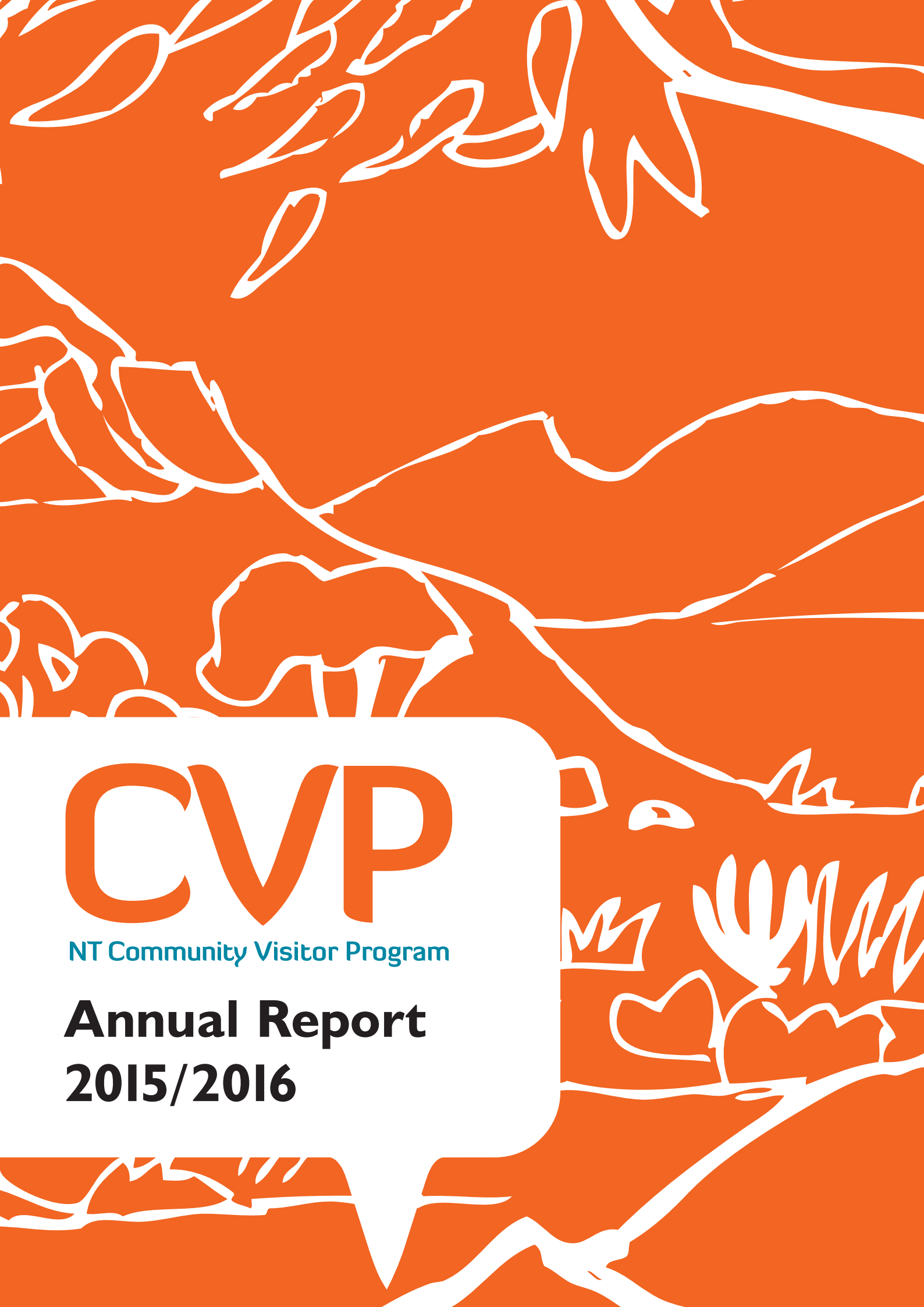


CVP

NT Community Visitor Program

Annual Report 2015/2016

NT Community Visitor Program

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

30 September 2016

The Hon Natasha Fyles
Minister for Health
Parliament House
State Square
DARWIN NT 0800

Dear Minister,

Re: Community Visitor Program Annual Report 2015-2016

I present to you the Annual Report on the activities of the Community Visitor Program for tabling in the Legislative Assembly.

This Annual Report has been prepared in accordance with section 115 of the *Mental Health and Related Services Act*, section 66 of the *Disability Services Act*, and section 101 of the *Alcohol Mandatory Treatment Act*.

I commend the report to you.

Yours sincerely,

Sally Sievers
Principal Community Visitor

TOP END
Level 7 9-11 Cavenagh Street
Darwin NT 0800

CENTRAL AUSTRALIA
Level 1, Alice Springs Plaza
Alice Springs NT 0870

SALLY SIEVERS
PRINCIPAL
COMMUNITY VISITOR

REFLECTIONS FROM THE PRINCIPAL COMMUNITY VISITOR

It is with great pleasure I deliver the fourth Annual Report for the Community Visitor Program (CVP) under my stewardship.

It has again been a busy year for the program. The number of matters raised with Community Visitors has increased by 13%. It is pleasing to see in all areas of the program that relationships are growing with people detained in services.

For the first time this year we received telephone enquiries from people in Alcohol Mandatory Treatment facilities asking to see Community Visitors. Asking to see the CVP is more common in mental health, where the program has been firmly established after 15 years of visiting.

You will notice this year's report is written in a different style. Our goal was to write in plain English to make it easier to access for a greater number of people. It also demonstrates the importance of the CVP being placed within the Anti-Discrimination Commission as the CVP works to protect, on a daily basis, the human rights of society's most vulnerable. The CVP's independent monitoring of those detained is key to protecting their human rights.

We are very aware that the CVP oversight and monitoring can be confronting, even for health practitioners who work in areas such as mental health where oversight has been in place for a long time. It can be especially challenging for areas such as Alcohol and Other Drugs, where it is occurring for the first time as they provide mandatory treatment.

The Community Visitors aim to perform their role in a polite and considered way, carefully walking the line of not straying into clinical decisions or getting in the way of the clinical relationships. A crucial part of the role, however, is to assess services against relevant legislation and best practice as set out in Australian and international standards.

Community Visitors are provided with ongoing development and training. Some CV Panel members are from specialist professions as part of their membership. The CVP uses external consultants as needed. Together, these strategies make sure we comment from a positon of knowledge as much as possible.

Over each year of the program, the ongoing monitoring through regular visits by Community Visitors and reviews by CV Panels has led to change that benefits all people using services. Sometimes change happens slowly, however there can be an urgency to issues raised when the safety of people receiving treatment in facilities could be compromised.

This year a number of very positive developments occurred in areas that the CVP has advocated for over a number of years. These include the opening of youth mental health program, seclusion reduction in Top End mental health,

moving towards transition for people with disabilities, and AMT services have for the first time been more settled.

However areas of concern remain. The CVP will be advocating strongly and monitoring closely in the next financial year for cultural safety across all programs, increased use of Aboriginal interpreters, safe facilities, good planning, and participation of carers and people in their own care and treatment.

There will also be an increased focus on the right of people to live in the community. At the broadest level, there is an urgent need for places for vulnerable people. People who need the right support to help them live in the community – having a secure home is essential.

I would like to thank the Chief Executive of Department of Health, Dr Len Notaras, the Top End and Central Australia Health Boards and their Chief Operating Officers for seeing matters raised and complaints as an opportunity to improve services. Their leadership is a key part of committing to the care and safety of clients at the centre of all work.

I would also like to thank the management and staff of all services that the CVP monitors. I thank them for their ongoing dialogue with the program, including robust exchanges, as we all work together to ensure best possible services and outcomes for people detained in the service.

This work is also made possible by the capable and skilled work of the CVP team, professionally led by Claudia Manu-Preston. Their fearless, independent monitoring and oversight of the three arms of the program, day to day diligence, and focus on keeping people at the centre of their work is what makes the program a success.

It is a year when we have said farewell to a number of long term CVP members, some of whom have been with the CVP from its earliest days. I particularly acknowledge the long and committed service of Carly Ingles, Alison Hanley and Pamela Trotman. This was also the final year for Graeme Berryman, who spent two years as the CVP Coordinator (AMT) for Central Australia.

Lastly thank you to those people detained or accessing the services, their families and supporters for taking the time to discuss their concerns with us. We understand that this is often an extremely stressful time in your life. You have shown the courage to raise issues and share concerns, so that you can receive a better service for yourselves and for all who come after you.

The CVP looks forward to a busy year ahead. The program will continue to adapt to changes and advocate for the best services for all those who are detained or receiving treatment in the community. Most importantly we will be guided by our values, respecting all, acting with integrity and independence, empowering those we work with, and being courageous when needed.

CONTENTS

OVERVIEW

The important work of Northern Territory Community Visitor Program (CVP) continued this year, reaching out to people in health facilities, especially those in involuntary detention. The CVP has been set up to protect the rights of people who are treated in health facilities, under the *Mental Health and Related Services Act*, the *Disability Services Act* and the *Alcohol Mandatory Treatment Act.*

People receiving treatment, their families, guardians or carers, can independently raise issues with the CVP that worry or upset them, including make complaints. The CVP also looks at the treatment and care of people in facilities to make sure the services are of good quality.

This work is part of Australia's obligations under human rights law. It is also part of the international principles for the protection of people with disabilities and those with mental illness.

The work of the CVP gives the community confidence that people are being looked after and their rights respected. To remove someone's right to live freely in the community, and require them to remain somewhere for their own health or the safety of others, is very serious.

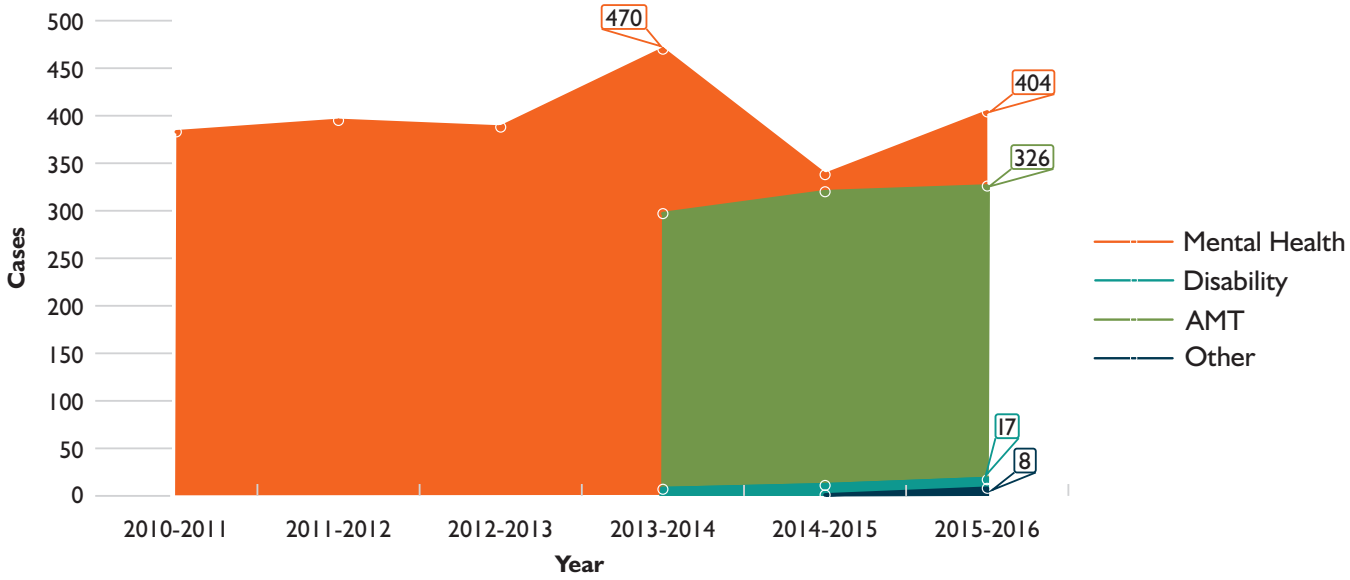
The information from people about their complaints, enquiries and inspections by the CVP helps the service. It helps them hear what is helpful, what is not, and what might be done differently. The CVP looks at all the information and considers it against human rights principles, standards, policies and best practice.

The CVP started in the mental health field in 2001-2002. In 2012-2013, two new areas of work were added. These were in the specialist disability and Alcohol Mandatory Treatment (AMT) areas. The AMT work has led to a big increase in the number of cases raised with the CVP.

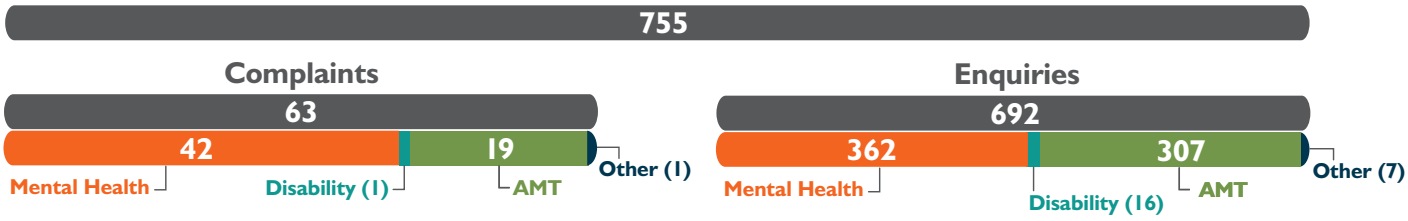
While the numbers of cases in the Northern Territory in the specialist disability field are small, this work is developing more depth as it progresses and additional places to visit are advised to the CVP.

Next year, the National Disability Insurance Scheme is rolled out across the Northern Territory. The Principal Community Visitor will continue to provide information about the work of the CVP as national and local discussions take place about the best way to support all people with disabilities living in the community.

History of CVP Case Data



Total CVP Cases 2015-2016



REACHING OUT THROUGH VISITS

The work of the CVP is different to other independent complaints organisations. While those organisations are needed, the CVP is available directly to vulnerable people by visiting the facilities.

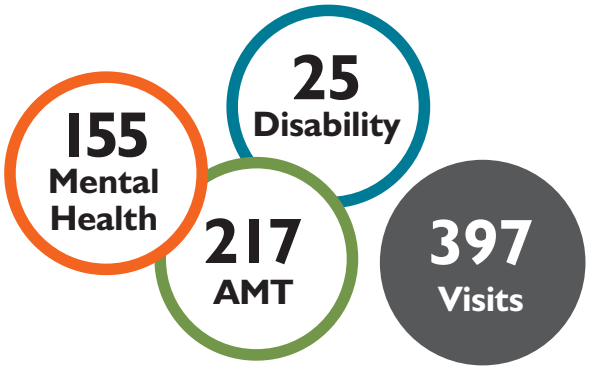
Nearly every week, the Community Visitors go to mental health and AMT facilities. Visits to disability facilities happen once a month to four times a year, depending on the type of place.

The visiting service helps those who may not feel comfortable calling or writing to someone for help. It gives people in the facility time to get to know the Community Visitor more. Of the cases raised this year, 75% were raised in person or during a visit by the Community Visitor.

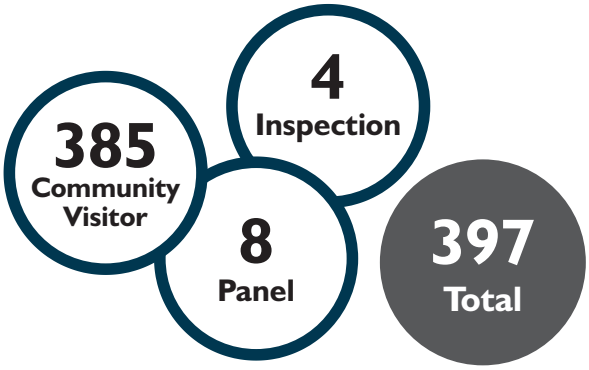
If someone asks to see a Community Visitor, by law, the CVP must make contact by the next working day. The CVP has a very high rate of success in making contact. The numbers of requests for a Community Visitor are much higher in mental health (86% of the 145 requests).

The CVP will continue to work towards its goal of contacting all people who ask to see a Community Visitor by the next working day.

CVP Visits 2015-2016

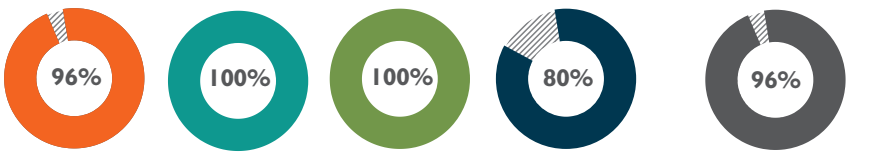


Visits By Type



755 Cases

Requests for CVP 2015-2016



Mental Health 125

Disability 1

AMT 14

Other 5

Total % contacted within 1 working day 145

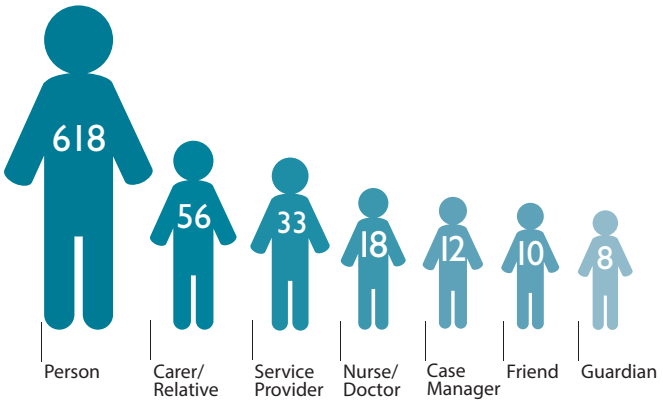
RAISING ISSUES

This year, 755 cases (enquiries and complaints) were raised with the CVP. Over 80% of the cases were raised by people receiving services or treatment. About 10% were raised by carers, guardians, friends or family. The remaining 10% were raised by staff.

The CVP would like to thank the people who raised issues with the Community Visitors. It is not always an easy choice to talk to someone independent of the service. Everyone in the CVP feels deeply honoured to be given the trust of people who ask for our help. This trust helps keep the CVP team strong.

What often drives people to speak up is that they want to see positive change, not just for themselves, but also for others.

Cases Raised By



This same goal is often what drives staff. Staff are united in their wish to do their jobs well, and to see people in their care improve, and return to live in the community.

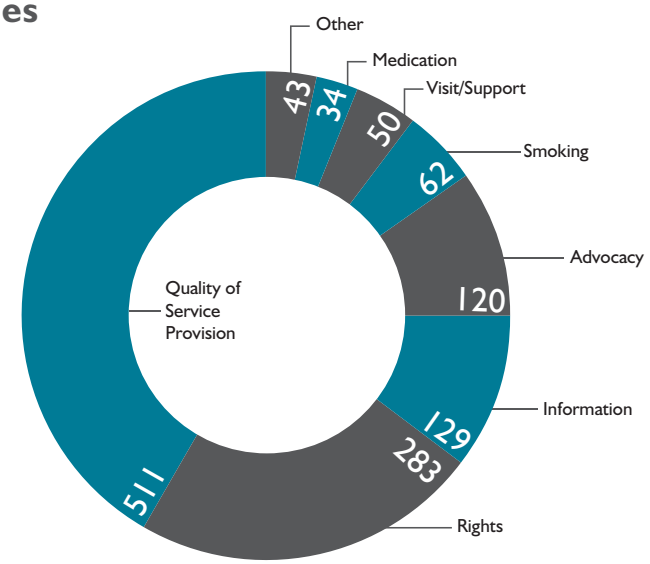
Like any service, unfortunately, things can go wrong. A mistake might have been made. There might be different opinions about the best treatment. A person may not have felt strong enough to speak up for what they needed (especially as the people who make decisions about them can have a lot of power over their lives).

The Community Visitors work to try and resolve any issues with the services, talking directly to the staff working with the person (rather than involving senior staff). This is usually the best and quickest way to move forward.

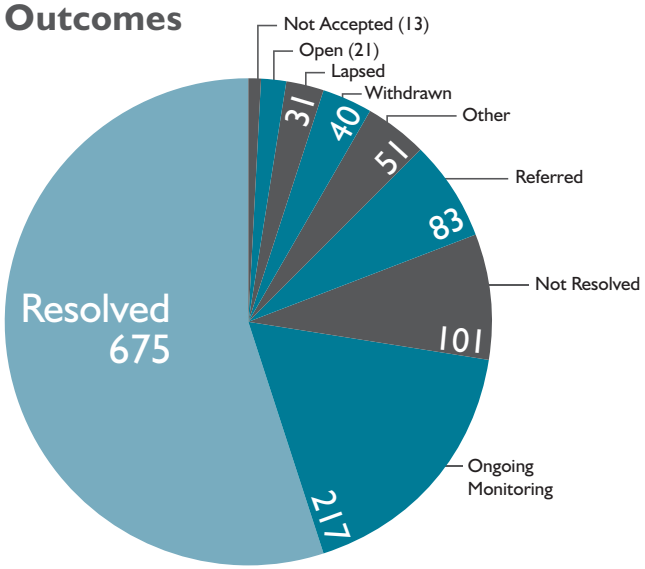
This year, as with previous years, the CVP's data shows that this way of working helps. Of all the issues raised with the Community Visitors this year, only 8% could not be resolved. Over 60% of all issues raised were able to be resolved or referred with the Community Visitor's assistance.

Appendix 1 has a full list of issues raised, by whom and in what service. Each chapter of this report also provides a snapshot of the data relating to that area of CVP work.

Issues



Outcomes



"Our daily work of answering people's enquiries and complaints helps to empower people who are experiencing a very challenging time."

[Community Visitor]

THE BIG ISSUES

The main issues raised this year across the CVP work were:

- 'least restrictive' decisions;
- assessment and treatment;
- cultural safety;
- planning for discharge;
- relationships with staff;
- requests for information;
- general advocacy; and
- smoking.

The most frequently raised issue related to a person's care and treatment was the 'least restrictive' option for them. The 'least restrictive' principle is core to all work in this field. Every person has the right to freedom of choice, including in health care.

In some cases, however, a person's rights might need to be restricted in order to provide them with the care and treatment. When this happens, at every point, the services need to be thinking about how and when this person's freedoms can be returned.

It is not surprising, therefore, that issues related to 'assessment and treatment' often come up in the CVP's work. The Community Visitors do not question clinical decisions of staff. However, sometimes people receiving services, or those close to them, might disagree with these decisions. The CVP tries to help by making sure that everyone is talking together well, and able to put forward their view.

When people come from different cultures, there can be misunderstandings or differences of view. When English is not a person's first language, or complicated issues need to be talked about, the service needs to make sure that language does not create a problem for good communication. The use of interpreters is especially important in that case.

Another common issue is people's relationship with staff. Interpersonal relationships can be difficult and sometimes very stressful. There may be personality clashes. Even with the best of intentions, things can go wrong.

In most cases, the CVP believes that good communication is the key. Good communication rests on each party being able to understand the other. Being able to speak freely. Being able

MENTAL HEALTH (WORKING WITH CARERS)

Jan, Emily's mother and carer, contacted the Community Visitor because she felt that Emily had not received the level of care and treatment that she needed. Jan was worried that not enough planning had been done to prepare for Emily's return to the community. With the help of the Community Visitor, a meeting was held between Jan and the health service. In this meeting Jan was able to talk about all her concerns about Emily's care. This meeting helped the medical team to get a better understanding of Emily's needs and to create a better range of plans for her treatment and return home. (C/2016/110)

MENTAL HEALTH (PROCEDURES)

Tom told the Community Visitor that he was unhappy because the rules on the ward meant that he was only allowed to use his laptop at certain times of day. This rule was making him very anxious and stressed because he had some urgent work he needed to complete. Tom wanted to use his laptop early in the morning when the ward was quiet. The Community Visitor raised Tom's idea with a senior member of staff. The staff agreed to be more flexible about the rules for using laptops. Tom was happy with the outcome, and was less stressed about managing both his treatment and other commitments. (C/2016/283)

to listen deeply. Accepting when something was not done well. Talking openly and honestly about how things can be done better in the future.

This year, the CVP has seen some great work from staff to help people who have had difficulties move forward. Often, also, the sharing of information between parties (including with the support of the Community Visitors) helps.

Unfortunately, this is not always the case. In just under 20% of all cases, the CVP has recorded that the main outcome is 'ongoing monitoring'. This indicates that there is more to do in this area, or more time is needed for the CVP to form a view.

Many of the 'smoking' cases could not be resolved because of the 'no smoking' policy of the Department of Health (which operates in nearly all of the facilities visited by the CVP).

Sometimes there has been aggression shown to staff and others in the facility because the person is upset about not being able to smoke.

The CVP does not advocate for or against the 'no smoking' policy. The CVP knows, and supports, the health benefits of giving up smoking. However, the freedom to choose, even unhealthy choices, is one that everyone has in society. Any restrictions need to be put in place consistently and thoughtfully.

The CVP concern is that the 'no smoking' policy creates additional worries and problems for everyone in the facilities, including staff. This issue needs to be considered more so that both the policy and a person's right to choose can be met.

AN INDEPENDENT VOICE

Good quality care comes from openness to different ideas, feedback and accountability to others. Part of the role of the CVP is to be an independent voice, raising ideas and feedback. The monitoring and inspection role of the CVP is also one way in which the services are accountable to a third party.

Four times a year the Community Visitors provide reports to the service about issues that have come up, including during the visits. Reports on seclusion and restraint registers, and inspections of community-based mental health teams, are regularly prepared.

The CV Panels provide another layer of independent oversight of the facilities. The CV Panels focus is more on systems rather than individual cases.

The Community Visitor and CV Panel reports are confidential between the service and the CVP. Only the open recommendations, and the comments in this report, are made public.

While the CVP respects the feedback of the services to reports and inspections, the independence of the CVP's views is a core part of the role. Something that is not factually correct may be changed in a report. Anything else is a matter of opinion. The CVP strongly stands by its reports as an independent voice to improve the quality of care.

DISABILITY (LIVING IN THE COMMUNITY)

Abraham spoke with a Community Visitor about wanting to be a 'free man'. Abraham said the only reason he was in the facility was because the judge said he had to be there. The Community Visitor spoke to Abraham's lawyer and guardian, letting them know that Abraham did not seem to understand why he was there. The lawyer reassured the Community Visitor that he regularly talks to Abraham. The guardian was happy to hear from the Community Visitor, and raised some other concerns about how Abraham was being supported to find a suitable house in the community. (C/2016/319)

COURAGE TO SPEAK UP

The work in this field is complex. No one person's situation is the same as another. Sometimes, people or staff will have strong ideas about what they would like to see happen.

The work of the CVP is, by its very nature, to raise things that are difficult. The work is about helping people to be heard, and if the matter is serious, make a complaint. It is about looking at systems and paperwork and making sure that everything is done properly.

For these reasons, the CVP has a professional value of courage. Sometimes the services welcome what the CVP gives as feedback. Sometimes, however, the Community Visitors will raise issues that staff do not agree with.

Courage might be needed from all parties to clear the air. Or to help people understand each other better. Or to work towards better services. The right and courage of all people raising complaints and giving feedback needs to be deeply respected.

The Community Visitors remain in awe of the strength shown by sometimes the most vulnerable. It can be a leap into the unknown to raise issues, and even with a Community Visitor by their side or helping out, there is no guarantee how it will be received.

KEEPING THE CVP STRONG

As with any complaints and advocacy service, it is important to make sure that the Community Visitors are well supported to do the job. The work of a Community Visitor requires people who can connect with others. Who exercise good judgment. Who bring the values of the CVP, such as respect, integrity and empowerment, to the facility in every visit.

As with any difficult conversations, there have been times when even the Community Visitors are talked to in a way that is not respectful. Or they have had their right to raise issues challenged.

> "…by focusing on the rights of clients, I was able to bring issues to the attention of services that may not have been noticed. I am hopeful that some of these discussions helped the service improve, while also helping to protect the rights of vulnerable clients."
>
> [Community Visitor]

This year, to keep the Community Visitors strong in their work, the CVP has started professional, external supervision. This helps Community Visitors to better reflect on the work and the best ways to help all parties move forward.

This year, the CVP has also increased the number of people who are available to go into facilities, sometimes at short notice. While there is a small team of Community Visitors permanently employed, the work is also done by casual 'sessional' visitors. The CVP will continue to grow the diversity of the Community Visitors, so that this service can be as accessible as possible.

The CVP has started refreshing and improving the information about the program. The updated CVP website went live at the end of June 2016. Work is also underway to update the CVP's policy manual.

IMPROVING DATA AND ANALYSIS

This year, the CVP has had the first full year in which the visiting and case data of the Community Visitors and CV Panel members has been brought together into a single system.

The CVP is now using software ('Resolve') that is commonly used in other independent statutory organisations in the Northern Territory. Resolve software was developed to provide a data management system for complaints handling and data analysis. The use of Resolve allows the CVP to consider different ways of looking at the data which in turn strengthens the advocacy of the program.

Lastly, the work of the CVP provides confidence that there are independent visitors to vulnerable people in health facilities. It gives confidence that their rights and ability to live their lives fully are important to all of the community. The work of the CVP is, and will remain a strong independent voice for some of the most vulnerable in our community.

> "It feels good when a client says thank you for the things we help them with. Much of our work is about many small changes … bit by bit. But it also makes me very proud to see how some big changes happen, sometimes after years of advocacy."
>
> [Community Visitor]

AMT (INFORMATION ABOUT RIGHTS)

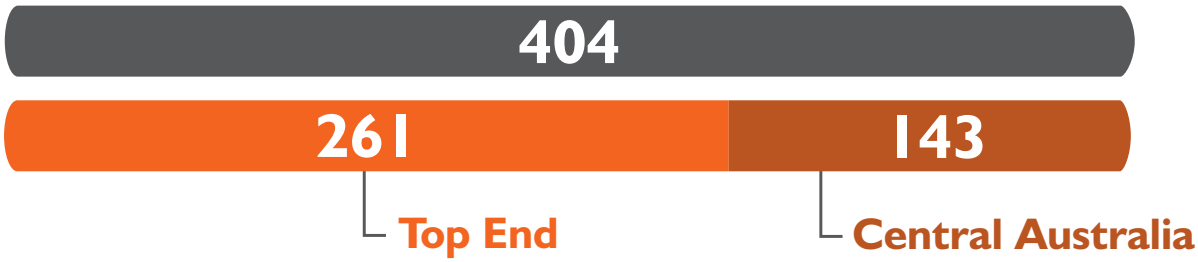
Cyril asked the Community Visitor to help him make a complaint about his time at the Alcohol Mandatory Treatment facility. Cyril did not want his name to be given to the Department of Health. Cyril said that when he was admitted, he was depressed and confused and did not understand why he was being admitted. He remembered being read a statement about his rights. Cyril was upset when he realised that things he had said were in the assessment report for the Tribunal. After the CVP was asked to help, the Department of Health told the CVP that Cyril's feedback would be used to improve the rights statement and educate staff in the AMT facility. (C/2016/00277)

MENTAL HEALTH

TOP THREE ISSUES

1. **Use of interpreters, especially for consumers admitted to hospital in mental health crisis.**
2. **Urgent need for more housing options for mental health consumers to live safely in the community.**
3. **Working with consumers and carers in an open and respectful way, seeing them as equal partners in mental health care.**

Mental Health CVP Cases



Cases Raised By

Mental Health Visits

The Northern Territory mental health service is an important service to the community. It helps people with mental health challenges be able to fully join in the community as much as possible.

There will always be the need for feedback from people who use the service, and oversight from an independent body like the CVP. This helps make sure that service works well. In fact, the independent work of the CVP in this area is part of how Australia meets international obligations to protect people with mental illness.

The CVP would like to acknowledge that, this year, there have been a number of positive changes in mental health services in the Northern Territory. As a result, there have been sixteen CVP (mental health) recommendations closed.

There are more services for youth, especially for children who have to be admitted to a facility.[1] The new youth in-patient facility in Darwin appears to have good ways of working that better meet the needs of young people.

In the Top End, there is also a successful new project called 'SafeCARE Top End'. This project has been designed to improve safety and working relationships of staff, consumers and carers to create a more positive health (therapeutic) environment.

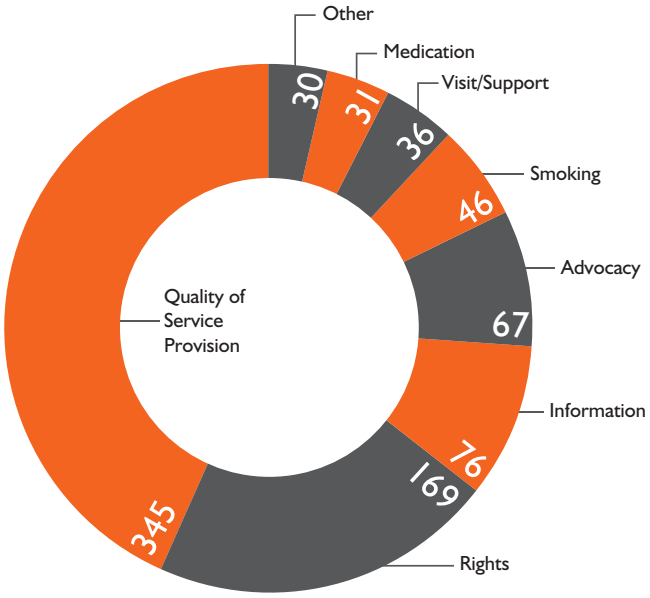
More work has been done to bring the views of consumers and carers into the quality systems. The environment of the mental health facilities is improving, with renovations and some upgrades taking place.

Even so, the work of the CVP goes on, supporting people in raising issues or making complaints if needed. The CVP continues to receive a large number of cases from the weekly visits to the mental health in-patient units in Darwin and Alice Springs hospitals. The CVP's work in mental health area makes up just over half of all cases raised.

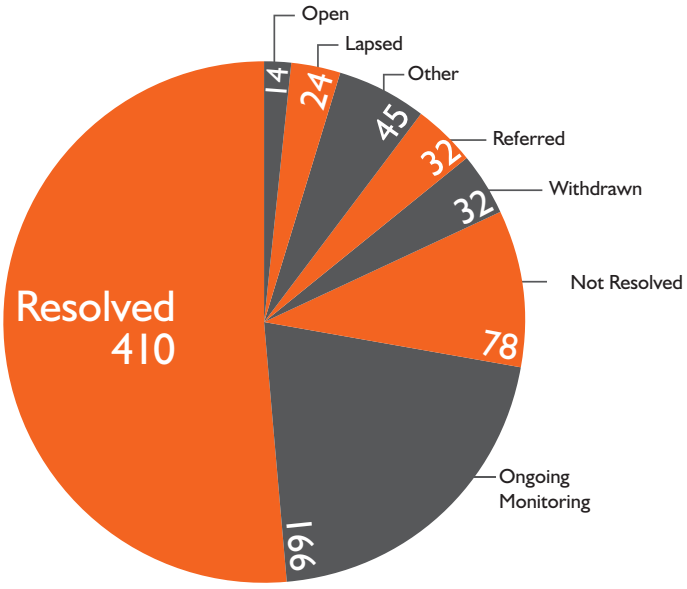
This year, there has been about a 20% increase in the number of CVP mental health cases. Some of this is because the Community Visitors were more careful to always record cases when consumers asked for help to be able to smoke.

The CVP data for mental health this year also shows a much larger number of issues being raised with Community Visitors. The Community Visitors think this is because of how issues can be better recorded and tracked in the CVP's database.

Issues

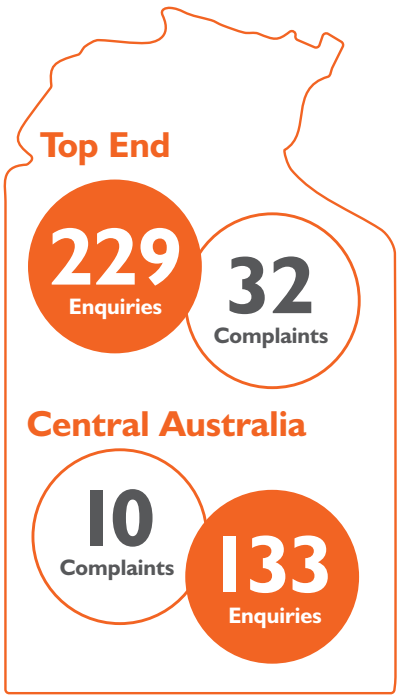


Outcomes



[1] The CVP uses the term 'child' for a person under 18 years of age, and 'youth' or 'young person' for both children and young people aged 12-25 years (unless the age range is specified).

Complaints and Enquiries



"They are brilliant here [in the unit] and so is my case manager in the community." C/2015/550

"The NT mental health service is amazing, I can't believe how easy it was to get help, even in [a small town]." C/2015/635

"People with mental illness just don't have the same experience as other people in hospital and in ED… The way a person with a mental illness is treated wouldn't happen in any other area of health… The things that happened to my [family member], over and over again, is just not acceptable." PC.26082016

The main area which has seen more issues recorded by Community Visitors is about the quality of services (over 120% increase in this area). The issues with the greatest increases were cultural safety, relationships with staff, and planning for discharge. This data has given more weight to the main issues that the CVP is highlighting.

YOUNG PEOPLE'S NEEDS

For many years, the Community Visitors have seen and heard first hand the stories of young people in crisis in a hospital facility, or having trouble getting the help they need in the community. This can be a very stressful time for children and families.

More and better 'early intervention' in the community is the key to helping young people stay mentally healthy into their adult lives. This work needs to happen with the child or young person, their family and in their community.

The CVP raises again the importance of mental health support for young people in the community ('early intervention'). Both area health services highlight their close work with the *headspace* service for young consumers. This service is mostly for young consumers living in Alice Springs or Darwin. Across the Northern Territory, there has also been a small increase in funding to improve services for young people in regional areas (in Gove and Tennant Creek).

"It appears the child [in the unit] is left in limbo due to a lack of other options… a long way from family in an unfamiliar environment."
C/2015/454

While this is good news, there still needs to be more coverage in remote areas of the Northern Territory. In the CVP inspection of a team that provides support to remote communities in Central Australia, it was noted by staff that there is no real ability to provide the same level of mental health visiting support to children living in their home communities.

Young People in Facilities

Sometimes a child or young person is at such a point of crisis or showing signs of mental illness that they might need to be admitted to an in-patient facility (usually a facility for adults). For a child or young person to be held in a mental health facility is a very serious step, which will affect them for years to come.

This year, the Community Visitors were aware that a small number of young children were admitted to in-patient facilities. Some children were in the care of the Northern Territory under child protection laws.

The CVP was very pleased to see the opening of a new youth in-patient program in Darwin. The CVP has raised the need for this for many years. The program has five beds for young consumers, and a good number and mix of staff. The program has been well designed to meet the needs of young people, including planning with families and careful use of medication.

This program is a big step forward for the Northern Territory in mental health support for young people, especially those in crisis or requiring treatment for mental illness. The way in which the program is set up is based on best practice.

"[Staff]: We're worried about [the child] being in here… We are looking at [the child] going to Darwin to the new program there." C/2016/131

The CVP celebrates this new service, along with the carers and young people who are helped by it.

Even with this service, however, it is possible that some children will still be admitted to adult in-patient facilities in crisis (especially in regional areas). This remains a concern to the CVP.

YOUTH DETAINEES

In last year's report, the CVP also raised the urgent need for more services for children who are in youth detention. This serious gap in the service has been raised by the CVP for the past few years.

At the moment, when a child is held in youth detention, the CVP understands that there is only a basic level of mental health care from the area health services. Mostly this is in the area of 'suicide risk' and consultations with the primary health care team.

The Department of Health has recently advised the CVP that there is an 'in reach' service by mental health services to youth detainees. The CVP cannot assess how well this works in practice. Other than suicide risk assessments, there has been no information from inspections of child and youth, or forensic mental health teams of this service being in place.

The CVP notes that the Department of Health has recently advised that it is looking at the procedures for children at risk while in youth detention. This is being done together with the Department of Corrections and the area health services.

Across the Northern Territory, there is no clear information about how the impact of trauma on young people in detention forms part of their mental health care. The type of mental health care that can be provided also has to take into account the young person's offending and their ongoing detention.

'Youth forensic mental health' (that is, mental health care for children who are in detention) is a specialised area of mental health. At the moment, this specialist service for youth detainees does not exist in the Northern Territory. Children who are held in detention fall into a gap in mental health services in the Northern Territory. This gap needs to be closed.

"They ask me lots of questions, but don't help me… when I stay here, I get more and more bad." C/2015/565

CULTURAL SAFETY

There has been a large increase in the recording of cultural safety issues raised by mental health consumers with the CVP. The Community Visitors think this increase is mostly about better recording with the new CVP database. It does, however, confirm the CVP's longstanding history of raising issues about cultural safety in mental health.

Of the just over 400 cases in the mental health area raised with the CVP, nearly 50% are raised by consumers who are Indigenous or culturally diverse.

Around two thirds of the general 'advocacy' issues of the CVP (64%) were raised by Indigenous and culturally diverse consumers. The issues mostly raised were about cultural safety, limits on their freedoms ('least restrictive'), planning for discharge and general advocacy.

This data confirms that visits to mental health facilities are very important to help Indigenous and other culturally diverse consumers. It helps to make sure their concerns are noticed and worked out. That they can speak up and be heard.

Using Interpreters

One of the main themes that came up again this year in the reporting by Community Visitors was the use of interpreters. The use of interpreters is being highlighted in more detail this year. This is because of the importance of interpreter use for quality health care and the wide use of many different Indigenous languages in the Northern Territory.

The Community Visitors often see staff talking in plain English with consumers, and using interpreters. The main concern, however, is that this is not happening all the time in the facilities. Sometimes it depends upon the skills and knowledge of particular staff, rather than it being a standard way of working for all staff.

The Community Visitors work hard to book interpreters, as much as possible, for visits to the mental health facilities. Sometimes, even doing this task can be difficult. This is because the task is based on good information from staff about which consumers need an interpreter.

Community Visitors may hear comments like 'that person speaks good English'. When the Community Visitor then talks to the person, they find the consumer wants to talk and listen in their own language. Another comment from staff might be that the person has 'not asked' for an interpreter. A culturally safe staff member will understand that an Indigenous person might feel 'shame' if they think their English is not good enough.

The sort of English needed for day-to-day talking and listening is very different from that used to talk about personal and sensitive issues in mental health care. For mental health assessments, there can be very serious consequences if miscommunication happens. For Community Visitors, they know that it can be hard to speak up about worries or make a complaint if the person is upset or is finding it hard to say what happened.

"They twist things around. They talk this way and that way and I don't understand what they are saying … I get angry when I don't understand."
C/2015/565

"I want an interpreter because I feel like I can speak more freely."
C/2015/512

"[In ward round] it gets too much, we can't follow what they're saying."
C/2016/375

The responsibility is on all staff to make sure that there are no barriers to communication. If there is any doubt, then booking an interpreter shows that staff care about the person being understood and able to talk freely.

Although this is an issue that is especially important for anyone in a mental health facility, it is also a concern that affects the staff working with consumers who live in the community. The Community Visitors in inspections of community teams have raised cultural safety issues, including the use of interpreters. Consumers living in the community also have the right to health care in their first language.

Understanding Rights in Another Language

Some of the conversations that staff have with consumers are very important, especially when they talk about the rights of a person who has to be admitted into a mental health facility. When this happens, the CVP is given the paperwork ('Form 10') that says whether a person has had their rights explained.

If the person needs an interpreter, this is only recorded on the form in the area about the right to an early hearing at the Mental Health Tribunal. The Community Visitors have noticed that there are only a very small number of consumers who chose to have an early hearing. For those where the paperwork clearly says that the person also needs an interpreter, this number is even smaller.

The right to have an early hearing is a complicated thing to explain. The data from the forms raises the question of whether a person who does not understand English well can fully understand their rights. It is the duty of the service to make sure that consumers know what rights are being explained.

Importance of Indigenous Staff

The CVP has often raised the need for more Indigenous staff, from qualified Aboriginal Mental Health Workers through to liaison staff and cultural mentors.

In the Top End, in particular, the Community Visitors have commented on the positive work of Aboriginal Mental Health Workers in the hospital facilities. In Central Australia, the service has recently told the CVP that it now has a part-time cultural consultant and has employed an Indigenous cadet.

Keeping an eye on growing the skills of Indigenous mental health staff so that there are more Indigenous staff in the future is very important. Most of the staff working in mental health are non-Indigenous, and yet a large number of consumers are Indigenous. This means the focus also has to always remain on how best to keep the service safe for Indigenous consumers.

This means not just cultural awareness training, but also ongoing training so that staff continue to work on their skills with Indigenous consumers. It also includes supervision, supported by Indigenous staff, so that staff can reflect on what could be done differently. It might also mean providing more resources to work better with families who are supporting the mental health staff in their work in remote communities.

This year, the CVP was pleased to see in the Top End the work that was being put into 'Sensory Mob – The Indigenous Way'. This project looks at how Indigenous

"[To CV, with interpreter]: The doctor said to me 'if you don't speak to us, we have to keep you here'… they didn't use an interpreter." C/2015/427

"[To CV, with interpreter]: no one showed me around… I just followed some people and found the activities that way, I really like that space." C/2015/426

consumers in the mental health facilities can have their needs better met. It also looks at how the service demonstrates respect for their culture, health practices and health beliefs.

In Central Australia, the service has advised that the remote team staff have started 'cultural learning days' and it is working with an Aboriginal organisation to improve information and understanding of mental health words in some languages.

These steps show that staff are looking for ways to improve so that Indigenous consumers get the help they need, in a way that makes sense to them. The CVP encourages the area health services to keep on working towards this goal.

> "[He] is not sick enough to be in that place, part of healing would be with family."
>
> C/2016/485

HAND IN HAND WITH CONSUMERS AND CARERS

There is always good feedback that the Community Visitors receive about some staff and their relationships with consumers. This is passed on whenever it is raised, either individually or in the quarterly reports.

The work in mental health can be at times very challenging for staff. The Community Visitors have also noticed that there have been times when staff turnover has been high. Some consumers have even commented to Community Visitors on the staff shortages and talked about their worries for staff coping with big workloads. The compassion and care goes both ways.

While this is clear, there are also times when the cases raised by consumers and carers show that things have gone wrong in the relationship with staff. Like all services, at the core of all good work is the building of strong relationships between staff and consumers.

This means taking the time to hear, to listen deeply, and to try and act in a way that shows no person is more powerful than the other. Keeping the balance equal can be hard, especially when some staff also have the power under law to hold someone against their will.

'Consumers are partners in the management of all aspects of their treatment, care and recovery planning'
(National Standards for Mental Health Services, 2010)

"Staff need to 'meet us halfway', and listen to clients more. We all need understanding, empathy, and compassion and sometimes those needs are not met." C/2016/264

"It feels like 'us' and 'them' – [the nurses] stand on the other side of the glass, and when I need something I am left there standing and waiting until someone looks up." C/2016/259

"It's like you're an inconvenience, you're just a number, it's horrible." C/2015/439

"I'm lonely, I don't know what's going on here, I got no one to talk to." C/2015/563

Consumers this year have told Community Visitors about their wish to be heard more. To have their knowledge of their own illness respected. That their story was not believed, or was misunderstood. That they were admitted to a facility against their will even though they had sought out help.

Once there, consumers wanted to be talked to more as a person, and not a patient. Or felt small, having to stand and wait for someone to notice them at a nursing station. They wanted to get to know their main nurse, to talk about why they are in the facility not just their medication. Or felt worried about what records were being written about them, when they had hardly talked to anyone.

For Indigenous and young consumers, the Community Visitors are sometimes told how hard it can be to sit in a room with lots of staff. To feel outnumbered. Or pushed into agreeing with something, without really understanding what is going on. To be told, or sometimes not even told, what is happening and why.

In over 40% of cases, the only outcome recorded by Community Visitors for relationship worries is 'ongoing monitoring'. This records that the Community Visitor is not sure there is positive change to resolve either this concern or ones like it in the future.

This shows the need for more work from staff to build equal relationships with consumers and carers, where power is shared and not held. This relationship is essential, as mental health care does not happen separate from that person, their family, friends and community.

The right people always need to be at the table with staff, to support the person to safely live and participate in the community. Family, friends and carers know the consumer best. Staff need these strong relationships to provide the best help and make the best plans.

This is especially true when a person has had to be admitted to an in-patient facility. The goal of this admission is to be able to help the person return to their home and community. This goal requires working together, hand in hand.

"It's not what they say, it's how they say it … it makes me think what am I doing ringing for help?" C/2016/205

"I want to let the staff do their job, but we also need information so we don't feel so stressed… Sometimes doctors forget about the power dynamic, and they feel condescending." C/2015/648

"This is not about me and my family member. It's about effecting change because so many people need the change." C/2015/579

Openness to Complaints and Feedback

One of the other ways in which the area health services can show that they want to work in partnership with consumers and carers is their response to feedback and complaints. Often, the Community Visitors hear that a person has decided to give feedback or even make a complaint because they want to help others (even if their situation cannot be changed).

Finding ways to encourage a culture of reacting positively to complaints and feedback, both raised internally and through the CVP, needs to be a priority for services. This year, both the Top End and Central Australia have completed a consumer survey. The Top End has a consumer consultant, and Central Australia has a part-time carer consultant. There has also been work in both services to establish consumer advisory groups.

All this work is positive. However the CVP has noticed that there needs to be more focus on how well the services respond to individual complaints. Some consumers have talked about their fears that raising matters will see them being 'branded' as troublemakers. Or that they will not get a good service if they raise a complaint.

"They don't like it when you tell them that what they're doing is wrong, when you've got an opinion." C/2015/622

"They called me and said 'you have gone to the mental health advocate'. They obviously didn't like that, but I said, 'I know my rights'." C/2015/551

"This is the first time in all my dealings with the system that I feel like people do listen. With the CVP, I don't feel so alone and it's helped me keep going with raising issues." C/2015/579

Complaints in particular are an opportunity to re-build a relationship and provide a better service for the consumer or carer. Formal complaints can be either raised directly with the service, or externally with the Community Visitors. This is part of the role of the CVP under the mental health law.

The Community Visitors and CV Panel members have also noticed that there could be a wider range of ways in which complaints are able to be raised, recorded and followed up quickly. Some consumers feel comfortable with the paper complaint form that is used by the area health services. Some, however, do not.

Some people may not be able, or want to write down a complaint. While the Community Visitor can help them to complete the form, the CVP is not in the facility every day. Some people might prefer to talk it through with another person they trust.

For people living in remote areas and receiving outreach services from community team, there needs to be more creative ways in which the service seeks out feedback from consumers and carers about how to improve.

A PLACE TO RECOVER AND LIVE WELL

Having a place to live that is secure and provides the right kind of support for someone's mental health needs can be the difference between recovery or more illness. Every year, the CVP raises one of the most important issues for helping consumers in the Northern Territory: the need for more supported housing.

Over time, there have been some positive signs that housing and facilities that provide extra support for recovery are part of the core business of area mental health services and the Department of Health. There is now secure funding for the Central Australia 'sub acute' facility. Work is happening for a similar place in the Top End.

This year, there was more funding for the Top End and Central Australia Health Services to employ housing officers. These staff are working to help close accommodation gaps for consumers, in partnership with other agencies. These positions are still being developed but are a good step in the right direction.

Yet the needs of consumers, and worries for their carers about secure housing continue to be raised with Community Visitors and noted by the CV Panels. A number of cases have been raised where people with special needs (for example young people, or

"The issue is that we need funding for his accommodation and support needs on release. Until we get that, I can't safely discharge him." C/2014/100

"I don't want to go back to that house, I want to go back to my family." C/2016/299

those with other health conditions or disabilities that need monitoring) have not been able to get the housing they need.

Some people have had to stay in hospital, on the mental health ward, for longer than they needed. This was because housing and the right support was not available. For others, they were discharged to a place where their carer was very concerned the right support was not there to help the person recover.

This issue requires close work across many levels of government and non-government to get right. It also needs greater funding to meet what can sometimes be very high needs of a small number of mental health consumers.

Every consumer has the right to live with the greatest freedoms possible and to live in the community. When a person is in a mental health facility, the goal is to discharge them; this can only happen if there is a place for the person to go. The CVP will continue to talk about mental health rights as they relate to housing to make this a reality.

THE IMPACT OF TRAUMA

Trauma has a big impact on a person. Trauma can occur at any time in a person's life. If the person who has experienced trauma enters the mental health system, understanding that person's specific experience of trauma and making the right care decisions to avoid causing more harm is very important. Last year, the CVP raised this issue formally in its annual report.

This year, there has been some information that shows the service is trying to better meet the needs of consumers who have a history of trauma. This is particularly true for the Top End Health Service. The new youth in-patient program has clearly been set up in a way that understands how to respond to trauma in children.

Understanding trauma is also clearly built into the 'SafeCARE Top End' project. This project includes trauma informed training for staff. It has put in place a number of ideas and changes that help staff to better support consumers who may have a trauma history.

"I've had some awful things happen to me… I just want them to understand why I reacted the way I did." C/2015/464

"Another time I spoke to a nurse about my previous traumatic experiences and the nurse stated 'that's not trauma'… When you suffer from traumas, the experience should be validated instead of making uninformed statements about trauma impact."
C/2016/308

In line with the project plan, some staff have been given more information about trauma informed care. The CVP would like to congratulate the Top End Health Service, in particular, in its steps towards responding better to trauma as part of its programs.

The feedback from consumers, however, shows that there is a lot more work to be done across the Northern Territory. This is especially the case in how a consumer's trauma history is taken notice of in their treatment plan, and how they are understood as a person and cared for with that history.

The CVP wants to see that trauma informed care happens all the time, for each consumer, without fail. The CVP's priority is also how this sort of care is available for children in the Northern Territory, including those in youth detention.

"The sessions with [nurse] were very useful and I am already looking forward to the next session. Her insight into anxiety was excellent and she is giving me great tools to work with this." V/2016/177

275
seclusion events in the Northern Territory in 2015/16

192
in the Top End

83
in Central Australia

THE USE OF SECLUSION

Seclusion means that a person is locked up alone in a room and cannot leave. All States and Territories have agreed to work towards stopping the use of seclusion and restraint in mental health facilities.[2]

Even so, seclusion continues to be used in mental health facilities in the Northern Territory, and other parts of Australia. The Northern Territory has the highest rate of seclusion events in Australia.[3] Although the seclusion rates between the Northern Territory and other States and Territories of Australia cannot be directly compared, the number of seclusion events remains very concerning.

The CVP has a role under the mental health law to inspect the records of any seclusion or mechanical restraint used in mental health facilities. This is a serious duty. The records are for the most restrictive action that can be done by law in a mental health facility.

The CVP's data from these records is noted here in the report. The comments made in this report come from looking at the records and also individual consumer's files (after they have been secluded). The CVP was also recently advised of a number of Top End Mental Health Service seclusion events that were not on the register at the time of inspection.[4]

This year, there has been a very big change in the number of seclusion events. The total number of events went down by 18% compared to last year. What is most important, however, is that the Top End Mental Health Service reduced their use of seclusion by 88% between the first and second reporting periods of the year.

Even with the additional events recently advised to the CVP, there has been a significant decrease in seclusion events over the year. This has been achieved by the Top End Mental Health Service having a detailed plan in place, the 'SafeCARE Top End' project. The project has excellent leadership by senior staff.

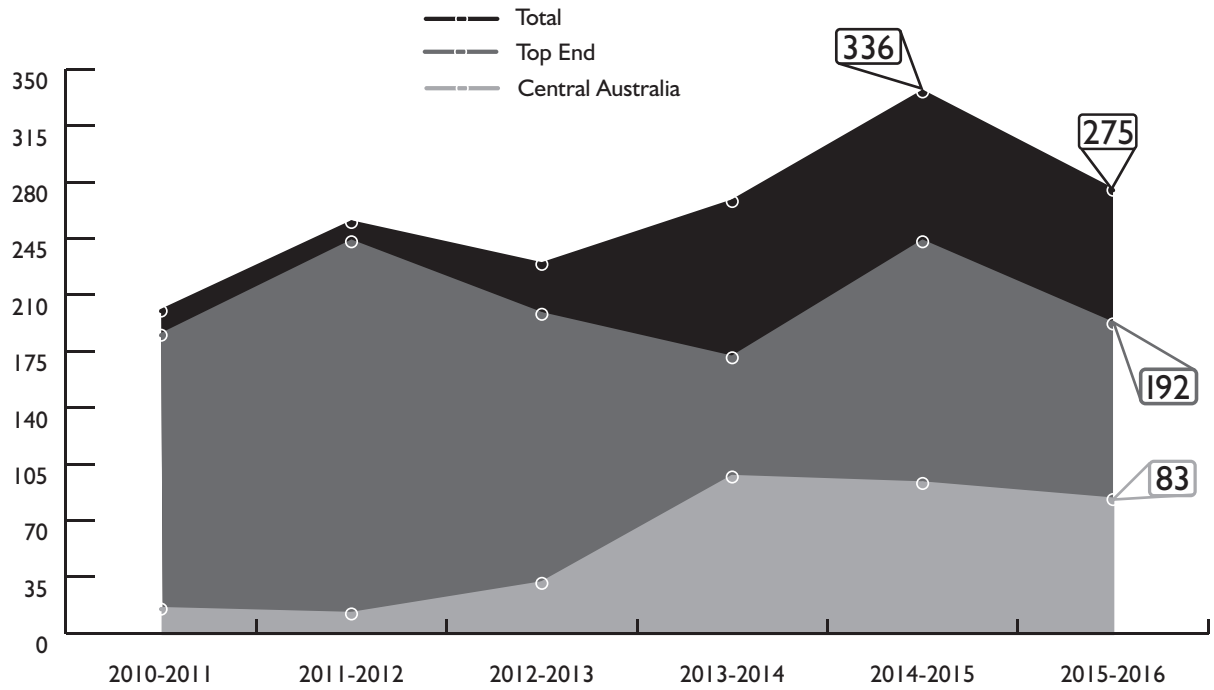
The plan uses ideas from many other health services, including overseas. These have been adapted to the needs of consumers in the Top End. There has been a good focus on how the plan will work with Indigenous consumers. There are more things in the facility that are comfortable. There are different ways to help people feel better (like music, art and craft, and a bush tucker garden).

The changes in the Top End include better training and understanding for staff about the impact of seclusion. The training has also looked at good ways to calm people down, and how to avoid people getting angry or frustrated in the first place. This includes staff using strategies such as 'positive words' in nurse handover.

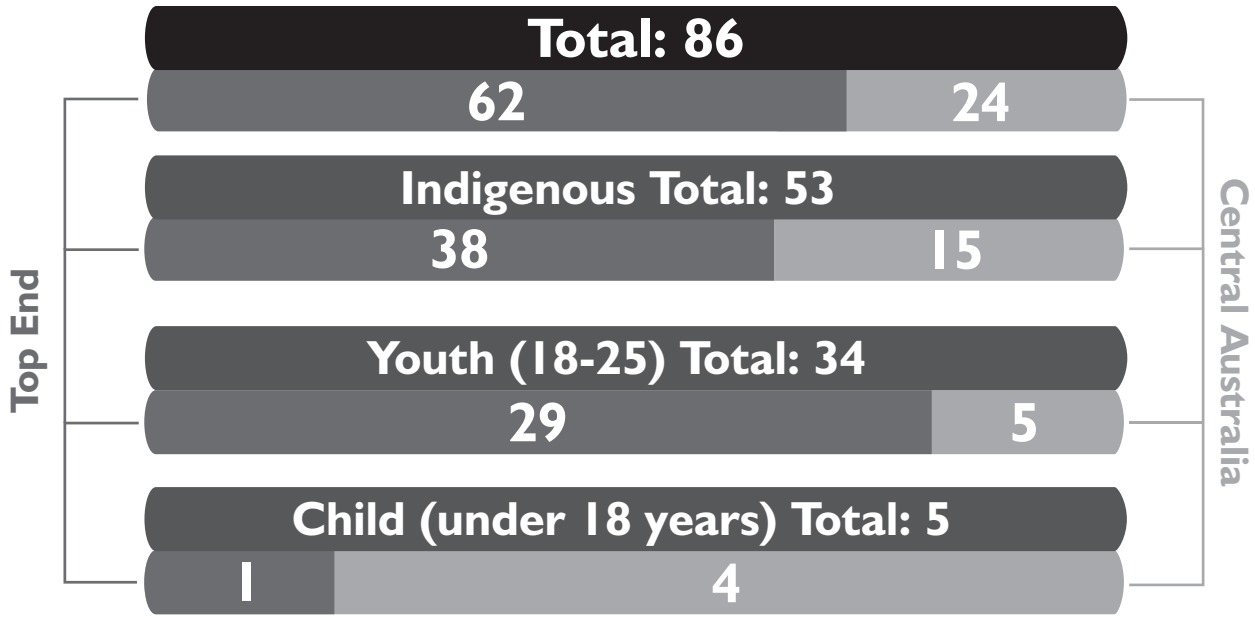
The CVP has been impressed at the Top End Mental Health Service's success in reducing seclusion. While it is only early days, this a good news story for the Northern Territory. It shows that with a strong focus on the task, seclusion can be reduced and even stopped. This makes mental health facilities safer for consumers and staff.

The CVP encourages the Top End Health Service to continue this project into the next year. The CVP highlights that this work in the Top End will be very helpful for Central Australia as it continues with its own 'SafeCARE' project.

Seclusion Events by Financial Year



People Secluded 2015-2016



[2]Council of Australian Governments (COAG) (2013), Response of the COAG to 'A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention' – A report by the National Mental Health Commission. Accessed at: https://www.coag.gov.au/node/515.
[3]Australian Institute of Health and Welfare (AIHW), Use of restrictive practices during admitted patient care, 2014-2015. Accessed at: http://mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices/.
[4]The data related to the 24 events has been included in the graphs and statistics in this report, however the events have not been inspected in depth by the CVP.

Seclusion of Disadvantaged Groups

The CVP pays close attention to any seclusion events for children and young people. The use of seclusion is known to cause trauma. It does not help consumers get better (it is not 'therapeutic').

The CVP continues to put on the record that there needs to be more procedures in place about the use of seclusion of young people. Ideally, there should be no seclusion of children in mental health facilities.

The CVP also notes that all behaviours of concern have a function. Behaviour that might lead a staff member to consider the use of seclusion needs to be thought about from the consumer's eyes. It needs to be understood through the consumer's history, from childhood right to their admission into and care in hospital.

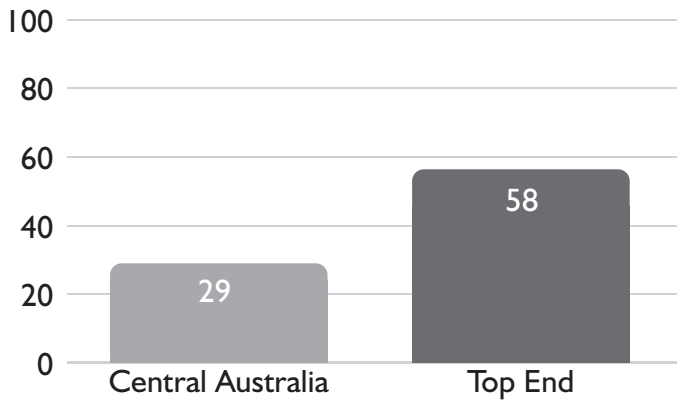
When a person is from a different culture, or speaks a different language, this can be harder to do. Some of the records looked at by Community Visitors this year (especially in Central Australia) showed that there needs to be more focus on making sure that a person's first language is known and recorded.

There also needs to be a stronger focus on using interpreters and involving Indigenous staff. Every person who is secluded should be talked to about the event later. What might have worked for one person may not for another.

Looking at the success in the Top End this year, there are very good signs that the Northern Territory can take a national leadership role in showing the way for reducing seclusion. This work needs to keep the light on reducing seclusion, especially for particular groups of consumers who may need extra support.

> "He threatened to put me in seclusion … sometimes people who are sick in here might swear, but staff need to cope with this, they're just words"
>
> C/2016/264

Seclusion Events Over 4 Hours 2015-2016

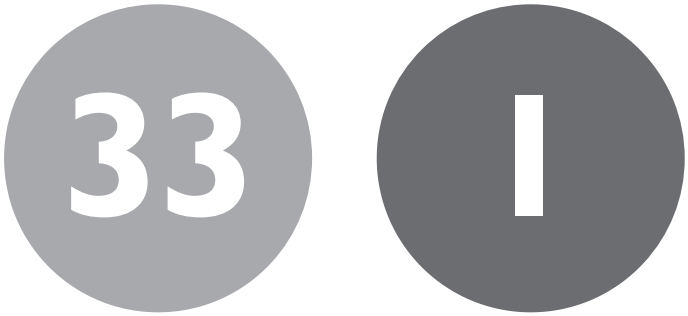


32%

of all seclusion events went for longer than

4 HOURS

Number of Seclusion Events of a Child



Central Australia **Top End**

12%

of all seclusions were of a

CHILD

62%

of all people secluded were **Indigenous**

5

children (under 18 years) were secluded

34

youth (aged 18-25 years) were secluded

"[Teenager]: It all just happened so quickly, they all crowded into the room, **I yelled at them and told them 'don't touch me'**, but they got hold of me. … Maybe I deserved it … but no one does really. I can see how it happened but they all came in and made it worse"

C/2015/533

"[Woman restrained]: **They were too rough…** there was two men on me"

C/2015/541

SERVICE SNAPSHOTS

TOP END MENTAL HEALTH SERVICE

Achievements:

- 10 CVP recommendations closed. The Panel closed a number of recommendations that had been open for many years (about discharge planning, use of Aboriginal staff, and information for consumers).
- Opening of a new Youth In-Patient Program (YIPP) to provide special care for consumers under the age of 18 years, separate from the other wards with adults. The program is going well, and has a good mix of staff.
- Good success with the seclusion reduction project ('SafeCARE Top End'), with a big decrease in seclusion events especially in 2016.
- Work to make the 'SafeCARE Top End' project culturally safe (the 'Sensory Mob' work supported by a leading international Occupational Therapist).
- Return to using a special room in the Joan Ridley Unit (JRU) for consumers to relax in (the 'wait a while' room).
- A new consumer advisory group started.
- Lots of positive things to do in the activity centre in Cowdy ward, including a garden.
- Aboriginal Mental Health Workers (AMHWs) work well with consumers, and the workplace is flexible so that some AMHWs can work on weekends.
- Return of a trained nurse to provide psychotherapy to consumers on the ward.
- Beginning of much needed renovations to the JRU.
- Involuntary consumers, with a doctor's approval, can now have short periods of unescorted leave (which can be used to smoke).

Areas for Improvement:

- Consumers and carers often tell the Community Visitors that JRU feels 'prison-like', and that there is not enough to do there while the person tries to get better. Some people may spend a long time in JRU. Some women have reported not feeling safe, and their shared room is cold. The facility is not as clean as it needs to be, and some bathroom door locks are broken. While the CVP welcomes the renovations, there is a lot of work needed to make the JRU the best 'low stimulus' area that it can be.
- While there is now a staff person who offers activities in JRU, this is still not happening as often as it should be. Consumers also often complain about not having enough time in fresh air.
- The 'high dependency unit' of Cowdy ward is not a welcoming space for any consumers who have to stay there. The Panel wrote that it is 'bleak'.
- The Cowdy ward has had a long history of problems with the water pressure and temperature in showers. This upsets consumers and needs to be fixed.
- Making sure that processes are in place so that internal complaints can be made by consumers privately, and are well followed up.
- The service has to let the CVP know if someone is detained against their will ('involuntary treatment'). This year there have been problems with the information coming through to the CVP regularly (although it has improved recently).

TOP END MENTAL HEALTH SERVICE CONTINUED

- Many consumers who are smokers, especially those in JRU, are frustrated about not being able to smoke. Some say that things like nicotine replacement do not work for them to manage their addiction when they cannot smoke.
- It is important to be respectful of the role of the CVP to help consumers and carers.
- That the seclusion register be carefully maintained as current and complete record for inspection by the CVP.

Priority Concerns:

- People who do not have English as their first language have the right to understand and take part in decisions about their health. The Community Visitors have noticed a number of concerns about the use of interpreters in the Top End. The records about the interpreter bookings have not been reliable at different times. It is therefore not possible to know with confidence how often interpreters are booked. Sometimes Community Visitors have noticed that someone has not yet seen an interpreter even though they have been in the in-patient unit for many days. It is important that health professionals make sure that the person's right to talk and listen to staff, especially at key points, is noticed and acted upon by booking an interpreter.
- Staff need to be more aware of the power imbalance between them and the carers and consumers. Some consumers and carers have felt like their knowledge has not been part of treatment planning. Some have felt talked to, rather than with, so have switched off from treatment plans. Some people have felt very afraid of being involuntarily treated or held, especially if they have made the first steps or are thinking about seeking help from the service.

"These people here in Cowdy ward, they are my saviours. I was back home, but I wasn't 100%. I needed a safe place to come, I feel really good here." C/2016/00394

"It has changed so much, the nurses they have now are wonderful. I mean there were always good nurses around… [but] it's such a friendly place now. I am really happy with being here." C/2016/325

"I have enjoyed helping in the garden at the Activities Centre. Also they are giving me a proper discharge plan so I can get ongoing support, so everything will be ok when I get out." C/2016/180

CVP RECOMMENDATIONS TOP END MENTAL HEALTH SERVICE

		Made By	Date	Status
1	That a comprehensive accommodation and support model is developed, adequately resourced and provided in the Top End of the Northern Territory. (Reworded, 2016)	CV Panel	Nov 2006	Open
2	That the Mental Health Service ensure that interpreters are present at assessment for all consumers whose first language is not English. It is further recommended that interpreter assistance is then arranged for all further assessments and to assist the consumer at any hearing before the Mental Health Review Tribunal.	CV Panel	May 2007	Open
3	That the service provide evidence that in the process of involuntary admissions that there is adequate explanation of rights to consumers, including legal status on admission, offering of interpreters and early access to the Mental Health Review Tribunal. (Reworded, 2016).	CV Panel	Nov 2011	Open
4	Provide education to all staff working in the Joan Ridley Unit (JRU) on the expectation of the Approved Procedures to notify families/carers and adult guardian of seclusion events.	Community Visitor	Nov 2012	Open
5	Strategies to ensure the cultural safety of clients with a particular focus on the needs of Indigenous clients in line with Top End Health Service-Mental Health values and objectives.	Community Visitor	Nov 2012	Open
6	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.	CV Panel	Apr 2013	Open
7	That Top End Health Service-Mental Health considers strategies to reduce the number and length of seclusion events for young people and involve child and adolescent approved psychiatric practitioners (APPs) in the assessment and strategies for alternative interventions.	Community Visitor	May 2013	Open
8	That the involvement of clients in their care planning becomes a proactive feature of treatment (Katherine Mental Health).	Community Visitor	Jan 2015	Open
9	That all clients have a clearly identifiable care plan which is readily accessible to any staff providing care and the client him/herself (Katherine Mental Health).	Community Visitor	Jan 2015	Open

"You never have to ask twice, and I can see that they are short staffed." C/2015/550

"I've got nothing but compliments for the [staff], every time I've spoken to them, they've had time to talk." C/2015/558

"The allied health roles are really important, there needs to be more allied health as they keep the day full. The Occupational Therapist has really helped with preparation for my discharge." C/2016/259

CENTRAL AUSTRALIA HEALTH SERVICE - MENTAL HEALTH

Achievements:

- 6 CVP recommendations closed.
- New 'swipe card' access to bedrooms, making the space feel safer (especially for female consumers).
- Consumers often make positive comments about the allied health staff, and the work they do, in the mental health unit.
- Wide range of activities for consumers, including trips out of town, regular walks, cooking and games. This led to a recommendation about activities being closed, which had been open for many years.
- Good record of making sure the CVP is told about people admitted to the in-patient unit against their will ('involuntary treatment'), which led to a CVP recommendation being closed.
- Continued work to improve cultural safety, including staffing (part-time) the cultural consultant position, two new Indigenous staff at the sub-acute facility, new Indigenous trainee/ cadet positions, and working with other non-government organisations (the NPY Women's Council and the Royal Flying Doctor Service).
- A Housing Working Group has been formed with other non-government organisations.
- The service has been working hard to help a long term young person on the ward achieve a safe discharge with the right supports in place.

Areas for Improvement:

- Return to the policy of having the main door to the mental health unit being unlocked. This year it was locked for most of the time, which had a big impact on consumers.
- Making sure that consumers' possessions are always kept safe.
- Increasing the number of Indigenous staff across the service, in particular in the forensic, community, and child and youth teams, and the mental health unit.
- Making sure that the in-patient unit in particular is fully staffed.
- Improving the response to complaints (internal and CVP), including making sure that there are a range of ways in which making a complaint is supported and that the complaint is dealt with quickly and with an open mind.
- Improving contact between consumers and professional staff in the in-patient unit, especially for consumers with anxiety, depression and/or suicidal thoughts.
- Better ways of engaging with young people in assessment and review, in particular having less staff involved so that young people feel safe to participate.
- That the seclusion register be carefully maintained as a current record for inspection by the CVP.

Priority Concerns:

- Together with the Office of Disability, urgently moving forward with helping the long term young consumer with a disability to live in the community.
- Funding to meet the unmet mental health needs of young people living in remote areas and those who are detained in youth detention facilities.
- Continuing to focus on ways of reducing seclusion, in general but especially for young people, paying particular attention to what has worked in the Top End's SafeCARE project. In this year, the CVP notes that 4 children were secluded in Central Australia, and 41% of seclusion events happened to children (because of the high number of seclusions for one child).

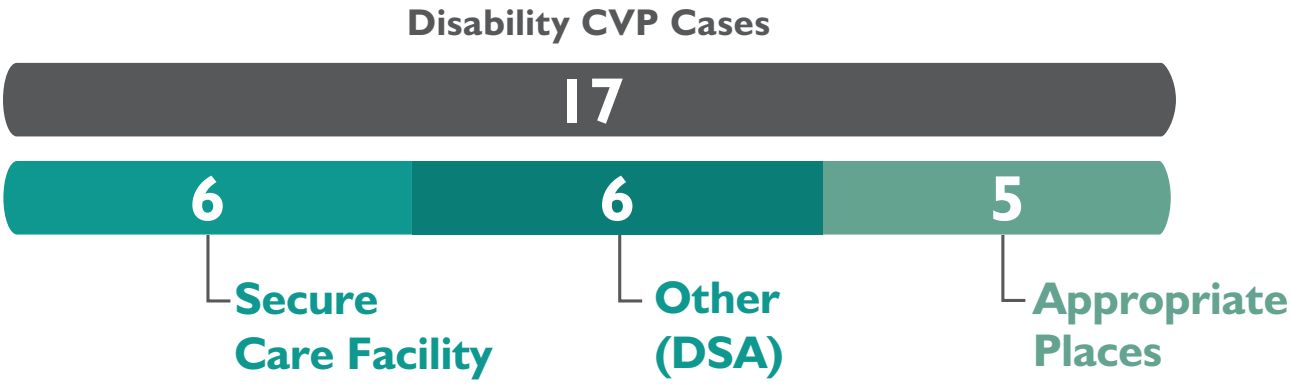
CVP RECOMMENDATIONS – CENTRAL AUSTRALIA HEALTH SERVICE – MENTAL HEALTH

		Made By	Date	Status
1	That the Remote Team advise the CVP on how feedback and complaints will be gauged and recorded, even if written feedback forms are not utilised.	Community Visitor	Nov 2013	Open
2	That there be a focus on what early intervention approaches the Child and Youth Team could implement, including contributing to early intervention programs, for its clients.	Community Visitor	Nov 2013	Open
3	That the Child and Youth Team and the Remote Team (with the CVP) do an analysis of clients by nationality/heritage and investigate the number of clients under 18 years being seen by the Remote Team to gauge whether or not there is a group of Child and Youth Team clients 'missing out' on services.	Community Visitor	Nov 2013	Open
4	That the Mental Health Unit review its seclusion practices and introduce strategies aimed at reducing the rates of seclusion, with a special focus on de-escalation techniques. (Reworded)	CV Panel	Dec 2013	Open
5	That significant efforts are made to recruit to the Aboriginal Mental Health Worker position within the Forensic Mental Health Team.	Community Visitor	Aug 2014	Open
6	That the Central Australia Health Service (Mental Health) develop and implement an action plan to reduce seclusion incidents.	Community Visitor	Mar 2015	Open
7	That specific policies and procedures relating to the seclusion of minors are developed by the Department of Health and/or the relevant health service. (Reworded)	Community Visitor	Mar 2015	Open
8	The Panel supports the ongoing efforts of the Mental Health Unit to work out the best possible future option for the long term High Dependency Unit (HDU) patient, and recommends that the issue be closely monitored in a mutually cooperative approach with Disability Services.	CV Panel	Jun 2015	Open
9	That the Mental Health Unit continue to monitor the issue of interpreter attendance and work closely with the Aboriginal Interpreter Service to ensure that all three major Central Australian languages are covered with intensive mental health training.	CV Panel	Nov 2015	Open
10	That steps be taken to ensure that clients' complaints be facilitated until resolution is achieved and outcome recorded.	CV Panel	Nov 2015	Open
11	That Mental Health Unit seclusion be authorised in line with Section 62(4) of the Act which reads: A patient may be kept in seclusion only where it is approved: (a) By an authorised psychiatric practitioner; or In the case of an emergency, by the senior registered nurse on duty.	CV Panel	May 2016	Open

DISABILITY

TOP TWO ISSUES

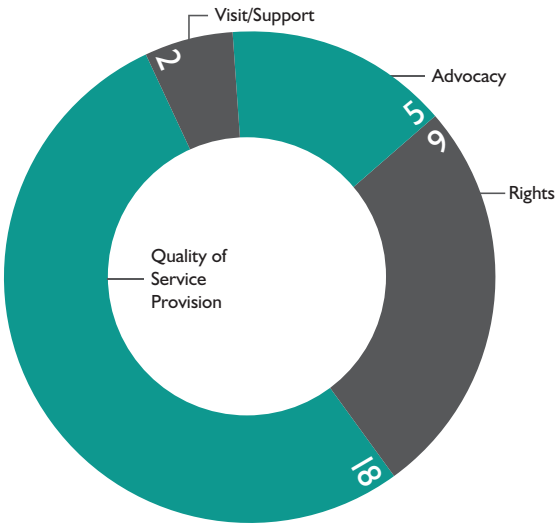
1. **People living in specialist disability places need more (carefully planned) opportunities to try living safely in the community.**
2. **There needs to be better systems in place for care and treatment of people in specialist disability places, especially independent reviews of the positive behaviour plans, planning for supported return to the community, and risk management.**



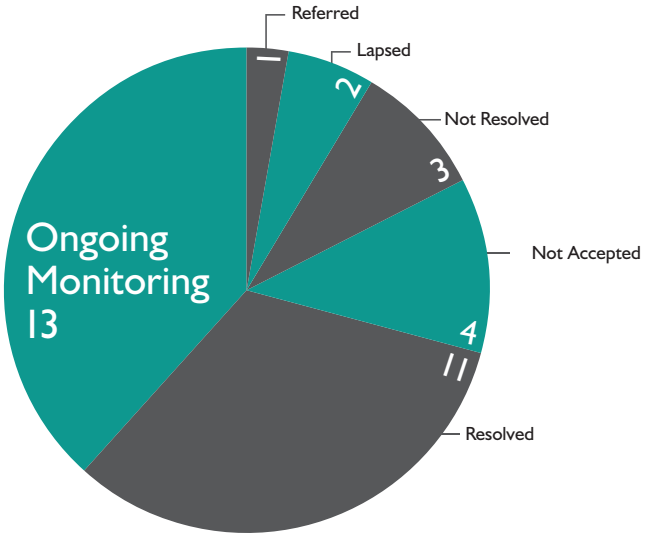
"[CV]: I always receive a warm welcome from staff"
VIS/2015/355

"[CV question about staff]: Yeah, they're ok, it's alright"
VIS/2015/372

Issues



Outcomes



The CVP has a role in visiting and looking out for people with disabilities who are under 'specialist' disability services in the Northern Territory. This year the number of people with disabilities covered by the CVP's work increased.[5]

The main places that the CVP visits are the Secure Care Facility (in Alice Springs) and a facility next to the Darwin Correctional Centre (called 'the Cottages'). A small number of other people with disabilities are also covered by the *Disability Services Act*. For some, their day-to-day care may be provided by another party however the Department of Health has responsibility for their care and treatment.

In every report that the CVP has sent to the Office of Disability this year, the Community Visitors have talked about the good relationships that people with disabilities in the facilities have with staff.

There is lots of information that shows people in the facilities are taking part in activities in the community, or visiting family and friends. This gives people a more independent life with everyday experiences, which is very important to them.

The work in the specialist disability area is sometimes very difficult. Sometimes staff have been hurt, or needed police or prison officers to help them deal with behaviours. Yet staff will return to work and continue to talk, laugh with and support people with complex needs. The CVP would like to thank the Office of Disability, particularly the disability support workers, for their daily work for people with disabilities in their care.

The CVP would also like to acknowledge that this year has been very busy for the Office of Disability, as it works towards the rollout of the National Disability Insurance Scheme (NDIS) in the Northern Territory.

"I'm getting a big cake tomorrow, it's my birthday"

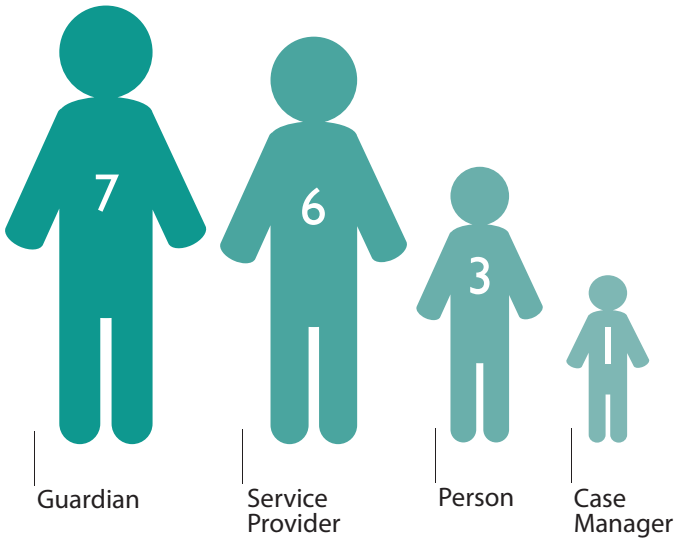
VIS/2016/90

"[CV]: He gave me a thumbs up and waved goodbye"

VIS/2016/203

[5]The Office of Disability has advised the CVP that in 2015-2016, there were 14 clients covered by the *Disability Services Act*. These clients were in the Secure Care Facility (5), in an appropriate place (3), in 'other premises' (2), under 'specialist outreach' services (2), and in the Complex Behaviour Unit located at the Darwin Correctional Centre (2).

Cases Raised By



This year, there has been a small rise in the number of places visited and the total number of cases received by the CVP in the specialist disability area. More issues have been raised by interested parties (such as the person's guardian or staff). This is a good sign that the CVP is being used by more people.

Some of the cases were also raised by the Community Visitor, if they noted particular issues during the visit. As people in disability facilities and houses are especially vulnerable, this is one way in which the CVP records its actions to look after the person's individual rights or interests.

A few cases were not able to be accepted by the CVP for further follow up. This is because the CVP does not have a role for people who do not *live* at the facility or house. Even if the case cannot be accepted, the CVP still notes the issues that were raised. All enquiries and complaints help the CVP to better understand specialist disability services.

TO BE A 'FREE MAN'

Importantly, two of the cases raised by people with disabilities were about the person wanting to be a 'free man'. Both people were living in the more restrictive Secure Care Facility. Both were under orders to live there from the Supreme Court.

The law that requires a person with a disability to stay in a specialist facility protects both the person with a disability and the community. These decisions are made by a Court. In order to move on from the more restrictive places, the Court makes the final decision about when a person with a disability can live somewhere with more freedoms.

The Court does so, however, using information given to it by the Office of Disability. This means that the Office of Disability's planning, programs and documents for that person are very important to what the Court decides in its annual review of a person's order.

For the people with disabilities themselves, who have complex 'cognitive impairments', it can be very hard to understand why they are being held somewhere

"I've been here a long time, I want to go home, be a free man" C/2016/319

"[Staff:] he won't tell you this, but he keeps asking to see his family" C/2015/573

(but not in prison). They will often understand, in general, that a judge has made an order. It may be very difficult for them to understand how their behaviours on a daily basis relate to the order.

What is important for people in specialist disability facilities is that they can live a regular, everyday life as they choose. To live as a 'free man'. Being able to do this is a basic human right for all people. Article 14 of the United Nations Convention on the Rights of Persons with Disabilities specifically talks about people with disabilities not being held against their will without good reason ('arbitrarily').[6]

"I want to live in town, get a house… I could live with my uncle" C/2016/44

"I like going there [transition house]" VIS/2016/196

Article 26 talks about people with disabilities having the right to be as independent as possible, living in the community in a full way.[7] This part of international law also raises the importance of 'rehabilitation services' (such as that provided in specialist facilities) being based on the person's individual needs and strengths.

At a national level, in 2014, all States and Territories agreed to a national framework to reduce and stop the use of 'restrictive practices' for people with disabilities.[8] This agreement is based on the human right of people with disabilities to have freedom of choice and independence. It also puts forward that, as a starting point, people with disabilities can make decisions about their life or, if not fully, join as a partner and be supported to make those decisions.

MOVING TO LESS RESTRICTIONS ('TRANSITION PLANNING')

With that bigger picture in mind, the CVP has kept its focus this year on how the Office of Disability has been working to help 'transition' people with disabilities that are under their direct care. This means the ongoing work to help them be ready to live in the community with the right support.

When people with disabilities are moving from prison to a secure disability facility, this is a positive step towards more freedoms for the person. This year, the Community Visitors noted that a small number of people moved into the disability facilities from prison, and a smaller number again moved back to their community.

Unfortunately, some people have also had to move back to prison after spending time in the care and treatment of the Office of Disability. This shows how much is at stake for the person with disabilities when they come into the care of the Office of Disability. The CVP will be looking at this more closely next year.

For the past year, the CVP has had concerns that there were no transition plans for people to move to community-based accommodation. This has now changed. There is now a written 'transition plan' for each person in the Secure Care Facility.

Each of the transition plans are, however, very short and mostly the same. The plans have very little information about the individual person and their transition needs, in the plans. Making sure that all plans are unique for the person is a core part of any work with people with disabilities.

The plans also rely on houses being available in the community for people with disabilities to live. In Alice Springs, the Secure Care Facility has started to use a house owned by the Department of Housing, and leased to the Office of Disability. Staff stay overnight with the person, and make sure that the person is

[6]United Nations, 2006. Convention on the Rights of Persons with Disabilities. Accessed at: http://www.un.org/disabilities/convention/conventionfull.shtml
[7]United Nations, 2006. Convention on the Rights of Persons with Disabilities. Accessed at: http://www.un.org/disabilities/convention/conventionfull.shtml
[8]Australian Government, Department of Social Services, National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector. Accessed at: www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/national-framework-for-reducing-and-eliminating-the-use-of-restrictive-practices-in-the-disability-service-sector

"[About transition place]: it's a big beautiful house"

VIS/2016/90

supported. This is a very good step, and the people with disabilities clearly enjoy living in this house.

There is, however, only one house available. This presents a practical problem. With three people all staying (on separate days) in the one house, each person using the house for transition cannot complete the next stage of their individual transition plan.

In the Top End, there are similar issues with any plans to move people from the Darwin 'Cottages' to places closer to the person's family and community. Although not every person is ready for this yet, for those who are, there does not seem to be progress towards making this happen.

The CVP has been told by the Office of Disability that they are seeking more leases for houses in Alice Springs. In the Top End, the CVP has been told about attempts to find a house closer to a person's community.

Doing whatever is required to find and secure the right 'step down' housing has to be a bigger focus of the Office of Disability's specialist disability work. Without more houses being leased, or other solutions put in place, people in specialist places cannot move safely through to everyday community life. Finding practical solutions is necessary for the specialist disability work to be meaningful.

POSITIVE BEHAVIOUR WORK

Each person in a specialist disability place has a 'positive behaviour support plan'. These plans are at the centre of their care and treatment. The plans guide the disability support workers on a day-to-day basis, and set out what the professional staff believe can be achieved for each person. By law, the plans also have to be reviewed at least once a year.[9] This helps keep the plans relevant and useful.

The observations of CV Panel members, Community Visitors and other key people (such as guardians and staff) are that some people have improved their behaviours. Some people have made good steps forward. These achievements are celebrated, and are a credit to the work of the staff.

At the same time, in the CVP's view, the strengths that the person with disabilities have shown also need to be more formally recorded. Their daily achievements need to be bought into reviews of that person's behaviour so that the plans look at all aspects of the person.

The CVP has noted that the plans and other records kept about people in care do not draw upon this 'strengths' based way of working. The purpose of the specialist disability work is to assist people to develop better skills to manage their needs. It is very important therefore that good records of positive behaviours are kept.

The plans are also meant to be unique to the person. They are meant to be very detailed about exactly what behaviours the person is using to get their needs met ('functional analysis'). The plans should clearly set out what will be done to help the person

"[From activity reward]: I got a new bike, look" VIS/2016/139

"I've got a gardening job" VIS/2016/204

[9] *Disability Services Act*, section 39(1).

"[Staff, in response to question about client reviews:] it's mostly done by email or phone" VIS/2016/57

develop better ways of meeting their needs. In order to record the person's progress over time, the plans need to say how data is being collected at the beginning of and throughout the plan.[10]

Last year, the CVP wrote in detail about concerns that the plans in specialist disability places did not have this level of detail. There is no change this year in the amount of information in the plans looked at by Community Visitors. Some Community Visitors also noted that some plans did not seem to be current for the person.

A good example of this in the Secure Care Facility, where the plans suggest ways of working that do not seem to be in place when the Community Visitors ask about how well these ideas work. In the same way, the person's progress with their daily activity program, which for some can be very positive at times, does not seem to form part of their plans. This means that the plans are not as useful or relevant to the person and their disability support workers.

At present, there is no way for the plans to be independently reviewed other than the comments of the Community Visitors. From the CVP's view, the *Disability Services Act* included an independent way to review the plans through a 'Review Panel'. The CVP has been talking with the Office of Disability for many years about getting this Panel established.

This year, the CVP has been told by the Office of Disability that, by law, this Panel only has to review plans when they include 'restrictive interventions' and someone requests it. As people with disabilities in specialist places are vulnerable, and the quality of their behaviour support programs is so important to the person's ability to achieve more freedoms, this is a major area of concern to the CVP.

FRAMEWORKS FOR CLIENT CARE AND SAFETY

The Office of Disability is responsible for safety of all people in specialist disability places. The Office of Disability is also responsible for the overall care and treatment of people with disabilities living in or visiting those places as part of a transition plan.

The CVP knows and respects that care and treatment decisions rest with the Office of Disability professional staff. It is important, however, that the day to day work of these professional staff happens within a strong framework ('quality assurance'). The Office of Disability is not part of the Top End or Central Australia Health Services. It therefore has to have its own quality frameworks.

"[Staff:] He jumped the fence and threw rocks at cars" VIS/2015/419

"[Staff]: We called the police" VIS/2016/196

The CVP has been looking at the Office of Disability's quality frameworks, as these have a big impact on the care and treatment of people. This is part of the independent role of the CVP. The quality frameworks also help staff be clear about what their job requires of them.

In some cases, people with disabilities living in specialist places have behaved in very unsafe ways. The behaviour may have been enough

[10]These comments are based on best practice standards regarding positive behaviour support work. An example of the best practice standards referred to is: Victorian Department of Human Services (2011), Positive practice framework, accessed at: http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/reports-publications/positive-practice-framework-ppf.

that the Office of Disability staff might need to contact the police or arrange for the person to return to the prison for a period of time.

In this year, the Community Visitors have also noticed that there have been more people with disabilities living or visiting specialist disability facilities, yet considered by the Office of Disability to be under the care and control of others. These other agencies are usually either forensic mental health or corrections.

All of these different arrangements for care, and movement between care of the Office of Disability and another agency, make for a potentially complicated, confusing situation. This can lead to safety risks. In the specialist disability work, these kinds of risks to safety can be expected as the people in care have known unsafe behaviours. As a result, it is very important that there are good systems in place to address care and safety issues. At present, the CVP is not sure that enough safety processes are in place.

On a practical level, for a number of years the CVP has raised concerns about the duress alarms not working well enough in the Secure Care Facility. This year, the Community Visitors also raised some concerns about planning for safety when people with disabilities are living in or visiting the community. Some staff have found themselves in situations that were unsafe, and injury or a 'near miss' happened as a result.

There is some evidence of the risk systems in place (such as the use of the incident recording system, Riskman). The Office of Disability has recently advised the CVP of some of the processes that it considers to be part of its quality frameworks. The CVP has formed the view that these processes are not strong or detailed enough.

Of greatest concern in the quality frameworks are: the review of positive behaviour plans, how well the plans are put into place, safety planning, and the quality of care planning within and between the Office of Disability and other agencies.

> "I've got a pain, I hear voices in my head" VIS/2016/204

THE PERSON AT THE CENTRE

The Office of Disability needs to have very good arrangements in place to make sure that the care of the person with disabilities is consistent. A person cared for by different agencies is still the same person. Every action that another agency takes in relation to that person will affect the other agency's care as well.

It is very important therefore that there is a 'person-centred' way of looking after people moving between the general care and facilities of different agencies. The Office of Disability is the main agency that looks out for the care and treatment of people covered by the *Disability Services Act.*

The CVP is interested in how the Office of Disability is making sure that care by other agencies fits in with their goals for that person's care and treatment. In the CVP's view, the Office of Disability has a role to push for that person's care goals to be also a part of the care plan of other agencies. This area will be a focus of the CVP in the year ahead.

> "[Staff]: He's back in prison… he threw a stone when he was out and hit [someone]… they're laying charges"
> VIS/2016/90

PROTOCOL BETWEEN THE CVP AND OFFICE OF DISABILITY

The law requires that the CVP be given 'reasonable assistance and cooperation' to do its work under the *Disability Services Act*. For the past two years, the CVP has talked with the Office of Disability about the importance of getting good information about who the CVP is responsible for visiting.

Importantly, a small number of cases this year have asked the question whether someone receiving support from the Office of Disability might be covered by the CVP (that is, whether legally the CVP has a role for that person).

In this year, the CVP was told about a further four people with disabilities who are receiving direct support from the Office of Disability. For different reasons, there were still challenges in the Community Visitors being able to do their work with two of these people.

As mentioned above, there are also some people who are under the care of other agencies visiting or living in the disability facilities. It is very important, therefore, that the role of the CVP in relation to these people with disabilities is clear.

The CVP and the Office of Disability have signed a protocol in early 2013. As issues have come up with information and advice about people in disability facilities and houses, the CVP has requested that this protocol be updated. Progress with updating the protocol has been slow. The CVP has recently made a formal recommendation to prioritise this.

"[Staff, in response to question about client reviews:] it's mostly done by email or phone" VIS/2016/90

"Speak to my guardian, tell her what I told you"
C/2016/161

"I went home this week, I saw my family, listened to music, watched the footy there"
VIS/2016/204

"I took lots of meat for my family, I was the BBQ cook"
VIS/2016/204

SERVICE SNAPSHOTS

SECURE CARE FACILITY

Achievements:

- 2 CVP recommendations closed.
- Good mood in the facility, with staff and people in the facility getting on well.
- Lots of activities, with the plans for the activities being well designed for each person in the facility.
- People in the facility continue to have lots of time spent out in the community doing different things, including catching up with family.
- Some people from the prison are now doing 'jobs' around the facility, which gives people in the facility more contact with other Indigenous people in their 'home'.
- Some people in the facility have made good steps in showing positive behaviours in what previously had been very difficult situations for them to manage well.

Areas for Improvement:

- The complaints register needs to work in a way that records the full range of worries or concerns that people in the facility raise (that is, using a better definition of what is a 'complaint' because the people in the facility have a disability).
- An agreement was signed between the CVP and the Office of Disability so that the Community Visitors now have access to the electronic records ('CCIS'); however independent access to the records still needs to take place.
- There needs to be a clear way by which the CVP is always told directly about people moving into the facility, or leaving, so that the Community Visitors can prepare for and complete visits properly.
- Use of interpreters for people in the facility, especially at key points in assessment and review.
- There needs to be a way in which the Positive Behaviour Support Plans are independently looked at to make sure the plans are of a good quality. This is especially needed if the Review Panel in the *Disability Services Act* is seen as being only for those plans that include restrictive interventions and/or on formal request for review.

Priority Concerns:

- The way in which risks are managed needs to be improved to make sure everyone is safe (that is, the 'risk management framework'). This includes the duress alarms in the facility, plans for community access and visits home, and when people in the facility are on overnight stays in the community house.
- The plans for people in the facility to 'transition' to community accommodation are not detailed or individual enough for each person in the facility. At a practical level, people in the facility cannot move on with their plan because there is only one house that can be used.

SECURE CARE FACILITY CONTINUED

- The Positive Behaviour Support Plans still do not have enough detail to show a very clear plan for how the person's behaviour is being guided to change. The records of positive behaviour also are not as clear, and there is not enough information to be sure that the full range of information (including positive behaviours) is going into new plans.

"That man from Darwin, he's a nice man"

VIS/2016/90

CVP RECOMMENDATIONS SECURE CARE FACILITY (SCF)

		Made By	Date	Status
1	It is recommended that appropriate security features are installed, particularly duress alarms for all staff and visitors.	Community Visitor	May 2013	Open
2	That Mental Health Unit and Secure Care Facility management and senior staff meet and work out a process for the referral and transition from Tier 1 to Tier 2.	CV Panel	Dec 2013	Open
3	That the service provides the quality assurance framework documentation and process that underpin quality assurance for the Secure Care Facility and appropriate places.	Community Visitor	Aug 2014	Open
4	That the Positive Behaviour Support Panel be established in accordance with sections 36 and 40 of the *Disability Services Act.*	Community Visitor	Aug 2014	Open
5	That Secure Care Facility management and the Aboriginal Interpreter Service meet to organise an orientation session for interpreters called to have language and cultural assistance with the Secure Care Facility residents.	CV Panel	Oct 2014	Open
6	That Secure Care Facility management explore options for accommodating women within the facility separate from men.	CV Panel	Oct 2014	Open
7	That information available about early childhood of residents is taken into consideration when Positive Behaviour Support Plans (PBSP) are established.	CV Panel	May 2015	Open
8	That a clear individualised transition plan be established for each resident at the facility upon admission, showing steps achieved towards exit. (Reworded)	CV Panel	May 2015	Open

9	That the roles of the Occupational Therapist and Clinician be located on-site at the Secure Care Facility and recruitment to these positions prioritised. (Reworded)	Community Visitor	Jul 2015	Open
10	That to ensure proper consideration of biological and/or psychiatric causes of significant difficult behaviour incidents, a clear procedure should be developed for notifying the General Practitioner and psychiatrists of such incidents and of subsequent actions taken by both.	CV Panel	Jun 2016	Open
11	That the Secure Care Facility provide evidence of reflective behaviour and analysis associated with incidents and behaviours of concern.	Community Visitor	Jul 2016	Open
12	That the Secure Care Facility update each resident's Positive Behaviour Support Plan to include a more detailed therapeutic program of specific and measurable interventions.	Community Visitor	Jul 2016	Open
13	That the Secure Care Facility implement a quality data analysis and measurement process related to each client's therapeutic program, including improved processes for individual client review.	Community Visitor	Jul 2016	Open
14	That the Secure Care Facility document an individual, detailed transition plan for each client.	Community Visitor	Jul 2016	Open

APPROPRIATE PLACES

Note: Information is very general to protect people's privacy. In the Top End, there is a facility near the Darwin Correctional Centre. In Central Australia, there have been two residential houses that have been 'appropriate places' under the Act.

Achievements:

- People in these places have good access to the community, in particular being involved in jobs (that is, 'vocational activities'), sports and cultural activities.
- The Community Visitors have particularly noticed that information kept about people in these places is clearly used by staff to review the person's care and needs.
- The staff have good relationships with the people in these places, and some staff have been caring for them for a long time. The feeling of the places is often described by Community Visitors as friendly, respectful and relaxed.
- People in these facilities or houses have some pride in their space, and have made it like home.

Areas for Improvement:

- The Community Visitors have noted some changes to facilities would help clients; in the Top End, the 'Cottage' facility needs air conditioning units. In Central Australia, one residence needs some improvements to make it more homely.

APPROPRIATE PLACES CONTINUED

Priority Concerns:

- For the Top End, although the facility is home to the people that live there, the Community Visitors have been told that options to live close to family and community are being explored. There is not enough evidence that these options are being followed up actively.
- The CVP has questions about how consistent care for a person is maintained when/if people move back to the prison. This is a priority concern if restrictive practices that are not in the person's positive behaviour support plan are used on the person (such as seclusion) by prison staff.

Nil Recommendations

OTHER PREMISES

Note: Information is very general to protect people's privacy. In the Top End and Central Australia, there have been three people living in residential houses (or similar) that the Office of Disability told the CVP are covered by this part of the Act.

Achievements:

- The Office of Disability told the CVP of three people in 'other premises' under the *Disability Services Act.* This meant the CVP was able to do its work with those people.
- Where visiting has happened, the Community Visitors have noticed very good relationships between the people and their disability support workers. The disability support workers seem to have a very good understanding of the person and their needs.
- In the Top End, there are plans in place to move the person to the care of a non-government organisation. The plans are going well.

Areas for Improvement:

- The Office of Disability told the CVP of one person in the Top End who is covered by the Act, however raised worries that the person's guardian did not want the Community Visitors to visit. The CVP understands that a guardian might have questions or worries, however the visiting role is part of the law. The CVP has not been able to talk to the guardian as there is not enough information from the Office of Disability to do so. The Office of Disability needs to help the CVP move forward to make the visits take place.

Priority Concerns:

- The CVP relies on the Office of Disability to say when people are covered by the *Disability Services Act.* The CVP has had problems with knowing who is covered by the Act and who is no longer covered. The Office of Disability needs better systems in place to keep the CVP updated so that the CVP can do its work.

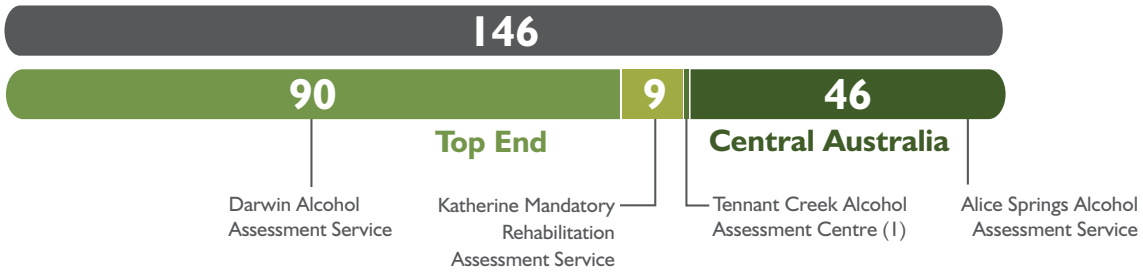
Nil Recommendations

ALCOHOL MANDATORY TREATMENT (AMT)

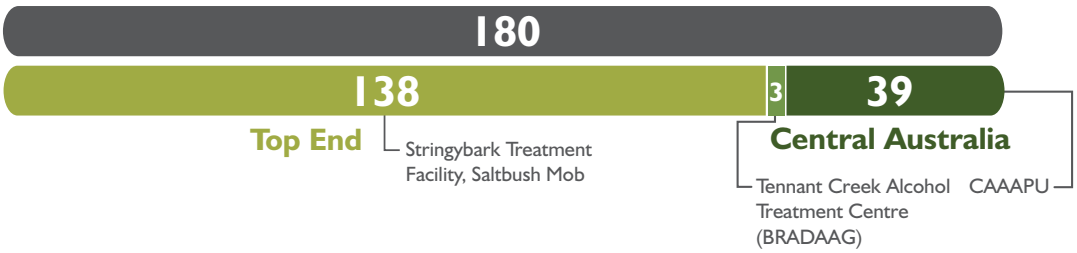
TOP THREE ISSUES

1. **The model used for AMT treatment, which is a joint government and non-government one, creates problems and risks because each party's roles and responsibilities are not clear.**
2. **In every decision made in AMT facilities, the 'least restrictive' option for the individual person must be considered, however in practice this is not always done.**
3. **Looking after people's rights, like making sure that people's rights in AMT are clearly explained and whether the basis for their detention can be challenged.**

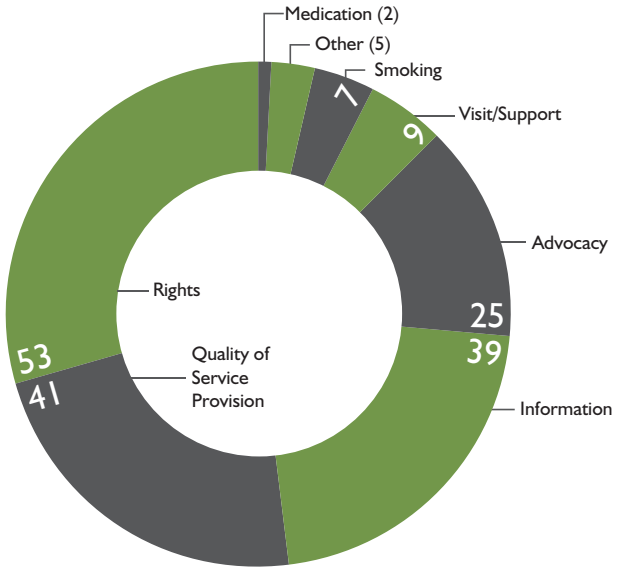
AMT (Assessment) CVP Cases



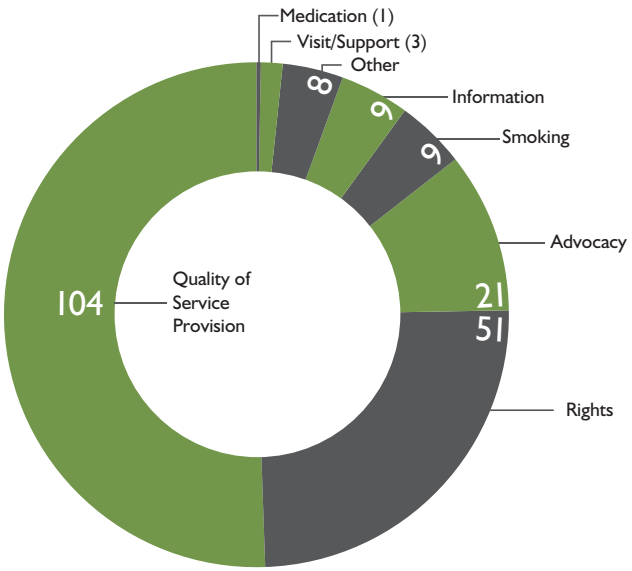
AMT (Treatment) CVP Cases



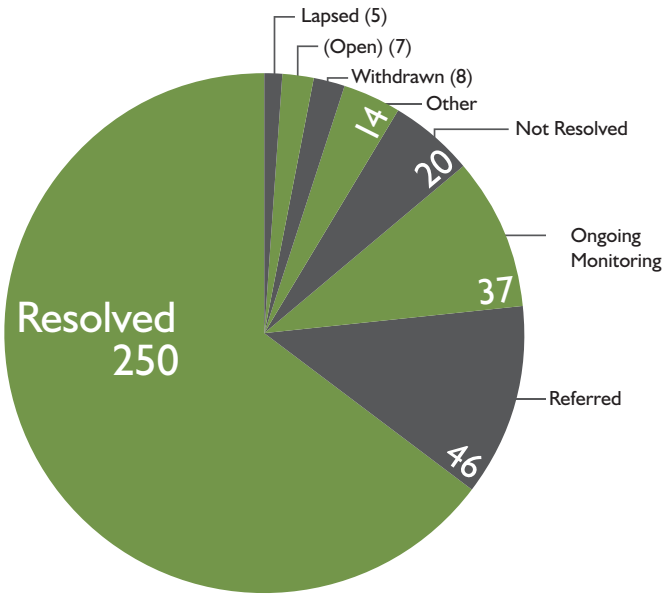
Issues (AMT Assessment)



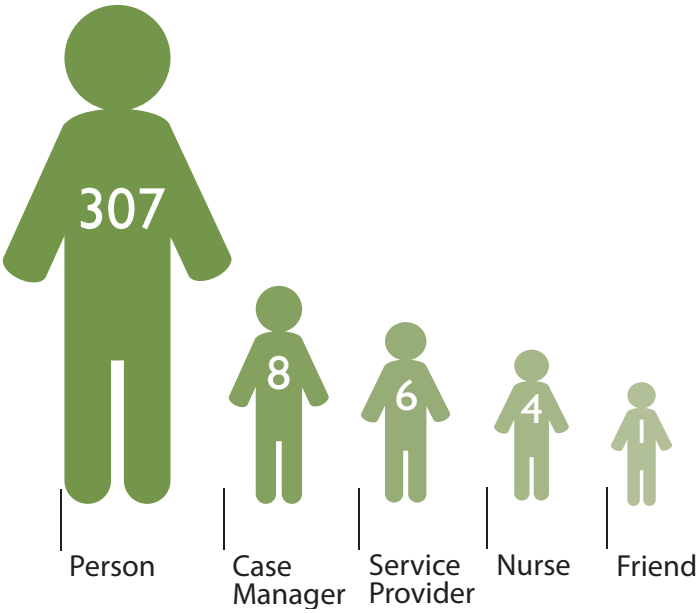
Issues (AMT Treatment)



Outcomes



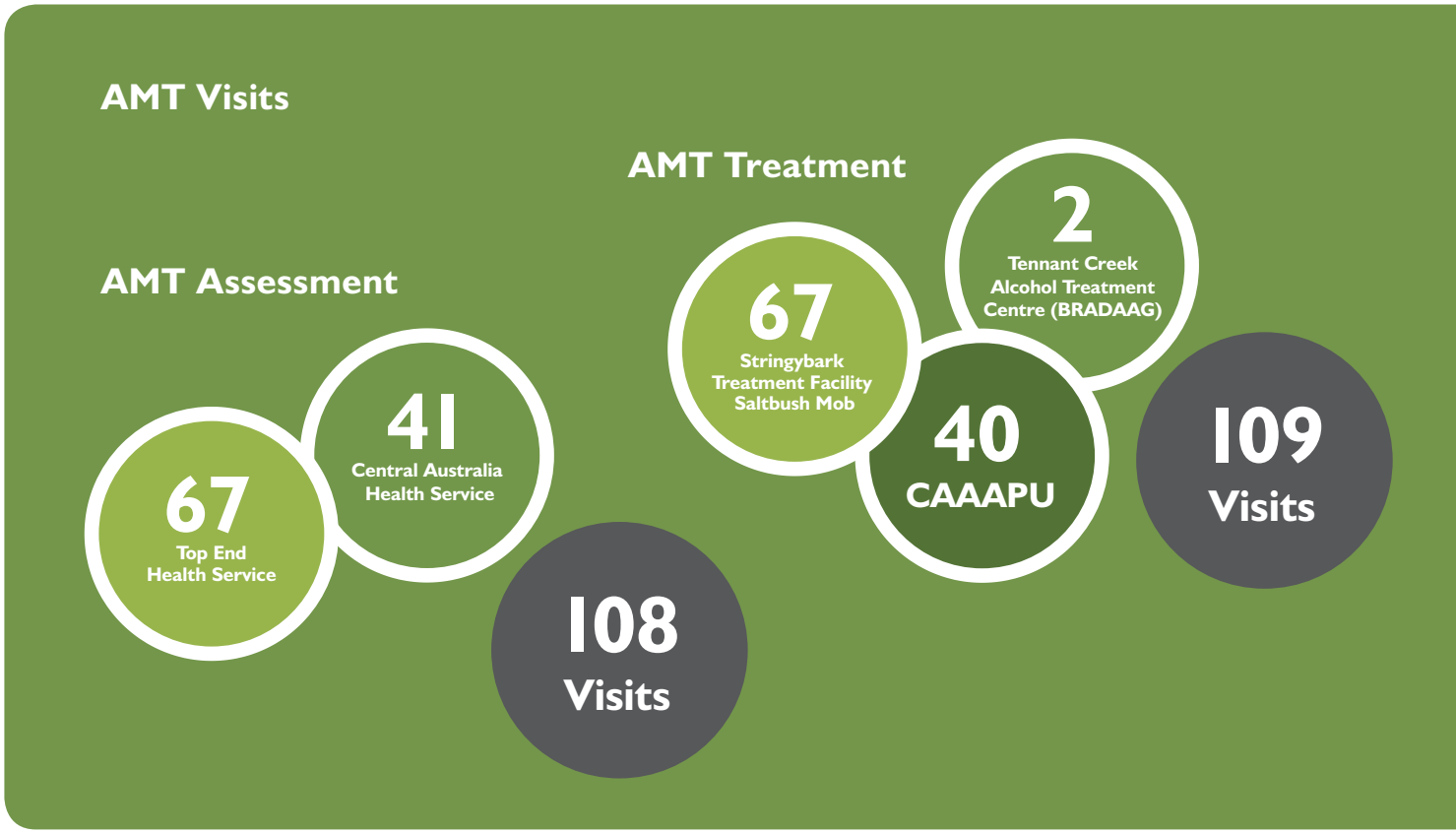
Raised By



Complaints and Enquiries

AMT Assessment

AMT Treatment



The number of CVP cases in Alcohol Mandatory Treatment (AMT) has stayed about the same this year. There is a small increase in the number of cases referred by staff from the facilities. There were a small number of phone requests from people in facilities to see a Community Visitor. This is positive as it shows the CVP is becoming better known in the AMT facilities.

In this year, there have been some changes in how AMT services are delivered in the Northern Territory. The Tennant Creek AMT facilities were closed by January 2016 as there were not enough people admitted. The responsibility for Alcohol and Other Drug service delivery was moved to the health boards (the Top End Health Service and the Central Australia Health Service).

The Department of Health still has a service development team (the AOD Directorate). Its role is to set policy and make sure that the delivery of AMT services across the Northern Territory is broadly the same ('procedural oversight'). This area also manages the non-government organisation contracts to make sure that the services are delivered as expected. The changes in AMT policy and operational work between the Department and the two Health Services are still settling.

The AMT program in the Northern Territory is quite new. The CVP has an important role in these facilities because people's right to leave the facility has been taken away by law. The AMT assessment facilities are provided by the government. The two treatment centres are run by non-government organisations.

The non-government organisations providing AMT treatment in the Northern Territory are:

- Saltbush Mob (part of the Karen Sheldon Group) in Darwin; and
- Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU) in Alice Springs.

As non-government organisations are holding people for involuntary treatment, their work in AMT treatment can at times be very difficult. It can also be hard for staff, especially in non-government organisations, to understand the work of the Community Visitors.

The work of the CVP in this area is also still quite new, so organisations are less familiar with the independent role of the CVP. This has meant there were some stressful times this year between the Community Visitors and the AMT treatment providers. The Community Visitors

particularly want to thank the AMT treatment providers, recognising that mandatory treatment is a new area of work for them. The CVP knows that all parties want a strong, honest relationship.

The CVP appreciates robust discussions in response to its reports, including recommendations and action items. The detail of these discussions, including responses by AMT providers, is confidential. As a result, not all detail about work towards resolution of matters is included in this report.

The discussions are, however, a valuable part of the protections for care and safety of people in AMT facilities. The CVP is looking forward to continuing its work with all AMT providers in the next year.

The CVP wants to thank all staff in the AMT facilities. On a daily basis, the staff try to provide a safe and caring place. The staff support people in facilities who may be upset or struggling with change and their work is appreciated. The Community Visitors often hear positive comments about staff. These are passed on where possible so that staff know that their help is appreciated.

> "They [staff] are beautiful… there's no arguing with others here"
>
> VIS/2016/238

> "Not in a hurry to go back home, quiet and peaceful here"
>
> C/2016/215

INDEPENDENT EVALUATION OF THE AMT PROGRAM

This year, the independent evaluation of the AMT program has started. This is long overdue. The CVP has called for this evaluation to take place in each annual report since the AMT program started. A well planned evaluation needs to be started at the outset of any program. This makes sure that baseline and other data can be collected to track change over time.

If the AMT law means that someone's freedom to leave is taken away, and they may have to go to a treatment program for months, it is very important that there is proof (evidence base) that the program works. The CVP thinks the evaluation will help with better information about how to help people with alcohol problems in the future.

Part of the evaluation is to decide if the AMT program works and is good value for money ('cost effective'). The CVP is still concerned about the usefulness of the AMT treatment programs. The Community Visitors have seen and heard good stories about treatment in AMT. However, one of the other reasons that the CVP is concerned about whether the AMT programs work is the number of people that return to AMT assessment and treatment facilities.

The Community Visitors have noticed a number of people who have been in the AMT assessment facility many times. For example, over a four week period when the Community Visitors looked at the 'handover' sheet, 59% of clients had been previously admitted to the facility. In June 2016, the Minister for Health also told the Parliament that 25 people have gone into AMT treatment more than once.[11]

The CVP understands that people struggle with addictions, and giving up successfully often takes many attempts (with 'relapse rates' up to 60%). If involuntary treatment orders are made, however, this means extra attention has to be paid to whether the program works well to justify such serious action.

A person can spend up to nine days detained in an assessment facility before going to AMT Tribunal.

[11]Northern Territory Parliament, Questions Taken on Notice, 4.9 Number of people returning to AMT program, Estimates Committee, 16 June 2016. Accessed at: http://notes.nt.gov.au/lant/hansard/estimatesqton.nsf/aa1313c185efdc5269256d0200100b3a/65de0ec64f9defa069257fd4002b2149?OpenDocument

To do so over and over is a major concern. The purpose of AMT detention is to assess and, if needed, treat a person's alcohol problem. If the person is not able to do treatment, or the treatment programs are not working well for them, the CVP is concerned that it is an abuse of a person's rights to keep putting that person back in detention.

MODEL OF CARE AND SAFETY (TREATMENT)

The CVP continues to be concerned about how AMT treatment services are set up. The main concern is that the structure of AMT treatment centres is complicated. It involves both government and non-government staff working together. The CVP's view is that this model can create risks to safety for people and staff in the facility. It can also affect how well services are provided.

The area health service has a Senior Treatment Clinician and nurses working at the treatment facilities. The treatment programs, however, are run by the non-government providers. In Darwin, the facility itself is also provided by the Department of Health.

The Senior Treatment Clinician has a number of very important roles under the AMT law. These include making decisions about a person's treatment plan and any decisions about leave while the person is in the centre. The Senior Treatment Clinician also has to work out the plan for support when a person leaves the facility ('aftercare').

The non-government organisations are responsible for providing the treatment program and most day-to-day matters in the centre. The non-government organisation designs and runs the programs, helps people with their leave, makes sure the facility is a safe place to live and for staff to work, and prepares people to return home after the program ends.

It is clear that the work of the government and non-government staff in AMT treatment crosses over. Some information needs to be known by both parties, especially any issues relating to the health and safety of people in the centre.

This complex picture of who is responsible for what in AMT treatment centres can also be seen in the CVP open recommendations. Although the CVP visits one place, there are multiple parties responsible for different action items and recommendations. The discussion around who is responsible adds a further layer of complexity to resolving matters and moving forward.

Understanding Shared Interests

With this much common ground, it is not possible to make good decisions for a person in treatment, or to keep everyone safe in the centre, unless there is good information sharing. There have to be systems so that everyone can work well together.

To do this, staff need good guidelines about who is responsible for what in a treatment facility, and how to work out common issues. The jobs of each person in the facility need to be well understood by everyone who works there (regardless of who the staff member works for).

The CVP raised these concerns in last year's Annual Report. This year, the Department of Health provided some extra guidelines for the AMT treatment providers. There have been regular meetings with the CVP, in particular at the Stringybark centre in Darwin, to work through issues. These are good steps forward.

Yet, the CVP often sees issues come up in AMT treatment facilities relating to how government and non-government staff work together. The CVP's view is that the guidelines do not cover these issues in enough detail. There needs to be more information that clearly outlines how the area health services and the non-government organisations work together in the centres.[12]

A good example is in the area of risks. As the Department's new guidelines say: 'sometimes things go wrong'.[13] The guidelines talk about how to notice, think about and record risks. The guidelines do not say clearly how the area health services and the non-government organisation will work together to manage what has or might go wrong.

The CVP has been raising this with the Department of Health for a long time and still have not received enough information. In the CVP's view, clearer, more detailed guidelines are needed to make sure treatment happens in the way

> "[Staff:] He shouldn't be here, he can't understand the program."
>
> C/2015/474

set out in the Act, with a qualified area health service person (the Senior Treatment Clinician) overseeing what happens, and to reduce risks.

Each of the non-government organisations, and the area health services, are trying to work to improve this. For example, in Darwin, the Community Visitors have been told that a Senior Treatment Clinician 'procedural manual' is being written, and there is a protocol between the area health service and Saltbush Mob. In Alice Springs, an agreement is being worked on between CAAAPU and Alcohol and Other Drug Services Central Australia (ADSCA).

These are good signs. It does not make sure, however, that there is the same way of sorting out common issues in both Darwin and Alice Springs AMT treatment centres. It is the CVP's view that, even though there are regional differences, it would be best if there was one common document.

This common document needs to have enough detail to give clear directions to government and non-government staff working in AMT treatment centres. This will continue to be discussed between the CVP and the Department in the year ahead.

[12]A research paper on a Western Australian Aboriginal and mainstream service partnership in substance use treatment also supports the value of strong systems for collaboration, including standardised documentation, processes for sharing information (especially with high staff turnover), and focusing on the practical aspects of the relationship. See Taylor, K.P, Bessarab, D, Hunter, L, and Thompson, S.C (2013). Aboriginal-mainstream partnerships: exploring the challenges and enhancers of a collaborative service arrangement for Aboriginal clients with substance use issues. BMC Health Services Research, 13 (12).

[13]Northern Territory Health, External Service Providers AMT Practice Guidelines, HealthIntra-1880-8146, p20.

CULTURAL SAFETY

The number of Indigenous people that are held in AMT facilities is very high. The numbers are so high that the CVP always looks for and reports on signs that the service is culturally safe. If a service is not culturally safe, at worst it could be harmful for a person; at best, it will be harder for the person to be helped.

The issues raised with Community Visitors are things such as meeting cultural obligations, attending funerals and needing interpreters. Although issues of cultural safety make up only a small part of the total data, about half of all the AMT cases where people raised cultural safety issues were 'resolved'.

This is a positive sign, and is also seen by Community Visitors during visits. When a person has talked with the Community Visitors about worries with meeting cultural obligations, the Community Visitors often report that there is a good response from the service. The visit reports also talk about there being a good range of activities that interest Indigenous people in AMT facilities.

Even if a person in a facility does not raise an issue with the Community Visitor, one of the roles of the visitor is to think about what is working well in the facilities in general ('adequacy of services').

One of the things that Community Visitors have been noticing in AMT facilities is the use of interpreters. This was noticed as a concern more often in AMT treatment centres. In AMT treatment, the person's plan has to involve the person and make sense to them. The person's thoughts and wishes have to be well heard and understood by the treatment staff.

If a person needs an interpreter in order to fully understand and talk about their health needs and wishes, it is essential that this need is first noticed, and then acted upon by staff. Without this, there can be no guarantee that what is being talked about by either party is really understood.

As some people are coming back through the AMT program, and being picked up again by police and taken to AMT assessment facilities, this raises the question of whether the treatment programs are working. It may be that problems with understanding each other are affecting how well the AMT program can work. The CVP hopes that the independent evaluation of the AMT program will shed some more light on this issue.

The CVP also notes that a culturally safe place is also one where Indigenous people are working. The CVP is very pleased to see that there seems to be high numbers of Indigenous staff working for the AMT treatment providers. There also seems to be a lot of commitment to cross-cultural training.

Although this is good, the Community Visitors notice that staff in the facilities often leave and new staff join. The CVP understands that, nationally, it is difficult to find staff with the right skills and work history in the area of alcohol and other drugs. However, being able to build good relationships with Indigenous people in AMT facilities, especially AMT treatment centres, takes time and is not helped by high staff turnover.

"I need to see my children and grandchildren… it will keep me going another month."
C/2016/142

"I want to go home to put flowers on the grave."
C/2015/524

"I don't want to miss another funeral."
C/2015/627

"My family are worried back home… my dad needs me."
C/2016/350

"I've had another one [case manager], another one, a lot mixed up… too many of them." C/2016/172

SAFELY MANAGING BEHAVIOUR

An issue that has come to the CVP's attention this year has been the ways that AMT assessment and treatment facilities manage difficult behaviour. It is not surprising that some people are very upset or angry when they are detained. Each person's ability to manage their behaviour will be different. Some people have made threats of harm to themselves or others. Some people have damaged property.

While not happening every day, this behaviour is something that the facility staff need to prepare for to keep themselves and anyone else in the facility safe. The AMT Clinical Practice Guideline refers to managing 'risk and complex behaviours'. The guideline refers to the use of force to make sure that people are safe when in an AMT facility. Only 'authorised officers' under the AMT Act, who receive special training, can use physical force to hold someone.

The Community Visitors are told that staff try to deal with these kinds of situations by talking to the person and trying to calm them down ('de-escalation skills'). The Community Visitors will sometimes look at the 'use of force' records; there is no evidence of any use of force. The CVP is pleased with this, as it is the 'least restrictive' way of handling a difficult situation.

When Community Visitors have asked staff in AMT facilities about how unsafe behaviour is managed, they are sometimes told that leave for the person is used. At times, if behaviour is very unsafe, police are called to the facility and a person is taken away by police.

While a practical way of dealing with the situation, this can put the person in a legal 'limbo'. For example, if a person in an AMT assessment facility is given leave before their assessment is complete, it 'stops the clock'. There is no guidance about what that person's legal situation is then under AMT law. The use of leave as a way to respond to difficult behaviour is also not covered in the AMT Clinical Practice Guideline.

For AMT treatment centres, where the non-government organisation also has an important role in keeping the facility and people in it safe, the guideline needs to be very clear. In AMT treatment facilities, both the area health service and the non-government organisation have common safety concerns and need a single, agreed way of responding. The law and the practice for managing people with difficult behaviour need to be clearer.

"If I go there [treatment centre], I will do something wrong… go mad and punch them… might do something crazy." C/2015/489

"We'd be calmer if we can smoke… stop us stressing." C/2016/215

THE 'LEAST RESTRICTIVE' WAY

During this year, the CVP has raised problems with the AMT law, both how these affect people in facilities and how well the area health services know and apply the law. The CVP was pleased that the Department of Health decided to keep a record of these problems when the law is considered for any change.

The CVP thinks this is important because holding people in detention for health assessment and treatment is a very serious limit on someone's rights, which means that it is vital for any problems with the law to be fixed.

One of the key principles of the AMT Act is that a person in an AMT facility is treated in the 'least restrictive' way possible (section 6). The AMT Act is written in way that gives the Senior Assessment and Senior Treatment Clinician a wide power to decide what is the 'least restrictive' for any one person.

The duty to take the 'least restrictive' approach applies to all staff, including AMT non-government organisations. This will apply to things such as outings from the facility.

In this year, in AMT facilities, around 14% of all the AMT issues raised were about 'least restrictive' options. Most of these cases were able to be resolved (over 60%). In some cases, however, what people think is the 'least restrictive' way differs.

The Community Visitors can help people in facilities raise their requests or worries if this happens. Some issues raised by people with the Community Visitors have included:

- at times, a person in an AMT assessment facility is recommended for release but is held in the facility until the Tribunal day (which might be many days later);
- some people have not been able to attend church services, because the treatment provider said they did not have enough staff to make this happen; and
- some decisions are made that apply to everyone in the facility (such as where people can sit outside, through to if outings are happening) without the decision being made on an individual basis.

In every case, the AMT law requires that the 'least restrictive' way is considered for each person held in the facility. The AMT law is written in such a way that the treatment and care has to be based on that person's individual needs. The 'least restrictive' principle is well known in other areas of health, such as mental health, where people are held by law in a facility.

The CVP would like to see a stronger focus on each person's individual needs being at the core of all decisions made in relation to them. Records made about decisions need to show how the person's individual needs were considered.

The CVP knows and respects that the final decision is for the services to make. The CVP has asked the Department of Health to develop a workshop with the CVP about 'least restrictive' principles. This is to help services to know more about these principles and how they might work in practice.

"We're not all the same"
C/2016/142

"It's good for us to go out, instead of us sitting down here in one place."
C/2016/329

"I don't like it when one person does wrong, it's not fair for other people that don't do wrong… it makes me wild."
C/2016/215

RIGHTS STATEMENT

Explaining a person's rights to them is a central part of the AMT law. Under the law, a 'rights statement' has to be explained when a person is taken to an AMT assessment facility, and again (if they get a residential treatment order) at the AMT treatment centre.

Many people in AMT facilities do not have English as their first language. This means it is very important that steps, including the use of interpreters, are taken to make sure their rights are understood.

The Community Visitors may check if people in the facility feel that they understand their rights, or perhaps want to hear it again or with an interpreter. People can become very upset if their rights are not clear.

The CVP data shows that just over half of all issues raised with Community Visitors in AMT assessment facilities are about 'rights' or 'information'. In AMT treatment facilities, 'rights' or 'information' cases are also about one third of the issues raised with Community Visitors.

In 2015, the Department of Health put the 'rights statement' into plain English. This was a difficult thing to do, as legal rights language is a very specific type of English. When the CVP read the 'rights statement', the CVP told the Department it was worried that the plain English version did not have all the information it had to under the AMT law.

During this year, it was not clear which was the correct 'rights statement' to use. Different statements were being used in different AMT facilities. In the Top End, the area health service went back to an older version of the statement. In Central Australia, however, the AMT facility is still using the plain English one.

The Department of Health has said it is working on a new statement that covers all the information in a better way and also uses plain English. The CVP knows that this is a hard task and welcomes the Department's effort to improve the information about rights given to people in AMT facilities.

Having one way of talking about the rights of the people in AMT facilities will help. The area health staff (Senior Assessment and Treatment Clinicians) need to make sure that interpreters are used to explain the 'rights statement' if needed. The area health services also need to make sure that the spoken ('audio book') versions of a person's rights are available in the main languages of that region.

Together these changes will help make sure that people in AMT facilities understand their rights under AMT law, as much as possible. This is a basic human right of all people being detained.

"I thought they just wanted to hear how I talk, how I react … it should have been explained." C/2016/277

"I'm not sure what's happening… they haven't explained me. I'm just sitting here with no information." C/2016/350

LAWFUL DETENTION

During visits, some people in AMT facilities have talked with Community Visitors about how they came to be in the facility. In most cases, to end up in an AMT facility, the police must have put the person in 'protective custody' three times in two months. Sometimes, people have told the Community Visitors that they did not think the police made the right decision. The Community Visitors will advise people of their right to complain about treatment by the police. This information is also available in the AMT assessment facilities.

Although making a complaint is possible, the CVP has raised with the Department of Health that there is a broader legal point to make. There does not seem to be a way for a person in an AMT facility to challenge their detention, that is, in a court of law.

Once in an AMT assessment facility, the person must wait for the AMT Tribunal to decide what happens next. The Tribunal does not cover the details of police 'protective custody' events that led to a person being detained.

This is a very serious issue, as an important principle of Australian law and international human rights law is that anyone who is detained can have the reasons for their detention looked at by a court. Detaining someone is a very serious act. It has a big impact on the person's rights. The CVP has raised with the Department of Health for some time that the AMT law should be changed in this area. This is something for the Northern Territory Government to consider.

This year, there have continued to be some problems with people being taken to an AMT assessment facility when the law has not allowed for this. This includes being picked up by police while on leave, or while living in the community on an AMT order ('Community Treatment Order'), and then taken to an AMT assessment facility without all the right conditions being met.

These problems mean that a person may be held in a facility against the law ('wrongfully detained'). This is a very serious concern to the CVP. The Department of Health and area health staff have responded to these issues. This is positive as it shows the Department, area health services and the police are working out problems with processes and systems. The CVP will continue to closely follow the individual reasons that led to a person being detained in an AMT facility.

"I was picked up by them [police] for no reason … I was not drunk… I was in a group of 10 when police came."

C/2016/237

"I was only walking slow and quiet."

C/2016/345

SERVICE SNAPSHOTS

ASSESSMENT SERVICES

DARWIN ALCOHOL ASSESSMENT SERVICE (DAAS)

Achievements:

- 5 CVP recommendations closed.
- Positive comments from people in the facility about staff, including about staff helping with practical needs and cultural business.
- The CVP data shows that over 75% of the issues raised by people in DAAS are 'resolved'. Only 4% of issues could not be resolved.
- Extra information is in the facility, for example, about Centrelink, legal help, banks, AMT treatment, and making complaints about police.
- More activities are available, and people in facilities say the food is better.
- Curtains are now up, making the bedrooms more private.
- The staff made forms and procedures better, to stop people on Community Treatment Orders (CTO) being taken to an AMT facility by police without a 'protective custody' event.
- The 'least restrictive' principle was well understood and applied.

Areas for Improvement:

- Clearer law and procedures about removing people from the facility if it is not safe for the person to be there.
- Clearer law and procedures about people in the facility who need a mental health assessment. At the moment, there is nothing about the way in which this happens in the AMT clinical practice guideline.
- If a person in the facility has been recommended for release by the Senior Assessment Clinician, there needs to be a clearer understanding of when leave might be granted before the Tribunal hearing.
- The 'rights statement' needs to be both plain English and cover all of the rights that people in the facility need to know.
- That the AMT law is clearer on exactly when the assessment report has to be finished and given to a person before their Tribunal (the '96 hour' rule).

Priority Concerns:

- Some people have been taken into the facility when the legal requirements were not met (for example, when the person was on leave from a treatment facility, or on a Community Treatment Order, and correct processes were not followed).
- People in the facility are not able to challenge the basis for their detention (that is, the police 'protective custody' events that led to detention).
- Some people are detained in the AMT assessment facility after more than three 'protective custody' events, while others may be detained when three events happen. This means that people in the same situation in the community can end up with a very different result (that is, one person might remain free while another is detained in an AMT assessment facility and possibly held for treatment for up to three months).

CVP RECOMMENDATIONS (DAAS)
DEPARTMENT OF HEALTH

		Made By	Date	Status
1	That Department of Health consider recommending amendments to the AMT Act: • to allow persons admitted for assessment to request early review of the grounds for their detention; • to require that Assessable Persons be released from detention pending a Tribunal hearing when their Assessment Report recommends a release order; or provide that an AP can be released from detention pending their Tribunal date at the discretion of the Senior Assessment Clinician (SAC); or • to require that the granting of leave under s 76 pending a Tribunal hearing be considered in situations where release is recommended. That in the meantime, a protocol be developed to expedite hearings where release orders or Community Treatment Orders are recommended by the Senior Assessment Clinician.	Community Visitor	Mar 2015	Open
2	That liaison take place between Department of Health and NT Police to clarify the documentation which is required when an Assessable Person is brought to an Assessment centre while on a Community Treatment Order (CTO) under section 128B of the *Police Administration Act*; and that a Transport Advice Notice (TAN) (or similar document) be required in these situations.	Community Visitor	Jul 2015	Open
3	That Department of Health review the Rights Statement currently in use within DAAS (and other AMT Assessment facilities) to ensure that all necessary information about the rights of Assessable Persons (APs) is included.	Community Visitor	Mar 2016	Open
4	That the AMT Clinical Practice Guideline be amended to specify that Assessable Persons (APs) must be admitted and detained by a Senior Assessment Clinician (SAC), in accordance with section 14 of the AMT Act.	Community Visitor	Jul 2016	Open
5	That in accordance with recommendations in Department of Health's Review of the Alcohol Mandatory Treatment Act (2013), Department of Health recommend amendment of section 17(2) of the AMT Act so completion of the assessment report is explicitly included in the 96 hours; and insert a provision after section 20 stating that the Assessable Person must be released if neither actions under sections 20(a) or 20(b) are taken within the specified timeframe.	Community Visitor	Jul 2016	Open

CVP RECOMMENDATIONS (DAAS)
TOP END HEALTH SERVICE

		Made By	Date	Status
1	That DAAS ensure there is an accessible and obvious complaints process and that Assessable Persons know they have the right to complain.	Community Visitor	Feb 2014	Open
2	That when Assessable Persons are identified as having cognitive impairments or other needs beyond DAAS scope of practice timely and appropriate referrals are followed up on.	Community Visitor	Mar 2014	Open
3	That the Aboriginal Interpreter Service be contacted as soon as an Assessable Person arrives at DAAS to ensure that every endeavour is made to provide an interpreter during the assessment.	Community Visitor	Mar 2014	Open
4	That protocols be developed in relation to urgent guardianship applications and referral of Assessable Persons to NT Aged and Disability Services.	Community Visitor	Mar 2015	Open
5	That Stringybark management liaise with community rehabilitation service providers to develop streamlined processes for transferring clients assessed as suitable for those facilities.	Community Visitor	Mar 2015	Open

"[I want to] sit out front… bit of open space… need a view, more open space instead of seeing high walls."

C/2016/169

"They [staff] are good, food is OK… I want more meat."

VIS/2015/377

"It's safer here"

VIS/2015/377

KATHERINE MANDATORY ASSESSMENT REHABILITATION SERVICE (KMARS)

Achievements:

- 4 CVP recommendations closed.
- Positive comments about staff made by people in the facility.
- Staff started daily meetings to make sure people in the facility have important health needs met (for example, medications).
- Staff have been trying to get all assessments done more quickly than the law says they have to, so that people can get a Tribunal hearing as fast as possible.

Areas for Improvement:

- Difficult to keep good staff, and for staff there to develop their skills (even if there are low numbers of people coming into the facility).
- Better outdoor space – current space is very small and not comfortable.
- That the AMT law is clearer on exactly when the assessment report has to be finished and given to a person before their Tribunal (the '96 hour' rule).

Priority Concerns:

- People would like to sit in more comfortable outdoor areas. The CVP would like to see the 'least restrictive' way of working out this problem, for each person at the facility (not just a single decision that affects everyone in the facility).

CVP RECOMMENDATIONS (KMARS)

DEPARTMENT OF HEALTH

		Made By	Date	Status
1	That policies be clarified by Department of Health regarding the processes to be followed in situations where Assessable Persons who are subject to Community Treatment Orders (CTOs) or Mandatory Residential Treatment Order (MRTO) leave conditions are apprehended by police at a significant distance from the relevant treatment centre.	Community Visitor	Jul 2015	Open
2	That liaison take place between Department of Health and NT Police to clarify the documentation which is required when an Assessable Person is brought into an Assessment facility under section 128B of the *Police Administration Act* while subject to a Community Treatment Order (CTO); and that a Transport Advice Notice (TAN) (or similar document) be required in these situations.	Community Visitor	Jul 2015	Open

TOP END HEALTH SERVICE

1	That steps be taken to provide an accessible and appropriate outdoor area for sole use by MARS clients.	Community Visitor	Jul 2015	Open

ALICE SPRINGS ALCOHOL ASSESSMENT SERVICE (ASAAS)

Achievements:

- 1 CVP recommendation closed.
- Positive comments about staff often made by people in the facility.
- Community Visitors often noticed that the decisions made by the Senior Assessment Clinicians seemed to be the 'least restrictive'.
- Staff try hard to get interpreters to talk with people who have English as a second language.

Areas for Improvement:

- The rights statement 'Talking Book' still needs to be translated into Pitjantjatjara (see Annual Report 2014-2015).
- That the AMT law is clearer on exactly when the assessment report has to be finished and given to a person before their Tribunal (the '96 hour' rule).
- Although the recommendation about managing difficult people in the facility was closed, at the end of the year the CVP had new concerns in this area. These worries are more about the law and admitting people (including people with disabilities) whose behaviour is unsafe.

Priority Concerns:

- There have been staff shortages in key roles. Recently, one person has been doing both the Nurse Manager and Senior Assessment Clinician roles. The CVP is worried the problems with staffing will affect care of people in the facility.

CVP RECOMMENDATIONS (ASAAS)
DEPARTMENT OF HEALTH

		Made By	Date	Status
1	That the Department of Health develops clear policies and procedures for management of Assessable Persons with diagnosed or suspected cognitive impairment within the Alcohol Mandatory Treatment Program.	Community Visitor	Jun 2014	Open
2	That Department of Health clarifies the confusion regarding whether the assessment report has to be completed within the 96 hour timeframe (*Alcohol Mandatory Treatment Act*, section 17(2)).	Community Visitor	Jul 2015	Open
3	That the Rights Statement includes an explanation of section 113 about representation at the Tribunal contained within it and that the new Rights Statement being used by Department of Health is amended to include important information that is missing.	Community Visitor	Jul 2015	Open

CVP RECOMMENDATIONS (ASAAS)
CENTRAL AUSTRALIA HEALTH SERVICE

		Made By	Date	Status
1	That appropriate security features are installed, particularly duress alarms for all staff and visitors	Community Visitor	Jul 2016	Open

Note: There is no report card for the Tennant Creek Alcohol Assessment Service. This facility closed during 2015-2016 and the CVP did not visit before the service closed.

TREATMENT CENTRES

STRINGYBARK TREATMENT CENTRE (OPERATED BY 'SALTBUSH MOB')

Achievements:

- 13 CVP recommendations closed.
- Saltbush Mob has achieved a lot with the treatment program in a short amount of time.
- Saltbush Mob has set up a 'participant advisory board' so that people in the facility can put forward their ideas to improve the facility and programs.
- Community Visitors notice some people coming back to the facility after they have left, which suggests that the 'aftercare' service is helpful for them.
- Saltbush Mob helps people develop skills for work and create pathways to job opportunities.
- Saltbush Mob finished its 'policy and procedure' and case management manuals.
- A high number of staff in the facility are Indigenous.
- The new records system (Redicare) is better than the one used in late 2015.
- Staff try to help people to have contact with family and friends.
- The facilities have improved, and there are a range of cultural activities for people.
- Staff are often flexible with people's requests, especially cultural obligations.
- Saltbush Mob have set up a small 'shop' at the facility (not for profit) to buy items.
- Saltbush Mob and the Top End Health Service have got better systems to transfer people from the AMT assessment facility to the treatment facility.
- Saltbush Mob put up cameras to monitor valuables stored in the office.
- The CV Panel noted in its two visits that, overall, things are better since Saltbush Mob has taken on the contract for AMT treatment in Darwin.
- Training sessions with the Aboriginal Interpreter Service.

> "I really enjoyed it… it was always interesting… I learned a lot about grog and what it can do for you."
>
> VIS/2015/338

STRINGYBARK TREATMENT CENTRE (OPERATED BY 'SALTBUSH MOB') CONTINUED

Areas for Improvement:

- Saltbush Mob has set up 'rewards' for people participating in the program; if people in the facility are participating well, they can earn extra things like outings. The CVP is concerned that for the idea to work well, the rules need to be very clear to everyone. Staff need to use it in the same way with everyone, and a professionally trained staff member needs to review how it works.
- There has been a high number of staff leaving and starting with Saltbush Mob over the year. The plans for the program have had to change because positions have been vacant. The CVP is concerned that there have been problems with employing and keeping professional staff.
- A number of people raised concerns about paying fees. The CVP also asked questions about the process for talking through what would happen if fees were not paid. The CVP has been told at the time of writing that fees will no longer be charged by Saltbush.
- That the programs provided by Saltbush Mob be reviewed by an addiction specialist.
- That the Department of Health arrange for special training in the use of force for Saltbush Mob staff.

Priority Concerns:

- Clearer process for how requests for leave are handled, noting that by law, only the Senior Treatment Clinician has the power to approve leave.
- Two people raised concerns about the security of their items with the Community Visitor. The security of the general storage cupboard was improved, but the project to give the men more lockable cupboards has not yet been finished.
- The Panel remains very concerned about hanging points (suicide) and unsafe items in the AMT treatment facility. As the provider of the facility, the Department of Health is responsible for this issue.
- It is still not clear how the Department of Health can know and deal well with all the risks in AMT treatment.
- There does not seem to be a high use of interpreters in the AMT treatment facility, but a lot of people in the facility have English as a second or other language. The CVP believes the use of interpreters is especially helpful for key things like working out a person's treatment plan, and making sure the support plan when they leave is strong.
- Making sure that medical care is able to be provided, as there is only one doctor (for example, when this doctor is on leave or if the numbers of people held in the centre increase). This also includes the arrangements for getting medical help after hours are clear and have enough detail. The CVP was told by the Department of Health that they think the medical arrangements are appropriate.

CVP RECOMMENDATIONS (STRINGYBARK TREATMENT)
DEPARTMENT OF HEALTH

		Made By	Date	Status
1	The Department of Health (DoH) reviews the suitability of the facility for mandatory alcohol treatment, considering Affected Persons' potential risk of suicide/self-harm. (Reworded)	CV Panel	Sep 2015	Open
2	Policies and procedures regarding tobacco are reconsidered by Department of Health with a particular emphasis on their impact on alcohol rehabilitation.	CV Panel	Sep 2015	Open
3	That Department of Health develop an incident recording/ risk management system which ensures oversight and review by Department of Health incidents across the AMT system, including services contracted to non-government organisations (NGOs) in facilities jointly staffed and overseen by Department of Health.	Community Visitor	Mar 2016	Open
4	That the AMT Clinical Practice Guideline be amended to include policies and procedures relating to situations where an Affected Person who has been granted leave is apprehended by police; in particular clarifying: • The circumstances in which contact from police about an Affected Person who is on leave may lead to an apprehension order being issued; • That an apprehension order must be issued before police can apprehend the person and bring them to an AMT facility. Further, that Department of Health gives consideration to recommending an amendment to the *Police Administration Act* to clarify apprehension powers in situations when people are within periods of authorised leave from AMT facilities.	Community Visitor	Mar 2016	Open
5	That Department of Health arrange for the P3 online training component to be made available to Saltbush Mob as soon as possible.	CV Panel	Mar 2016	Open
6	That Department of Health provide furniture at the Centre to enable affected persons to store personal items securely as matter of priority. (Reworded)	CV Panel	Mar 2016	Open
7	The Department of Health review the health care services provided by other similar types of centres, such as prisons, detention centres and residential mental health facilities, to ensure the proper health care of the affected persons, notwithstanding the contract arrangements between the Department of Health and Saltbush Mob.	CV Panel	Jun 2016	Open

CVP RECOMMENDATIONS (STRINGYBARK TREATMENT)

TOP END HEALTH SERVICE

		Made By	Date	Status
1	That both Saltbush Mob and Top End Mental Health Services strive to improve and strengthen their relationship to help facilitate appropriate assessment and treatment of mental illnesses of Affected Persons. The existing protocols should be reviewed to streamline the processes. (Reworded)	CV Panel	Sep 2015	Open
2	Less restrictive interventions are thoroughly and systematically considered for all Affected Persons.	CV Panel	Sep 2015	Open

AMT TREATMENT PROVIDER

1	That comprehensive information be provided to all relevant Stringybark staff and AMT management regarding: • Arrangements for medical coverage (including availability of Saltbush Mob medical officers on and off-site); and • After-hours procedures for requesting medical or nursing assistance and dispensing medication. The CVP also recommends that AMT management monitor these arrangements and provide feedback to Saltbush Mob regarding their adequacy.	Community Visitor	Aug 2015	Open
2	Less restrictive interventions are thoroughly and systematically considered for all Affected Persons.	CV Panel	Sep 2015	Open
3	That both Saltbush Mob and Top End Mental Health Services strive to improve and strengthen their relationship to help facilitate appropriate assessment and treatment of mental illnesses of Affected Persons. The existing protocols should be reviewed to streamline the processes. (Reworded)	CV Panel	Sep 2015	Open
4	That a Clinician, who is a registered health practitioner, oversight any behavioural modification interventions to ensure they are implemented fairly and consistently and that they are efficacious.	CV Panel	Mar 2016	Open
5	That the therapeutic programs are reviewed by an appropriately qualified and experienced addiction specialist to consider and enhance their effectiveness.	CV Panel	Mar 2016	Open
6	That a safe way of placing coverings on the windows be explored and implemented as a matter of priority.	CV Panel	Mar 2016	Open
7	Saltbush Mob review the arrangement with the medical practitioner and consider whether it meets the need of mandatory alcohol treatment for clients with complex and chronic conditions.	CV Panel	Jun 2016	Open
8	Saltbush Mob clarify whether accommodation, activities and the rehabilitation program are consumables, as per section 70 of the AMT Act, and take steps to ensure there is compliance with the legislation.	CV Panel	Jun 2016	Open

CENTRAL AUSTRALIAN ABORIGINAL ALCOHOL PROGRAMMES UNIT (CAAAPU)

Achievements:

- 4 CVP recommendations closed.
- Since CAAAPU has come out of administration, there have been improved changes to the treatment program.
- In the second half of the year, CAAAPU has worked well with other services in Alice Springs, and encourages services to come to CAAAPU or helps people to go into town for programs. This now also includes helping people go to the main clinic in town for Aboriginal people if the doctor is not available in CAAAPU at the time.
- CAAAPU has stopped using interpreters who are not independent.
- Medication training has been provided to staff.
- Since March 2016, CAAAPU has made sure there are regular visits from the Central Australian Aboriginal Congress workers who will be supporting people when they leave the program ('aftercare').
- CAAAPU has contracted a psychiatrist to visit the facility regularly.
- People in the facility are helped to do training and work there as much as possible.
- There are a range of good activities that people in the facility enjoying doing.
- There has been a recent increase in the number of times that the Senior Treatment Clinician has gone back to the AMT Tribunal to ask that an order be changed. The CVP sees this as evidence that people's individual cases are being looked at regularly.
- Although the Board at one point in 2015 made the decision to stop full access for the Community Visitors to do their job, both the CVP and CAAAPU were able to work through this and visiting started again without any concerns.

Areas for Improvement:

- There have been a number of people in the key role of the Senior Treatment Clinician. Each person has seen their role a little differently. This makes it hard for CAAAPU and the Department of Health to have a solid relationship.
- The plans for people did not have much information about exactly what is being done to help them. The CVP will keep a close eye on this in the next year.

CENTRAL AUSTRALIAN ABORIGINAL ALCOHOL PROGRAMMES UNIT (CAAAPU) CONTINUED

- There needs to be an increase in the use of qualified interpreters at important times, such as when a person first comes into the facility (rights and rules), and in the treatment programs and planning.
- The independent review into the death in care has been completed. The review talked about the issues for CAAAPU when the main decisions about treatment and care are made by the Department of Health 'Senior Treatment Clinician'. More detailed policies and procedures to help CAAAPU and the Department of Health work together needs to be available.
- There has been a number of staff leaving, especially with CAAAPU going into administration. This always makes it hard for people in facilities to develop a good relationship and for programs to work smoothly.

Priority Concerns:

- For most of this year, CAAAPU has said that people in the facilities cannot get leave to go to church because there are not enough staff to make sure the people are supervised. There has also been some cases where a 'one size fits all' decisions has been made, based on worries that people might abscond from the facility. The CVP thinks that there needs to be more understanding of the 'least restrictive' principle that is part of the AMT law, and needs to be part of all decisions about a person's care and treatment.

CVP RECOMMENDATIONS (CAAAPU)

DEPARTMENT OF HEALTH

		Made By	Date	Status
1	That the Rights Statement be amended to give a clear explanation of section 113 of the *Alcohol Mandatory Treatment Act*.	CV Panel	Aug 2015	Open

CENTRAL AUSTRALIA HEALTH SERVICE

1	That the Department of Health urgently improve the responsiveness of referrals of Affected Persons to Aged Care, Disability Services and for cognitive assessment so that relevant assessments can be undertaken whilst an Affected Person is in treatment at the Treatment Centre.	Community Visitor	Jul 2014	Open
2	That urgent attention be given to the availability of appropriately qualified medical staff at all times, so that non-medically trained staff are not being required to make medical decisions.	CV Panel	Dec 2014	Open

CVP RECOMMENDATIONS (CAAAPU)
AMT TREATMENT PROVIDER

		Made By	Date	Status
1	That the Alcohol Mandatory Treatment Centre (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	Jan 2014	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.	CV Panel	Jun 2014	Open
3	That trained interpreters are used for critical assessments and planning.	Community Visitor	Jul 2014	Open
4	That the treatment program be reviewed and improved using the Model of Practice as a guide.	Community Visitor	Dec 2014	Open
5	That CAAAPU improve food provided to Affected Persons to ensure the menu is nutritionally appropriate for persons with chronic disease, and that food preparation is hygienic.	CV Panel	Aug 2015	Open
6	That CAAAPU incorporate Department of Health AMT procedures into the CAAAPU Treatment Manual and that the Department of Health and CAAAPU develop clear guidelines for the reporting and follow up of incidents. (Reworded)	Community Visitor	Jun 2016	Open

TENNANT CREEK ALCOHOL TREATMENT SERVICE (OPERATED BY BRADAAG)

Achievements:

- On the visit the CVP did before the facility closed, one person in the facility said that it was better than another AMT treatment facility they had been in.
- Staff worked well with the Community Visitor to respond to worries raised by the people in the facility.
- The treatment program had a good mix of general life skills, healthy activities and talking about alcohol use. People in the facility had lots of outside activities and visits.

Areas for Improvement:

- Low numbers made it difficult for the staff to have enough work experience and training to do the job well.

Priority Concerns:

- No duress alarms were available for staff or visitors
- No complaints procedure had been set up.

Nil Recommendations: As both the AMT Tennant Creek assessment and treatment facilities have closed, the CVP closed both recommendations. The same recommendation was in place for both facilities.

	Mental Health			Disability				Alcohol Mandatory Treatment					Other	
	CAHS	**TEHS**	**Total**	**Secure Care**	**Appropriate Place**	**Other (DSA)**	**Total**	**Assessment (CAHS)**	**Assessment TEHS)**	**Treatment (Central Aust)**	**Treatment (Top End)**	**Total**	**Total**	**TOTAL**
VISITS	70	86	155	12	9	4	25	41	67	42	67	217		397
Community Visitor	66	81	147	11	9	4	24	41	67	41	65	214		385
Inspection	2	2	4											4
CV Panel	2	2	4	1			1			1	2	3		8
CASES	143	261	404	6	5	6	17	47	99	42	138	326	8	755
Complaints	10	32	42	1	0	0	1	1	3	0	15	19	1	63
Enquiries	133	229	362	5	5	6	16	46	96	42	123	307	7	692
Case 'Raised By'														
People/Consumer	124	181	305	2	0	1	3	42	97	35	133	307	3	618
Carer/Relative	5	48	53	0	0	0	0	0	0	0	0	0	3	56
Service Provider/Case Manager	9	13	22	0	4	3	7	3	1	5	5	14	2	45
Nurse/Doctor	4	10	14	0	0	0	0	2	1	1	0	4	0	18
Guardian	0	1	1	4	1	2	7	0	0	0	0	0	0	8
Friends	1	8	9	0	0	0	0	0	0	1	0	1	0	10

Cases	**CAHS**	**TEHS**	**Total**	**Secure Care**	**Appropriate Place**	**Other (DSA)**	**Total**	**Assessment (CAHS)**	**Assessment TEHS)**	**Treatment (Central Aust)**	**Treatment (Top End)**	**Total**	**Total**	**TOTAL**
ISSUES RAISED	284	516	800	14	9	11	34	66	115	64	142	387	11	1232
Quality of Service Provision	118	227	345	7	6	5	18	10	31	25	79	145	3	511
Assessment and Treatment	21	34	55	2	0	1	3	3	1	10	2	16	0	74
Cultural Safety	21	34	55	2	2	1	5	4	11	3	12	30	0	90
Management Plan	4	24	28	1	1	1	3	0	0	0	15	15	0	46
Activities	6	5	11	0	0	1	1	0	4	1	7	12	0	24
Discharge Planning	13	36	49	1	2	0	3	0	6	2	4	12	0	64
Facilities	2	16	18	0	0	0	0	0	3	1	3	7	1	26
Relationship with Staff	28	26	54	1	0	0	1	0	1	3	4	8	1	64
Aftercare	1	0	1	0	0	0	0	0	0	2	2	4	1	6
Health - Physical/Mental	1	10	11	0	0	0	0	0	0	0	7	7	0	18
Procedures	16	22	38	0	1	1	2	2	0	0	3	5	0	45

Cases (Continued)

Consultation - Carers/Consumers	3	11	14	0	0	0	0	0	0	0	4	4	0	18
Other	2	9	11	0	0	0	0	1	5	3	16	25	0	36
Rights	64	105	169	4	2	3	9	23	30	19	32	104	1	283
Least Restrictive Alternative	23	40	63	0	2	1	3	12	7	11	22	52	0	118
Legal	1	12	13	0	0	1	1	4	11	1	2	18	0	32
CV Information on Rights	2	5	7	1	0	0	1	1	2	0	0	3	1	12
Detention/Early Review of Detention	1	8	9	0	0	0	0	3	2	3	1	9	0	18
Community Accommodation	12	4	16	2	0	1	3	0	0	0	0	0	0	19
Respect for Dignity	6	10	16	0	0	0	0	0	0	0	2	2	0	18
Safety	5	10	15	0	0	0	0	0	1	2	1	4	0	19
Voluntary/Involuntary	8	8	16	0	0	0	0	0	0	0	0	0	0	16
Transport by Police	1	1	2	0	0	0	0	3	6	0	2	11	0	13
Other	5	7	12	1	0	0	1	0	1	2	2	5	0	18
Information	16	60	76	0	0	0	0	15	24	2	7	48	5	129
Request for Information from CVP	10	28	38	0	0	0	0	9	14	2	5	30	3	71
Information Provided	4	17	21	0	0	0	0	6	7	0	0	13	2	36
Other	2	15	17	0	0	0	0	0	3	0	2	5	0	22
Advocacy	41	26	67	3	0	2	5	16	9	16	5	46	2	120
Smoking	24	22	46	0	0	0	0	0	7	0	9	16	0	62
Visit/Support	5	31	36	0	1	1	2	2	7	0	3	12	0	50
Other	7	23	30	0	0	0	0	0	5	1	7	13	0	43
Medication	9	22	31	0	0	0	0	0	2	1	0	3	0	34

Outcomes

Resolved	116	294	410	1	5	5	11	43	81	35	91	250	4	675
Ongoing Monitoring	110	56	166	8	3	2	13	14	4	17	2	37	1	217
Not Resolved	37	41	78	1	0	2	3	1	9	5	5	20	0	101
Referred	3	28	31	0	0	1	1	7	17	3	19	46	5	83
Lapsed	9	15	24	0	1	1	2	0	0	3	2	5	0	31
Withdrawn	1	31	32	0	0	0	0	0	0	0	8	8	0	40
Other	8	37	45	4	0	0	4	1	1	1	11	14	1	64
(Open)	0	14	14	0	0	0	0	0	3	0	4	7	0	21

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.

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 and Alcohol Mandatory Treatment legislation.
3. Increase recognition of the CVP and its role throughout the Territory.

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.

CVP
NT Community Visitor Program

The CVP would like to acknowledge the artwork of Alexandra Hullah (Sweatshop Creative Pty Ltd) used on the cover page of the report. The report's graphic design was by Sophie Cavies from Bellette Pty Ltd.

DARWIN:

7th floor, 9-11 Cavenagh St
Anti-Discrimination Commission
DARWIN NT 0800

LMB 22 GPO
DARWIN NT 0801

ALICE SPRINGS:

Level 1, Alice Plaza
ALICE SPRINGS NT 0870

PO Box 721, Alice Springs
NT 0871

GENERAL ENQUIRIES

Telephone: 08 8999 1451
Freecall: 1800 021 919
Facsimile: 08 8981 3812

Email: cvpprogramadc@nt.gov.au
Website: www.cvp.nt.gov.au