP has a great team, all passionate advocates for the rights of those most vulnerable. I would like to acknowledge here the dedicated work of the staff, panel members and sessional Community Visitors.

The CVP acknowledges the challenges faced by the various service providers both government and the community sector whose services we monitor; and are aware that it has been a year of significant change for them.

The CVP is aware from experience over the years of the importance of working with service providers to achieve real change. We thank Dr Len Notaras and those in the different health teams for their co-operation and assistance throughout this year. It is crucial that Department of Health continue their approach of seeing complaints and queries raised as an opportunity to improve their systems and the essential services they provide to some of the Territory's most vulnerable citizens. We look forward to continuing and building on our good working relationship.

Finally and most significantly I acknowledge the people who the Community Visitors have spoken to, taken enquiries and complaints from throughout the year. It takes courage to raise issues of concerns, when you maybe at your most vulnerable or have a family member receiving mandated care.

A snapshot of the Community Visitor Program's achievements 2013 -2014;

- Managed the expansion of the CVP to undertake their role in monitoring the Mandatory Alcohol Treatment Program throughout the NT.
- Handled 774 complaint and enquiry matters, assisting vulnerable people in resolving 388 of those matters (an increase of over double the matters dealt with in the previous year).
- Fulfilled legislative requirements under the MHRSA, AMT Act, DSA, (with exception of 1 Disability Panel Visit) in the past year, including having a 99% response rate to requests for assistance within 1 business day.
- Maintained and developed strong and respectful working relationships with Department of Health staff and Non-Government organisations, despite the significant changes in structures and changes in leadership, staff and the complexities of the different areas.

SALLY SIEVERS
PRINCIPAL COMMUNITY VISITOR

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1.1 Vision and Mission Statement

Vision

The human rights and dignity of people affected by mental illness or cognitive impairment and people receiving Alcohol Mandatory Treatment services 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 *Mental Health and Related Services Act*, *Disability Services Act* and *Alcohol Mandatory Treatment Act*; and
- Promoting the rights of people in these circumstances 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 our clients, seeing the situation from their perspective, appreciating that all points of view are valid, striving to understand their journey and maintaining hope at all times.

Courage: We provide a robust service to our clients by giving frank comment, advocating for them, 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 the rights of individuals, including their right to high quality treatment and standards of care.

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*, *Disability Services Act* and *Alcohol Mandatory Treatment Act*.
2. Improve CVP governance and capacity to encompass the expanded role under the *Disability Services Act* and *Alcohol Mandatory Treatment Act* legislation.
3. Increase recognition of the CVP and its role throughout the Territory.

1.2 CVP Overview

The NT CVP is established under Part 14 of the *Mental Health and Related Services Act* (MHRSA), Part 6 of the *Disability Services Act* (DSA) and Part 5 Division 2 of the *Alcohol Mandatory Treatment Act* (AMT Act). The program is an essential component of a system of checks and balances designed to protect the legal and human rights of people receiving treatment from Mental Health, Disability, and Alcohol Mandatory Treatment services in the NT. It is also one of the mechanisms in place to ensure that the standard of the services provided under these Acts is of a high quality. The CVP is located in the Anti-Discrimination Commission to guarantee its independence from the providers of services.

1.2.1 Jurisdiction

The jurisdiction of the Community Visitor Program in Mental Health, Disability Services and Alcohol Mandatory Treatment includes a range of treatment facilities and agencies approved under the Acts.

Mental Health

Inpatient, outpatient and community mental health clinical services are provided in the Top End and Central Australia by two approved Treatment Agencies, Top End Mental Health Service (TEMHS) and Mental Health Central Australian Health Service (MH-CAHS). TEMHS covers the geographical area north of Elliott and MH-CAHS covers the area from Elliott to the South Australian border.

The Approved Treatment Facility for the Top End is the TEMHS Inpatient Unit at Royal Darwin Hospital, comprising Cowdy Ward, the Joan Ridley Unit (JRU) and the Contained Assessment Unit (CAU). The Approved Treatment Facility for Central Australia is the Mental Health Unit (MHU) located within Alice Springs Hospital.

Disability Services

One Secure Care Residential Facility has been established in the NT. Kwiyrnpe House in Alice Springs provides involuntary treatment and care for people with complex cognitive impairment who engage in repetitive high risk behaviours that are likely to result in harm to themselves or to other people

Two 'Appropriate Places', one in Darwin and one in Alice Springs, provide accommodation, supervision, care and treatment for persons with mental impairment, pursuant to Supervision Orders made under the Criminal Code.

Alcohol Mandatory Treatment

Approved facilities for the mandatory assessment and residential treatment of persons detained under the AMT Act were established in 2013 in Darwin, Alice Springs, Katherine and Nhulunbuy, as follows:

- Darwin Alcohol Assessment and Treatment Service, Medi-hotel, Royal Darwin Hospital
- Alice Springs Alcohol Assessment Service operated in a secure facility
- Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU), a non-government organisation in Alice Springs
- Katherine Alcohol Mandatory Assessment Rehabilitation Service, Katherine Hospital.

➤ Nhulunbuy Alcohol Assessment Rehabilitation Service

1.2.2 Principal Community Visitor

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

1.2.3 Manager Community Visitor Program

The CVP Manager is part of a seven-person team made up of six 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 mental health or alcohol mandatory treatment facility and for the secure care residential facility. Each Panel is appointed by the Minister for Health and has three members - a medical practitioner, a legal practitioner and a community member.

Additionally, the MHRSA empowers the Principal Community Visitor to establish a Special Community Visitors Panel to investigate and report on the overall operation of an Approved Mental Health Treatment Facility or Agency. For example, a Special Panel may be appointed if a visit to both an Approved Treatment Facility and Agency is necessary in order to investigate a particular aspect of treatment and care of a person or people receiving mental health services.

The Minister appoints one member of each Panel established under the disability services and alcohol mandatory treatment legislation to be the chairperson. The Principal Community Visitor appoints one member of each mental health Panel as chairperson.

Community Visitors Panels undertake the inspection and monitoring functions of the Program. Panel members are required, as a group, to visit the 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.

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.

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 and Alcohol Mandatory Assessment and Treatment facilities on a weekly basis so that as many clients as possible have access to a Community Visitor. Visits to Kwiernpe House occur on a monthly basis and Approved Places on a three monthly basis as clients have longer stays in these residential facilities. The Community Visitors respond quickly, within the same day if possible, to complaints and requests from clients. The legal obligation is to respond by 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.

1.2.6 Administrator Community Visitor Program

The Administrator ensures the corporate functions of the Community Visitor Program are carried out efficiently and effectively in accordance with relevant Acts, Regulations and Guidelines.

1.2.7 Advocate

Subsequent to the introduction of the AMT Act, the Advocate was appointed to provide independent impartial advice and advocacy to a person to assist them in their interactions with the Alcohol Mandatory Treatment Tribunal in Darwin. The Advocate's role is to provide information, assist the person to put their case and wishes to the Tribunal, and liaise with others to ensure the rights and instructions of the person are understood and respected.

1.3 Personnel 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 2014, one staff of the Anti-Discrimination Commission, employed under the Public Sector Employment and Management Act, were appointed as Community Visitors.
3. Sessional 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.
4. Advocate.
5. Administrator.

Community Visitors & Panel Members

CVP Staff Members



Sally Sievers
Principal Community Visitor



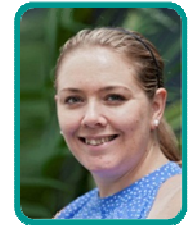
Claudia Manu-Preston
CVP Manager



Hiltrud Kivelitz
Coordinator
Top End



Tessie Reinsch
Coordinator
Central Australia



Alice Gibb
Administrator



Kaylene Arnell
AMT Advocate



Graeme Berryman
AMT Coordinator
Central Australia



Shona Lawrence
AMT Coordinator
Top End
(Resigned)



Margo MacGregor
AMT Coordinator
Central Australia
(Resigned)

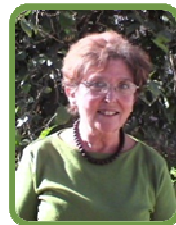
CVP Sessional Community Visitors & Panel Members



Alison Hanley
Chair



Georgia McMasters
Chair



Maya Cifali
Chair



Carly Ingles
Chair



Mark O'Reilly



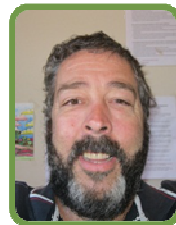
Sarah Giles



Kate Lloyd



Andrew Scholz



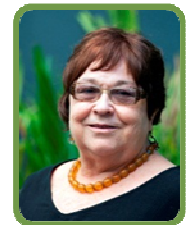
Caisley Sinclair



Julian Robinson



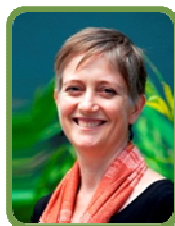
Elizabeth Keith



Pamela Trotman



Denise Taylor



Traci Keys



Ken Lechleitner



Teja Lipold



Garry Halliday (Resigned)

1.4 Performance of the Community Visitor Program

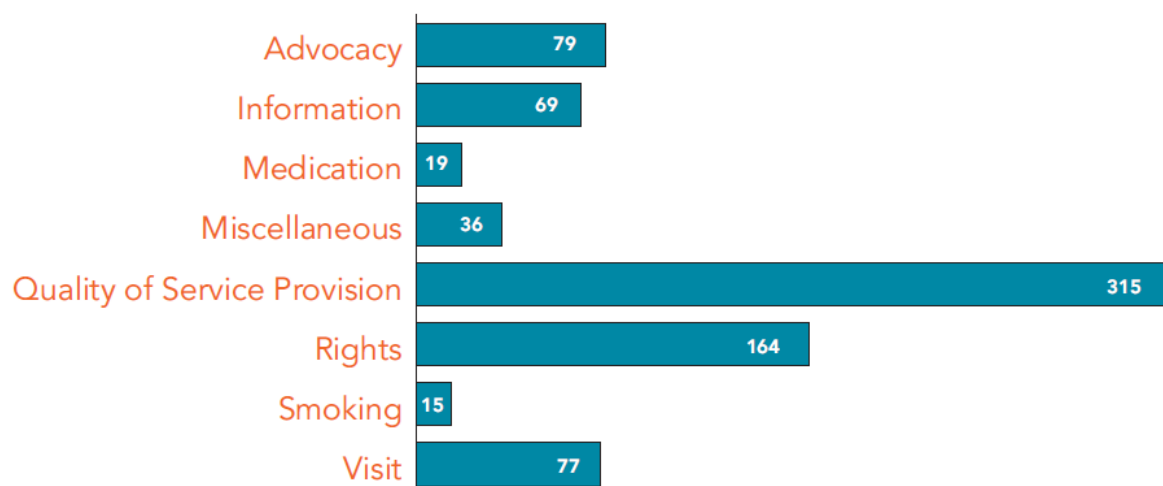
Performance of the CVP is measured against its legislative requirements and is reported under the Anti-Discrimination Commission in the Department of Attorney General & Justice Annual Report.

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 2013-2014 related to *Mental Health and Related Services Act, Disability Services Act and Alcohol Mandatory Treatment Act*.

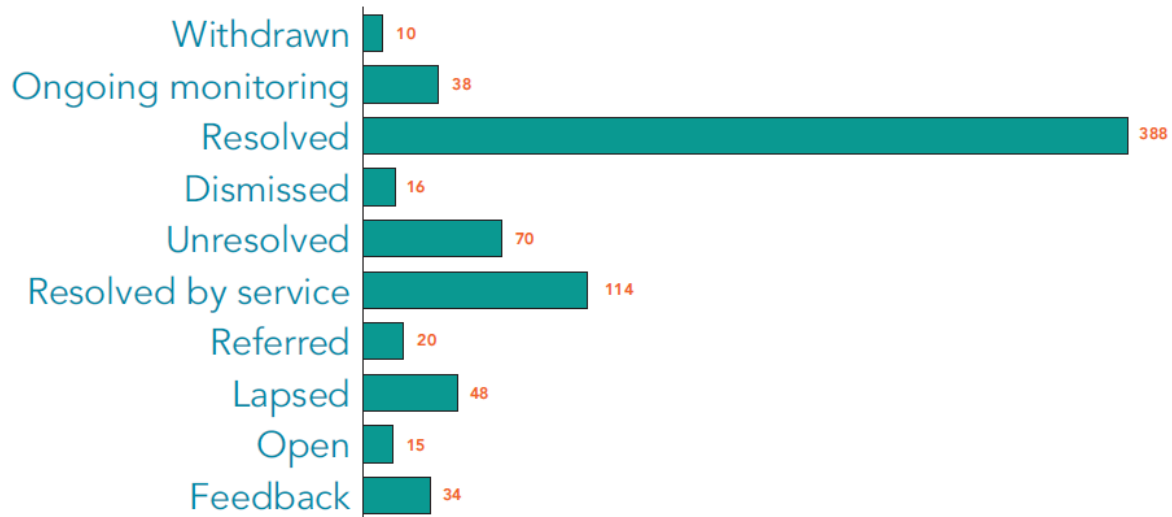
There were a total of 774 Complaints & Enquiries dealt with by the CVP Program during 2013-2014.

LEGISLATIVE REQUIREMENTS	TOTAL
CV Visits	267
CV Panel visits	7
Contact within 1 working day upon request	99%
Enquiries received	666
Complaints received	108

Categories of Enquiries and Complaints



Outcome of Enquiries and Complaints



The next part of the Report has been divided into sections to enable the reader to obtain all the information about the particular area in that section. The order has no priority of significance and has been determined by how long the CVP has been operating in the jurisdiction.

In the report people who receive treatment have been referred to using different terms throughout the document. This has been to keep in line with the term used in the respective legislation and in recognition that not all people receiving treatment are clients of the CVP.

Case examples are used to illustrate specific issues throughout the CVP Annual Report. In all cases details such as gender or diagnosis and location may have been changed to protect confidentiality with a view to protecting both the 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 2013-2014, are not detailed in this report.

Part 2: Mental Health Services

The *Mental Health and Related Services Act* (MHRSA) provides the legislative framework for the care, treatment and protection of people with mental illness in the Northern Territory.

The legislation includes provision for the review of the voluntary and involuntary admission and treatment of people in approved inpatient treatment facilities and approved treatment agencies in the community.

The jurisdiction of the CVP includes regular visits to approved treatment facilities and agencies and inspections by a Community Visitors Panel at least once in each 6 months.

2.1 Significant Issues

In accordance with the functions set out at section 104 of the MHRSA the CVP has identified the following areas as significantly impacting on the life and care of people living with a mental illness in the Northern Territory. They affect the provision of timely and high quality treatment and care in the least restrictive environment. These areas are key priorities for the CVP and need to be addressed as a matter of priority by Mental Health Services (MHS):

- ➔ Early intervention and young people in mental health services
- ➔ Seclusion and Restraint
- ➔ Cultural safety
- ➔ Supported housing and accommodation

2.1.1 Early Intervention and Young People in Mental Health Services

Early intervention is widely recognised as an effective way of preventing future episodes of mental illness, and reducing the severity of the impact of such episodes. Models of early intervention are primarily associated with care for young people, but are not restricted to this group. In light of this, the CVP has previously raised the need for a comprehensive model of early intervention to be implemented across MHS, but as yet this has not been actioned.

There are ongoing concerns for services provided for young people (12-25 years)¹ across the NT. The NT has the highest rate of youth suicide, twice as high as other jurisdictions in Australia,² and there are limited youth-specific services to address the complex and diverse mental health issues of this group. The NT Government has acknowledged the need for urgent action to address gaps in service delivery and implement prevention strategies. Commitment to this area was confirmed at the inaugural NT Suicide Prevention and Wellbeing Conference in June 2014, but to date, this commitment has not translated into actions that improve mental health services for young people.

When considering services for young people, the CVP promotes a comprehensive model of care, which includes early intervention, especially for psychotic episodes, staged interventions, reliable community support in close liaison with families, workforce development, a youth-friendly environment and care tailored towards the needs of young clients in inpatient care. Although some improvements have been made in recent times, the

¹ Congruent with definition of young people in Orygen Youth Health and Australian Clinical Guidelines for Early Psychosis (EPPIC Guidelines)

² Legislative Assembly of the Northern Territory: *'Gone too soon: A Report into Youth Suicide in the Northern Territory'* (2012)

CVP remains concerned about the lack of youth-specific services, or a comprehensive model of care, for young clients, in both community and inpatient settings.

The current practices of treating young people in adult inpatient units are concerning and, in the CVP's view, unacceptable. The CVP is also concerned at the use of seclusion and restraint for young people, even though the numbers are low. Furthermore, forensic mental health services for young people are extremely limited, particularly in Central Australia.

The CVP expects to see a greater commitment from MHS to implement more proactive strategies to address the issues of early intervention and youth mental health service provision.

2.1.2 Seclusion and Restraint

Seclusion and restraint are the most restrictive practices under the MHRSA and should only be used as a measure of last resort. They are not considered to be therapeutic interventions and are generally found to be traumatic for the client and others involved. This is particularly significant because people in an acute phase of mental illness or risk of self-harm already experience trauma, from their emotional and mental state, and often other life experiences. Whilst restrictive measures appear to be necessary in the moment of crisis to protect the person or others, the potentially negative long-term effects of restrictive measures may compound existing trauma and adversely affect treatment. Alternative approaches, such as sensory modulation, have been evidenced as assisting the reduction of seclusion and restraint incidences.

For many years, mental health services and Human Rights agencies in Australia and overseas have been committed to reduce or work toward eliminating seclusion and restraint (physical and mechanical);³ however, they remain widely used practices.

The National Mental Health Commission launched the National Seclusion and Restraint Project.⁴ It will identify why seclusion and restraint are still being used and develop strategies for further reduction and work towards elimination in Australian mental health services.

According to national figures from 2012-13, the Northern Territory has been identified as having the second highest seclusion rates in Australia, however it must be noted that, according to AIHW, the 'data from smaller jurisdictions should be interpreted with caution, as small changes in the number of seclusion events can have a marked impact on the jurisdictional rate'.⁵ It must also be noted that the NT rate fell between 2011 and 2013, with the figures showing a decline from 25.7 events (per 1,000 bed days) in 2011-12, to 15.8 in 2012-13. This decline in use of seclusion is to be commended. Comparative national figures for 2013-14 were not available at time of writing.

In 2013-2014, the CVP has noted some positive changes to seclusion and restraint practices in the NT (see section 'Inspection of Seclusion and Restraint Registers'). However, a number of significant issues remain, particularly in regard to the seclusion of young people, the

³ Survey of Seclusion and Restraint Initiatives in New Zealand: <http://www.tepou.co.nz/library/tepou/survey-of-seclusion-and-restraint-reduction-intiatives-in-new-zealand>

National Mental Health Consumer and Carer Forum: Ending Seclusion and Restraint in Australian Mental Health Services: <http://www.nmhcf.org.au/documents/Seclusion%20&%20Restraint.pdf>

⁴ National Seclusion and Restraint Project by the National Mental Health Commission <http://www.socialequity.unimelb.edu.au/seclusion-and-restraint/>

⁵ *Mental Health Services in Australia: Use of restrictive practices during admitted patient care* - <http://mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices/>

length of seclusion incidents, and the use of culturally-safe interventions for Indigenous clients.

The CVP has recommended that the MHS develop and implement an action plan to reduce the events of seclusion and restraint in the NT.

2.1.3 Cultural Safety

The term cultural safety refers to a responsibility of healthcare to provide care in a manner that is respectful of a person's culture and belief and free from discrimination. Standard 4 of the National Mental Health Standards expresses this expectation; and section 11 of the MHRSA sets out principles to underpin the admission, care and treatment of Aboriginal and Torres Strait Islander people.

Due to a range of social, economic and historical factors, Indigenous people in the NT are particularly disadvantaged and have poorer health outcomes. Additionally, many Indigenous people are strongly connected to their traditional cultures and values. For health services to be effective, they must be responsive, respectful and flexible to these needs.

The CVP regard that embedding culturally safe practices across all of the NT's MHS systems and processes is of critical importance. Of particular concern is effective communication regarding treatment, health and client rights in culturally and linguistically appropriate ways. This is facilitated by the reliable use of interpreters from admission to discharge and strengthening in the role of AMHW in the bridging of cultural gaps between clients and the services. The CVP acknowledges that both TEMHS and MH-CAHS have extensive experience and knowledge in working with Indigenous clients, however, this is an area which requires ongoing commitment and improvement.

2.1.4 Supported Housing and Accommodation

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 NT. 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.⁶ 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.⁷

Some significant additions to the accommodation services in the Top End and Central Australia were made in 2013-2014. Although they are positive they do not fully address the demand.

Community-based accommodation with the appropriate level of support remains very limited both in urban centres and remote communities and as a result people experience homelessness, are forced to stay in undignified or unsafe places, or are itinerant. People with complex or aged related needs and people who are eligible to exit the justice system are particularly disadvantaged.

⁶ Manu-Preston C.L. (2011), *Home & Help...What Works*, Churchill Fellowship Report

⁷ National Press Club address: Allan Fels on mental health and suicide prevention, August 2012

This lack of supported accommodation also leads to protracted admissions to inpatient units or, in some cases, remaining in the criminal justice system due to a lack of suitable discharge options.

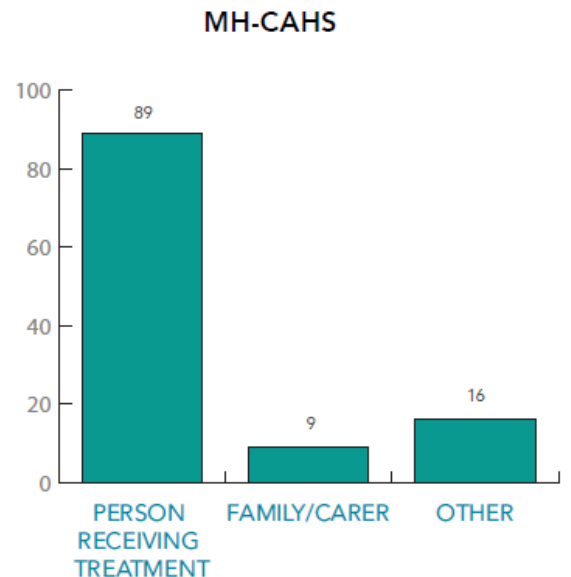
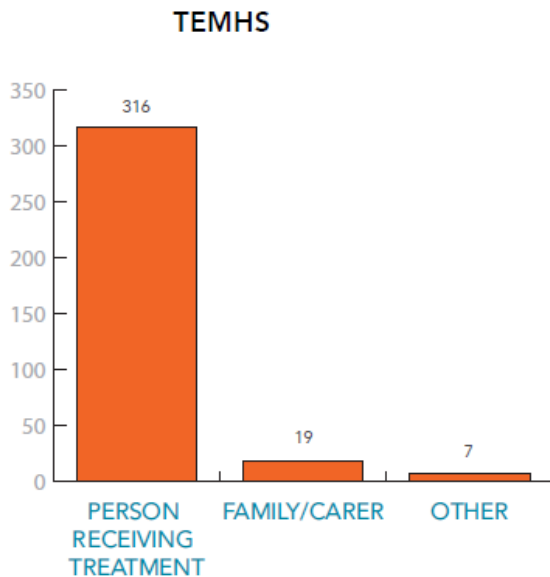
It remains the view of the CVP that a comprehensive analysis should occur to determine what are the current and emerging mental health accommodation and support needs required for the NT. This information would provide an evidence base to assist in clearly identifying the priority needs and the investment required.

VISITS & INSPECTIONS	TOTAL
CV visits	127
Seclusion and restraint registers	4
Approved treatment agencies	6

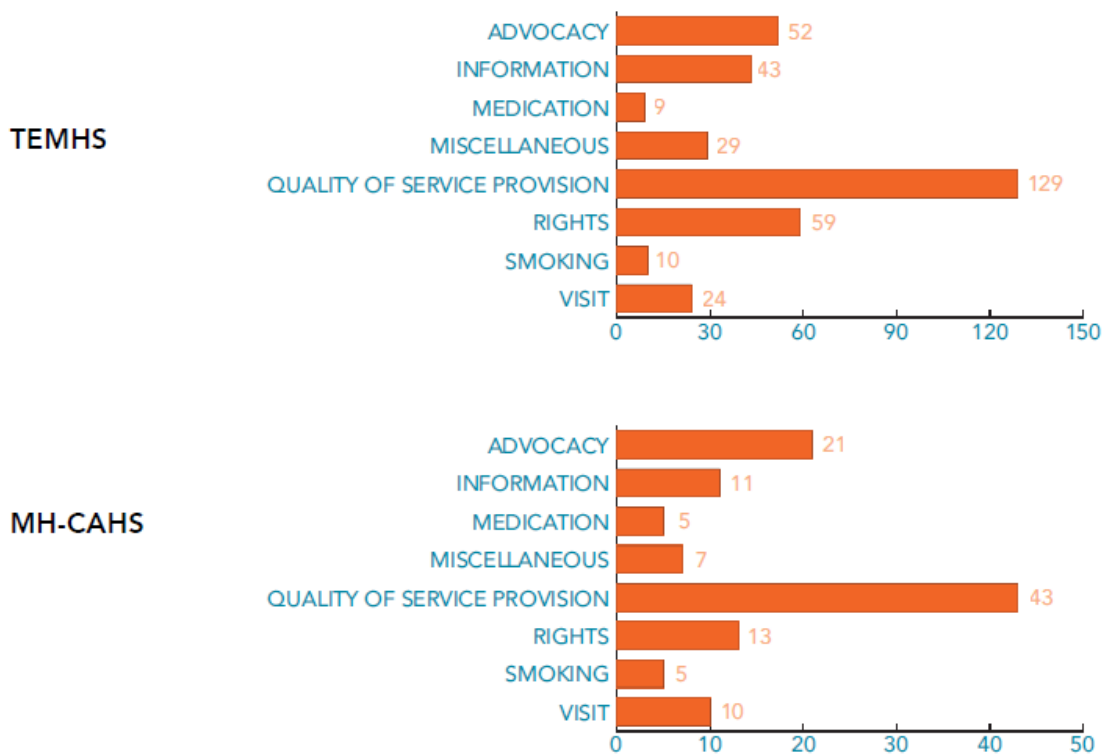
TEMHS: TOP END MENTAL HEALTH SERVICE

MH-CAHS: MENTAL HEALTH - CENTRAL AUSTRALIA HOSPITAL SERVICE

SOURCE OF ENQUIRIES & COMPLAINTS



CATEGORIES OF ENQUIRIES & COMPLAINTS



OUTCOME OF ENQUIRIES & COMPLAINTS	%
Withdrawn	2%
Ongoing monitoring	8%
Resolved	54%
Dismissed	3%
Unresolved	8%
Resolved by service	8%
Referred	4%
Lapsed	2%
Open	2%
Feedback	8%

2.2 CVP Visits & Inspections of Approved Treatment Facilities and Agencies

2.2.1 Quality of Service Provision

Client and carer participation

The CVP recognises that the MHS will generally attempt to include client and carers in decisions made about their treatment, and sometimes there are factors that complicate such involvement. Nonetheless, based on feedback from clients and carers, this does not always occur and to ensure that their participation is a fundamental element of treatment and decision-making processes, there is need for improvement in this area.

Standards 1.10, 1.11 and 1.12 of the *National Standards for Mental Health Services (2010)* address the rights of clients and carers. Principles under Sections 9 & 12 of the MHRSA specify the requirement for active participation and involvement of clients and carers in processes around their therapeutic care, which is re-iterated by the *Carers Recognition Act*.

The CVP has witnessed and been involved in positive examples of client and carer participation.

Case example

Albert had developed complex needs due to his mental and physical illnesses. It was deemed unsafe for him to return home. He remained in the Inpatient Unit for several months.

Samantha, Albert's daughter, who had been living with her father for several years, was reluctant to agree with the options proposed by MHS, which impacted significantly on her own life, and sought carer advocacy through an NGO. The MHS and NGO worked consistently and respectfully with Samantha by involving her in the planning to find a sustainable long-term solution for Albert's care.

However, client feedback and file reviews indicate that the active involvement of clients and carers in the treatment planning remains low. Clients report that they feel decisions are being made *for* them and not *with* them and they cannot exercise the level of self-determination that they would prefer. Treatment plans show minimal evidence that clients or carers actively contribute to them. There appear to be more Stay-strong⁸ plans undertaken and relapse prevention plans encouraged, but it is unclear how they are integrated into the overall treatment.

Self-determination is the key principle for recovery-based treatment and determines the nature of the relationship with clients. The long-term expertise and desires of clients (and carers) to manage their illness needs to be respected and incorporated into the proposed treatment as much as possible.

Carers need to be acknowledged for the important role they provide in the acute and ongoing support of a person with a mental illness. Although many carers stated they are satisfied with the level of involvement they are allowed, some report that the lack of their involvement has impacted negatively on the care and repercussions for their own life.

⁸ A recovery tool for relapse prevention for Indigenous people developed by Menzies School of Health Research (AimHi)

Having sufficient administrative structures in place to record carer details and involvement might further enhance the cooperation between MHS and carers and has been pointed out by the CVP repeatedly.

In the Top End, the CVP continued to receive complaints about the lack of response from the CATT when carers requested interventions for their loved ones. The CVP acknowledges that this is partly a challenge created by the current legislation, but at the same time reiterates the importance of staff understanding and respecting the important long-term and intimate knowledge about the person they care for. Carers repeatedly are frustrated when the information they provide is not taken into account in treatment decisions and then results in relapse and potentially avoidable admissions.

Both TEMHS and MH-CAHS employ Consumer Consultants which is an acknowledgement that the perspectives of clients are pivotal not just in individual treatment, but at a level of 'planning, service delivery, evaluation and quality programs'⁹. Individuals employed in this capacity have a lived experience with mental health issues. As of 2014, MH-CAHS also employs a carer consultant.

Young People

Since 2007, the CVP has made recommendations and has advocated for improved services for young people in community and inpatient treatment (see section 'Early intervention and young people in mental health services'). The CVP acknowledges the particular challenges of service delivery in rural and remote areas. While there are some encouraging developments within TEMHS and MH-CAHS, concerns remain for the treatment of young people and their families.

TEMHS

A protocol for 'Ensuring the Effective Treatment of Minors in the Inpatient Unit' was endorsed in 2013. It commits a youth worker, who works in the inpatient unit, or nurse to be on 'special' duties with the young client at all times. The youth worker (F/T) works closely alongside clients under 25. This person assists with developing coping strategies, Stay-Strong Plans,¹⁰ and provides education on mental health, liaison with families, one-on-one support and monitoring of high-risk clients and support for ward round and tribunal processes.

Close cooperation with the family or guardian is expected throughout the admission. The CVP notes that young clients, especially under-aged, are often accompanied by a boarder. Boarders are supported and valued by the staff of the Inpatient Unit. Cooperation with staff of the Child and Adolescent team is sought for some clients.

However, at this point TEMHS does not have a youth framework, does not provide ongoing youth case management and does not consistently use youth appropriate spaces in the Inpatient Unit. The CVP deems that it is unacceptable to accommodate people under 18 on an adult inpatient unit. The CVP Panel made a recommendation in 2007 for TEMHS to develop 'with urgency a comprehensive framework for youth friendly inpatient services', and the recommendation remains open.

The IPU makes considerable efforts to nurse young people in the Contained Assessment Unit (CAU), or the High Dependency Unit (HDU), both of which provide appropriate space for

⁹ National Standards for Mental Health Services (2010) Standard 3

¹⁰ A recovery tool for relapse prevention for Indigenous people developed by Menzies School of Health Research (AimHi)

young clients.¹¹ However, there continue to be a concerning number of young clients nursed in Cowdy ward or in JRU. The CVP believes that both environments are unsuitable due to their proximity to adults, but that JRU is particularly inappropriate for young clients, as it can be intimidating and may impact on future decisions to seek help.

Given that the CAU was designed with the purpose of providing an appropriate space for young clients, the CVP urges that this area is used to nurse all young clients and that barriers preventing this be addressed.

Case example

Melinda is 15 years old and was brought in to RDH from a remote community after an alleged suicide attempt. The clinic in her community noted that Melinda's family provides little support to her; she has experienced violence and sexual abuse. She is also known to misuse cannabis and alcohol.

When Melinda found herself in Cowdy ward after being under anaesthetics for transport and was not allowed to leave, she became agitated and distressed, attacked nurses and was consequently secluded in JRU. On the next day she was transferred to CAU and provided with the support of a Youth Worker and AMHW, with both of whom she formed a trusting relationship. This had an immediate positive effect and although Melinda's behaviour remained challenging at times, she was more accepting of her admission.

Case example

Sandy is the mother of James, who experienced a first episode of psychosis at the age of 19. Sandy had initiated the contact with TEMHS and following the advice from CATT had taken her son to ED. James was admitted to JRU, because he was seen as at risk of absconding and his behaviour was very agitated.

Sandy stated that they had never had contact with mental health services before and she was very surprised and shocked by the level of restriction in JRU. She thought it was making it worse for James, because he wasn't even allowed to go out for a cigarette.

The CV contacted the consultant and asked if a transfer to Cowdy or CAU could be considered and to discuss this with Sandy. The consultant explained to Sandy why at this stage an admission to JRU was seen as necessary. Although Sandy accepted this, she remained disappointed about the experience and stated she would find it difficult to convince herself and her son to seek assistance of TEMHS again if JRU was the place of treatment.

MH-CAHS

The CVP is concerned about the lack of services available to young people with mental health issues in Central Australia, particularly those living in remote communities and involved with the criminal justice system. The CVP is aware of work occurring within MH-CAHS that seeks to address needs of young people living remotely. MH services for young people in the criminal justice system are almost non-existent.

It is noted that inpatient admissions of young clients are avoided where possible, and that people up to 18 years old are generally managed on other wards with a designated staff

¹¹ CAU has an area purpose built for the admission of young people. Opening this area for use depends on the availability of staff and number of clients in IPU. The HDU of TEMHS is different from the HDU of MH-CAHS. See section 'Facilities'

member. However, there were cases of young clients receiving treatment at MHU for short periods in 2013-2014. An area in MHU has been constructed and designated for the nursing of young clients in these instances, but has not yet been completed to a usable standard.

Given the particular vulnerability of people under 18 in an adult environment, the CVP urges the service to complete this space to enable utilisation during admissions of young clients.

Cultural safety

This section addresses issues of cultural safety at the level of service delivery, particularly for Indigenous people. MHS in the Northern Territory provide a number of responses to accommodate the needs of its culturally diverse population.

The CVP has continually advocated for the use of interpreters and AMHWS at all stages of the treatment process. There are encouraging signs that the MHS appreciate the value of using interpreters more than in the past. There continues to be a need for improvement, particularly around assessments, medical reviews, seclusions, and escalations in challenging behaviour. The CVP is particularly concerned by the lack of culturally-safe interventions around incidents of seclusion and restraint.

AMHWS and interpreters are extremely important to facilitate safe and supportive service delivery to Indigenous people, for whom MH services may feel alienating and unsafe.

Case example

Benjamin is a young man from a remote community. He communicates relatively well in English.

When the CV saw him with an interpreter, he stated that he would like to have an interpreter also when he sees the doctor. He stated that so far no interpreter had been booked for him at any of the assessments. He described that he understands most things, but sometimes he doesn't understand what the doctors are saying and also he can't say everything he wants to say.

The CV and Benjamin agreed that the CV would raise this with the nurse coordinating bookings and his consultant. Both were slightly surprised by the request and stated that this was no problem.

TEMHS

Significant improvements were noted in the inpatient unit this year. Talking Posters are now available to clients in Cowdy ward. These posters give basic information about client rights in the local languages.

The use of interpreters has continued to be consistent, which is possibly attributable to a dedicated nurse having the main responsibility for coordinating and booking interpreters. The absence of interpreters at assessments and reviews appears to be primarily a matter of lack of coordination between doctors and the person booking the services.¹² However, there appear to be ongoing issues with proper identification of the person's first language at admission and appropriate recording of this information, which informs whether an interpreter is accessed for the duration of that person's admission.

There have also been significantly fewer enquiries from clients about not understanding their treatment plan. The close contact between Indigenous clients and AMHW continues. Occasionally notes of AMHWS are found in client files. However, anecdotally it appears that clients in JRU have less access to AMHWS than clients in Cowdy ward.

¹² The issues related to availability of interpreters through AIS is acknowledged, but not discussed in this document.

Ten AMHWs are employed by TEMHS with five in the IPU¹³, one in the Forensic Mental Health team, one in CATT,¹⁴ East Arnhem and Katherine Mental Health team have one AMHW each. Unfortunately the position of an AMHW in the Adult team has remained vacant for over a year now.

MH-CAHS

In 2013-2014 MH-CAHS established an AMHW Coordinator's role. Based on evidence from the CVP inspections of the MH-CAHS community teams and anecdotal discussions with staff, this has been an extremely valued role. It appears to have been instrumental in exploring innovative practice development and training for MH-CAHS staff. The implementation of this role demonstrates a strong commitment to continuous improvement in culturally safe service delivery.

There are four AMHWs across MH-CAHS, with one in MHU, one in the Adult community team, and two within the Remote team. While other teams have some access to the expertise of the AMHWs, particularly the Child and Youth team and the Forensic team, indicated that they would greatly benefit from AMHW in their teams. The Forensic team has an AMHW position allocated, but it has remained vacant.

The MH-CAHS community teams contribute to improvements of mental health services across the sector, through working with other Government and non-Government agencies to develop culturally-appropriate resources, advocating for funding, and identifying ways to address current gaps in services, such as for young people in remote communities.

The CVP received an increase in enquiries related to client access to ngangkari¹⁵ and other traditional healers this year. In the majority of cases, the Discharge Nurse at MHU was able to work with the NPY Women's Council Ngangkari Project staff to support a ngangkari to attend to the client.

Case example

Joshua told the CV that his current mental health state was related to spiritual issues, and that he would like to see a ngangkari to assist him. The CV raised this issue with Joshua's psychiatric consultant, who discussed the matter at the ward round meeting.

A ngangkari was arranged, and funded through NPY Women's Council, and came to see Joshua within two weeks. He reported to be feeling much better after that, and was discharged shortly after.

Interactions between clients and staff

The CVP recognises the inherent challenges in day-to-day management of Inpatient Units, and commends the staff for showing ongoing commitment to facilitating the best possible outcomes for clients.

¹³ However, one part-time female is currently trialling working with the perinatal mental health team

¹⁴ With a focus on health promotion and community development

¹⁵ This definition of Ngangkari is by Ngaanyatjarra Pitjantjara Yunkunytjatjara Women's Council: Ngangkari are Anangu traditional healers, who have received special tools and training from their grandparents. Anangu have a culturally based view of causation and recovery from physical and mental illness and attribute many illness and emotional states to harmful elements in the Anangu spiritual world. Ngangkari are highly valued for their unique ability to protect and heal individuals and communities from this harm.

In the majority of instances, the CVP received positive feedback in relation to staff, and observed genuinely positive interactions between clients and staff, showing good rapport, respect and consideration. The CVP usually relays this feedback to staff.

Client comments

[nurse name] is more like a mate than a worker.

The staff here are beautiful, and do a really good job.

The staff are really caring and supportive. I have no problems here.

One client in the Activity centre at TEMHS came back after his discharge to help installing a computer program. He stated, 'They have given me so much while I was here, so I wanted to give something back.'

However, clients occasionally raised issues with the CVP in relation to problematic interactions between staff and clients. This was often in regard to a perceived lack of respect and acknowledgement from staff towards clients and carers.

Case example

Tracey stated that a few times she had asked a staff member if they could talk to them about something, and the staff member had said 'Yes, I can talk to you in 15 minutes', but had then forgotten. Tracey said that it made her feel very small, especially as she really need to talk to someone and was kept waiting several times. She understood that often the ward can get very busy and unexpected things come up, but that it would have been better if staff had been honest and gave a time they would be able to follow through with it. With Tracey's agreement, the CV raised this with the CNM, who discussed the issue with staff.

During involuntary admissions, a client's control over their own decision-making is considerably restricted, and people often find this hard to accept. Due to this, clients reported to the CVP their appreciation when the limited opportunities for self-determination available to them were respected and fostered by staff.

Acknowledgement of the inherent power imbalance between clients and the mental health services is pivotal in understanding the experience of clients and their reactions. An appreciation for the client's dignity, their life experience, an acknowledgement of the challenges resulting from their illness and the restraints of treatment should remain at the forefront of all interactions between clients, carers and staff.

Case example

In the early days of Martin's admission he experienced a lot of agitation as part of his illness. On two occasions he was treated with Accuphase medication. He reported:

'When they injected me the first time, it was really terrible. I understand that sometimes that's what they have to do. But they just wrestled me down and stabbed me with the needle. I felt really terrible and upset. I felt that they could do anything to me and that was really scary.

The second time Sally (nurse) came to me and spoke very quietly and calmly. She said they needed to give me another injection. But she gave me a choice. She said, I could just come with her when I was ready and do it in a calm way, or I could struggle and then it would probably end up like the first time. It wasn't much, but even having a small choice is better than none. And the way she talked to me was really good. So I accepted the injection from her and it was ok.'

Facilities

TEMHS

Cowdy Ward

Clients repeatedly mention the positive environment of Cowdy ward. The courtyard and the Activity Centre have often been singled-out as positive elements. At present the Activity Centre is only open four days a week and whenever staff are available. Client would greatly benefit from extended hours of operation.

However, some issues continued this year, namely the state of disrepair and hygiene in some bedroom and bathrooms remained to be raised as complaints. In one bedroom was refurbished this year and other work is listed as urgent at the time of writing. Work was also undertaken in the kitchen in Cowdy and JRU (which are generally not accessible for clients) and the nursing station of Cowdy.

The High Dependency Unit (HDU) in Cowdy ward also remains sparse in appearance. Improvements to signage around the entrance areas have been noted, but remained confusing for visitors.

Since Cowdy became a locked ward approximately four years ago, the CVP has continued to advocate to TEMHS management for the development of a plan to reverse this decision. TEMHS have not provided evidence that a change is being considered and even for voluntary clients the ward remains a highly restrictive environment. The CVP questions why TEMHS does not adopt a policy similar to the MHU in Central Australia, which is predominantly open and only occasionally closed according to current service needs and client acuity. This appears more in-line with upholding the least restrictive alternative.

Client comments

I have been to a few other mental health wards around the country. I think this place here really has what it takes to make people feel good: lots of light, the courtyard, and the activity centre; there is a lot of open space, that's really nice. And the staff are very good, too.

Joan Ridley Unit (JRU)

This year TEMHS has completed work on an outdoor space for clients in JRU. Staff try to facilitate access to this space, but use remains limited due to the level of staffing required to accompany clients.

The sensory modulation room in JRU appeared underutilised during 2013-2014. The Occupational Therapist (OT) stated that some repair and staff training for the usage was planned. Sensory modulation is considered to provide comfort to clients and de-escalate agitation, and is an important tool to prevent seclusions and restraint.

There are no significant improvements in the indoor and undercover courtyard areas. The CVP remains concerned about the impact of the current amenities and levels of hygiene. Clients repeatedly describe the negative impact on their wellbeing and express feelings of disempowerment, stress, fear and apprehension. The lack of privacy of bathrooms causes a feeling of vulnerability for some, especially female clients.

Client comments

This is a hospital, isn't it? I think they should take the Governor General here to show her what it's like. Maybe that would make them change something. It's not like a hospital at all. I shouldn't have to be in a place like this.

I miss fresh air. It makes me feel bad, my skin feels strange and everything else in my body.

At the time of writing, the Acting CNM was negotiating an extension of hours of the cleaning contractors to ensure better levels of hygiene in all wards. Under the current governance the maintenance of the ward falls under the responsibility of RDH.

Contained Assessment Unit (CAU)

CAU is a secure area with five beds and has been in operation since 2012. It has bright facilities and a pleasant atmosphere, and has a purpose built area designed to suit the needs of young people. It is often used as an 'overflow' or 'step-down' from JRU or for clients for whom Cowdy ward can be over-stimulating. Usually clients appreciate the environment of CAU. As mentioned above, the unit is not always open and depends on client numbers and staff.

Oleander Room

The Oleander Room is a room in the Emergency Department (ED) in which mental health clients usually wait for assessment prior to admission. The CVP has commented on the unwelcoming ambience of the room. Together with often long hours of waiting, this may contribute to additional stress for people during a mental health crisis.

The CV Panel discussed possibilities for improvement with ED and TEMHS management. Whilst the actual appearance of the room cannot be changed for a number of structural and safety reasons, ED and TEMHS have implemented and/or have committed to the following improvements: employment of a TEMHS mental health nurse practitioner full-time days a week, training of ED staff in de-escalation techniques, weekly meetings of TEMHS and ED, improved Guideline for Management of Acute Behavioural Disturbance in the Emergency Department and installation of a secure TV box.

MH-CAHS

The CVP found that the doors to the MHU were consistently unlocked during 2013-2014. The CVP consistently received positive feedback from clients about the MHU facilities. The common area was found to be clean, and the outdoors area well maintained and utilised by clients.

In the previous reporting period MH-CAHS had proposed installing locks on client bedrooms, which can be activated by swipe cards. The CVP considers this an improvement to client safety and privacy and continues to advocate for this change.

The High Dependency Unit (HDU)¹⁶ is a four-bed locked area of the ward, for treatment of people who are of higher risk of harm to themselves or others, or for whom there is a high risk of absconding¹⁷. This area appears to be suitable for its purpose, but challenges arise when managing multiple clients with higher needs.

Physical health

TEMHS

The significantly lower life expectancy of people with a mental illness requires a strong commitment of mental health services to also care for the physical health of their clients.¹⁸ The CVP recognises that TEMHS hopes to increase capacity to improve services for clients.

Despite some improvement, the CVP still noted problems with the IPU Discharge summaries being sent to GPs or with delay. This was confirmed by a client's complaint.

Tamarind provides services of the Clozapine Clinic (CC) to approximately 100 clients in urban and remote areas. The MHS provide evidence to a national oversight agency to maintain their license to prescribe Clozapine.¹⁹ This screening process is required to monitor physical health and TEMHS reports that their clients are generally in good health. In comparison, other clients who are treated in the community did not consistently receive scheduled screening of their physical health. However, NTMHS launched a policy in August 2014 to enhance the care of the physical health of clients, especially in regards to preventing metabolic syndrome.²⁰

Allied Health Care in IPU

The CVP considers the contribution of allied health professionals is an important factor in the care and support of people in IPU. The feedback from clients supports this. Whilst some aspects of current allied health care are positive, others require improvement.

¹⁶ Different from the HDU in TEMHS Cowdy Ward

¹⁷ HDU consists of a seclusion room, a low stimulus common area with a TV and colourful foam couches, a small outside area and a comfort room.

¹⁸ Minister for Mental Health and Ageing Mark Butler and NSW Minister for Mental Health Kevin Humphries 2013:

http://www.health.nsw.gov.au/news/Documents/20130523_00.pdf

¹⁹ National Adult Clozapine Titration Chart, <http://www.safetyandquality.gov.au/wp-content/uploads/2013/01/National-Adult-Clozapine-Titration-Chart.pdf>

²⁰ Disorder of energy utilization and storage, diagnosed by a co-occurrence of 3 out of 5 medical conditions: abdominal obesity, elevated blood pressure, elevated fasting plasma glucose, high serum triglycerides, low high-density cholesterol levels. Associated with increased risk of cardiovascular disease and diabetes

Structured Activities

The importance of physical and other meaningful activities is recognised as best practice and referenced in the National Standards for Mental Health.²¹ During 2013-2014, the CVP has advocated for continuous improvement in the activities programming at inpatient units due to their importance as recovery-focussed interventions.

TEMHS

The Activity Centre in Cowdy ward is considered to be outstanding, offering a wide range of structured and unstructured activities addressing the physical, mental and creative needs of clients.

However, the CVP has repeatedly commented on the lack of structured activities or equipment in JRU. Clients frequently mention that they are bored and miss having free access to outdoor spaces. Clients in JRU have access to a TV, an exercise bike and occasionally to music either in the sensory room accompanied by staff or in the dining area. Staff attempt to facilitate access to the Activity Centre for JRU clients individually, but this requires sufficient staff resources and hence often falls behind other priorities.

The CVP acknowledges that clients requiring high security at a particular point of their treatment may also require a low stimulus environment. However, a number of clients spend several weeks in JRU and especially young and physically capable people suffer from a lack of opportunity for meaningful activity over large parts of the day.

MH-CAHS

The role of the Occupational Therapist has remained vacant in this period. This has resulted in a significant lack of structured activities in the MHU. The CVP noted that staff occasionally facilitated the use of the activities room on request and linked clients with MHACA programs. A number of volunteer groups have also provided some activities for clients. Clients have repeatedly given feedback that they miss structured activities and programs, which would enhance the therapeutic benefit of the admission.

The CVP acknowledges the difficulties to recruit staff to the OT position, but has repeatedly urged MH-CAHS to find other ways of providing structured activities through existing personnel.

The lack of structured and physical activities particularly impact on clients in HDU. Whilst the need for low-stimulus environments is acknowledged, the CVP advocates for assessment and responses to individual needs.

Psychological support

Whilst it is acknowledged that psychological interventions may not always be appropriate at a time of high arousal, the CVP is concerned about the lack of evidence that emotional distress and trauma are addressed with psychological, trauma-informed care. This includes psychological responses to suicide attempts or suicidal ideations. Clients are assessed thoroughly on their current risk of suicidal ideation, but it appears that psychological support and interventions do not take place as standard care. This has been noted by the CVP through client feedback and file reviews.

²¹ National Mental Health Standards, Standard 10.5.12

TEMHS

Clients in Cowdy ward have repeatedly given good feedback about the sessions they have with the Nurse Consultant, who is trained in CBT. However, in June 2014 the person in this role has ceased to work in this position and has not been replaced. There is no psychologist working in the IPU.

Nurses provide a high level of psychological and emotional support and care. However, clients at times state that 'nobody really talked to them' about their psychological and emotional needs.

MH-CAHS

Clients have raised issues that show they would benefit from greater access to psychological care while admitted to MHU. Clients are able to utilise the services of the MH-CAHS psychologist, and those in private practice. However, access to these psychologists for people while they are admitted has been unclear at times, and meant that people felt they were not getting the psychological care they required.

Case example

Kiran raised with the CV that the MHRT had suggested that psychologist appointments be arranged for him, which he thought was a good idea. However, to his knowledge this had not been followed-up. He asked that the CV raise this with the staff and find out what the process was and how to progress this issue.

The CNM advised that the Consultant should make a referral for Kiran and the Consultant agreed to do so as soon as possible.

Electro-Convulsive Therapy (ECT)

In the NT, only the Inpatient Unit in Darwin has a facility for ECT.

The use of ECT must be approved by the Mental Health Review Tribunal under section 66 (2)(a) of the MHRSA, with further instruction detailed 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.

Section 66(1) of the MHRSA states the expectation that use of ECT is consented to by the person receiving treatment and/or the carer's consent, where possible. To obtain consent, it is essential to conduct a timely and comprehensive consultation with the client and provide sufficient information about the treatment

In 2013-2014, the Panel inquired into the ECT treatment in the inpatient facility, including ECT procedures, guidelines and compliance with the MHRSA. At the time, TEMHS were reviewing the 2006 ECT Guidelines and the Panel recommended that an expert, external to the NT, be involved in the review process. At the time of writing a comprehensive external review is still outstanding but the Panel expects to be updated when the process is concluded.

The Panel highlighted the need to ensure that all relevant documentation for ECT is in the individual client file, as well as in the ECT register. Documentation showing evidence of consent, the MHRT order, diagnosis, and pre-and post-assessments or other related assessments must be diligently maintained to ensure that all relevant information is accessible when required.

TEMHS has stated that it is committed to implementing improvements to ECT processes, through ward rounds for clients who have more than 12 ECTs or significant side effects,²² development of a more effective database to capture comprehensive demographics of ECT, and the separation of recovery area from treatment area.²³

The CVP acknowledges that TEMHS has made improvements in the area of information and communication about ECT to clients and their families. However, file reviews showed that for Indigenous clients who receive ECT involuntarily, this is less evident. TEMHS have a DVD available that explains the procedure to clients and families which has also been produced in Yolngu Matha and additional funding is required to produce this DVD in other Indigenous languages.

2.2.2 Rights

Advocacy

The MHRSA recognises the role of advocacy services, the rights of clients to access them and the commitment of the MHS in providing information to the client about access to the CVP.²⁴ The CVP is legislated to provide this service, which also contributes to increasing the client's understanding of and participation in their own journey through the MH system.

The CVP data reflects that a large portion of the CV's work is in providing advocacy for clients during visits to the wards. The CVP appreciates that staff of the MHS often refer clients to the CVP and facilitate access. Providing this service enables clients to resolve concerns at a low level, minimising the time and energy spent on escalating issues further. The CVP recognises that the majority of client concerns can be dealt with in this way, which is a testament to the MHS, their respect for the concerns of clients, rights and a good understanding of the CVP role.

In these instances advocacy often takes the form of the CV listening to the client's concerns, informing the client of their rights and the CVP's role, discussing possible courses of action the client may wish to take, and the CV providing assistance with that action as needed. While the outcome may not always be what the client hoped for, this process provides a mechanism for support by an independent agency, the client's involvement in their care, and an acknowledgement of their concerns.

Case example

Jacob spoke to the CV about his difficulties with medication, side effects and the feeling that he was forced to take something that made him feel worse. He understood that medication was needed for his condition, but felt that the current dosage was not suitable for him and that this was not being heard by his Consultant.

The CV attended a meeting with the client and the consultant. The consultant agreed to consider changes to the medication in the near future but felt that Jacob's current conditions required for him to stay on the current dosage. Although Jacob was not really satisfied with the outcome, he felt that his views had been heard and requested that the CV continue to attend future reviews with the consultant.

²² According to the NT ECT Guidelines

²³ According to standards required by the Royal Australian and New Zealand College of Psychiatry

²⁴ MHRSA Sections 3(q), 87 (1B), 90 (1), 100 (5)

Least Restrictive Alternative

The objective of the MHRSA 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'.²⁵ The principle by which this balance is achieved is the least restrictive alternative,²⁶ which means the least restrictive or least intrusive treatment should be provided in the least restrictive environment. If a person is to be admitted involuntarily, 'there must be no less restrictive means of ensuring that the person receives the treatment'.²⁷ The CVP is obliged to monitor and comment on policies and practices which are likely to limit the freedom of people receiving care.

The CVP acknowledges that the final decision of what is the least restrictive option for each client and situation lies with the treatment team.

Apart from providing advocacy, the CVP's most frequent enquiries are about the level of restriction clients experience during involuntary admissions. Having to accept an involuntary admission is often difficult for clients and carers. The CVP's experience is that clients who actively seek help themselves, and agree to inpatient treatment, often find it hard to accept the rationale behind an involuntary admission to ensure their safety. Clients repeatedly state that the level of restriction makes them apprehensive towards the services and that they would be unlikely to seek help again.

Client comment

I have been in mental health treatment for over 20 years in a number of states. I know when I need mental health care and get myself to the hospital. But I have never been an involuntary client before and not in place like JRU.

This might also impact on carers, who are concerned that their own relationship with the client may be affected if they persuaded them to seek help. Carers express concern that their loved one is not likely to trust the services or the carer, because of the high levels of restriction and less likely to be persuaded again to come to hospital if needed. This potentially has repercussions on the long-term support for clients and their families.

Carer comment

My son just moved up here from interstate. This (being in a locked ward) has never happened to him before. I am really worried that he'll never go back and then all the support falls back on me. I have no idea how I'm gonna cope with this.

Led by client wishes, the CVP is obliged to assist clients to express their wish for less restrictive treatment approaches. This involves asking treatment teams to explain their decisions, or reconsider a decision with more information from client. Whilst clients might not agree with the decisions made, it is important that they have an opportunity to express their wishes, contribute to treatment planning, are able to better understand the reasons why the treatment team makes a particular decision and what is required or expected of them to enable a less restrictive option.

²⁵ MHRSA Section 3(a)

²⁶ MHRSA Section 8(a)

²⁷ MHRSA Section 14(c)

Case example

Fran made a complaint to the CV about her admission to JRU. She stated that she had chosen to come to hospital herself, had expected to be admitted to Cowdy ward, but was placed on an involuntary order in JRU. She felt that 'her intelligence was insulted'. She had chosen to seek treatment but felt that she was not allowed to 'make even the smallest decisions'.

The CVP raised this with Fran's consultant, who provided an extensive reply explaining the reasons for the decisions at the time. Although Fran did not agree with all of the assessments by the treating team, she appreciated the response and wanted to work with her case manager to have on her community records a relapse prevention plan. She hoped that this would assist her to approach TEMHS at an earlier stage and receive a less restrictive intervention.

Transport by Police

The National Safe Transport Guidelines and APs state that respect for the client and their involvement in the choice to be admitted should be the paramount principles guiding decisions about transport to hospital. Transport by Police should be the last resort and other possibilities of transport must be considered first.

Clients have repeatedly raised issues in regard to their transport by the NT Police to the hospital during a MH crisis. Clients usually report that they are deeply distressed by these events and it often also has a negative impact on other family members, especially children. Additionally clients are concerned about the impression this leaves with neighbours, as they feel they were 'treated like criminals'.

The CVP recognises that the assessment of risk involved for self and others may differ between the client and agencies such as the CATT and the Police. A reduction in distress caused by transport can be achieved through considering if more clients can be transported with less intrusive form and ensuring that Police receive mental health training, which may enhance the quality of the interactions when it occurs.²⁸

TEMHS

This year TEMHS re-initiated a Regional Area Mental Health and Emergency Services Meeting with a meeting held in February and a further meeting in August with a commitment to bi-monthly meetings. TEMHS and NT Police are also committed to re-commencing mental health training for Police staff.

The CVP hopes that this liaison will contribute to reduce distress for clients when being transported.

Discharge Planning and follow-up

TEMHS

In this year a number of improvements were noted in the discharge planning process and its documentation. A comprehensive discharge summary, which includes bio-psychosocial issues, is now found frequently in client files. There was also some improvement in the notes relating to identification of issues that might impact on discharge, however, this was not consistent at the time of review.

²⁸ V. Harrington, K. Clifford, P.F Lawrence, S Ryle and R. Pope: The Impact of the NSW Police Force Mental Health Intervention Team: Final Evaluation Report, 2009

There is still evidence found that suggests delays in discharge, particularly for clients from remote areas. If potential issues related to discharge are not identified and addressed throughout the admission, delays in organising transport or accommodation may be the result. This potentially impacts on the client's liberty.

The two consultants responsible for treatment of clients from remote areas have been in their roles for several years and visit the communities frequently. They demonstrate good knowledge of the social environment of clients from remote areas. Weekly ward rounds are held with doctors and other staff from remote clinics via video link when possible to ensure a holistic picture of the client and effective referrals back to their communities.

However, a number of clients return to IPU admissions often after a short period of time. To date the CVP has not investigated these issues systemically, but an individual review showed that there appeared to be no use of an interpreter during the first admission, despite the identified need.

Even in urban areas, the follow-up of clients after discharge is an ongoing challenge. Again in this year some improvements have been made in the communication between IPU and community teams, following a complaint from a carer, whose family member had not been followed up for several weeks after discharge. The position of an Intake Nurse at Tamarind has also improved the follow-up. However, this position is currently not filled and concerns are that this will affect the quality of services in this regard.

2.2.3 Procedures

Compliance with Legal and Procedural Requirements

Due to the complexities of mental health care and the powers to significantly restrict the freedom of clients, legal and procedural checks and balances need to be adhered to with diligence. The CVP regularly monitors compliance with those procedures that are required by legislation or are most likely to impact on the rights and safety of clients and carers.

Compliance with Requirements for Involuntary Admissions

The CVP monitors the compliance of MHS with the requirements for involuntary admissions. The legal framework is provided under sections 39 & 42 of the MHRSA. The Form 10 provides evidence of this procedure and is required to be sent to the Principal Community Visitor (PCV) for every involuntary admission.

TEMHS

Requirement	Compliance Rate	Comment
Notify PCV of Involuntary Admission ²⁹	98%	Significant improvement and CVP satisfied with outcome
Evidence for second APP assessment undertaken in legal timeframe ³⁰	94.75%	1.25% no evidence of second APP authorised admission 4% second assessment out of time or no time noted.
Client is informed of their right to apply for an early hearing at the MHRT ³¹	37%	Improvement especially since use of revised Form 10
Client need for interpreter identified	45.5%	Improvement especially since use of revised Form 10
Adult Guardian or primary carer to be notified of involuntary admission ^{32 33}	2.75%	From nearly 0 to 10% in last quarter since use of revised Form 10

This data shows a significant improvement, especially since the introduction of the revised Form 10 in March 2014. However, low compliance relating to informing the client of their right for an early review, the clients need for an interpreter and the notification of carers remain a concern.

MH-CAHS

Requirement	Compliance Rate	Comment
Notify PCV of Involuntary Admission	88.75%	Went from 100% in first three quarters to 55% in final quarter
Evidence for second APP assessment undertaken in legal timeframe	48.5%	Highest compliance was 75% in 3 rd quarter, with lowest 45% in 2 nd quarter
Client is informed of their right to apply for an early hearing at the MHRT	7.5%	Generally very low compliance, 27% compliance in 2 nd quarter
Client need for interpreter identified	7.5%	Generally very low compliance, 27% compliance in 2 nd quarter

According to the Form 10s sent to the CVP, there was a very low level of compliance with the requirements under the MHRSA to inform clients of their right to apply for an early MHRT hearing, and to identify the need for an interpreter. The CVP urges MH-CAHS to work with staff to improve this rate.

Compliance to notify the PCV of involuntary admissions, and corresponding documentation with 2nd APP assessment, appeared to be impacted by changes of staff and the CVP hopes to see this back to a reasonable level in 2014-2015.

²⁹ Section 41(1)(e)(i) and 43(1)(e)(i)

³⁰ For mental illness: Section 39(1)(a): 24 hours; for mental disturbance 42(1)(a) 72 hours

³¹ Section 41(4)(c) and 43(4) (c)

³² Section 41(1)(b),(c) and 43(1)(b),(c)

³³ A potential decision by an APP not to inform a carer needs to be confirmed by the MHRT; Section 41(2),(3) and 43(2),(3)

Information: Processes around Mental Health Review Tribunal (MHRT)

The MHRT is a process that often causes confusion and anxiety for clients. Decisions about ongoing involuntary admissions, ECT or community management orders are important for clients, due to the significant restrictions associated with them. Section 132(1) of the MHRSA states that clients 'must be given access to his or her medical records and reports that are before the Tribunal'. Clients are entitled to legal representation when going before the MHRT, and this was consistently provided by the MHRT.³⁴

When enquiries from clients are raised with the CVP in regard to MHRT, staff often state that the MHRT process has been explained to clients. Due to the complexity of the information and the clients' level of wellness this might need to be repeated and the CVP often provides this.

In previous reports the CVP has raised concerns about the late access of clients to the content of the application by MHS to the MHRT, which contains information explaining why the person requires an order. The CVP considers this to be procedurally unfair, because it does not give the client (or their carers) the chance to prepare for the hearing.

Case example

Jason told the CV that he had a MHRT hearing the following day, but did not know why his doctor wanted him to stay and for how long. The CV explained his right to have access to the application, but the request to read the application was refused by the senior nurse and the Consultant due to concerns that the relationship between the client and the treating team could be jeopardised if the client misunderstood the information.

The CV raised the issue with the Clinical Director, citing section 132(1), and advocating for procedural fairness and transparency. The Clinical Director acknowledged the rights of clients under the MHRSA whilst also recognising the concerns of the treatment team. The Clinical Director committed that all APPs and senior staff would be advised that the content of the application needs to be discussed with the client at least a day before the MHRT hearing and that the report needed to be handed out if specifically requested. He also committed to undertake spot checks of client files to ensure this is carried out.

Although Jason did not benefit from this decision, the CVP noted improvements in clients' awareness of the upcoming hearing.

2.3 Quality Assurance

In 2013-2014, the governance structures for both TEMHS and MH-CAHS moved under the Hospital Network administration. For the CVP and clients, the impact has been minimal. It appears that most processes and procedures within the services continued unchanged.

Continuous improvement strategies are necessary to ensure ongoing high quality service delivery. The MHRSA states in section 145 the establishment of an Approved Procedures and Quality Assurance Committee (APQAC) to monitor and review the approved procedures, make amendments and assess and evaluate the quality of mental health services and clinical practices.

³⁴ From January 1st, 2014 clients were again consistently represented by NAAJA and NT Legal Aid Commission.

Although APQAC had been established with an expectation to meet every three months, the committee did not meet at all this year. APQAC is an important quality assurance mechanism and the CVP expects that meetings should resume as a matter of priority.

2.3.1 Other Issues

Admission on grounds of complex cognitive impairment

Both the MHRSA and the *Disability Services Act* (DSA) allow for clients with a dual diagnosis of mental health and a complex cognitive impairment, who fit the criteria to be admitted to the Secure Care facility under an order for up to two years.³⁵ The Secure Care Facility provides a therapeutic environment, with Positive Behaviour Support Plans (PBSP) that seek to provide pathways to a less restrictive option for clients in the future.

In Central Australia, the CV Panel has consistently raised the issues around the implementation of legislation that provides for admission and treatment on the grounds of complex cognitive impairment, and the pathways available for clients to be transferred from the MHU into the Secure Care facility (Kwiynernpe House).³⁶

Based on CVP information, there appears to be a lack of clarity between MHS and Disability Services as to whether this remains the intent of the Secure Care facility, and how it is to be implemented in appropriate cases. To ensure clarity and transparency on this issue, the CVP has recommended that there be a meeting between the senior management of Mental Health and Disability Services to establish the current intent of the Secure Care facility in accepting clients from Mental Health Services, and the process through which this can be facilitated. The CVP is unaware as to whether this meeting has occurred, and to date this recommendation remains open.

The CVP is aware of at least one client who might meet the criteria and has remained on an inpatient ward for over 18 months due to a lack of other accommodation and care options. The lack of long-term options and institutionalisation of the client's behaviour by remaining in an unsuitable acute care facility is concerning. The CVP remain unclear as to how the Secure Care Criteria and admission is now being managed.

Smoking

The Department of Health Non-Smoking policy has been in place for a number of years, prohibiting any smoking on hospital grounds. While this policy is outside of the control of the MHS, the CVP draws attention to the issues raised by clients on how this policy affects them. The CVP notes that generally clients are accepting of the non-smoking rules. MHS provide nicotine replacement therapy (NRT). In the TEMHS Inpatient unit, an NGO attends the client morning meetings weekly, providing support for smoking reduction and cessation. Staff facilitate client access to smoking off the hospital grounds within certain rules.

However, it is common that clients raise issues related to smoking with the CVP, mainly when they are on involuntary orders. Some clients have raised that they feel that nurses and doctors do not show much empathy when clients struggle with not being able to go out for a smoke.

³⁵ DSA s16(1)

³⁶ MHRSA section 8AA and section 44; DSA Section 8 (3)(b)

Case example

Yvonne stated that she was struggling with not being able to smoke and had been really 'edgy'. In the next review with the doctor had apparently said "Why are you making such a big deal out of this? It's only a cigarette. It can't be that important."

Yvonne felt that the doctor had no understanding of the level of agitation tobacco withdrawal can have on a smoker. The CVP encouraged the client to give this feedback to the doctor, which she did.

The CVP is concerned that potentially client agitation related to not smoking may result in restrictive practices.

Client comment

They tell me I can't go outside before I calm down and feel better. But I can't calm down because I can't go outside and have a smoke. I know that I am addicted to the smokes, but these patches don't do anything and I'm feeling sick.

The CVP continues to advocate for innovative, constructive ways to respond to client stress around access to smoking, such as decisions being based on individual risk assessments.

Housing and Accommodation

TEMHS

Within the last year, three additional clients with complex needs due to dual diagnosis have been accommodated in an NGO-operated facility. These clients all had repeated or prolonged admissions to the Inpatient Unit prior to their placement and have since then been managed successfully in the community.

In Darwin another eight-bed facility with 24-hour support opened in June to provide long-term accommodation.

One client has been transferred to a psycho-geriatric facility interstate because no such option is available in the NT. Another client with high support needs remains in the Inpatient Unit with currently no long-term plan for appropriate support.

MH-CAHS

MH-CAHS opened a Sub-Acute facility, designed to be a 'step-up/step-down' service, with six beds available for six week periods, and two beds available for two year periods. This service is for voluntary clients, and aims to provide a supported environment for people in a sub-acute phase of mental illness. The CVP has received positive anecdotal feedback and has observed it to be a welcoming, clean and well-functioning service during visits.

2.4 Inspection of Seclusion and Restraint Registers

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, authorisation responsibilities and conditions to ensure the person's safety, including nursing observations and medical reviews. The person must be released without delay if the criteria cease to be met.

Mechanical restraint is regulated in section 61 of the MHRSA. 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.³⁷

Section 61(14) and 62(14) require that the CVP inspects the Register at least every six months. Individual client files are reviewed when the inspection of the register raises concerns or questions, such as repeated or extended seclusions, medical concerns or the youth of the client.

TEMHS

	2013-2014	Comment
Incidents of seclusion and restraint	171	14% decrease from 2012-2013 ³⁸
People secluded	72	35 in first reporting period 37 in second. It is possible that some individuals were counted as two because they may have appeared in both reports.
Indigenous people secluded	33	13 in first reporting period 20 in second, as above
People 25 or under secluded	16	
People 18 or under secluded	5	Not included in the category above
Seclusions continuing after four hours	43%	
Seclusions continuing after twenty-four hours	6.5%	Increase from previous year (4.35%)

The CVP analysed the use of pre- and post-incident interventions³⁹ and found no significant difference in the use of pre-incident interventions compared to the previous year. This indicates that there has been no significant shift in practice. The CVP commends the trend to involve AMHW more in potential prevention and post-intervention and recommends its continuation and that TEMHS will systematically analyse the effectiveness of interventions and actively promote the use of strategies based on positive interactions.

Pre-Incidence Interventions	2012-2013 In %	2013-2014 In %
PRN	49.5	53
De-escalation	57	64
Cultural intervention	0.7	3
Low Stimulus Environment (LSE)	37.5	40
One-on-one	27	26

Post-Incidence Intervention	2012-2013 In %	2013-2014 In %
PRN	22	33.5
Debriefing/counselling/One-on-one	59	60.5
Cultural intervention	1.35	10

³⁷ MHRSA Section 61(12)

³⁸ This reduction continues the trend from the previous year (13%) and exceeds the national average of reduction.

³⁹ This is not a comprehensive list of all pre- and post-incident interventions, but only those are listed which are strongly associated with the direct impact on the client

2.4.1 (a) Compliance with the MHRSA

Section 62(4),(5),(6) – Authorisation and Length of Seclusions

The compliance with the legislative requirements for authorisations was generally sufficient.

Section 62(8) – Observations and Medical Reviews

The requirement of observations every 15 minutes was sufficient.

On 17 occasions, four hourly medical reviews were late or had no time recorded. On a further 17 occasions, no evidence of a required medical review was found.

Section 62(11) – Cessation of Seclusion

The person in seclusion must be released if they do not meet the criteria specified in section 62(3) any longer. The assessment of this appears to be of concern. The CVP continues to find that clients remain in seclusion despite lack of evidence of need for seclusion, i.e. the client is asleep or calm for extended periods. This is often noted during night time hours. Clients are repeatedly reviewed by the medical officer through the window, seclusion continues and clients are released when the treatment team sees them in the morning.

Section 62(12) – Maintenance of the Seclusion and Restraint Register

The compliance with the legislative requirement for maintaining the Seclusion and Restraint Register was sufficient.

Section 62(15) – Notification of Adult Guardian

The Register gives little evidence as to whether adult guardians were notified of seclusions. The CVP noted one example of an Adult Guardian being notified. The CVP is aware of one other person who was under Guardianship and whose Adult Guardian was not notified.

2.4.1 (b) Key Issues of Concern

Seclusion of young clients

In 2013-2014, there were five people under 18 secluded, one of whom was 14 years old. Seclusion of young people contradicts best practice of mental health care and is likely to induce trauma and distress in an environment that is responsible for care and protection. This is likely to impact negatively on the young person's perception of mental health care, which may be associated with fear and disempowerment. This might prevent the person or their family to readily seek mental health care in the future.

Additionally, the CVP found little evidence that carers or family members are informed of seclusions and only one record of a family member being debriefed after the seclusion of a young client. Whilst the CVP did not collect data on how many clients have carers who could or should have been informed, the evidence suggests that this contact does not occur regularly.

Case example

Dana is a 17 year old girl from a remote community. Her family found her with a cord around her neck after a family argument. She was considered as high risk by the local clinic, was anaesthetised and flown unaccompanied to Darwin.

During her assessment in ED of RDH she was very disorientated and became very distressed. She cried and stated repeatedly that she wanted to go home and be with her mother.

She was admitted to JRU where staff were unable to settle her distress and she was deemed suitable to be placed in seclusion. This seemed to increase her distress and she hit the walls of the seclusion room so hard that staff were concerned she would hurt herself. She was placed in a non-restrictive seclusion gown and finally fell asleep.

In the following days Dana was described as repeatedly crying and asking to be brought home to her family. Dana was discharged after a few days, but the notes did not indicate if her family had been contacted during her admission.

Length of seclusions

In 2013-2014, 43% of seclusions lasted for over 4 hours and there was a slight increase of seclusions that lasted over 24 hours (6.5% this year and 4.35% last year). The Approved Procedures suggest that seclusions should not exceed four hours, however a significant number of seclusion incidents continue to be over four, and even 24, hours. The longest seclusions were between 50 and 71 hours. The CVP recognises that the length of seclusions are individually assessed, however raises for serious consideration whether a number of seclusions could be reduced in length of time given the concerns stated above (*Section 62(11) – Cessation of Seclusion*).

Case example

Zachariah is 15 and was admitted initially to Cowdy ward in the company of his uncle. He was in an agitated state already and when he realised that he was not allowed to leave he became fearful and aggressive to staff. He was placed in seclusion where he settled after about 30 minutes and slept the whole night during which the doctor reviewed him through the window. However, the door of the seclusion room was not opened.

When Zachariah awoke in the morning and found himself still in seclusion, he tried to strangle himself with the sheet. Staff prevented this, but had to physically restrain him.

Cultural safety

Indigenous clients are 36% more likely to be secluded repeatedly. Cultural interventions (for example, use of AMHWs and interpreters) are infrequent. This would suggest that there are significant disadvantages for Indigenous people in the context of restrictive practice.

Case example

Gregory is from a remote community and has a minor cognitive impairment and a physical condition that impacts on his ability to control his emotionality. He was admitted after concerns in the community of violent behaviour.

His first admission lasted a few days, but no interpreter was engaged and he had several lengthy seclusions. He was discharged, but re-admitted after four days due to similar issues in the community. Only after another series of seclusions an interpreter was involved and behaviour issues improved.

2.4.2 MH-CAHS

	2013-2014
Incidents of seclusion	97
Incidents of restraint	22
People secluded	21
Indigenous people secluded	14
People 25 or under secluded	6
Seclusions continuing after four hours	23
People requiring an interpreter secluded	5

The number of seclusions has increased significantly when compared to previous years. It is noted that there was a period between 2011-2013 when there was no seclusion room in operation at MHU. However, in the years 2009 – 2013, during times when there was an operational seclusion room, there were between 11 – 31 seclusion incidents per annum, averaging 17 incidents.

PRE-INCIDENCE INTERVENTIONS	2013-2014 IN %
PRN	44%
De-escalation	79%
Cultural intervention	0%
Low Stimulus Environment (LSE)	72%
One-on-one	19%

The CVP has raised issues around the extremely limited use of cultural interventions. It is hoped that MH-CAHS will systematically analyse the effectiveness of interventions and promote the use of strategies that decrease the need for seclusion and negative impacts post-incident.

POST-INCIDENCE INTERVENTIONS	2013-2014 IN %
PRN	49%
Debriefing/ counselling/One-on-one	82%
Cultural intervention	2%

Client quotes regarding seclusion

People might be looking for help but instead they feel like they are being punished by being put in seclusion.

I would rather have a security guard follow me around than be put in seclusion.

2.4.2 (a) Compliance with the MHRSA

The CVP acknowledges that the Register shows overall a reasonable level of compliance with the legislative requirement.

Section 62 (4),(5),(6) – Authorisation and Length of Seclusions

The CVP found evidence that legislated authorisation occurred in all but a small number of seclusion events, and these inconsistencies were documented in the notes and appeared to be a result of communication errors.

Section 62(8) – Observations, Medical Reviews and personal needs of clients

Observations every 15 minutes were recorded consistently throughout the year. Medical reviews in the first period were inconsistent and there were a small number of incidents during which the review did not happen within the legislated timeframes. There was a marked improvement in the second period, during which a medical officer attended every seclusion episode that extended over three hours.

There was evidence to suggest that clients' personal needs (food, drink, access to toilet) were attended to. This information is not recorded in the Register and CV relied on file reviews to gauge compliance.

Section 62(11) – Cessation of Seclusion

The CVP noted examples of when seclusion was not broken despite there being no evidence of need for seclusion, such as the client had been sleeping or calm for over an hour. The CVP has sought the advice of MH-CAHS as to how this relates to the Approved Procedures and MHRSA criteria for seclusions.

Section 62(12) – Maintenance of the Seclusion and Restraint Register

The CVP recommendations from the previous period appear to have been implemented and the documentation was generally completed to a satisfactory level.

Section 62 (15) – Notification of Adult Guardian

There were two people secluded who are under Adult Guardianship this year, and the CV found no evidence that guardians were contacted.

Case example

The CV did a file review on seclusion incidents concerning Joanna, who was secluded successively for two weeks, often with multiple seclusions in a day. The longest seclusion lasted over ten hours. She was described as highly irritable and angry, threatening violence to staff, and appearing unresponsive to counselling. There was a comment in the client file stating that the client was 'not taking responsibility for [her] actions'. Not being able to smoke and the presence of security guards seem to further escalate Joanna's distress and agitation.

The CV found evidence of times when seclusion was avoided by staff escorting Joanna to her bedroom, which was found to be sufficient to de-escalate her agitation. Concerns about money were noted to be contributing to Joanna's distress. This was partly addressed when the social worker assisted her to contact Centrelink.

2.3.2 (b) Key Issues of Concern

Increased use of seclusion

As previously noted, the rates of seclusion during 2013-2014 were high compared to patterns in previous years (although it is noted that there was a significant period during which a seclusion room was not in operation). The CVP is concerned that this may indicate an over-reliance on seclusion. The CVP urged MH-CAHS to analyse patterns and trends around use of seclusion, and report back to the CVP, APQAC and relevant regulatory bodies, with the aim of reduction.

Cultural safety

On only two occasions cultural interventions occurred after a seclusion episode, but there were no details to show what the intervention was. There were no instances when a cultural intervention took place before a seclusion event. Given that 21 Indigenous people were secluded and five people recorded as needing an interpreter, the figures suggest that in most instances the person secluded was not able to be de-escalated, counselled or de-briefed with in their first language, nor were there interventions that recognised their cultural needs.

Practices and strategies to decrease incidence and trauma associated to seclusion events

While de-escalation strategies were used in many cases, the details of those strategies are unclear. The CVP questions if a wider range of de-escalation strategies could be employed, such as sensory modulation. Similarly, the types of de-briefing and counselling offered after seclusion are unclear. The CVP seeks further information about how best practice is being implemented following seclusion incidents, with the aim of reducing the negative impact of incidents.

Notification of family, carers and guardians

The Approved Procedures state that:

Family members or friends may be distressed or confused by the use of seclusion as will other patients who may have witnessed the incident. Explanation and debriefing should be offered as appropriate, within limits of confidentiality.

According to the CVP's interpretation, this recognises the importance of informing those people caring for the person, whether they witnessed the event or not, of seclusion

incidents relating to the person while they are in an inpatient unit. This information should be conveyed as stated above respecting limits of confidentiality.

In 2013-2014, the Register noted only three occasions where contact with carers about seclusion was recorded. In the case of guardians, there was no evidence to show guardians were contacted, despite clients being under guardianship. This raises concerns that carers, families and guardians are not being informed about incidents that may strongly impact on the person they are caring for.

Recording of physical restraint ⁴⁰

The CVP is concerned that details of restraint are not being described. The standard form does not have a section to prompt a description. The CVP was informed that MH-CAHS is working to revise the form, and that staff have been reminded to include information of restraints in the progress notes. The CVP noted some change in this practice in the latter half of the year, and awaits further improvements.

⁴⁰ Mechanical restraint is not used at MHU.

2.4 Recommendations

Community Visitors and Community Visitors Panels are able to make recommendations to MHS based on observations made during visits and inspections or arising from complaints and enquiries received. Generally, before a recommendation is made, an attempt will be made to resolve the issue with the MHS management. If this is unsuccessful, and the matter remains unresolved over time (generally about six months), the Panel or Community Visitor is likely to make a recommendation. Recommendations are closed when suitable and sustained evidence has been received.

2.4.1 TEMHS

	TEMHS Open Recommendation	Made by	Date
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)	Panel	Apr 2013
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.	Panel	Apr 2013
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)	Panel	Apr 2013
4	It is recommended that information services to Aboriginal consumers be improved by providing greater access to Aboriginal Health Workers including when admitted out of hours, advocating for improvements to the interpreter service and providing appropriate visual material.	Panel	Apr 2013
5	It is recommended that discharge planning procedures be improved by identifying and referring to preferred ongoing General Practitioners.	Panel	Oct 2004
6	It is recommended that a comprehensive accommodation and support model is developed, adequately resourced and provided in the Top End of the Northern Territory (in addition to the accommodation currently provided through the Manse). It is further recommended that the model takes into account the varied and diverse circumstances of consumers in the NT, and is developed collaboratively with consumer groups and mental health professionals	Panel	Nov 2006
7	It is recommended that the Mental Health Service ensure that Interpreters are present at assessment for all consumers whose first language is not English	Panel	May 2007
8	It is further recommended that Interpreter assistance is then arranged for all further assessments and to assist the consumer at any hearing before the Mental Health Review Tribunal.	Panel	May 2007
9	It is recommended that for those under 18 admissions to the inpatient unit that are unavoidable, TEMHS develop with urgency a comprehensive framework for a "youth friendly" inpatient service which also ensures youth under 18 have access to expert assessment and management.	Panel	Nov 2007

10	It is recommended that there are systems to ensure that AMHWs are integrated into the clinical care of all Aboriginal consumers. There should be documented evidence of their role in individual consumer care.	Panel	May 2008
11	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.	Panel	Nov 2011
12	It is recommended that all consumers who are admitted voluntarily to the TEMHS Inpatient Unit are provided with: <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 consumer during the admission 	Community Visitors	Jan 2011
13	Strategies to ensure the cultural safety of clients with a particular focus on the needs of Indigenous clients in line with TEMHS values and objectives	Community Visitor	Nov 2012
14	A review of the reasons for extensive lengths of seclusion and strategies to reduce them significantly.	Community Visitor	Nov 2012
16	Provide education to all staff working in JRU on the expectation of the Approved Procedures to notify families/carers and adult guardian of seclusion events.	Community Visitor	Nov 2012
17	That TEMHS considers strategies to reduce number and length of seclusion events for young people and involve child and adolescent APPs in the assessment and strategies for alternate interventions.	Community Visitor	Nov 2012

Recommendations Closed in 2013-2014

	TEMHS Closed Recommendations	Made by	Date
1	It is recommended that funding is made available for the major works required to enable consumers in JRU to spend some time outside each day.	Panel	Nov 2006
2	It is recommended that procedures to ensure TEMHS' legal obligations to notify the CVP pursuant to s41 and s43 of the Mental Health and Related Services Act are put in place forthwith and that the CVP is formally notified of these procedures in writing.	Community Visitors	Apr 2006

2.4.2 MH-CAHS

	MH-CAHS Open Recommendation	Made by	Date
1	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.	CVP Quarterly report	Apr – June 2013
2	It is recommended that there be close monitoring of the new referral process between the On-Call and Child and Youth Teams.	CVP Approved facility inspection	2011-12
3	It is recommended that the seclusion event report forms be amended to include type of restraint.	CVP Seclusion report	2013-14
4	It is recommended that MHU management arrange a meeting with the Secure Care facility management and senior staff to discuss ways in which the transition of clients with complex cognitive impairment to secure care could be facilitated.	CV Panel	Dec 2013
5	It is recommended that the MHU review their seclusion practices and reverse the current upward trend, with a focus on sensory modulation practice.	CV Panel	Dec 2013
6	It is recommended that the Child & Youth Team and the Remote Team do an analysis of clients by heritage, to investigate the number of clients under 18 being seen by the Remote Team to gauge whether or not there is a group of C&Y clients 'missing out' on services.	CVP Approved facility inspection	2012-13
7	It is recommended that the Remote Team advise the CVP on how feedback and complaints will be gauged and recorded, even if written feedback forms in language are not utilised.	CVP Approved facility inspection	2012-13
8	It is recommended that the Remote Team continue to advocate within CAMHS to the DoH about recording and use of information across electronic databases, including the recording of early psychosis and diagnosis.	CVP Approved facility inspection	2012-13
9	It is recommended that significant efforts are made to recruit to the AMHW position within the Forensic Mental Health Team.	CVP Approved facility inspection	2013-14
10	It is recommended that CAMHS address the need for increased forensic psychiatric services, including consideration as to whether increased utilisation of psychiatrists based in Alice Springs may assist.	CVP Approved facility inspection	2013-14

Recommendations Closed in 2013-2014

	MH-CAHS Closed Recommendations	Made by	Date
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.	CV Panel	June 2013
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.	CV Panel	June 2013
3	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
4	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 sections 41 and 43 of the MHRSA.	CVP Quarterly Report	Jan - March 2012
5	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

Part 3: Disability Services

The *Disability Services Act* (DSA) provides the legislative framework to enable the operation of residential facilities for people with disabilities in the NT.

The legislation applies to three different types of residential facilities. The first are Secure Care Facilities, where persons with complex cognitive impairment who are engaging in repetitive high-risk behaviours which are likely to result in harm to themselves or to others, may be placed involuntarily, under a supervision or treatment order, to receive therapeutic treatment.⁴¹ Eligibility for admission to the Secure Care Facility depends upon these criteria being met and the likely benefit a person may obtain from the treatment. The second are Appropriate Places other than a secure care facility, which are residences for persons placed on a supervision order made by the Courts. Lastly, there are provisions for other residential facilities where a person with a disability may live and receive treatment and care, administered by the Department of Health (DoH).

The principles that underpin the care and treatment of residents in these facilities are based on the least restrictive option possible in the circumstances and ensuring that the person continues to obtain therapeutic benefit from the placement.

The role of the Community Visitor Program (CVP) is set out in Part 6 of the Act. The independent oversight provided by the Northern Territory CVP is similar to that provided in various other jurisdictions.

The jurisdiction of the CVP includes visiting all the aforementioned facilities. As prescribed by the DSA, the Secure Care Facility is visited monthly and the Appropriate Places quarterly. The particular vulnerability of residents in these facilities and the level of restriction they live under require a regular, independent oversight mechanism to ensure that their rights are being observed and that a quality service is being provided.

Outside of the Secure Care Facility, and Appropriate Places (one each in Darwin and Alice Springs), the CVP was not advised by Disability Services that there are any other facilities under this legislation.

A mandatory and important part of informing the care of people in Secure Care facilities and Appropriate Places are behaviour support plans. Individual Positive Behaviour Support Plans (PBSP) are extensive documents that provide a strength-based understanding of the individual, identify the areas for development, provide strategies for staff to assist the person to develop skills in each area identified and provide consistent guidelines on how to manage behaviours of concern. The PBSP includes whether and to what extent restrictive practices can be used for a particular resident.

As much as possible residents, and their primary carers or guardians, should be involved in establishing the PBSP. This is an important tool to ensure that all staff involved in the care of the client understand the short-term and long-term goals and provide accountability towards the resident, their carers and/or adult guardians, and the judiciary overseeing the supervision order. The PBSP is scheduled for review every six months.

The CVP monitors if PBSP include pathways to address barriers to a less restricted life for clients and to what extent they are being implemented in residents' activities and care.

⁴¹ The MHRSA defines a person with a cognitive impairment in Section 6A(1) and (2)

In 2013-2014, the CVP received low levels of complaints and enquiries relating to people receiving services in residential facilities. It is recognised that this is partly due to the nature of providing an advocacy and complaints mechanism in the disability setting, as residents have variable capacity to understand the role of the CVP, and identify and articulate issues. Furthermore, the number of people in residential care is comparatively low.

3.1 Significant Issues

3.1.1 Transition from Secure Care

The Northern Territory Government has established one secure care facility. The Secure Care Facility (Kwiernpe House in Alice Springs) is not designed as a permanent residence, but as a facility in which to further assess the functional ability and support requirements of residents, and build capacity and skills that will enable them to transition to less restrictive community environments. For the current residence, the Supreme Court makes the final decision about the individual's place of residence. The decision is informed by reports prepared by DoH and guided by the work being done with clients in Kwiernpe House.

Currently, it is not clear as to what the intended processes or timeframes are that would enable residents to transition from Kwiernpe House into a less restrictive residential environment.

It is recognised that some people with a disability may never reach the aim of living independently, or without significant support in the community. However, the therapeutic interventions of Secure Care should aim to overcome barriers and work towards providing a less restrictive setting in accordance with best practice principles and consistent with the person's own wishes and aspirations.

The CVP urges that the program at Kwiernpe House continues to target the development of skills and positive behaviours in residents with the long-term aim of transition and discharge to less restrictive living arrangements.

3.1.2 Limited supported accommodation options for people with disabilities

Whilst some residential services and facilities have been established to support people living with disabilities in the NT, options are significantly limited, particularly outside of urban centres. A comprehensive needs analysis has not been undertaken across the NT; however anecdotal evidence suggests that the range of supported accommodation options required to ensure safe and appropriate living conditions for people with substantial disabilities is insufficient for the current level of need.

In accordance with the principle of least restriction, options must be available for people to live in less restrictive community environments with support appropriate to their level of need. Hence, ideally, Secure Care would be one of a suite of accommodation options for people with disabilities.

The lack of transitional and other long term options for people in need of residential care and support is a matter of ongoing concern to the CVP.

SOURCE OF ENQUIRIES		TOTAL
Person receiving treatment		4
Carer/Guardian		1
Staff		2
CATEGORIES OF ENQUIRIES		TOTAL
Advocacy		4
Information		1
Quality of Service Provision		1
Rights		1
OUTCOME OF ENQUIRIES		TOTAL
Resolved		2
Open		5

VISITS & INSPECTIONS		TOTAL
Secure Care Facility - Alice Springs		11
Approved Place - Alice Springs		3
Approved Place - Darwin		1
CV Panel inspections		1

3.2 Secure Care Facility – Kwiyernepe House

The objective of the Secure Care model is to provide a safe, structured and stable environment in which residents are encouraged to learn new daily living, social and communication skills and manage their reactions to triggers for their high-risk behaviour.⁴²

In 2013-2014 the CV conducted 11 visits to Kwiyernepe House (KH) pursuant to section 54 of the DSA and the CVP Panel visited once, pursuant to section 63. During the visits, the CVP found the staff to be welcoming, helpful and willing to assist as needed, and commends all the staff for this.

Visits include interactions and conversations with residents, observations of interactions between residents and staff, discussions with staff, file and policy reviews and observations about the facilities.

Overall the CVP concluded that the residents are receiving therapeutic benefit from residing in KH. Staff were observed to have a good rapport with residents, providing opportunity for choice and treating them with respect. Residents generally presented as relaxed, willing to engage with those around them and with positive levels of self-care. Daily visits in the general community and a range of programs and activities in KH all provide therapeutic benefit and opportunities to build life skills.

The CVP received three enquiries and complaints directly from residents in 2013-2014. Two further enquiries were raised by staff advocating for the residents. Two issues were resolved, the remaining three requiring ongoing monitoring and advocacy. The issues raised were mainly about matters related to discharge.

3.2.1 Quality of Service Provision

Facilities

The CVP is consistently given access to a key pass to enable free movement around the building. During visits, the facilities were noted to be clean and friendly, despite the restrictive nature of the building. The 8-bed facility has a variety of rooms and the equipment required for the different functions.⁴³ All doors can be secured, and there are cameras in all rooms, excluding bedrooms, for surveillance from the staff area.

In the common areas, photos of residents and staff are displayed, which gives a homely feeling. Colourful information cards are displayed that detail best practice principles of disability service provision as a reminder for staff. In the activity room there are pictorial displays to communicate with residents and provide information about their routine, diet, behaviour, likes and dislikes etc.

The outside area appears to be well-utilised, with a shady BBQ area and vegetable gardens that have been established by the residents.

There is no functioning duress alarm system. This is a safety concern. It is essential that appropriate security features are installed; particularly duress alarms for staff and visitors.

⁴² 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

⁴³ The facility has an activity room, a seclusion room, a sitting room with couches and a TV, and a kitchen which opens out on to the outside area. In the centre of the facility is the locked staff area, surrounded by windows. The activity room has musical instruments and exercise equipment available for use.

The CVP made a recommendation last year that this should be rectified and understands that work to address this has commenced.

Community access

The residents participate in a daily community access program. The activities associated with community access appear to be based on the wishes of residents, and facilitate access to family and community and, to a degree, skills and capacity development. Residents spend time in Alice Springs, and with family members in town camps and in communities that are in close proximity to Alice Springs.

The CVP observed enthusiasm of residents related to community access, and this has been confirmed by their feedback. The CVP noted that on occasions community access is denied to residents as a consequence for incidents, but this appears to be rare and well-documented.

Skills, capacity development and physical health programs

KH provides programs that focus on skills and capacity-building. They appear to change at times, dependent on certain factors, particularly the resident's choice.

An activity officer regularly spends time with the residents and assists in some aspects of skill development, particularly around practical activities such as carpentry, painting and gardening. Residents are also involved in preparing meals and complete a cleaning routine of their living space every morning. Upon a resident's request, KH was able to purchase bikes for the residents' use and there is also a stationary exercise bike and running machine.

Case example

With the assistance of an activity officer, John constructed and painted a wooden cross to be placed on his father's grave. When this was a success, John made a few more, and was able to sell them for \$10 each. Demand continues to grow amongst John's family and friends for wooden crosses, and John is able to complete the process of construction with less assistance as his skills develop.

Maintenance of physical health and the development of healthy living habits are important for residents. The CVP notes ongoing engagement with primary health services as needed, and that staff discuss with residents their individual health needs.

Residents exercise choice

The CVP noted that the residents exercise choice in a number of ways; for example, decisions in regards to decorating their rooms, participation in daily activities (as appropriate), the food they prefer and, if a resident wants to sleep outside, this is facilitated by staff.

It was observed that residents meetings took place in the early phase of the facility's establishment. The meetings involved the staff having 'sit down' time with the residents to discuss the program, and give them an opportunity to express their wishes. However, it appears that these meetings have not occurred for some time.

While it is recognised that the residents each have different levels of capacity to engage with this kind of process, it is important that appropriate mechanisms are established to

maximise participation in the therapeutic process and in decisions affecting daily life and that these are followed through as a standard activity.

Reflective practice around Behaviours of Concern

The goal of behaviour management is to ameliorate risk behaviours to enable a less restrictive life for the residents. Changes in behaviour can be achieved by actively supporting positive behaviour and analysing the triggers and context of the behaviours of concern.

While the CVP has noted sufficient documentation around serious incidents and behaviours of concern, there is little evidence to show that the information around these incidents is used to further develop or review behaviour management plans or other responses.

It is expected that such reflection would involve investigation into why the incident may have occurred, and what proactive strategies are needed to ameliorate this in the future. For example, if there is a violent incident associated with an unexpected change of plans, then it can be expected that staff will develop strategies to minimise the impact of changes by controlling the events (triggers), and working with the person to strengthen their ability to better tolerate unexpected changes.

The CVP expects to see more evidence to show that risk behaviours are being targeted, with associated program responses and measurements of outcomes.

Restrictive Interventions

It is the CVP's responsibility under section 55 (1) (d) to inquire into the use of restrictive interventions.

The PBSP prepared for each resident states the range of strategies to be used in managing the person's behaviour, including potential seclusion and restraint as a last resort.⁴⁴ Seclusion is not a therapeutic practice and is to be avoided where possible.

The CVP have observed staff practices in response to behaviours of concern that suggest a commitment to the principles of the least restrictive alternative. For example, staff are frequently noted to employ strategies around re-direction and allowing the person 'time-out'. Seclusion was not used in 2013-2014 and the CVP commends the facility for this.

Over the year, there have been marked improvements in completion of section 43 forms, which give details around restrictive practice.

There were some incidents whereby PRN (i.e. 'as needed') medication was administered up to one hour after an incident occurred and the client had already calmed down. This was discussed with senior management, who supplied sufficient reasoning for the particular incidents. Nonetheless, the CVP will continue to monitor the use of PRN medication around incidents, as it is of critical importance that this is used for therapeutic benefit only to address genuine risk of harm, rather than as first option in behaviour management.

Culturally safe practices

All current residents of KH are Aboriginal and speak languages other than English as their first language. However, interpreters are not frequently used in the interactions with the

⁴⁴ *Disability Services Act*, section 36

residents. The CVP encourages that staff at Kwiyrnpe House use interpreters more frequently in the program, for example for weekly meetings with each resident.

As with all disability service provision, age and gender appropriate language, naming, activities and programs are crucial. For Aboriginal people this includes respect for cultural values, including a person's relationships to others, land, ceremony, and their identity as an initiated adult. There is evidence that the community-based activities provided by KH recognise and accommodate the cultural needs of the residents.

In the 2012-2013 Annual Report, the CVP suggested that a comprehensive cultural safety strategy be developed to strongly embed culturally safe practices into all aspects of the operations and care planning. The CVP reiterates the necessity for this strategy to ensure continual strengthening of such practices.

3.2.2 Rights

Schedule 2 of the DSA outlines the rights of people with disabilities, and guides service delivery under the Act.

Visits to country

Under Schedule 3, Objective (E) states that:

The program or the services should be designed and administered to meet the needs of people with disabilities who experience a double disadvantage as a result of their gender, ethnic origin or Aboriginality.

There is a recognised need for Aboriginal people to maintain connection to land and culture. Visits to country should be recognised in the context of therapeutic benefit and as such, the service is required to facilitate this.

Additionally to frequent visits to communities close to Alice Springs during daily outings, there has been one overnight visit to country for a resident. This involved significant preparation, increased staffing and working with the person's family. The service is to be commended for their work on this outcome. It is the view of the CVP that more trips such as this need to be provided to enable residents to maintain the cultural connection to their land and family and as part of their preparation to leave secure care.

Advocacy

The CVP has noted a willingness of staff to advocate for residents as needed, and raise issues with the CVP.

Case example

A staff member raised with the CV that Bob liked to call his grandfather once a week, who is in Darwin Correctional Centre (DCC). A recent change of practice at DCC meant that Bob was unable to make phone calls to his grandfather anymore. The CV raised this issue with the Senior Clinician, who made contact with DCC and was able to negotiate phone calls between Bob and his grandfather to recommence.

Complaints procedures⁴⁵

It is the role of the CVP under section 55 (1)(a)&(b) to inquire into complaints procedures. Due to their diminished capacity, the clients of KH are considered to be particularly vulnerable, and hence there is a necessity to have complaints procedures in place appropriate to their cognitive and conceptual abilities. The CVP is one such mechanism, but others should also be in place. Any mechanisms need to be well understood by residents, carers and staff and easily accessible.

Talking posters⁴⁶ with information about the rights and responsibilities of residents have recently been created in the local Indigenous languages, including those spoken by residents, and installed in KH. This development is commended.

The CVP is not aware of KH having received any complaints in 2013-2014.

Staffing

The CVP noted that the staff remained quite consistent at KH over 2013-2014. This has benefits for residents in terms of maintaining established rapport, trust and stability.

However, the key positions of Occupational Therapist and Clinician remain vacant at the time of writing. It is noted that work pertaining to these roles is being supported by Darwin-based staff. As the numbers of residents increase, this will place increasing pressure on all staff and is not sustainable in the longer term. It is the view of the CVP that recruitment to these roles should receive priority.

The CVP was informed that shift supervisor meetings have commenced to enhance program development and to improve resident management plans. A local disability behaviour specialist is also reportedly engaged for a monthly de-briefing, staff development and to enhance reflective practice.

3.2.3 Procedures

File reviews

During every visit, the CVP conducts a file review to ensure that documentation and records are being kept in accordance with the DSA. KH staff have been consistently willing to facilitate CVP access to requested information, and are responsive to any feedback and issues raised. The CVP particularly focuses on responses to incidents, reflective practices around behaviours of concern, and the use of restrictive practices. This process has been hindered by the CV being unable to access the CCIS database, and a recommendation has been made to that effect.

In general, reports by staff were found to be written in a measured and reasonable way. The CVP encourages ongoing commitment to quality and reflective report writing.

⁴⁵ *Disability Services Act*, section 45

⁴⁶ 'Talking posters' are pictorial displays with embedded buttons which, when pressed, play a recording of a description of the corresponding picture. For example, next to an illustration of a Judge is a button which describes legal processes in appropriate terms and language.

Behaviour Support Plan Review Panel ⁴⁷

The DSA includes provisions for an independent Review Panel to be appointed by the Minister. The intent of this Panel is to provide a review mechanism where a restrictive intervention is included in the behaviour support plan for a resident. In reviewing an application, the Review Panel must either confirm the decision to include the restrictive intervention in the behaviour support plan, or direct that the restrictive intervention be removed, or direct the CEO to prepare a new behaviour support plan for the resident in accordance with the court order.

The role of the Review Panel is essential in providing professional and independent oversight of the PBSP, ensuring an independent avenue of appeal for the resident, and the timely and appropriate preparation of behavioural support plans, particularly in the context of informing reviews of the orders before the Supreme Court.

To date, although the process has reportedly commenced, the Review Panel has not been established. The CVP urges that the Review Panel be established as a matter of priority.

Access for female and non-forensic clients

The Secure Care Facility was established under the DSA and Mental Health and Related Services Act (MHRSA) to provide therapeutic services for people who meet the stated criteria as an early intervention and prevention service, and to enable residents to live as independently as possible.

To date, no female residents have accessed the facility and all male residents have been transitioned solely from the Alice Springs Correctional Centre (ASCC). While the pressing needs and human rights considerations for people in this situation are acknowledged, the CVP understands that KH was not intended exclusively for forensic residents, or males.

The CVP has requested information on the practical application of these provisions under the MHRSA and DSA, including whether they will be utilised in the future and how these matters are being assessed. If the original intent remains to utilise the Mental Health Unit for assessment and potential transfer of residents to KH, it is also recommended that management of Disability Services and Mental Health Services clarify the practical application of this legislative framework.

Audit and quality assurance processes

The model of Secure Care facilities for this client group is still relatively new, both in the NT and other jurisdictions, where only a few have similar facilities. As such, benchmarks for service delivery are not well established. According to KH, their practice is guided by the national standards for disability services and the requirements set out in the DSA.

While the CVP provides a level of independent oversight in line with the legislation, its scope and capacity are limited. Coupled with the need for a documented quality assurance framework and protocols to underpin residential services, it is the view of the CVP that further rigor and independent evaluation/quality assurance and audit processes are needed to ensure the highest possible standard of care for this client group.

⁴⁷ *Disability Services Act*, Division 1 & Section 40 - Review of behaviour support plan – review panel;

3.3 Disability Services - Appropriate Places

The role of the CVP also applies to residences deemed as an Appropriate Place.⁴⁸ A Panel is not required for Appropriate Places as part of the CVP's function.

In performing its role, the CVP visits an Appropriate Place every three months, has contact with the residents, undertakes reviews of the files and other documents relevant to their care, and obtains information from staff.

3.3.1 Top End

Specialist Residential Facility

Only one Appropriate Place operated in the Darwin region this year.⁴⁹ This place will be referred to as the Specialist Residential Facility (SRF) in this document. In 2013-2014, SRF provided residence to one resident on a full-time basis; another resident visited the facility several days a week, whilst still residing in Darwin Correctional Services. These visits are part of the person's transition into the full-time care of Disability Services. Both residents are male.

The SRF re-opened in December 2013 after construction. Visits by the CVP pursuant to the legislation commenced in early 2014. Only one visit occurred in the reporting period.

DS staff were accommodating and prompt in their responses to any enquiries from the CVP. The CVP appreciates the professional and collegial relationship and interactions with staff of Disability Services.

3.3.1 (a) Quality of service provision

Facilities

The facility is located in a rural setting and secured by a 4-5 m high fence and locked gates. The buildings provide for the resident's (a bedroom, a kitchenette and bathroom), an office building, which is generally not accessible to the residents, and a well-equipped sensory room.⁵⁰ The outdoor areas are spacious and well-maintained. A large under-cover outdoor area between the residential and office buildings provides a sitting area and an outdoor kitchen, which is used daily for meal preparation. The large garden is maintained by the resident. There is space for games, as well as growing fruit trees and vegetables.

Positive Behaviour Support Plans

Both residents have very well-written and comprehensive PBSPs meeting the expectation of strength-based approach to resident care. Plans demonstrate a thorough understanding of the resident's personality, identify possible behaviours of concern and include detailed recommended responses. The recommended activities are targeted to life skill enhancement and strategies for staff to manage, and for residents to self-manage, potential challenges. It appears that for both residents, their behaviour and wellbeing has improved significantly since transition to the Appropriate Place. This is evidenced by low levels and incidences of behaviours of concern and other incidents. When incidents occur, there is clear evidence that staff reflect on possible triggers and potential prevention strategies.

⁴⁸ Section 59 DSA

⁴⁹ Section 43ZA(1)(a)(ii) of the Criminal Code Act

⁵⁰ Sensory rooms are widely used in services for people with cognitive disabilities, mental health issues and age-related degenerative diseases and utilised to provide comfort and assurance to clients when distressed or relaxation in every-day life.

Health care

Both residents are shared residents of Disability Services (DS) and Top End Mental Health Services (TEMHS). The resident in full care of DS is reviewed by the relevant psychiatric team every month. Other health checks and appointments are well documented and communicated among staff to enable follow-up. The health care for the resident in transition remains with Correctional Services until the transition is completed.

Community Access

One resident goes on daily community access, and the other resident almost daily community access.⁵¹ Some activities are recurring; others are flexible and orientated to the residents' needs, wishes and capacity (see also Cultural Safety). They provide opportunities for residents to interact with peers, family and the general community, build social and daily living skills, entertainment and connect to their cultural origins. The feedback from residents is that they enjoy the activities.

Cultural Safety

The SRF is committed to ensuring the connection of residents with their culture. Both residents are Aboriginal, however communicate primarily in English. Especially for the full-time resident, his desire to maintain a strong connection with his culture has been identified as a high priority and activities are planned accordingly, by providing contact with family when possible, and access to music and films. He also attended the festival in his community of origin, which he greatly enjoyed.

Living skills

Daily activities for the full-time resident include personal care, meal preparation and associated tasks and gardening. Plans for expanding skills into other areas are underway at the time of writing.

Staffing

Two support workers are rostered at all times for the care of the full-time resident. The resident visiting from the Correctional Services is accompanied by staff of the prison. The recruitment and retention of Support Workers is at times a challenge. Most have related qualifications and some have several years of experience in their profession. Some Support Workers have known the full-time resident for several years, developed a respectful and caring relationship and are well aware of his likes and dislikes. It also appears that they are able to manage potential risks and deflect potential triggers for behaviours of concern. Reliable positive relationships are generally associated with emotional stability for the residents and therefore a greater likelihood of better outcomes.

The resident also has frequent (at least weekly) contact with an Occupational Therapist who is responsible for the development and oversight of his behavioural management, skill development, health care management and activity planning. The Senior Clinician and the Supervisor of the facility also have frequent face-to-face contact with the residents.

⁵¹ Dependent on transport issues or when there are prison procedures which do not allow this.

3.3.1 (b) Procedures

File Review

DS has developed a high standard of documentation, including reporting templates, forms, charts and lists to ensure safety, accountability and evidence for interventions and to ensure evidence-based care planning. They include: daily progress notes, behaviour observation charts, community access checklist, incidence reports, risk management tools, medication charts and medical files. In this first review period all documentation was well maintained and procedures diligently followed.

3.3.2 Central Australia

In this reporting period the CVP visited one Appropriate Place in Alice Springs. In 2013-2014, the supported accommodation component of service was transitioned from DoH to Lifestyle Solutions, a non-Government organisation. There is currently one male resident in the house.

The CVP conducted 3 visits to the house this year, with a focus on learning about the policies, procedures and standard functioning of the house, and establishing rapport with the resident. During these visits, one issue was raised by the resident, and one issue was raised by his Adult Guardian.

3.3.2 (a) Quality of service provision

Facilities

The CVP observed the home to be moderately clean and orderly. There is evidence that the resident has been able to exercise choice over the decoration of his surroundings, and musical instruments and CDs/DVDs are available.

Positive Behaviour Support Plans

For this resident a management plan has been developed instead of a PBSP to guide staff responses to him. Staff reported that the person generally displays only few behaviours of concern and only one incident was recorded in 2013-2014. Due to this fact, and the limited documentation around the program, it was difficult to ascertain to what degree this plan guides the actions of the support staff in times of escalated behaviour.

Health care

The CVP received information that the physical health of the resident had been declining, and that this impacted on visits to country. The CVP was informed that the person receives regular health checks and medical appointments are attended.

Community Access

The resident has a program of almost daily community access in and around Alice Springs, which involves regular contact with family, and weekly cook-ups. The CVP will continuously monitor the program to ensure it relates to the person's therapeutic goals.

Cultural Safety

Based on limited observations, the cultural needs of the resident appear to be understood, as reflected in the discussions and rapport between the staff and resident, and in the resident's management plan. Lifestyle Solutions employs one Aboriginal support worker for this person. Other Aboriginal support staff, employed by DoH who have worked with him in

his previous placements, continue to maintain a relationship with him through scheduled visits.

However, it was raised clearly by the resident that he would like to visit his country, and that this had not happened for some time. It had previously been stated to the CVP that these visits would occur every 6 weeks.

Given the importance of spending time on country for Aboriginal people, the CVP urges that a visit to country be arranged for the person as soon as possible, and regular visits are re-instated.

Staffing

One staff member is rostered on at all times with the resident, with hand over periods. The staff were observed to have a good rapport with the resident, and receive support from a network of professionals who have worked with him over many years. An understanding of 'triggers' and the person's likes and dislikes was observed, including things that make him laugh, and giving him space to exercise choice, particularly in relation to food.

3.3.2 (b) Procedures

File review

It is noted that the documentation systems in this NGO-run house are not as established and comprehensive as those in the DoH-run facilities. The CVP has sighted daily progress notes, health documentation (e.g. records of doctor's appointments), medication administration and incident reports (although minimal), and the CVP will continue to monitor that the documentation is appropriate to the level of care required.

Information sharing

Under the *Adult Guardianship Act*, the appointed Adult Guardian has the responsibility to promote the best interests of the person. To fulfil this role, the guardian needs to have access to all relevant reports, particularly related to the order under which the person is receiving treatment. It appears that this does not always occur in a regular and timely fashion.

The CVP urges that relevant information be shared with all appropriate stakeholders, particularly those with responsibilities to the resident under the *Adult Guardianship Act*.

3.4 Recommendations

	Recommendation	Made by	Status
1	It is recommended that the Mental Health Unit and Secure Care Facility management and senior staff meet and work out together a process for the referral and transition from Tier 1 to Tier 2.	CV Panel	Open
2	It is recommended that appropriate security features are installed, particularly duress alarms for all staff and visitors.	Community Visitor	Open
3	It is recommended that recruitment to the roles of Occupational Therapist and Clinician be prioritised	Community Visitor	Open
4	It is recommended that the service provide the quality assurance framework documentation and process that underpin quality assurance for Kwiyeerpe House and appropriate places.	Community Visitor	Open
5	It is recommended that the Positive Behaviour Support Panel be established in accordance with sections 36 and 40 of the DSA.	Community Visitor	Open
7	It is recommended that the CVP be granted CCIS access to enable file reviews.	Community Visitor	Open

Part 4: Alcohol Mandatory Treatment

A New Legislation and Model of Care

The *Alcohol Mandatory Treatment Act* (the AMT Act) establishes the Alcohol Mandatory Treatment Program (the AMT Program). The AMT Program operates Assessment Facilities and Treatment Centres in the Northern Territory.

The purpose of the AMT Act is to mandate assessment and treatment for people who chronically misuse alcohol in public areas⁵², who are either unlikely or unable to voluntarily access treatment options⁵³ and have been in protective custody of the NT Police three times in two months⁵⁴. The objects of the Act are to address the person's health issues, improve social functioning, restore their decision-making capacity regarding lifestyle and link them with ongoing treatment.⁵⁵

The Community Visitor Program (CVP) acknowledges the NT Government's approach in using a health based legislative framework to combat public chronic alcohol misuse and commends them for ensuring that the legislation incorporates an independent, impartial oversight mechanism such as the CVP for the purpose of upholding the rights of those involuntarily undergoing assessment or treatment.

There are examples of mandatory treatment for chronic alcohol problems in other jurisdiction, both nationally and internationally⁵⁶. However, each model is different, and applies to different cohorts of people. There is limited and inconclusive evidence about the effectiveness of mandatory treatment for alcohol, and other drug problems. However, from the evidence available, there is agreement among experts about best practice principles that should guide mandatory treatment and residential treatment whether mandatory or not.⁵⁷ The CVP adopts these principles when carrying out its oversight role.

Briefly described, once a person triggers the operation of the AMT Act, they become an 'assessable person' and, subject to certain matters, are transported by NT Police to an Assessment Facility.⁵⁸ The assessment takes place within specific timeframes, and, unless treatment is required under the *Mental Health and Related Services Act*,⁵⁹ an application is made (with a recommendation for the type of order) by a Senior Assessment Clinician (SAC), to the Alcohol Mandatory Treatment Tribunal (the AMT Tribunal).⁶⁰ Ideally the assessable person is represented and their representative is able to advise the Tribunal of their relevant circumstances and attitude to the order (if any) recommended by the SAC.

⁵² Minister Lambley, 15 May 2013, Alcohol Mandatory Treatment Bill 2013, Second Reading Speech, Legislative Assembly of the Northern Territory 12th Assembly, 1st Session, viewed 23 September 2014,

<http://notes.nt.gov.au/lant/hansard/hansard12.nsf/WebbyMember/9F9FD27C817D61D669257BDB00224ECD?opendocument>

⁵³ Second Reading Speech, AMT Bill, NT Parliament

⁵⁴ Section 128A of the *Police Administration Act* (NT)

⁵⁵ Section 3, AMT Act

⁵⁶ *Mandatory Treatment Position Statement*, Australian National Council on Drugs (ANCD), April 2014

⁵⁷ For example: *Mandatory Treatment – Position Statement*, Australian National Council on Drugs (ANCD), April 2014; *Drug and alcohol treatment guidelines for residential settings*, NSW Health, February 2007; *QIC Health and Community Services Standards*, Quality Improvement Council, 6th edition, 2010.

⁵⁸ Section 128A of the *Police Administration Act* (NT)

⁵⁹ Section 21 of the AMT Act

⁶⁰ Sections 20, 22 of the AMT Act

The Tribunal can order:

- Treatment in a secure residential Treatment Centre (Mandatory Residential Treatment Order, or MRTO)⁶¹, with a mandatory income management order (if the person is an eligible welfare payment recipient)⁶²;
- A Mandatory Community Treatment Order (MCTO)⁶³, which orders treatment with a community residential or non-residential Treatment Provider where secure treatment is not warranted or available, or MCTO with a mandatory income management order (if the person is an eligible welfare payment recipient)⁶⁴;
- Release from the Assessment facility⁶⁵; or
- Exemption from further assessment under the AMT Act for a specified period.⁶⁶

The Community Visitor Program in Alcohol Mandatory Treatment

The role of the Community Visitor Program is to promote and protect the rights and dignity of people who receive AMT services through advocacy, complaints resolution, inspection, monitoring and reporting.⁶⁷

Of particular importance in mandatory treatment is the application of the least restrictive intervention principle⁶⁸. For this new program, the CVP has applied its extensive experience with the least restrictive principle obtained through monitoring voluntary and involuntary treatment within the NT Government mental health facilities and agencies over the last 12 years. In so doing, the CVP draws from the experiences of people receiving treatment and reviews treatment and practices against the AMT Act, national standards, human rights conventions, and the evidence available to describe best practice.⁶⁹

Establishing the Community Visitor Program Role

Due to the rapid expansion required for the CVP to start this role⁷⁰, it was not possible for visits to commence when the AMT Program began on 1 July 2013. The CVP commenced visiting Assessment Facilities and Treatment Centres on 11 December 2013.

The AMT Act creates an advocate role, primarily for unrepresented persons at the AMT Tribunal.⁷¹ The Advocate, based within the CVP, commenced in Darwin late November 2013.

⁶¹ Section 12 of the AMT Act

⁶² Section 33(a), 34 of the AMT Act

⁶³ Section 11 of the AMT Act

⁶⁴ Section 33(a), 34 of the AMT Act

⁶⁵ Section 33(b) of the AMT Act

⁶⁶ Section 35, 41 of the AMT Act

⁶⁷ Part 5, Division 2 of the AMT Act

⁶⁸ Section 6 of the AMT Act

⁶⁹ For example: *Mandatory Treatment, Position Statement*, Australian National Council on Drugs (ANCD), April 2014; *Statement on funding principles for non-government organisations providing alcohol and other drug treatments*, ANCD, April 2014; *Drugs and alcohol treatment guidelines for residential settings*, NSW Health, February 2007; *QIC Health and Community Services Standards*, Quality Improvement Council, April 2010, 6th edition; *Universal Declaration of Human Rights*; *Shaping the Future: The Victorian Alcohol and Other Drug Quality Framework*, Department of Human Services, Victorian Government, April 2008; Academic writings of Dr Maggie Brady.

⁷⁰ Prior to July 2013, the CVP had only 2.5 staff, and did not receive any NT Government recruitment dispensations.

⁷¹ Section 113 of the AMT Act

NT Alcohol and Other Drugs Sector Overview – general comment

The CVP acknowledges and commends the Department of Health (DoH) and the NGO partners on the extensive work that was undertaken to implement the Alcohol Mandatory Treatment Program in July 2013, with a very short lead in time.

The CVP recognises that this occurred whilst the DoH Alcohol and Other Drugs Program was being restructured, and while other major reforms to health and hospital services were being made throughout the Territory. All of these changes resulted in new structures and substantial changes in leadership roles and personnel. Getting the AMT Program operating in this environment of change, has required enormous concerted effort from many staff and services and is acknowledged as a significant achievement.

Notwithstanding these challenges, the CVP has observed a number of issues associated with the speed of the rollout.

The CVP's role is to provide independent, fearless and frank advice on matters related to the AMT Program that impact on the quality and safety of services provided to assessable and affected people. The CVP comments throughout this Report are provided in that context. The most significant of the matters identified with the commencement of the Program and still requiring attention are discussed in Significant Issues, section 4.1.

Prior to the role of the CVP in the AMT Program, there was no external oversight in the Alcohol and Other Drugs services sector in the Northern Territory, notwithstanding that some NT NGOs have commenced an external accreditation process. The importance of external oversight is increased when the treatment is mandatory, and this is acknowledged by the NT Government and Department of Health as an important part of the AMT Program.⁷²

The CVP is aware, from its experience in mental health and disability services, that independent oversight can be confronting and challenging to service providers, especially those experiencing it for the first time. There have been varying degrees of receptiveness to the CVP role, both positive and negative. The CVPs experience over this year is that the best outcomes have been achieved when the approach between the CVP and service providers is collaborative and cooperative. The CVP is committed to continuing to work with the AMT Program in this manner. Ongoing training at Assessment Facilities and Treatment Centres about the CVP role and approach will continue to be provided.

⁷² Quote from the Second Reading Speech, AMT Bill, NT Parliament: *'The bill establishes arrangements for the oversight of complaints and to support advocacy for clients, as well as scrutiny of services and processes to promote service and program quality through an extension of the Community Visitor Program and Community Visitor Panel. This is an important safeguard and accountability measure consistent with the Mental Health and Related Services Act.*

Quote from *'Alcohol Mandatory Treatment - Frequently Asked Questions'*, NT Department of Health, 2013: *'Clients in the mandatory treatment system are protected by a range of mechanisms. These include: an oversight body in the form of a community visitors program, like that in operation for mental health clients. This program will regularly visit clients in the facilities to check on their welfare...'*

4.1 Significant Issues

In carrying out its functions, the CVP has broad powers to enter Assessment Facilities and Treatment Centres, speak to assessable and affected persons, inspect facilities, review records and documentation and inquire into matters considered appropriate having regard to the principles and objectives of the AMT Act.⁷³ These functions are carried out by Community Visitors who visit Assessment Facilities and Treatment Centres weekly, to fortnightly, and the Community Visitor Panels who visit Treatment Centres biannually. The CV observed a systematic approach to the management of the physical health needs across the Territory of affected persons, some of whom have long standing, serious chronic health conditions.

However, as noted above, in this first 8 months of monitoring the AMT Program, the CVP has identified a number of priority areas for improvement in other key aspects of the Program. Although they may have been identified in a specific service, in general, significant issues are systems issues that have implications for the entire Program. These issues will be the focus for continued monitoring by the Community Visitors and Community Visitor Panel in the coming year.

The Significant issues are detailed in this section and identified in the reviews of the various Assessment Facilities and Treatment Centres.

4.1.1 Assessment & Treatment

At the heart of effective treatment in any chronic health problem is the extent to which clients are involved in their care, the range of treatment options, and the process to facilitate goal setting and individual decision-making. How well the environment is created to support client participation will be a major contributing factor in transition from a mandatory passive phase to the active self-determining phase in the management of their alcohol dependency, use or subsequent cessation.

There is an inherent conflict in the NT model of care between the therapeutic objects^[2] of the AMT Program and the power to mandate treatment. The CVP considers it is essential that this conflict is identified and resolved and that a health promotion approach, with evidence based strategies, is included across the whole program.

The AMT Program is based on an abstinence model. Most people managed through AMT will have problems associated with chronic alcohol abuse and current evidence suggests that relapse is the norm in this context. A 'one size fits all' one off intervention is unlikely to lead to sustained benefit for most of this group. The CVP believes current evidence supports offering a range of personally and culturally relevant harm minimisation strategies in a respectful and engaging environment, as the most likely way to achieve sustained benefit.⁷⁴

Since 1993, harm minimisation has been the national approach to drug and alcohol treatment.⁷⁵ How the NT AMT model uses mandatory treatment to incorporate harm reduction and health promotion including longer term after care will significantly influence whether sustained change is achieved for affected people.

⁷³ Part 5, Division 2 of the AMT Act, particularly section 88, 90, 91, 98, 100

^[2] Sections 3, 6 of the AMT Act

⁷⁴ Giving away the grog: Aboriginal accounts of drinking and not drinking." Canberra: Commonwealth Department of Human Services and Health, for the National Drug Strategy (1995).

⁷⁵Single, Eric, and Timothy Rohl. "The national drug strategy: mapping the future." *Canberra: AGPS* (1997)

4.1.2 Interpreter Use and Cultural Competency

The NT Program is unique among the mandatory alcohol and drug programs provided in other Australian jurisdictions in that the predominant recipients of mandatory care are Indigenous people. The CVP understands, and has observed during visits to assessment facilities and treatment centres, that approximately 98% of those under Alcohol Mandatory Treatment are Indigenous people.

The CVP's experience is that English is a second or third language for the majority of assessable and affected persons received into the AMT Program.

This has significant implications for the application of traditional clinical assessment processes and tools. Assessment tools and programs must be available, or adapted and monitored to meet the cultural context and achieve the best possible outcome.

An accurate assessment under the section 10 criteria requires detailed inquiry into many facets of a person's life. It is the start of the therapeutic relationship. All available research indicates that a person expresses themselves better, and with more confidence, in their first language, especially if they are dealing with unfamiliar concepts.⁷⁶ Effective treatment and aftercare planning relies heavily on an affected person being able to meaningfully participate.

Failure of AMT Program staff to communicate effectively may result in interventions being perceived as a threat to a person's rights, rather than providing the intended layer of protection.

The use of qualified interpreters at appropriate stages is critical to the success of a person's participation, and experience, of the AMT Program, and therefore, critical to the success of the AMT Program as a whole. This is acknowledged in the AMT Act⁷⁷ and DoH policies and procedures. It is also an underlying principle of the Quality Improvement Council for the AOD sector.⁷⁸

Concern about the failure to use interpreters was a recurring subject in both Community Visitor, and Community Visitor Panel reports throughout the AMT Program this year. For example, at both Assessment Facilities and Treatment Centres the CVP observed inconsistent approaches to determining whether or not an interpreter should be used. CVP reports expressed concerns about the lack of interpreter use at all in some circumstances.

It was observed on numerous occasions in communications that leading questions were being used (such as 'you don't need an interpreter, do you?') giving rise to the risk of gratuitous concurrence, and confusing questions being put without an interpreter present (such as 'do you drink 1 to 10 cans per day?') potentially leading to inaccurate conclusions.⁷⁹

⁷⁶ "If a person speaks English as a second language and has had limited education in English, it is likely that you should work with an interpreter. This is especially true when you are dealing with specialized language and unfamiliar situations such as court and police interviews." (Northern Territory Government, Aboriginal Interpreter Service).

⁷⁷ Section 15(3) and 55(3) of the AMT Act

⁷⁸ Standard 2.2 and 2.3 of the *QIC Health and Community Services Standards*, Quality Improvement Council, April 2010, 6th edition

⁷⁹ Gratuitous concurrence is when a person appears to assent to every proposition put to them even when they do not agree. For many Indigenous people, using gratuitous concurrence during a conversation is a cultural phenomenon, and is used to build or define the relationship between the people who are speaking, <http://www.lsc.sa.gov.au/dsh/ch03s04.php>

Case example

John is a middle aged traditional Aboriginal Man who lives on a remote community. He has two children and has come into town for a course, and to attend the Rodeo. When the CV spoke to John she found it difficult to understand what he was saying but on inquiring with the SAC about how language difficulties had been managed, was told that an interpreter was not used at the assessment. This was despite John being identified as requiring an interpreter at a previous admission.

The CVP's view is that the use of interpreters is not only best practice, but enables health practitioners to meet their professional obligations. The CVP advocates strongly that the identification of the need for an interpreter and the use of interpreters, be improved throughout the AMT Program as a priority.

4.1.3 Culturally Respectful Healthcare⁸⁰

Working effectively with Indigenous people requires healthcare providers not only to acknowledge history and appreciate diversity, but also to examine their own perspectives on health, belief systems and the ways in which individuals communicate.⁸¹

It is the CVP view that culturally respectful services have the following elements:

- Cross cultural training for staff that supports cultural competency skills;
- Policies and processes that enhance culturally safety;
- Indigenous staff, whose skillsets demonstrate cultural knowledge and competencies; and
- Culturally appropriate activities and therapies.

The development of audio tools in different languages for the Top End and Central Australia occurred. This was a positive development however disappointingly there were discrepancies in the use of these tools throughout the NT as noted in the following service reports.

The CVP is pleased to see that the staffing structure of the DoH services included designated positions for Indigenous workers in most of the services and that this policy is also evident in the workplace of CAAAPU.

As part of the multidisciplinary team Indigenous staff bring valuable cultural skills that can contribute to cultural safety. However it is important for services to not assume that every Indigenous person will want to be referred to those staff members or have an Indigenous worker involved. The CVP asserts that the 'individual rights' of affected Indigenous people are obtained through appropriate engagement and instructions based on their individual needs and choices.

The CVP observed varying degrees of culturally appropriate activities being provided in the AMT Program and commends the services for introducing cultural activities such as fire pits for cooking Kangaroo tail, fishing, and supporting the reconnection with family and associated support networks. The DoH's engagement of Indigenous organisations as

⁸⁰ Alcohol Treatment Guidelines for Indigenous Australians, Pg 1.13

⁸¹ Culturally unsafe practice is defined as 'any actions that diminish, demean or disempower the cultural identity and wellbeing of an individual' (Cooney 1994, cited in *Cultural Safety: Exploring the Applicability to the Concept of Cultural Safety to Aboriginal Health and Community Wellness*, Brascoupe, S & Waters, C, in the Journal of Aboriginal Health, 2009, page 7)

treatment providers is also commended; as noted by the community visitor panel during a visit to CAAAPU, 'Aboriginal organisations appear to bring cultural understanding'.

On seeking feedback on a draft of this report from DoH, the CVP was provided with a Aboriginal Cultural Security Policy and advised that it applies to all DoH staff. The Policy states it is mandatory that staff attend cultural training.

Whilst attention is being given in the Program to staff mix, and culturally appropriate activities for the people receiving services, it was unclear over the past eight months, to the CVP how the first two elements (ie cross cultural training and policies that enhance cultural safety) as there were limited examples provided that demonstrated how cultural safety was incorporated into the AMT Program.

Whilst this is the situation, the AMT Program management acknowledge that culturally respectful healthcare is an area that requires further refinement and work.

4.1.4 Model of Care and Treatment Program

The CVP understands a 'model of care' to be a multi-faceted concept, which broadly defines the way health services are delivered⁸² by describing the principles, objectives, aims and resources underpinning the Program. This provides the framework necessary to facilitate consistency in assessment and treatment, and assists clinicians, support staff and other stakeholders to interpret legislation in practice. The broad objective of developing a model of care is '*ensuring that people get the right care, at the right time, by the right team, and in the right place*'.⁸³

The CVP's view is that the AMT Program model of care should adopt best practice especially tailored to the target client group. The predominant group for the Program is clearly identifiable by demographic analysis of clients in the first year. Predominantly, those admitted to the program are Indigenous people with problems of alcohol dependence and binge drinking, and are either homeless in urban centres or have come in for a short term stay from a remote community and have nowhere affordable or appropriate to stay.

The CVP is concerned that, despite the Program being operational for almost 12 months, the Department has not finalized a model of care for the program.

By mandating treatment, the AMT Program introduces a new approach to care for all service providers in the NT. Although the legislation details and describes the objects and principles of the Program, it is not adequate, on its own, to define and guide implementation of the various roles and functions of the Program.

To augment this, the DoH AMT Directorate is developing a raft of different policies to define and guide different aspects of the AMT services and has provided these to the CVP.

But, in the absence of an identifiable model of care, the information is fragmented, and lacks the detail required to successfully operationalise a Territory-wide program. In addition, the policies provided to the CVP so far relate more to the Assessment Facilities and, although this area warrants particular focus, policies for the Treatment Centres are limited or lacking. Guidelines for the Treatment Centres are particularly important, given that mandatory treatment is new to the Treatment Centres, there are different organisations providing

⁸² Queensland Health, *Changing Models of Care Framework* (2000)

⁸³ Model of Care Overview and Guidelines, WA Health Networks, 2005

treatment across the AMT Program, and the high staff turnover rate experienced by service providers.

The DoH is aware of the CVP's concerns and is working towards finalisation of a model of care, policies and infrastructure. However, the CVP is of the view that, given that these fundamentally underpin all assessment and treatment, the documents, particularly the model of care, should have been finalised prior to the commencement of the AMT Program.

On seeking feedback on a draft of the report from DoH, the CVP, received advice that an expanded Model of Service Delivery is now completed. This Model has been developed for all of AOD services and contains a specific section related to the AMT services. The DoH has further advised that there will be practice guidelines to augment the model. The CVP need to review the Model and will monitor the training to all relevant staff on the Model and its implementation across the NT.

The CVP has observed that the lack of clear direction has resulted in key features of the legislation not being fully implemented in a consistent manner in areas such as treatment, aftercare planning, unclear program objectives, the level of restriction (associated with systematic review and freedom of movement whilst in AMT), fees and charging inconsistencies, risk assessment and management, and restraint practices. This was the subject of enquiry and recommendation throughout the past eight months and detailed in the CV and panel reports.

This situation has risk implications for affected persons and service providers. It is very concerning to the CVP that a comprehensive Model has only just been provided. The CVP strongly advocates that the infrastructure, framework, implementation of the model of care and policy & practice guidelines be finalised as a matter of priority.

4.1.5 Quality Assurance and Safety

With the newness, and uniqueness of the AMT Program, it is particularly important that there are robust structures and processes in place to ensure quality and safety in service delivery, proportionate to what one would expect from an equivalent mandatory treatment facility in any health environment.

The objective of quality assurance is to facilitate continual improvement in the quality of services, safeguarding care by creating an environment that strives for clinical excellence in responding to the changing needs of the community or people using the service.^[1]

The CVP is aware that there are no quality assurance and safety national standards specific to AOD services and that work to develop quality guidelines was occurring in the AMT Program. In the absence of other Health & Community Services information, the CVP has referred to the Quality Improvement Council (QIC) national standards for guidance^[2] and other relevant AOD & Mandatory Treatment reference material.^[3] The CVP had suggested that consideration be given to adopting similar practices and standards in Assessment Facilities and Treatment Centres to those used in mental health inpatient facilities to monitor the safety of people undergoing detoxification or where restrictive practices that require close observation and quality control are employed.

^[1] The NSW Health Clinicians Toolkit describes quality improvement under clinical governance as being; *"the framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish"*.

^[2] QIC Health and Community Service Standards for Quality Improvement Council, 6th Edition, April 2010

^[3] For example: *Mandatory Treatment – Position Statement*, Australian National Council on Drugs (ANCD), April 2014; *Drug and alcohol treatment guidelines for residential settings*, NSW Health, February 2007 and earlier references noted.

On seeking feedback during the preparation of this Report, the AMT Program advised that the Program refers to the National Quality and Safety Standards^[4] and the AMT Program provided the CVP clinical governance and quality risk framework documents. The CVP was informed that there is an Expert Reference Group which has now become a Standing Committee of Clinical Governance.

The CVP also notes that the NGO partners have some quality processes in place and are preparing for accreditation and this is commended. However it is unclear at this stage how the type of accreditation sought relates to the pertinent aspects of their AMT service provision.

The CVP remains concerned about the quality assurance in the AMT Program and how these frameworks are being implemented throughout the various services. Quality assurance and safety incorporates clinical governance and a critical component is the management of risk and clinical safety which is discussed further.

4.1.6 Risk Management Plans for All Services – with a Focus on Environmental Safety

In October/ November 2013 prior to the commencement of visits, the CVP requested that a Risk Management Plan be prepared by the Department for the program with a particular focus on assessment of environmental safety. The CVP was advised that a review was undertaken of the various contextual risks in the Darwin-based unit. The CVP was told that the review was out of date, as most of the recommendations had been accepted and acted upon. The CVP has requested a copy of the review but it has not been received to date.

In December 2013, the CVP was informed that the Department was developing a risk management strategy. All incidents would be reported through the NT DoH-wide RiskMan database; a Risk Register specific to the AMT Program would be routinely reviewed by senior DoH AMT Program management and would include the following;

- a. Environmental risks
- b. Client risks related to aggressive behaviour; injury; medical matters, safety, and cultural security
- c. Staff risks in terms of injury, fatigue, recruitment and retention.

The CVP understands that to date the Risk Register is incomplete. Problems have arisen due to system flaws and the system has not been applied to the entire AMT Program, including NGO partners. It is not yet evident how DoH will systematically monitor and evaluate risks identified in or arising from NGO services.

As noted by the CVP in its reports about the Darwin Alcohol Assessment and Treatment Service (DAATS), Katherine Alcohol Assessment Service and Central Australian Aboriginal Alcohol Programme Unit (CAAAPU), concerns have been identified regarding the adequacy of facilities and associated risks. The planned move to Berrimah Prison will require preliminary and ongoing risk analyses.

The CVP expects that key risks identified for any facility are recorded, and that action plans that detail strategies to minimize the risks from incidents and broader risks to the program are implemented, and evaluated. The CVP has been advised that quality officers have been included in the new AOD structure and views this as a positive development.

^[4] <http://www.safetyandquality.gov.au/wp-content/uploads/2011/01/NSQHS-Standards-Sept2011.pdf>

The CVP has observed risks associated with assessable and affected persons with aggressive behaviours, or comorbid conditions such as cognitive impairment, or early onset dementia, coming into the AMT Program. The CVP raises three concerns with this: the capacity of people with these challenges to benefit from the mandatory treatment (and whether or not they meet the section 10 criteria); how aggressive behaviour is safely managed for the affected person and other clients and staff; and how discharge from the AMT Program is safely achieved.

The CVP was advised that when issues of capacity are identified at assessment, the person will not receive an Order, and an Exemption under section 35 of the Act would occur. However discrepancies have been noted in the application of this throughout the NT.

The CVP inquired into at least five cases where issues of capacity were not identified at assessment, and the Treatment Centres were called upon to manage aggressive behaviours against staff and other clients from these clients.

The CVP observed difficulties for service providers in establishing how far the duty of care extended for such vulnerable people upon discharge. This raised particular concerns in light of the inadequacies of aftercare options, and waiting lists for access to appropriate disability services. For example, at least two affected persons with suspected cognitive impairment finished their mandatory treatment orders prior to there being any proper investigation of the suspected cognitive impairment. In these cases the Treatment Centre made appropriate referrals, but waiting lists with appropriate services meant that these were not progressed prior to discharge. The CVP has requested that the DoH defines a clear position about how such clients are to be managed when they enter into the AMT Program.

4.1.7 Evaluation of the Program

The CVP understands from discussions with senior management and staff across all service providers that there is a lack of process for evaluation of the assessment and treatment procedures across the whole AMT Program. No systematic or routine review, or evaluation is undertaken of individual client files, or the treatment program as a whole (except for medication audits).

Anecdotal feedback from clients and staff indicates that some successful outcomes have been achieved. However, no analysis of data has been completed to quantify or qualify those outcomes, nor has there been an evaluation to determine what parts of the treatment program may have contributed to the outcomes. As a minimum, the CVP suggested that a client satisfaction survey (suitable to the client base) be implemented.

It is the CVP view that the DoH has a responsibility to contribute to the body of knowledge in this important area and that an independent evaluation process should be developed to assess the effectiveness of the legislated program and the health benefits and other outcomes for affected people. This is particularly important given the AMT Program is without precedent in Australia due to the predominance of Indigenous people being admitted to the Program.

On seeking feedback on a draft of the report from DoH, the CVP were advised by the Department that an evaluation plan had been developed and is awaiting approval. The CVP looks forward to receiving details of the proposed evaluation.

4.1.8 Emerging Issue

Least Restrictive Alternative

The CVP is obliged to monitor and comment on policies and practices which are likely to limit the freedom of people receiving care. The objective of the AMT Program is to balance the obligation to provide for the care, treatment and protection of people who misuse alcohol while at the same time complying with section 6 principles.

Contemporary best practice in mandatory health service is underpinned by the principle of the least restrictive alternative.⁸⁴ This means that a person is provided with the treatment and an environment that places the least restriction upon them.⁸⁵ The CVP's view is that, in the context of mandatory treatment, a systematic application of the least restrictive principle must occur in both the assessment and the treatment phases, and must be individually considered and applied to each affected person, noting that best practice is not observed by a one size fits all model.

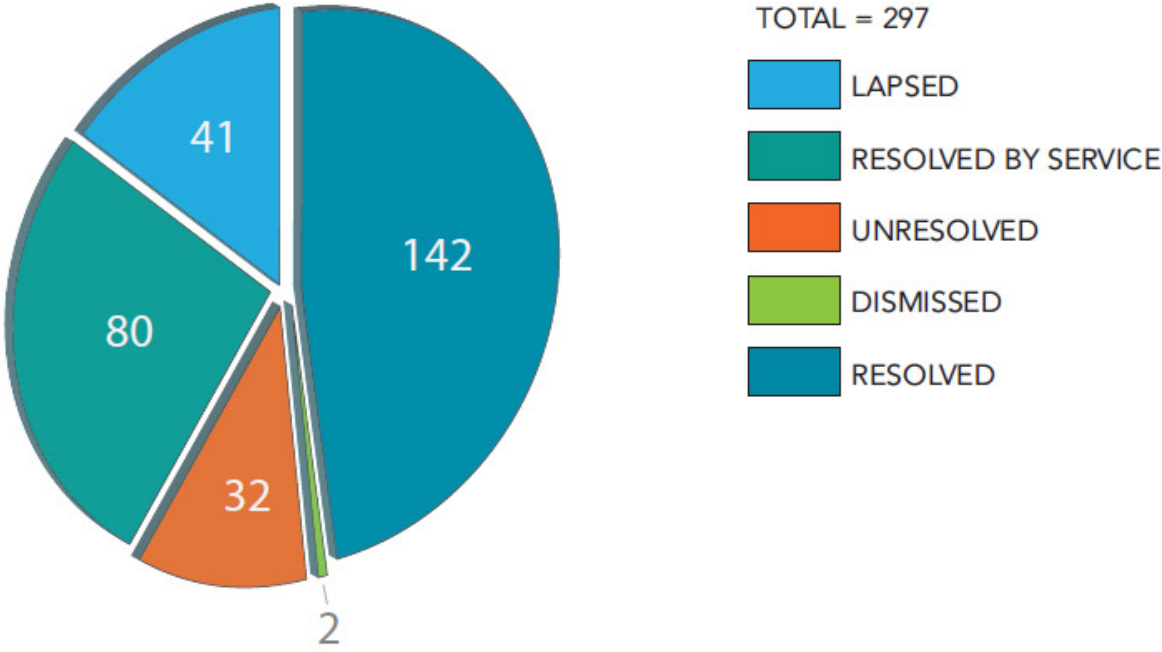
The CVP acknowledges that the final decision of what is the least restrictive option for an affected person is the role and responsibility of the assessment & treatment team. However, the observable lack of a systematic approach to applying the least restrictive intervention principle in the treatment phase for both the Darwin and Alice Springs Treatment Centres was a recurring experience.

The CVP sees this as a consequence of the lack of a clear model of care and practice guidelines. A clear model of care and use of good systems (such as treatment planning) will contribute to the Treatment Centres compliance with this fundamental legislative principle.

⁸⁴ For example, see *The Least Restrictive Alternative – is it Too Restrictive?* Clisby J, and Starr M, Conference Paper, The Mental Health Services Conference, 2007 for background on the evolution of the principle in mental health treatment; *Mental Health Statement of Rights and Responsibilities*, Department of Health, Australian Government, 2012.

⁸⁵ Ibid

OUTCOME OF ENQUIRIES & COMPLAINTS



VISITS	DAATS – ASSESSMENT FACILITY	DAATS – TREATMENT FACILITY	CAAAPU	ASAAS	AMT KATHERINE
CV Visits	36	42	25	22	1
Panel visits	n/a	1	1	n/a	n/a

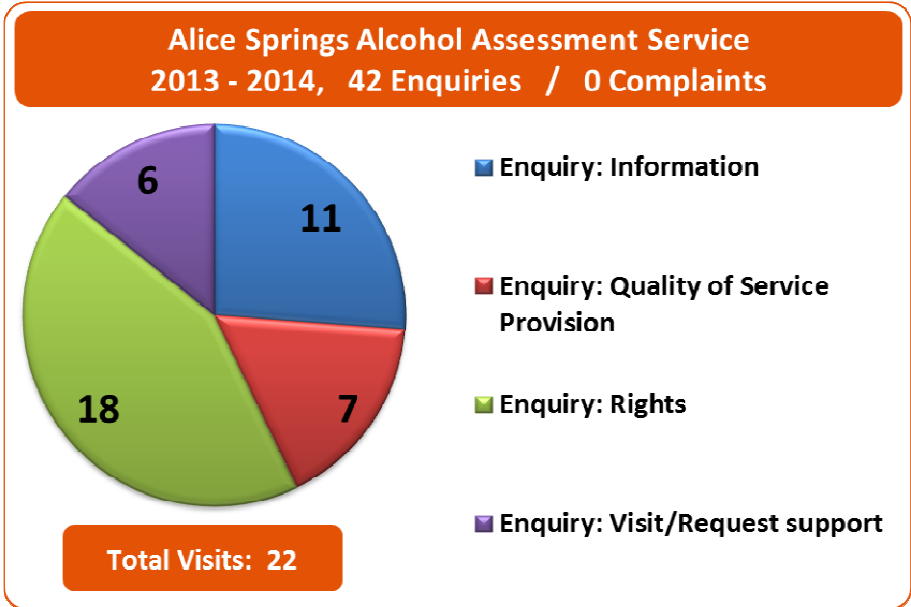
4.2 CVP Visits & Inspections of Assessment Facilities and Treatment Centres

In this section the work of the CVP over the reporting period and the issues raised by people receiving assessment and treatment as well as those arising from visits and inspections are discussed separately for each Assessment Facility and Treatment Centre providing services for affected persons detained for the purpose of Alcohol Mandatory Residential Orders pursuant to the AMT Act.

4.2.1 Alice Springs Alcohol Assessment Service (ASAAS)

The Alice Springs Alcohol Assessment Service (ASAAS) provides alcohol withdrawal and assessment services. The Centre is managed by the DoH, Drug & Alcohol and has eight beds in a facility purpose built for secure care purposes.

CVP visits to the service commenced on 19 December 2013, and have continued on a regular basis.



4.2.1(a) Quality of Service Provision

Staff

The service is staffed by a coordinator, Senior Assessment Clinician, Clinical Nurse Specialists and support staff. There is no Aboriginal Liaison officer.

General feedback from clients indicated that interactions with staff were positive and respectful.

Assessment and Treatment

The CV's observations and discussions with staff indicated a detailed systematic approach to the physical health of persons being assessed. Referrals for diagnosis and treatment were made where appropriate, and detailed records were kept, including the use of medication to assist with alcohol withdrawal. Assessments were carried out in a timely manner in line with the 96 hour timeframe stipulated in the AMT Act⁸⁶, with recommendations made in line with the least restrictive intervention principle set out in the AMT Act.⁸⁷

Assessments for Affected Persons with Previous Admissions and Treatment

The CVP noted that when previously admitted persons are re-admitted to the assessment facility, the new assessment documentation contained little or no detail regarding the affected person's previous assessment or treatment in the AMT Program. The CVP suggested that increased attention be given to previous admissions and treatment, as this could assist in making quality assessments and is extremely relevant material for the Tribunal's decision about what order to impose.

Use of Interpreters

There were occasions where the CV was of the view that due to language difficulties people did not fully understand the assessment process they were involved in, or the information provided to them. While interviewed by CVs, it was apparent that some people did not understand the recommendations made regarding their treatment, or the Tribunal process or functions. This also applied to the DoH Rights Statement, treatment costs and Income Management Orders.

Case example

Harry had been assessed and a Mandatory Residential Treatment Order (MRTO) recommended. Harry had requested an interpreter for the Tribunal hearing but an interpreter had not been requested by staff in time to allow an interpreter to get to the hearing, so the Tribunal ordered his release. As a consequence, the staff were reminded about the importance of booking interpreters.

There were a number of occasions that ASAAS staff advised the CV that interpreters were booked but did not arrive, and at times this contributed to the Tribunal making release orders. The CV suggested that ASAAS discuss this with AIS to find a solution. The CVP have continually recommended the need to increase the use of interpreters and have recently noted that more frequent use is occurring, particularly for assessments and Tribunal hearings.

Referrals

As well as referrals related to physical health, referrals are also made to other services including mental health, aged care and disability services. There have been limited responses to these referrals (see full discussion in CAAAPU section of this report). The CVP noted one occasion when referrals from ASAAS were not made prior to the assessable person's release, but clear directions were then issued to staff and subsequent file inspections by the CV showed that the direction was followed. On at least one occasion a

⁸⁶ Section 17 of the AMT Act

⁸⁷ Section 6 of the AMT Act

person identified as having possible cognitive impairment was not assessed or followed up by other services prior to their release from ASAAS.

Case example

Syd was recommended for release so that he could be referred for appropriate assessment of his suspected cognitive impairment. He was released, but the only referral made was to the Safe and Sober program at Central Australian Aboriginal Congress (CAAC), and that referral was made four days after his release.

Socio-Cultural Needs / Activities

ASAAS has a gentle activities program suitable for people in the early stages of alcohol withdrawal. There is a vegetable garden, fire pit for cooking kangaroo tails and, when resourcing permits, staff take affected persons out of the facility to search for bush foods in the wider perimeters. There are painting materials and a small selection of musical instruments. Staff also encourage involvement of family as appropriate, and where possible facilitate family members to visit affected persons at the service.

Several people spoke to the CVs about their socio-cultural needs, such as worry about attending funerals and about family members. The CVP consider that the provision of social and cultural support is important as it assists affected persons with often complex issues as they transition from assessment to treatment to aftercare.

4.2.1(b) Procedures

At times breakdowns in communication occurred between ASAAS and CAAAPU regarding issues such as transfer of clients, CAAAPU's involvement in the assessment process, and the coordinator's role in supervising the Senior Treatment Clinician (a DoH employee) based at CAAAPU. The CVP considers that a contributing factor in this is the lack of an operational protocol between the two organisations. This is also discussed in the CAAAPU section of this Report.

4.2.1(c) Rights

Rights Statement

The CVP was presented with a number of issues regarding the Rights Statement. The issues mainly centred on the statement not being provided in language where appropriate, statements not being signed by the affected person, and the method of communicating statements not being documented in records. To assist with this, the ASAAS started using language audio files of the rights statement to aid understanding.

The rights statement has a section entitled 'Legal help for you' which gives details of legal aid services, but there is no reference in the document to people being able to be represented at the Tribunal, or to request the Tribunal appoint an advocate, as per Section 113 of the Act. In April 2014, the CVP recommendation that the information be included; and has yet to be implemented.

Legal / Advocates

Initially there were numerous complaints from affected people at both the ASAAS and CAAAPU. For most of the first year of the AMT Program, neither legal representation nor an advocate was available to assessable persons for Tribunal in Alice Springs. The situation was different in Darwin and Katherine, where legal representatives and the advocate (in Darwin) were available. An advocate was provided by the CVP in Alice Springs for the month of June 2014, and there is currently a temporary advocate in Alice Springs with tenders being called for the advocate role.

The CVP has maintained the view that the 'Advocate's role' was not in place of legal representation and is a complementary service for affected persons who chose not to have legal representation. The CVP's view is that the affected person should have the choice of legal representation. A legal representative or Advocate can contribute to strengthen the decision making process at the Tribunal through independent representation of the person's legal and broader human rights.

The trigger for detention under AMT is repeated public drunkenness. Experience demonstrates that people who are largely homeless, often in poor health, and who have little, if any, resources to engage a private lawyer are those most likely to be detained.

The CVP believes that the optimal position would be that assessable persons can access free legal representation if they choose. This position is in-line with the minimal acceptable industry standards for mandatory alcohol and other drug treatments.⁸⁸

4.2.1 (d) Recommendations

	ASAAS Open Recommendations	Made by	Date	Status
1	That the issue of representation (both legal and Tribunal appointed advocacy) at the Tribunal be resolved as a matter of urgency.	Community Visitor	4/04/14	Partly closed. CVP monitoring
2	That the rights statement be developed into a poster in Central Australian languages, and that it have an explanation of section 113 about representation at the Tribunal contained within it.	Community Visitor	4/04/14	Open
3	That the Department of Health develop clear policies and procedures for management of Assessable Persons with diagnosed or suspected cognitive impairment within the AMT Program.	Community Visitor	18/06/14	Open / CVP Monitoring
4	That an Operational Protocol be developed between the Treatment Centre and Department of Health as both organizations are operating within the same Treatment Centre, at the same time.	Community Visitor	18/06/14	Open
5	DoH and CAAAPU examine ways in which threatening/ disruptive clients can be more effectively managed	Community Visitor	31/07/14	Open / CVP Monitoring

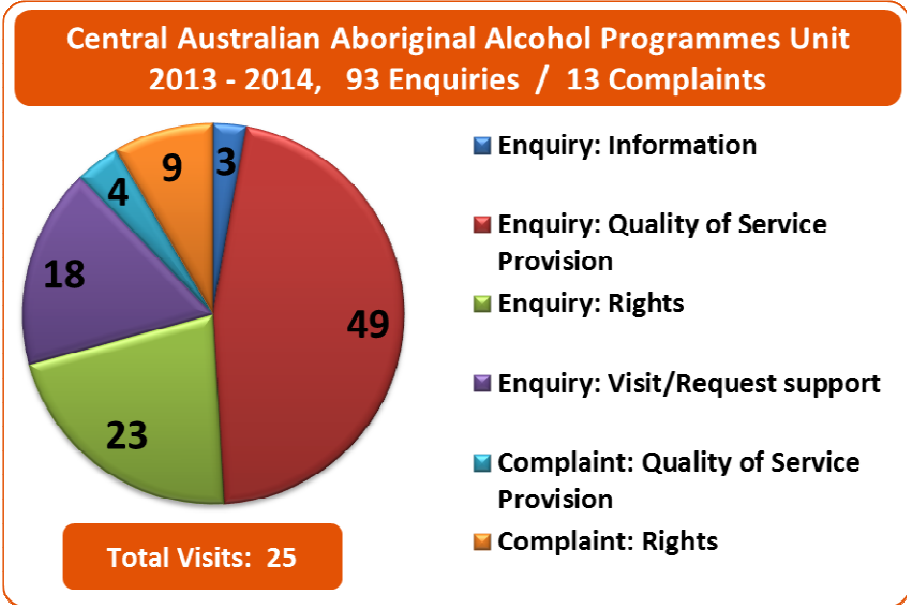
⁸⁸ The Australian National Council on Drugs (ANCD), page.9

4.2.2 Central Australia Aboriginal Alcohol Program Unit (CAAAPU) - AMT Treatment Centre

CAAAPU has been providing alcohol treatment programs for Indigenous people for a number of years, and became an authorised Alcohol Mandatory Treatment Centre (AMTC) under the AMT Act in July 2013.

The residential facilities for persons detained for treatment under the AMT Act are located in temporary demountable buildings within the CAAAPU service, which is set in peaceful grounds in the rural area of Alice Springs. The CAAAPU facility is surrounded by secure fencing. Affected persons can move freely between the AMTC and general CAAAPU grounds and utilise the general facilities. The AMTC is separated into male and female sections with each section having ten individual beds.

Visits to the Centre by CVs commenced on 20 December 2013 and have continued on a regular basis. The Community Visitor Panel (the Panel) also conducted a visit to the centre in June 2014.



4.2.2 (a) Quality of Service Provision

Staff

In general, staff at the centre display a level of positive, respectful engagement with affected persons and were seen by the CVP to suggest and support procedures that assist in making for a less restrictive and more supportive environment. This includes cultural activities and outings, visits by family, leave to attend funerals, access to phone calls and shopping trips.

Case example

George and his wife Phyllis were both in CAAAPU. George spoke to the CV telling him that he was worried about his wife as her teenage daughter had gone missing. The CV spoke with Phyllis and she said that she was very concerned and stressed as her daughter had been missing for two days and her father who her daughter was living with could not assist as he was in hospital in Adelaide. The CV, with the permission of Phyllis, spoke with her case manager who then promptly arranged to take Phyllis to the home where her daughter was living and to the police station. Fortunately the daughter later returned home.

Intake Process

The intake procedures are very basic and there is no evidence of any thorough assessment of individual affected persons at admission apart from the medical health needs assessment. Interpreters have not been used during intake assessments. The CVP views this as contrary to best practice, and a denial of the rights of affected persons.

Treatment Program

There are general programs in both the male and female sections. The programs tend to focus on life skills and recreational activities, covering areas such as literacy, numeracy, financial budgeting, sexual health, basic computer skills and music therapy. Programs on offer have limited links to addressing alcohol misuse. There are some group alcohol education and therapy sessions, but few individual counselling sessions, and these tend to only be of the brief intervention type.

The NSW Residential Treatment Guidelines (August 2007, p15 (6.1)) state that best practice treatment methods include motivational interviewing, social skills training and cognitive restructuring techniques, relapse prevention and active practice of relapse prevention skills during therapy, and preparation for re-integrating residents into the community. With the exception of social skills training, the treatment program does not include the best practice methods in the guidelines.

Until June 2014, there were no individual treatment plans being used, despite the statutory requirements that a treatment plan be prepared by a Senior Treatment Clinician as soon as practicable after admission to the Treatment Centre, and that the plan be regularly reviewed and revised.⁸⁹

Individual treatment planning is seen as central to treatment as it assists in identifying risks, establishes personalised goals for the affected person, determining appropriate treatment approaches and allowing for progress to be monitored. It is important for affected persons to be involved in planning their treatment to increase ownership of the plans and motivation to achieve goals. This is acknowledged in the QIC Health and Community Services Standards (6th ed, April 2010), and other best practice guidelines.

Least Restrictive Alternative

When the CV first started to visit the CAAAPU, affected persons made a number of requests and raised issues that centred on restrictive practices. With the work of staff, and support from the CVP, most of the requests were met very quickly. Some of the requests/issues raised included;

⁸⁹ Sections 56(2) and (3), AMT Act

The lack of external outings. They specifically asked to be able to;

- Go shopping;
- Go to the bank to check their bank balances;
- Go on excursions such as a walk outside the grounds, a ride in a bus for a change of scene and day trips to swim in a waterhole, have a picnic out bush and see a movie at the cinema; and

A further issue was sadness at being separated from country and family and asked to be able to share photos of themselves back to family, and also have photos of family put up in their rooms.

Comment made to the Community Visitor

We are all grown women here. Some of us are Grandmothers. We are doing our treatment, staying here. The staffs are good people, they try to help us and listen to us. We are not running away. We should be able to go shopping, go to the bank, see family, and come back here.

(CAAAPU S93 Treatment Report, Jan 2013)

After the Community Visitor raised the issues from both the women and men and discussed the requests with the Treatment Centre management, CAAAPU organised for shopping and banking outings to occur on a regular basis. Although the outings are at times restricted due to a lack of available transport and this was the subject of a recommendation. The affected persons were pleased that they were listened to and felt the staff and CAAAPU respected them. The staff commented that the clients had been happier and the environment was more relaxed.

Management and staff assist in providing an environment of least restrictive practice. However, the Panel identified that the least restrictive principle does not appear to be routinely applied in the context of making or facilitating the making of applications to vary or revoke their Mandatory Treatment Orders (MTOs). The Panel stated that they were told of only one example of an application to revoke an MTO, which was made because the client was progressing well and this was on his second admission.

The Panel stated that while there is evidence that shows better outcomes if persons stay in rehabilitation for 3 months or longer, there is also evidence to show that level of progress within treatment is a better indicator of success⁹⁰. The Panel stated that best practice supports highly individualized treatment which includes flexibility in the length of treatment according to an individual's needs.⁹¹

Aftercare Planning

Aftercare planning and processes are seen as critical elements in supporting clients to reintegrate into their communities, with the ability to sustain their achieved treatment outcomes. A primary concern expressed by the Panel was 'that the focus of the AMT program within the current model is on intervention and treatment, with limited acknowledgement of the importance of the aftercare process, and a lack of a systematic approach to identifying gaps in aftercare service to meet the persons aftercare needs'.

⁹⁰ *Contemporary Drug Abuse Treatment: a review of the evidence base*, United Nations Office on Drugs and Crime, 2002, quoted in Goodyer, P, "Finding the right rehab", *Of Substance*, vol 12, no. 2, 2014

⁹¹ For example, *Drug and alcohol treatment guidelines for residential settings*, NSW Department of Health, 2007, section 6.1 and 6.2, and section 7 (the NSW Residential Treatment Guidelines).

At the treatment centre, aftercare planning is done by individual case workers with oversight by the Senior Treatment Clinician (STC). The case workers attempt to talk to family and appropriate agencies that operate in the areas where clients state they will return to and make referrals to relevant agencies. Staff have told the CV that they are disheartened by the lack of response from other agencies, which is seen to be largely due to a lack of available resources in Central Australia.

On the other hand, when it is possible to put in place a detailed aftercare plan, good outcomes can follow. The CVP saw an example of a detailed and well thought out aftercare plan utilising service providers in the affected person's home community. The CVP had reports from the STC that subsequent contact with the remote community demonstrated that the plan had worked well, and improved the person's quality of life.

Interpreters

The CVP found that interpreters are rarely used despite the majority of affected persons not having English as their first language. The Senior Treatment Clinician (STC) informed the Panel that she had never used an interpreter for intake, and had only used the language audio version of the DoH Rights Statement twice. The intake is the only time that the Rights Statement is communicated to the clients at the CAAAPU treatment centre. Interpreters are rarely, if ever, used for the treatment program, including for the preparation of treatment and aftercare plans. No records are kept on the use of interpreter. This was discussed in significant issues under, 'Interpreter Use and Cultural Competency'.

Referrals

Referrals to other services, particularly to the Central Australian Mental Health Service and Aged Care and Disability teams (within DoH), were reportedly causing problems for CAAAPU. For example, in two separate incidents, the Crisis Assessment and Treatment Team (CATT) took four days to respond to requests for assessment of clients suspected of having mental health issues and showing aggressive behaviour. These delays were followed up with the Clinical Director of CAMHS by the doctor at the Treatment Centre, and by the CVP, after which improvement in response time was noted.

The CVP understands that the STC routinely makes referrals to the Aged Care Team and Disability Services for the relevant assessments, but the waiting lists for assessments are such that often the affected persons is released prior to assessment, or the assessment is done just before the affected person is released.

Case example

Referrals to the Aged Care team for two clients were made by ASAAS at the assessment stage and by CAAAPU early in the treatment stage. Referrals were for urgent assessment, but the referrals were not responded to within the three month period of the Mandatory Treatment Order.

The lack of response to referrals and other service gaps in Central Australia leads to the highly unsatisfactory situation of people leaving the treatment centre without urgent assessments having been completed or appropriate services being made available to support them. This leads to a situation where the person is likely unable to make best use of any of the treatment received in the AMT Centre, because of a lack of the support outside, leading in some instances to return admissions into the AMT Program.

Treatment for People with Diagnosed or Suspected Cognitive Impairment

There is nothing in the AMT Act to exclude a person diagnosed with, or suspected of having, a cognitive impairment from the operation of the AMT Act (sections 9, 14 and 54). However, an assessment as to whether a person with those difficulties could benefit from a Mandatory Treatment Order under section 10(e) is relevant to the consideration of the admission criteria. There is scope to exempt a person from further assessment under the AMT Act (s35).

Staff at both CAAAPU and ASAAS have expressed concerns to the CV that orders have been made for clients with suspected cognitive impairment. While staff have expressed that they recognise these clients may benefit from 'time out' from drinking and benefit from the physical care provided, they doubt their ability to comprehend or benefit from the treatment in a way that would enable them to improve future decision making in regard to alcohol misuse.

The CVP noted that some affected persons entered the AMT Program more than once, and that different assessments were made each time about whether or not they fulfilled the section 10 criteria, despite there being little, or any, change in their circumstances. This was noted in Significant Issues under 'Quality Assurance & Safety'.

The CVP has been advised that the situation has been rectified as the AMT Program would refer clients to Disability and then work with Disability on any alcohol misuse problems. However there have been issues in the identification initially of people with cognitive impairment and the subsequent safe discharge. The CVP will continue to monitor this in the coming year.

4.2.2 (b) Procedures

Operational Procedures between DoH and CAAAPU

At present, all staff in the Treatment Centre are CAAAPU employees, except the Senior Treatment Clinician, who is a DoH employee supervised during the year by the coordinator of ASAAS. Incidents have occurred that point to the need for greater clarity about roles and responsibilities. For example, in several areas there are separate CAAAPU and DoH policies related to the same topics. Several CVP reports have referred to the need for an operational protocol between DoH and CAAAPU to provide greater detail about communication, record keeping, roles and responsibilities for both organisations.

The DoH policies and procedures often purport to apply to staff in treatment centres and it is not clear whether these include CAAAPU staff. In practice at CAAAPU, the STC appears to be mainly operating under CAAAPU's policies and procedures, despite being a DoH employee. The STC told the Panel that DoH has not given any direction on this. As an example the STC informed the Panel that she had not recorded any critical incidents in the DoH RiskMan data base as required by DoH policies. This was referred to in Significant Issues, under 'Quality Assurance and Safety'.

The CVP advocates that the DoH policies and procedures should be finalised as a matter of urgency, with clear direction as to whom they apply. It is important that the roles and responsibilities of the treatment provider are clearly defined to avoid missing risks and to ensure harmony between the organisations.

The CVP has been provided with examples of miscommunication between the CAAAPU Treatment Manager (TM), the STC and Alice Springs Assessment Service ASAAS staff, see case example, below.

Case example

A person, who absconded from a Mandatory Community Treatment Order (MCTO) at CAAAPU, was located and taken to ASAAS. Both the CAAAPU TM and DoH STC advised the Acting Coordinator of ASAAS (in writing) that CAAAPU would not have the person back giving, the reasons why. The information was not passed to the Tribunal, and the Tribunal issued an MRTO ordering the person to the AMTC section of CAAAPU. As a result, once the miscommunication was discovered, the Tribunal held another hearing, and issued a release order. This meant that the person involved was held at ASAAS longer than should have been necessary and had to appear before the Tribunal twice.

Management of Client Money and Operation of Income Management Orders

The CVP received several enquiries and two complaints about client monies and CAAAPU charges for board and lodging. The CV discussed the enquiries and complaints with the Treatment Manager, and as there appeared to be a lack of clarity re the processes for the charges. The CVP requested that CAAAPU supply written policies and procedures to enable the investigation of one of the complaints (see case study below), and to ensure that appropriate systems were in place to protect client funds. The CAAAPU have now supplied a written procedure.

The system used for the payments is for the clients to sign Centrelink Centrepay Deduction and Nominee authority forms so that payment goes directly to CAAAPU from clients Centrelink accounts. CAAAPU were also operating a system where a set amount would be included that would be held by CAAAPU to allow clients to purchase goods from a small “shop” that they were operating.

Clients expressed some anger and confusion regarding the charges. The anger and confusion related to the fact that some of the clients were aware that clients in Top End facilities were not being charged for board and lodging and also to a lack of understanding as to the processes involved. The Treatment Manager has taken steps to attempt to ensure that clients have a good understanding of the board and lodging charges. This is to include the increased use of interpreters were appropriate. The small shop system has been discontinued.

Case example

A client, Jennifer, told the CV that she was really angry because “she (staff member) is stealing my money”. The CVP raised this matter with CAAAPU management requesting that the CV examine the records for this client and to also supply the policy and procedures for handling client monies, and the process used to convey financial information to clients.

The CV examined the records and later discussed the situation with the client involved. It was concluded that the complaint was made because the client had not understood the application of the fees charged and the income management order.

Clients Behaving in a Threatening Manner

During 2013-2014, the CAAAPU TM and the DoH STC reported difficulties with managing clients behaving in a threatening manner and expressed the need for protocols and procedures to guide them. The matter was also raised in the AMT Review report, which included a recommendation (32) covering the discharge of disruptive/violent clients from the residential treatment facility to the assessment facility.

Case example

The CAAAPU TM advised the CV of a situation where a client was making serious threats to harm other clients and staff and they found this situation very difficult to manage. The TM stated that they had made a request to the Acting Coordinator of ASAAS that ASAAS take the client for a period but the request was refused on the grounds that ASAAS already had two clients and were short staffed. The TM advised that they were able to eventually manage the situation but the Women's program was disrupted for several days and other clients and staff had suffered a period of intimidation.

On seeking feedback on a draft of the report from DoH, the CVP were pleased to be provided with the protocol for the management of clients using threatening/aggressive behaviour, however the process was not evident at this time to CAAAPU staff and STC. The CVP will monitor the application of this protocol.

4.2.2 (c) Rights

Complaints Procedures

Section 82 of the AMT Act stipulates that the STC must establish fair procedures to deal with complaints relating to persons detained at the centre and ensure those procedures are accessible to the following persons:

- persons detained at the centre;
- the primary contacts and guardians (if any) of those persons.

CAAAPU's complaints procedure appears to be ad hoc and informal. The only apparent reference to the complaints process for affected persons is a short section on complaints in the DoH Rights Statement. There is a complaints register but the Panel were informed by the STC that only one formal complaint had been received. This raises the question as to where, or if, the complaints made to the CVs are recorded. The Panel reported that it was unable to assess the effectiveness of the complaints process in any objective way because of the lack of detail in progress notes, and other documentation.

Coercive Powers

The Panel investigated compliance with a number of legislative provisions referred to as 'coercive powers'. These are;

1. Administration of medication with, or without consent (section 74)
2. Use of reasonable force by authorised officers (section 75)
3. Search and seizure by authorised officers (sections 77 and 78)
4. Directed breath testing by testing officers (sections 57 and 125)

The TM reported to the Panel that CAAAPU operate under DOH policies with respect to coercive powers but that staff are directed to only use them under very exceptional

circumstances. This approach is consistent with the broader objectives of the AMT Act, which are to focus on health and therapeutic interventions.

The Panel raised some concerns regarding the use of coercive powers, namely;

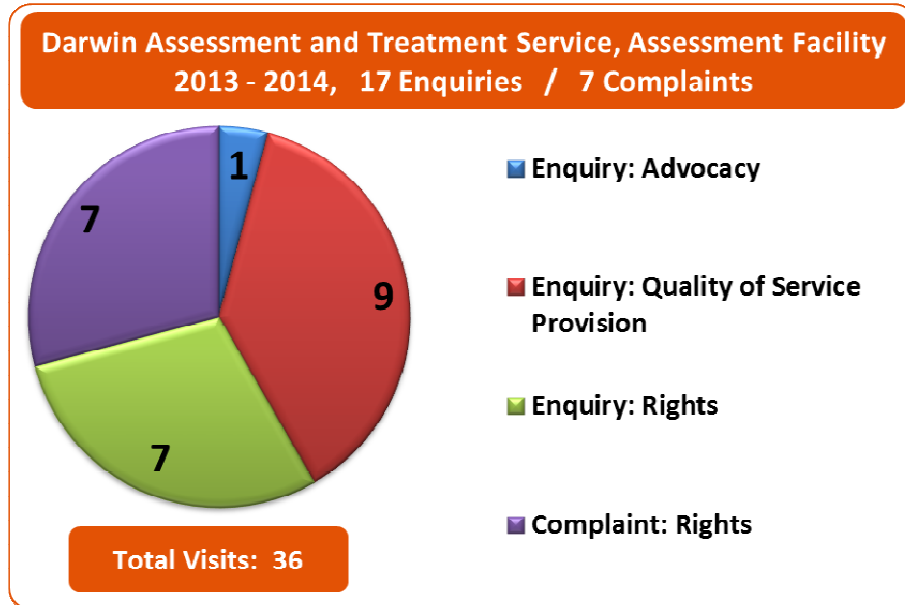
- (a) There is an inconsistency between the Use of Force policy, and Authorised Officer policy regarding at what stage police should be involved;
- (b) Staff without appropriate medication training are responsible for prompting, and overseeing clients taking medication. The Panel noted that CAAAPU have taken several steps towards managing medication risks, but the better position would be that staff are properly trained.
- (c) Whilst there have been no instances of the use of reasonable force, the TM has stated that the MAYBO training provided is inadequate, as it focuses on defensive, physical tactics, without a sufficient focus on de-escalation tools more suitable to the facility.

4.2.2 (d) Recommendations

	CAAAPU Open Recommendations	Made by	Date	Status
1	That DoH direct the Senior Treatment Clinician, and CAAAPU, to comply with the legislative requirements around treatment planning, aftercare planning and documentation of treatment and consent.	CVP Panel	12/06/14	Open
2	That the use of interpreters in communicating client rights, and during treatment, be significantly increased, and records kept of requests for, and use of, interpreters.	CVP Panel	12/06/14	Open
3	That the model-of-care be finalized by DoH urgently, and the treatment program be reviewed and improved by CAAAPU, in accordance with the DoH model-of-care, and include best practice, evidence-based and evidence-informed treatment related directly to alcohol misuse.	CVP Panel	12/06/14	Open
4	That a system of review, audit and evaluation of both individual client cases, and the treatment program as a whole be implemented as soon as possible.	CVP Panel	12/06/14	Open
5	It is recommended that the AMTC ensure that information about rights, including the CAAAPU internal complaint process is prominently displayed and in forms that cater for a variety of English literacy and learning needs	Community Visitor	17/02/14	Open
6	It is recommended that the Treatment Centre procure a bus for group outings.	Community Visitor	7/04/14	Open
7	It is recommended that an Operational Protocol be developed between CAAAPU and the Department of Health as both organisations are operating within the Treatment Centre at the same time.	Community Visitor	7/04/14	Open
8	It is recommended that the policies and procedures around the restrictive powers, appointment of authorized officers and testing officers be finalized and provided to CAAAPU as a matter of urgency, and appropriate additional training for CAAAPU be arranged.	Community Visitor	7/04/14	Open
9	It is recommended that the Department of Health urgently improve the responsiveness of referrals of Affected Persons to Aged Care and Disability Services so that relevant assessments can be undertaken whilst an Affected Person is in treatment at the Treatment Centre.	Community Visitor	18/06/14	Open/CVP Monitoring
10	It is recommended that clear protocols and procedures for the management of clients using threatening/aggressive behaviour be developed by DoH.	Community Visitor	18/06/14	Open

4.2.3 Darwin Assessment and Treatment Service (DAATS) Assessment Facility Report

The Darwin Assessment and Treatment Service (DAATS) is a residential 50 bed facility located in Darwin at the Medi Hotel. The Assessment facility and Treatment Centre are co-located with 8 beds allocated to the Assessment phase. The Assessment functions are provided in secure facilities although the facility is not purpose built.



4.2.3 (a) Quality of Service Provision

Staff

Retaining and recruiting staff has been a challenge for DAATS and according to some staff members, it has made it difficult for them to provide quality treatment. Since the CVP started visiting in December 2013 there has been approximately four different Senior Assessment Clinicians, four Managers and numerous changes in cases managers and other staff.

The CVP believes this has significantly impacted upon the quality of services provided at DAATS. Together with the lack of policy framework, it has created many challenges for both staff and affected persons, as discussed below in the DAATS Assessment Facility & Treatment Centre reports.

DAATS' multi-disciplinary team approach recognises the complexities involved in assessment and management of alcohol withdrawal, often in people who are unwell. The staffing team is made up of a Senior Assessment Clinician, Medical officer, Registered nurses, Aboriginal Liaison officer and support staff. The CVP commend the DAATS on using a multi-disciplinary approach inclusive of designated Aboriginal Liaison roles.

When the CVP commenced visits there were no formal processes for staff or client orientation. The CVP recommended that DAATS improve systems and processes across several areas, including documentation (record keeping), orientation, and training (including about the role of the CVP).

Staff Relationships with Clients

The CVs received mixed feedback from clients about the way they were treated by staff members in the DAATS Assessment section. Some positive comments were made and some clients expressed concern about the way they were treated.

Case example

The CV inquired how Gerard was going and Gerard said that he didn't mind being at DAATS as he could 'have a shower' and have a 'nice feed'. Staff 'were good'.

Facilities

The Assessment Facility is new, clean and comfortable with a large common room and dining room and three program rooms. The ambience during CVP visits has generally been low-key and relaxed. There are various spaces and rooms, including a music room with a CD player and several different instruments for use. The main living room area has a large television with comfortable lounge chairs, a table and an exercise bike.

During visits, the CVs have noticed affected persons using the outdoor space and the lounge room. Persons have access to drinks and snacks throughout the day in addition to meals.

Before commencing visits, the CVP requested that an environmental risk analysis be undertaken. The reason for this was that clients in mandatory withdrawal can be at increased risk of self-harm. A report was commissioned but the CVP has not received this, despite requests to AMT senior management. (See significant issues under Quality Assurance & Safety)

Physical Health Treatment

The CV observed the systematic approach to the management of the physical health needs of affected persons. The CVP acknowledges and commends the DAATS on the work in this area, noting that some people have long standing, serious chronic health conditions. The CVP note that the policies used for withdrawal and detoxification of affected persons are in line with the Department of Health guidelines and evidence based tools are applied.

Screening and Assessment Tools

The use of appropriate assessment tools is critical to the quality of assessments. Decisions regarding clinical assessment and treatment within the AMT Program are the province and responsibility of clinicians, and the CVP does not seek to undermine this.

The role of the CVP is to promote and protect the rights of individuals and advocate on their behalf, where needed. Any concerns the CVP may have about screening, assessment or treatment procedures are raised within this context, noting that whether or not a person is subject to mandatory treatment depends wholly on the quality of the assessment.

At DAATS, as in Central Australia, the majority of clients are Indigenous, and come from a diverse range of Indigenous backgrounds. This diversity must be accommodated during assessments, and could necessitate adjustment of the assessment tools, to achieve an accurate outcome. The CVP notes that some changes occurred in the assessment tools used throughout the year.

Accurate outcomes require a high level of skill, knowledge and care (including use of interpreters) by the clinician in making assessments. The CVP noted with concern that many of the assessments made in the early stages of the Program were undertaken by nurses with limited specialist qualifications in the alcohol and other drugs clinical field. These concerns were partially addressed by a decision made by DoH in 2014 that Senior Assessment Clinicians would be required to have post-graduate qualifications in alcohol and other drugs services.

The CVP notes that the changes made by AMT Program regarding the assessment tools to use and the need for SACs to have specialist qualifications, acknowledges the importance of continual improvement in the assessment process.

Medication

The CVP raised some instances of concern with DAATS and DoH regarding the use of anti-psychotic medication in the Treatment Centre. These queries were addressed adequately by the DoH. This is noted in the Assessment report as medication is prescribed here.

The AMT Program provided further advice to the CVP that medication is used as a tool to manage the symptoms associated with detoxification and distress. However it was unclear to the CVP if there were practice guidelines associated to the different types of PRN medication and how this was applied throughout the AMT.

During a file inspection by the DAATS Panel, it was noted that “an affected person was being treated with olanzapine on the basis that they “may become agitated” due to a situation arising. There was no indication that the affected person had previously received olanzapine treatment or had presented with symptoms or a psychosis”.⁹²

The CVP reiterates that, any use of PRN medication ought to be for the therapeutic benefit of the affected person and the reasons for such use should be in accordance with accepted therapeutic guidelines and be well documented.⁹³ The CVP will continue to monitor this in the year ahead.

Access to Allied Health and Other Health Services

The CVs were told by staff that there was a lack of access to mental health services for assessment under section 32(2) of the *Mental Health and Related Services Act*. CVs viewed files where affected persons were taken to the Emergency Department to be seen by mental health, at the suggestion of the mental health registrar, for a mental health assessment, and were not seen despite waiting all day.

The issue was raised with the Director of Service Delivery (AOD) who had agreed to commence a process to establish agreements between Top End Mental Health Service (TEMHS) and DAATS. The CVP is aware that this situation has improved; the CATT Team from TEMHS now undertake mental health assessments on persons at the AMT Assessment facility. The CVP has not been advised whether a written protocol has been developed.

On numerous occasions referrals were made to the Aged Care & Disability services as there was suspected significant cognitive impairment who may have been eligible for Adult Guardianship. The CVP provided advice regarding the need to prioritise assessment and acknowledges that priority cannot always be given.

⁹² CVP DAATS Panel report

⁹³ [Pro re nata medication for psychiatric inpatients: time to act](#), MF Hilton, HA Whiteford - Australasian Psychiatry, 2008

Use of Interpreters

The CVP was told by DAATS staff that affected persons were opting not to use an interpreter during the assessment process, even though they had requested one for the Tribunal. The CVP has earlier noted its concerns about the variable approaches in assessment regarding whether or not interpreters are required, and those concerns apply to the DAATS Assessment Facility.

The CVP observed that interpreter use during assessments improved over time; however it remains evident that the use of interpreters varies between different clinicians without a clear reason. The use of interpreters to provide a fair and accurate assessment of an assessable person and to provide culturally safe care is a significant and priority issue for the CVP.

Case example

Toby told the CV that he “did not do anything wrong” and was worried about going to the Tribunal. When the CV explained some of the process, he said that he had only been picked up twice. The CV talked to the SAC about Toby’s anxiety and the CV’s view that he needed an interpreter for the Tribunal. The CV confirmed that he was picked up three times and advised Toby of this, then checked to make sure the Advocate was representing him, where an interpreter was organised in the Tribunal hearing.

4.2.3 (b) Rights

Least Restrictive Alternative

The CVP notes that according to figures obtained from the Tribunal, the DAATS Facility made less recommendations for community treatment orders, releases or revocations per number of affected persons than the other AMT Services. As noted above, an emerging issue is that least restrictive interventions are to be used when a person is being treated or dealt with under this Act. It is of concern to the CVP that the exploration of alternative less restrictive treatment options appeared to vary between clinicians, with some being more willing to recommend less restrictive orders than others. There is a noticeable difference between DAATS and the other Assessment Facilities, where the CVP observed consistent application of the principle by staff.

The CVP sees this as an area where DAATS could improve. The introduction of practice guidelines by DoH would also greatly assist the situation. The CVP will continue to monitor this.

Rights Statement

As required by the AMT Act,⁹⁴ the CV routinely inquired with affected persons about their understanding of the DoH Rights Statement.

Initially the rights statement was a densely worded handout in written English, which was not supported by non-verbal or other prompts. The CV suggested that this statement would benefit from simplification and translation into the major Aboriginal languages. The CV also suggested accompanying resources to ensure information is available at any time or stage of admission and in forms that cater for a variety of languages and learning needs.

⁹⁴ Section 88(1)(c)(i) of the AMT Act

The CV saw this as critical in assisting affected people, and believed that it warranted particular attention given that people may have difficulty in comprehending and retaining information in the early stages of alcohol withdrawal (where short term memory may be adversely affected and the person is medicated). These factors are in addition to the obvious communication needs of Aboriginal persons for whom English may be a third or fourth language.

Upon raising this, the CVP was told that DAATS had already started the development of the Rights Statement in six Top End languages and in different mediums. The CVP noted this as a positive improvement; however, at the conclusion of the year, both the CV and the Community Visitor Panel observed that these resources were not in routine use. Improvements in this area will be monitored in the coming year.

Complaints Mechanism

In early visits the CVP found that complaints mechanisms were not obvious or accessible to affected persons. The role of the CVP includes assisting affected people to have their complaints heard and resolved. The CVs were told by affected persons that they were unaware of the complaints process and some would not feel comfortable making a complaint to a staff member.

Case example

A person told the CV that he was told to “talk to staff” if he had complaints but said he did not feel comfortable doing this and didn’t know which staff he would approach. The issues for this person were not resolved although the person thanked the CV for helping him talk to staff.

Procedural Fairness

The CVs were told that affected persons were not always getting copies of applications and assessment reports before the Tribunal.⁹⁵

Case example

Mary complained to the CV that information presented to the Tribunal was not included in the Assessment and that she had not had the opportunity to see it. She said that she felt the information was disrespectful and was relayed to the Tribunal as if she was not in the room.

The CVP observed, on occasions, even when the application and assessment report were provided to the affected person, additional verbal information was provided by the SAC to the Tribunal, without notice to the person or the Advocate.

These are both matters of procedural fairness. All affected persons have the right to have a copy of the completed application and assessment report prior to the Tribunal.⁹⁶ Additional information should not be added at the time of the Tribunal without the knowledge of the affected person. The CVP notes that these matters were taken to management and the issue was resolved.

⁹⁵ Reference to the AMT Act

⁹⁶ Section 23(2) of the AMT Act

4.2.3 (c) Procedures

Documentation

CVs have the power to inspect documents or records at Assessment Facilities and Treatment Centres⁹⁷ and routinely exercise that power. At the start of the CV visits, there were two hard copy files for each affected person. This resulted in discrepancies in the information shared between Assessment Facility staff, and the Treatment Centre case managers. The CVP raised these concerns with DAATS, and stated the expectation that records are maintained in line with the clinical documentation standards applicable to a health service.

Following this, the CVs were told that improvements were being made to documentation. The CVP understands that all files are now being kept electronically on the DoH PCIS database system. The CVP see this as a very positive and necessary improvement.

Discharge Arrangements – When Orders not made

The legislation is clear in stating that release must occur “as soon as practicable” after the Tribunal’s order of release.⁹⁸ There is also a duty of care owed to an assessable or affected person for safe discharge. The CVP was made aware of one case where a person was kept for a month after the release order. This is excessive and beyond what would be reasonably accepted as appropriate.

The CVP has recommended that a policy be developed to facilitate the discharge process in a more systematic and timely way. The CVP was informed that the situation would not occur again, as in future someone with an identified cognitive impairment would be released from DAATS and a section 35 Exemption sought. Matters surrounding the treatment of persons with diagnosed or suspected cognitive impairment, or behavioural issues, have broader program implications, as discussed further in the Significant Issues for the CVP.

Case example

A complaint was received from a client about being detained at DAATS for seven days after being released by the Tribunal. Following the resolution of that complaint the affected person missed their organised flight home due to a failure to get him to the airport on time. This was distressing for the person. The missed flight resulted in the person being held at DAATS over the weekend and caused unnecessary stress and unease which should have been avoided.

The CVP has noted this as a serious complaint and a breach of the AMT Act. In accordance with section 28 of the AMT Act; ‘Release on order of Tribunal’, the client must be released from the facility as soon as practicable. It is acknowledged that there may be circumstances where it may prove difficult to organise appropriate, safe discharge of an affected person. However there is no power in the AMT Act to keep an affected person for any longer than is absolutely necessary and greater effort should have been made to facilitate release and transport to a safe place in accordance with section 29 of the AMT Act.

Domestic Violence Orders

The DoH Rights Statement states that for affected persons: “this is a place where you can feel safe and become well”. A serious complaint was received about the safety of a person whose partner was the subject of a Domestic Violence Restraining Order (DVO) who was

⁹⁷ Section 91(c) and (d) of the AMT Act

⁹⁸ Section 28 of the AMT Act

then co-located with her at DAATS. The CVP contacted senior management to advise of the serious safety concerns arising from this situation. The CVP was told by DAATS staff that they did not know that the DVO prohibited contact. Following the weekend, the CV was informed that contact had occurred.

The CVP believes that DAATS inadvertently facilitated a breach of the DVO, as well as compromising the female affected person's safety. The CVP noted that there was no clear management plan in place for this case, nor any systematic process for identification of such risks at the stage of admission to the AMT Program.

The matter was resolved by the defendant to the DVO being moved to a different Treatment Centre. The CVP was assured that this type of situation would never happen again. The issue of assessable persons with a DVO in place should have been identified in a risk assessment by the AMT program. A process needed to be in place with the NT Police, for NT Police to communicate to the Assessment Facility the existence of a DVO on each person's admission to the Assessment Facility. However, even when the risk was identified, DAATS was slow to manage it, with contact occurring.

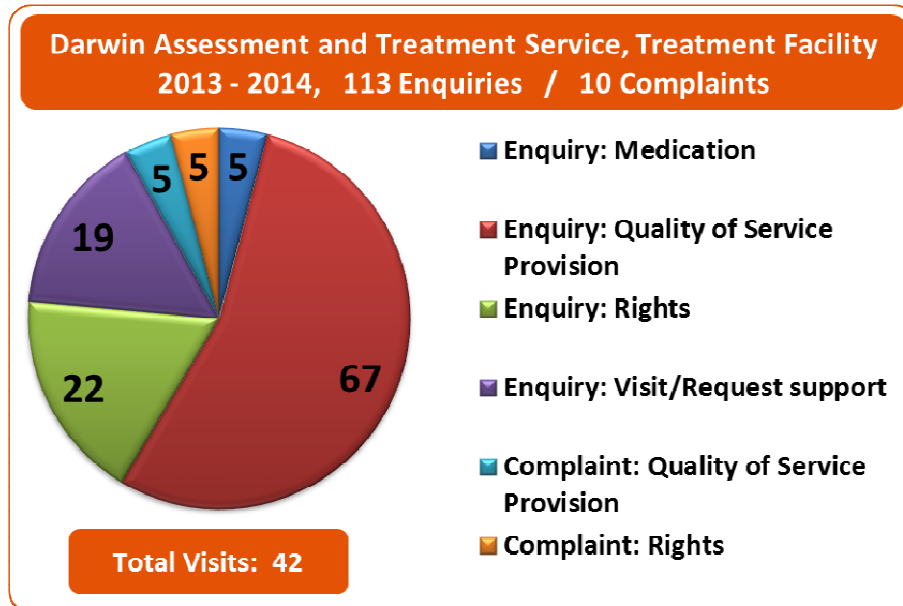
The CVP is of the view that this type of problem is a clearly foreseeable risk that could easily be appropriately managed with clear processes in place. To date, the CVP is unaware of any policy or procedure developed to systematically manage risks associated with family and domestic violence. This matter extends to management of client safety more generally and is noted as a significant issue under "Quality Assurance & Safety" for the CVP.

4.2.3 (d) Recommendations

	DAATS Assessment Open Recommendations	Made by	Date	Status
1	It is recommended that DAATS staff attend the "Appropriate Workplace Behaviour Workshop" and other training as indicated.	Community Visitor	10/02/14	Open /CVP monitoring
2	It is recommended staff undertake training in appropriate clinical documentation – to include treatment planning, case notes and discharge planning and to include client participation in formulating plans.	Community Visitor	10/02/14	Open/CVP Monitoring
3	It is recommended that DAATS ensure that information about affected persons rights is prominently displayed and that there is a system of checking that affected persons have had their rights explained to them orally and in their own language both in Assessment and Treatment and that they understand these rights.	Community Visitor	10/02/14	Open
4	It is recommended that DAATS ensure there is an accessible and obvious complaints process and that affected persons know they have the right to complain.	Community Visitor	10/02/14	Open
5	It is recommended that affected persons have access to phone calls more than once a day and when necessary prior to 3pm so they can contact family and conduct their business.	Community Visitor	10/02/14	Open/CVP Monitoring
6	It is recommended that the CVP be involved in the	Community	10/02/14	Open/CVP

	staff orientation program when developed to ensure staff understanding of the CVP, CV and Advocate's role and responsibility.	Visitor		Monitoring
7	It is recommended that DAATS develop as a priority a policy to address situations where domestic violence orders exist between affected persons when both parties are at DAATS.	Community Visitor	29/07/14	Open
8	It is recommended that when affected persons are identified as having cognitive impairments or other needs beyond DAATS scope of practice that timely and appropriate referrals are made and followed up on.	Community Visitor	19/03/14	Open
9	It is recommended that the Aboriginal Interpreter Service be contacted as soon as an assessable person arrives at DAATS to ensure that every endeavour is made to provide an Interpreter during the assessment.	Community Visitor	19/03/14	Open
10	It is recommended that DAATS consider release options and plans for affected persons at the time of assessment to ensure they are not held longer than necessary should they not be placed on an Order.	Community Visitor	19/03/14	Open
11	It is recommended that DAATS staff attend the Aboriginal Interpreter Service training to gain an understanding of the language needs and limitations of Indigenous affected persons.	Community Visitor	19/03/14	Open

4.2.4 Darwin Assessment and Treatment Service (DAATS) Treatment Centre Report



4.2.4 (a) Quality of Service Provision

The CVP acknowledges that there were additional challenges for the DAATS Treatment Centre at commencement of the program because the treatment program was being started 'from scratch', rather than being an existing NGO with a voluntary program already in place as in Alice Springs. However, whilst significant work was done to commence the service in a short space of time, and improve as problems arose, the CVP believes that the speed with which it was commenced gave rise to serious inadequacies in the quality of service provision for the DAATS clients, over and above those experienced in Alice Springs.

Staff

Staff Structure

The staff structure for the DAATS Treatment team consists of, a Senior Treatment Clinician, Aboriginal Liaison Officers (ALOs), Case Managers, support workers (known as green shirts), security guards and other administrative and hospitality staff. A medical officer and other allied health roles are provided as required.

There have been four Managers, four Senior Treatment Clinicians and significant changes to the case managers and support officers in this reporting period. There have been fewer changes in ALO positions.

As noted in the DAATS Assessment Report, recruiting and retaining staff and a lack of consistent leadership and management has been a significant challenge and it is the CVP view that this has affected the quality of services provided. The CVP was told that the high turnover in staff, in particular senior staff, had contributed to the lack of framework at DAATS and delayed the completion of structured therapeutic treatment program.

The feedback from clients regarding staff has generally been positive; however there were also serious complaints that gave rise to concerns for the CVP, as discussed throughout this section, below.

Case example

Delia was frightened of some of the other male clients threatening her and she made a complaint to the CV about this. She had raised concerns about her safety and wanted to talk to NAAJA about a possible appeal. She wanted her case manager with her when the CV and others met to talk about her concerns. She said that her case manager had listened to her concerns and had spoken up for her about 'right way treatment', and said to the CV that she could trust her and that she treated her the right way.

Staff Relationships

The AMT Act clearly states as a key principle in treatment that 'any interference with the rights and dignity of a person are to be kept to a minimum'.⁹⁹ This is supported in the DoH Rights Statement which states that clients '...will be treated with respect'. There were numerous complaints from clients that their treatment by staff was disrespectful. The CVP is concerned about the punitive approach adopted by some staff to the treatment of affected persons and a number of issues arose that brought into question the conduct of some staff in 'treating affected persons with respect'.

This is the subject of a CV open recommendation about appropriate workplace behaviour. The AOD Service Delivery Director responded promptly to these concerns, initiated a raft of staff training as well as a Planning Day on Values for DAATS. The CVP acknowledges that there have been improvements and will continue to monitor this.

Case example

Ben made a complaint to the CV about the way a staff member had spoken to him. Ben said that a staff member had threatened to use force to try and remove his writing book from his possession, and to search his room when he wasn't there. Ben discussed this issue with the CV and also with the Acting Manager of DAATS who addressed the matter with staff. Although he was very distressed by the incident, he felt reassured by the actions taken and considered the matter resolved.

The CVP notes that DAATS continue to be encouraging of family involvement and have accommodated family visits outside normal visiting hours. It is also noted that DAATS have worked at making arrangements with the Department of Children and Families to provide visits with clients and their children. This is very positive.

Assessment and Treatment

The CVP observed a systematic approach to the management of the physical health needs of affected persons. The CVP acknowledges and commends DAATS on the work in this area, as some of these affected people have longstanding, serious chronic health conditions.

⁹⁹ Section 6(c) of the AMT Act

Individual Treatment Plans

The CVP notes that Treatment Plans have systematically been drafted by DAATS at the commencement of an affected person's treatment and that the policies used for withdrawal and detoxification of affected persons are in line with the Department of Health guidelines.

However, Treatment Plans are not systematically updated or revised during the course of treatment, contrary to the AMT Act. This is also contrary to the commitment in the DoH Rights Statement that *'...we will involve you in decisions about your treatment and care'*.

Further in regard to individual treatment, there appeared to the CVP to be a lack of direction and focus which resulted in reactive engagement with the affected person's immediate circumstances and health issues, with the focus being on the 'here and now'. This focus overlooked the aetiology of the person's substance abuse history so there was no starting point for treatment or indeed rehabilitation.

There were no clear treatment or rehabilitation goals or aims with staff mostly responding to current issues and this is not consistent with the stated purpose of AMT. Engaging people and 'working with them' to achieve specific rehabilitation goals and 'empower them' as a focus was not apparent to the CVP, compromising the success of rehabilitation.

Individual counselling is not provided as a matter of course during treatment. It is left to the person to request counselling if they desire it. The CVP notes that this is not ideal as most affected persons do not access this and are not aware that the option exists. This is contrary to best practice. The CVP notes that any interaction between case managers and clients is an opportunity for therapeutic intervention and that counselling does not need to be a formalised process and can be conducted in a culturally sensitive manner appropriate to the individual.

Case example

The CVs were told "the green shirts are great but I don't know who my case manager is, I go over there and they keep telling me to come back".

Treatment Program

The CVP observed that DAATS AMT program was in a state of continuing evolution throughout the reporting period and over December 2013 there was limited programming on offer to affected persons as FORWAARD ceased providing the program. In the CVP's view this compromised the quality of the treatment.

Case example

Pamela is an Aboriginal woman who is well educated and communicates clearly in English. Pamela told the CV about her recent relationship breakdown and her previous admission to another AOD Rehabilitation service which was, in her view, related to her relationship breakdown. Pamela complained to the CV about the quality of treatment at DAATS and that she saw no reason to be there because 'all we do is watch videos'. Pamela said she wasn't sure who her case worker was as 'they don't speak to you'.

The CVP observed inconsistencies in what was offered in the program. For example, affected persons were permitted to go shopping and do banking; this was then removed,

and then re-instated. The inconsistencies were noted by the Community Visitor Panel which was unable to properly assess the program content or delivery.

*“The panel was informed by senior management that FORWAARD (a non-government organisation) facilitated group treatment programs to address alcohol misuse. However, the panel was advised by FORWAARD that they were only delivering basic maths and literacy instruction. The panel was later informed that that case managers were facilitating group treatment programs, providing individual interventions and developing a new treatment program. Content of the program was not ascertained during the panel visit”.*¹⁰⁰

More recently the CV has observed various new activities, such as men’s and women’s groups to address more specific alcohol and drug treatment and other allied health issues. The CVP has received some positive feedback about these groups from clients. The appointment of the Activities Co-ordinator has given more structure to the activities component of the treatment program and a bigger selection of activities, including structured activities to be held during alternate weekends. Of note were the communal women’s rug, the vegetable garden and the start of the Friday evening cookouts.

As noted previously, many of the CVP’s concerns relate to the absence, from the beginning, of a model of care and clinical governance framework (as well as the other DoH policies). The effect of this lack of structure was exacerbated at DAATS because it was a brand new treatment provider.

The CVP acknowledges that the DoH is working towards addressing these issues and that further improvements may flow from the proposal to transfer the Treatment Centre to an established NGO treatment provider.

Documentation

In early visits, the requirements of section 67(1)(a) of the AMT Act to keep details of all treatment given, and whether or not there was consent, was not met. This made it very difficult for the CVP to get any sense of an affected person’s progress during treatment.

Initially this was discussed with case managers who reported they didn’t have time to follow-up with treatment plans, they were “too busy running the program”. This was the subject of an open recommendation and discussed with the Senior Treatment Clinician and Acting Manager. The CVs were told that a policy, protocol, and templates regarding documentation had been developed and that training was to be provided. Unfortunately the training has not occurred although the filing system has improved and as noted in the Assessment Facility comments, all files are now recorded electronically.

Interpreter Use

During the CV Panel inspection visit, the files reviewed often stated that the client’s first language was not English and in some files there was no indication of language spoken. The CV Panel noted from the client files that when offered an interpreter, clients were noted as having declined. This was the subject of a Panel recommendation. Both the CVP and Panel recommend that more needs to be done to ensure that interpreter use is improved to ensure the client can communicate, understand their rights, and fully engage in treatment. (Refer to Significant Issue under Interpreter Use).

¹⁰⁰ CVP Internal Panel Report

Case example

The CVs arranged a meeting with an affected person and an interpreter as the person was being discharged after a 3 month Order. During the course of the meeting it became clear that Treatment and discharge plans had been made without the client's knowledge as no-one had used an interpreter to communicate with them.

DAATS have acknowledged that interpreter use is best practice and have told the CVP they endeavour to use interpreters when possible. The CVP made a recommendation for staff to attend the interpreter training to improve their skills in the area. The CVP commend DAATS for providing the training to staff which helps to remind them of the difficulties faced by Aboriginal people who do not speak English as their first language

Least Restrictive Treatment Options

Applications can be made (by the STC or the affected person) to the Tribunal for variation or revocations of mandatory treatment orders if it becomes apparent that a less restrictive treatment option is more suitable, or has become available.¹⁰¹

In figures obtained from the Tribunal the DAATS has the lowest number of revocations or community treatment orders of all the AMT Services although they have the highest number of clients. It appears to the CVP that there is no systematic review of the suitability of mandatory treatment orders against the least restrictive intervention principle during treatment at DAATS.

Case example

Presley asked the CV to help him seek a revocation order a month into his order as he wanted to return for men's business. Initially the case manager had referred the matter to NAAJA as he was not sure of the correct process. The CV asked the Advocate to assist and initially the treatment team supported the application and then changed for reasons that were unclear to both the Advocate and client. The matter lasted for over 4 weeks with numerous requests to meet which did not take place in a reasonable time. The affected person was visibly upset at the delays and the change in the support of the revocation, the person said 'the Tribunal should see how they have treated me and how I am not getting help here'.

In this case the revocation application was not approved by the Tribunal. However after this case, the CVP and DAATS agreed that with any revocation matter that a meeting should occur promptly after the request, where the treatment team and the client could talk about the reasons from the client's perspective and that the treatment team provide information of the basis of why the application was supported or not, as a matter of course.

The least restrictive intervention principle also applies during treatment in terms of the freedoms permitted to individuals. It should be applied to the treatment program as a whole, and then considered in respect of each individual's treatment. For example, affected people were unable to access the phone as readily as they required. This was the subject of numerous inquiries to CVs. The CVP advocated for a change in procedure, and the hours for phone access were extended. Clients can now use the phone daily after 3pm and from 9am to 8pm on weekends. However the CVP notes that in the other Treatment Centre access to the phone is not limited and the CVP queries the inconsistencies in terms of application of

¹⁰¹ Section 44 of the AMT Act

the least restrictive intervention principle. The DAATS staff told the CV that clients should be participating in the program in the day.

The DAATS Treatment team has demonstrated flexibility in granting leave of absences to clients needing to attend sorry business or other family matters and were supportive of clients visiting family members at Royal Darwin Hospital and Berrimah Prison.

Aftercare Planning and Referral

The AMT Act requires that an aftercare plan must be prepared for a person who receives treatment under a mandatory treatment order, which must then be lodged with the Tribunal.¹⁰² The CVP has noted variable quality in aftercare plans and that they do not appear to be constructed in a systematic way. The aftercare planning process was the subject of the first recommendation of the Panel in acknowledgement of the importance of the aftercare planning to the ultimate success of an affected person's treatment.

The CVP is concerned that, at times, accommodation referrals for clients have been left to the last two to three weeks of their three month order. This is generally not long enough to secure accommodation in supported or short term housing. Aftercare planning and housing are vital components of treatment, and securing housing is pivotal in maintaining the ongoing benefits of treatment for clients.

4.2.4 (b) Recommendations

	DAATS Treatment Service Open Recommendations	Made by	Date	Status
1	Aftercare planning – formal, documented interaction with community/non-government organisations in the continuing care of the affected person upon release.	CVP Panel	29/05/14	Open
2	Interpreters – use of interpreters is increased significantly in treatment consultations (not just the Tribunal proceedings), especially where English is a second language.	CVP Panel	29/05/14	Open
3	Safety: <ol style="list-style-type: none"> an audit of the facility with a view to minimising risk from hanging points and lethal materials; all staff receive training in the recording and reporting of 'use of force' incidents and that the policies are re-developed so that they are consistent with each other and the relevant legislation; and DAATS prioritise the development of a comprehensive suicide/ self-harm prevention policy, which may include details of staff training, screening, observations, post-screening management, communication about risk, safe housing and linkages to mental health services. 	CVP Panel	29/05/14	Open
4	Policies – it is recommended that all DAATS policies, procedures and like documents include a	CVP Panel	29/05/14	Open

¹⁰² Sections 65 and 66 of the AMT Act

	promulgation date, review date and owner.			
5	It is recommended that where issues of mental capacity are identified that appropriate referrals and assessments be made in a timely fashion and steps taken to find less restrictive treatment options.	Community Visitor	20/03/14	Open/CVP Monitoring
6	Staff attend "Appropriate Workplace Behaviour Workshop" and other training as indicated.	Community Visitor	10/02/14	Open/CVP Monitoring
7	It is recommended staff undertake training in appropriate clinical documentation – to include treatment planning, case notes and discharge planning and to include client participation in formulating plans	Community Visitor	10/02/14	open
8	It is recommended that DAATS ensure that information about affected persons rights is prominently displayed and that there is a system of checking that affected persons have had their rights explained to them orally and in their own language both in Assessment and Treatment and that they understand these rights	Community Visitor	10/02/14	open
9	It is recommended that DAATS ensure there is an accessible and obvious complaints process and that affected persons know they have the right to complain.	Community Visitor	10/02/14	open
10	It is recommended that affected persons have access to phone calls more than once a day and when necessary prior to 3pm so they can contact family and conduct their business.	Community Visitor	10/02/14	Open/CVP Monitoring
11	It is recommended that the CVP be involved in the staff orientation program when developed to ensure staff understanding of the CVP, CV and Advocate's role and responsibility.	Community Visitor	10/02/14	open

4.2.5 Katherine Mandatory Assessment Rehabilitation Service

The CVP made one visit to the centre in February 2014 and have contact with staff and clients via telephone and email at other times. The CVP is pleased that at the time of writing the report a Sessional Community Visitor has been recruited to undertake the role of the CV in Katherine. The first enquiry from an affected person was about an affected person's key card and this was resolved by a phone call. The other enquiry was regarding safe transport.

CATEGORIES OF ENQUIRIES & COMPLAINTS	KATHERINE AMT FACILITY
Quality of Service Provision	1
Rights	1

4.2.5 (a) Quality of Service Provision

Environment and Safety

The service is situated in a four bed hospital room within the Katherine Hospital with clients and staff sharing the same area. The CVP view this as highly unsuitable, as it presents safety risks for clients and staff, and does not provide for privacy or confidentiality. To highlight the safety concerns staff advised the CV that there had been two serious incidents that had occurred which put clients and staff at high risk. The CV noted that the potential danger of one of the incidents was lessened by the professional conduct of the Senior Assessment Clinician (SAC). As there is only the one room men and women cannot be located within the service at the same time. Despite these challenges the CVP observed on this visit the effort made by staff to ensure a quality service for clients.

In March 2014 the CVP made a recommendation that the service be relocated as a matter of urgency and were advised by DoH that a new facility would be available later in 2014.

Staffing

Staff members were observed to be client focussed with positive interactions with affected persons. Discussion with clients revealed that they had a good understanding of their situations, including the assessment and Tribunal process.

Use of Interpreters

It was noted that staff had put significant effort into developing a good working relationship with the interpreter service, and interpreters were used on a regular basis.

Least Restrictive Alternative

Senior assessment staff demonstrated an understanding of the principle of least restrictive treatment, and recommendations made to the Tribunal were indicative of this.

Legal Representation

All affected persons assessed at the service are provided with access to legal representation through Northern Australia Aboriginal Justice Agency (NAAJA).

4.2.5 (b) Recommendations

Katherine Assessment Open Recommendations		Made by	Date	Status
1	It is recommended that the service be relocated as a matter of urgency to ensure safety of staff and clients. This would allow for office space for staff and provide privacy and confidentiality for affected persons.	Community Visitor	12/03/14	Open

4.2.6 Advocate – for Alcohol Mandatory Treatment Tribunal

The Advocate is auspiced by the CVP. The President of the Alcohol Mandatory Treatment Tribunal (Tribunal) may appoint an Advocate under section 113 of the AMT Act to ensure the rights of an affected person to representation.

The CVP is auspiced by the Anti-Discrimination Commission. This preserves its independence, and also ensures the independence of the Advocate both from the Tribunal and the DoH where the AMT program sits.

The AMT Act, in regard to the Advocate, states the following:
113 (2) If the affected person is unrepresented, the President may appoint an advocate for the affected person:

- (a) to represent the best interests of, and assist, the affected person in a proceeding; and*
- (b) to perform any other functions conferred on the advocate by the Tribunal or under this or any other Act.*

(3) The advocate must be:

- (b) a person who is approved by the CEO and has expertise in the general care, health care, rehabilitation or treatment of persons who are misusing alcohol.*

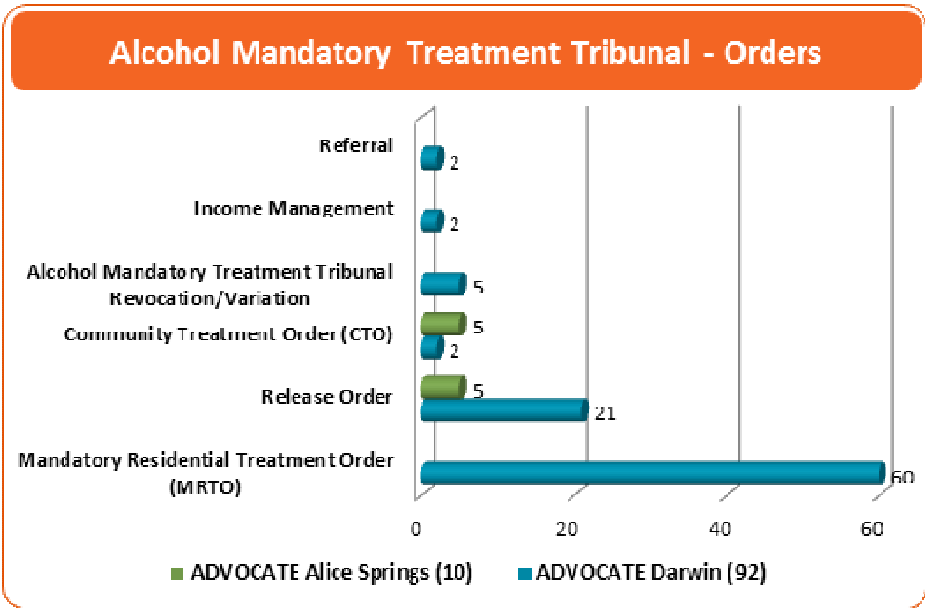
(4) The Advocate must be provided at no cost to the affected person

Advocate Darwin

The Advocate commenced in Darwin in November 2013. For 2013 – 2014 the Advocate has represented 92 affected persons in Darwin.

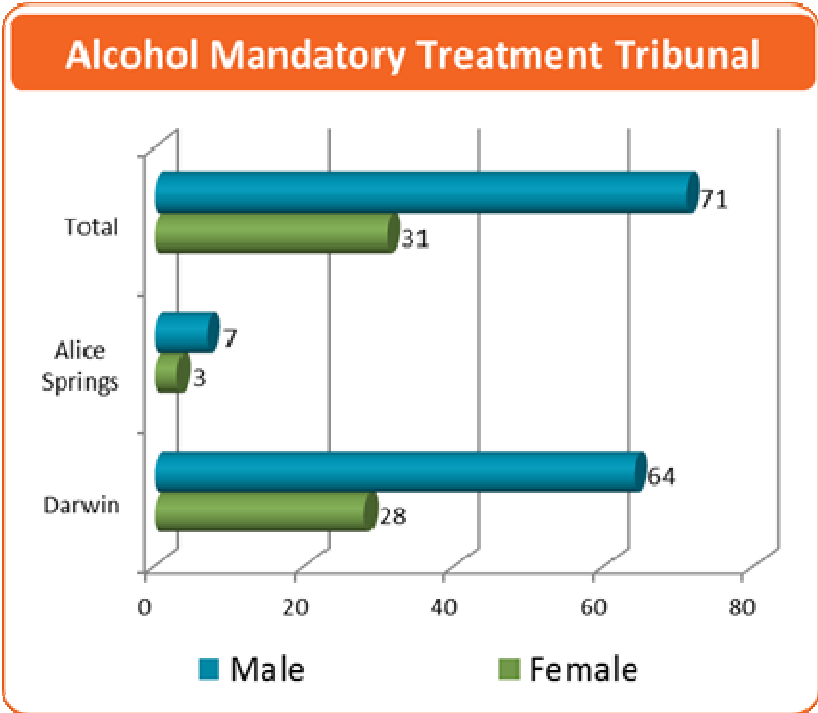
Advocate Alice Springs

The Advocate provided a service in Alice Springs 26 May 2014 until 30 June 2014 and represented 10 affected persons.



Note: Income Management, the Advocate represented 2 clients who were required to have their Income Management Orders backdated due to AMT legislation and Income management timeframes.

'Affected persons' gender identification



There have been two protocols in place between DoH and CVP in regard to the Advocate role during this period. The role was initially contained in the general protocol between CVP and DoH, but more recently a separate protocol was developed to ensure clarity of roles and an understanding of the different role the Advocate undertakes.

At present there is a standing arrangement that the Advocate is appointed for all unrepresented affected people at DAATS.

Acronyms

ALO	Aboriginal Liaison Officer
AMHW	Aboriginal Mental Health Worker
AMT	Alcohol Mandatory Treatment
AMT Act	<i>Alcohol Mandatory Treatment Act</i>
AMTC	Alcohol Mandatory Treatment Centre
AOD	Alcohol and Other Drugs
AP	Approved Procedures (to the <i>Mental Health and Related Services Act</i>)
APP	Approved Psychiatric Practitioner
ASAAS	Alice Springs Alcohol Assessment Service
ASCC	Alice Springs Correctional Centre
ASH	Alice Springs Hospital
CA	Central Australia
CAAPU	Central Australian Aboriginal Alcohol Programmes Unit
CAAC	Central Australian Aboriginal Congress
C&A Team	Child and Adolescent Mental Health Team
CAALAS	Central Australian Aboriginal Legal Aid Service
CAMHS	Central Australia Mental Health Service
CATT	Crisis Assessment Telephone Triage and Liaison Service
CAU	Contained Assessment Unit, Royal Darwin Hospital
CC	Clozapine Clinic
CV	Community Visitor
CVP	Community Visitor Program
DAATS	Darwin Alcohol Assessment and Treatment Service
DoH	Department of Health, Northern Territory Government
DVO	Domestic Violence Order
DSA	<i>Disability Services Act</i>
ECT	Electro-Convulsive Therapy
ED	Emergency Department
FORWAARD	Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties
F/T	Full-time

GP	General Practitioner
IPU	Inpatient Unit
JRU	Joan Ridley Unit, Royal Darwin Hospital
KH	Kwiyernpe House
MCTO	Mandatory Community Treatment Order
MHACA	Mental Health Association of Central Australia
MH-CAHS	Mental Health – Central Australia Health Service
MHRSA	<i>Mental Health and Related Services Act</i>
MHS	Mental Health Service, Northern Territory Government
MHRT	Mental Health Review Tribunal
MHU	Mental Health Unit (Alice Springs Hospital)
MIFANT	Mental Illness Fellowship Australia, NT
MRTO	Mandatory Residential Treatment Order
MTO	Mandatory Treatment Order
NRT	Nicotine Replacement Therapy
NAAJA	Northern Australian Aboriginal Justice Association
NGO	Non-Government Organisation
NT	Northern Territory
NTLAC	Northern Territory Legal Aid Commission
PBSP	Positive Behaviour Support Plan
PRN or PRN medication	<i>Pro re nata</i> (Latin), meaning ‘medication that is taken as needed’
QIC	Quality Improvement Council
RDH	Royal Darwin Hospital
SAC	Senior Assessment Clinician
SRF	Specialist Residential Facility
STC	Senior Treatment Clinician
TE	Top End
TEMHS	Top End Mental Health Service
TM	Team Manager