CVP

NT Community Visitor Program

2014/2015 Annual Report

Respect
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CVP

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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 Anastassia Briantseva from Bellette Pty Ltd.

CVP
NT Community Visitor Program

30 September 2015

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The Hon John Elferink MLA
Minister for Health
Parliament House
State Square
DARWIN NT 0800

Dear Minister,

Re: Community Visitor Program Annual Report 2014-2015

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
55 North Stuart Highway
Alice Springs NT 0870

REFLECTIONS FROM THE PRINCIPAL COMMUNITY VISITOR

Sally Sievers
Principal Community Visitor

This is the third Annual Report delivered by the Community Visitor Program under my stewardship. The Community Visitor role complements that of the Anti-Discrimination Commission. The traditional complaints process of the Anti-Discrimination Commission does not always suit vulnerable and disadvantaged groups.

In the areas that the Community Visitor Program works, there are many reasons why someone may not feel comfortable to use a conventional complaints process. If, however, you are visited and spoken to on a weekly or monthly basis, this can help conversations flow. Importantly, it can help things be resolved at the lowest possible level. This is one of the main aims of the Community Visitor Program.

As with the Anti-Discrimination Commission, the Community Visitor Program also works at a broader level – to identify barriers to equal opportunity or inclusion in our community. This gives a voice to people who might otherwise not be heard, by listening to their experience we all benefit.

The value of this approach, both to building relationships with agencies and helping people, has been proven since the program commenced in the mental health field in 2001.

Change is not always fast. With patience, and a commitment to working together, it does happen. Over time, this helps promote greater safety in the delivery of services, and positive change for consumers and the community.

I would like to extend my thanks to all the staff of the agencies with whom we work, from the Chief Executive of the Department of Health through to the managers and caseworkers working on the frontline with clients.

There are now non-government organisations working with the Community Visitor Program in the specialist disability and alcohol mandatory treatment areas. Working with the Community Visitor Program is a new space for many of their staff, and I appreciate that this can be challenging. I thank them for their assistance to the program throughout the year. It is important that we continue to work together, building relationships that benefit the community's most vulnerable.

I also would like to thank the staff of the Community Visitor Program, including the sessional Visitors and Panel members. All of the Community Visitor Program staff honour the voices of the most vulnerable and work tirelessly to ensure their rights are protected. Your hard work and dedication is greatly appreciated.

It is however appropriate in the Annual Report to acknowledge the individuals who take the courageous step to talk to us. This is often a very difficult step to take. Talking up for your needs and asking for change helps all of us for the better. On behalf of the Community Visitor Program we say thank you.

Contents

EXECUTIVE SUMMARY

The Northern Territory Community Visitor Program (CVP) is established under the *Mental Health and Related Services Act,* the *Disability Services Act* and the *Alcohol Mandatory Treatment Act* (the AMT Act).

The CVP continues to meet its obligations to visit facilities, to hear enquiries and complaints, ensure regular Community Visitors (CV) Panel visits, and to provide regular feedback to the services. The CVP responds within one working day to any requests to contact or visit individuals who are in facilities covered by the legislation.

The activities of the CVP consolidated this year, with complaints and enquiries at similar levels to last year. This followed the rapid expansion of the program in 2013-2014 when the CVP started to work in the alcohol mandatory treatment program.

Each jurisdiction of CVP activity is unique. For this reason, each chapter in this Annual Report (relating to mental health, specialist disability services and alcohol mandatory treatment) can be read on a 'stand alone' basis.

A brief summary of the CVP's main concerns is highlighted at the beginning of each chapter. The highest priority concerns identified for each area are:

- reducing the use of seclusion, especially for young people (mental health);
- actively working towards safe transition to community accommodation (disability services); and
- the need for an independent evaluation (alcohol mandatory treatment).

Regardless of the differences between each area scrutinised by the CVP, the common theme across the program is that the CVP monitors laws that restrict the rights of vulnerable people receiving health services.

These laws allow the rights of individuals to be restricted, such as their right to choose where they live, their right to consent to treatment and their right to freedom of movement. Where government is limiting rights by law, the services and treatment must be open to independent oversight.

The CVP is one way to monitor what is happening in the mental health, specialist disability, and alcohol mandatory treatment area. The CVP recognises that the oversight, advocacy, complaints and enquiry function is newer in the alcohol mandatory treatment and disability jurisdictions. While this can sometimes be a learning curve for agencies to adjust to the CVP role, in the end, this oversight benefits the client and improves outcomes.

The following summary highlights some of the key themes that cover all three areas of the CVP's work. It is important, however, for those with an interest in a particular field of the CVP's work to read the relevant chapter, noting the main concerns and significant issues. The issues in each area are very different, and the CVP sees the differences as much as the similarities.

This year the main concerns, identified above for each area of CVP work, all relate to the principle of the least restrictive alternative.

In each area that the CVP works, a core principle is that the agency must ensure that the 'least restrictive alternative' is used. This means that where the agency is considering what options are available to provide services and treatment to a person, the option that has the least impact on the freedoms of the individual must be chosen.

For example, if a person is receiving mental health services, the agency needs to weigh up carefully whether the person could be treated safely in the community or if they need to be admitted to an in-patient facility.

If a person must be detained for their own or others safety, then within that facility those services must also be the 'least restrictive' possible. This might mean, for example, that leave is approved to help the person remain connected to their community.

Even if a person is in a facility, the 'least restrictive' principle supports (to the extent possible) the individual to still be able to participate in activities they enjoy or that are important to them.

In newer areas of activity, such as alcohol mandatory treatment, the CVP knows that processes and procedures are still being worked through. While the CVP understands this, there are a number of issues of concern. These mostly relate to how an individual's circumstances and freedoms need to be at the forefront of decision-making.

Limiting someone's freedom is a significant decision that impacts deeply on a person. These are the issues that concern both individuals and the CVP at the highest level.

Each area of CVP work also consistently raises issues about cultural safety. A large number of consumers in the mental health jurisdiction are Indigenous Australians. In the disability and alcohol mandatory treatment jurisdiction, almost all of the people detained are Indigenous Australians.

The majority of the workforce in health services is non-Indigenous. This presents a large challenge for all agencies to make sure their staff are competent and skilled to work well with Indigenous Australians. Working cross-culturally is never easy and requires hard work, personal reflection and professional development to do it well.

The seriousness of this challenge, and the importance of it to Indigenous Australians, means that the CVP expects that this will continue to be a focus in the years to come.

Another common concern across all three areas of the CVP work is the need for high quality treatment. In the mental health field, the focus needs to be on engaging better with consumers and carers. Quality treatment has to be a partnership with consumers and carers. It needs to be recovery-focussed. It needs to avoid re-traumatising clients who may have experienced trauma in the past.

In disability services, quality treatment means that the services are better tailored to the individual and evidence-based. In this area of work, the agency is trying to support individuals to address behaviours that are unsafe to themselves and to others in the community.

It is possible to design programs that help people with complex disabilities change their behaviours. At present, the CVP is of the view that these specialist programs need to be better focused, and track successes and failures in a more sophisticated way. The aim is to have an evidence base that helps an individual to return to the community with the right support for their needs.

In alcohol mandatory treatment, quality in treatment programs is one of the issues that clients have raised when the Community Visitors and Panel members visit.

People in the alcohol mandatory treatment facilities may have to spend many months there. It is essential therefore that the programs provided in the facility are helpful when they return to the community. The programs need to provide individual and group support that help people move away from harmful use of alcohol.

The programs need to help people work out their own personal strategies to avoid alcohol-related harms when they return to the community. At the moment, there is little evidence that this is happening and this needs to be improved to inform how services are provided.

While every individual's journey through the services will be unique, in the end, each person will need to return to live in the community. When a person leaves a facility, having somewhere to live that is safe and supports their recovery or independent living is a consistent issue across all three areas of the CVP work.

Some individuals will need special support and housing, tailored to their unique needs. Others will just need a clear plan about where they are living, and what support is available. This plan will only be effective if it is developed closely with the person concerned.

The services all have a role in assisting people to reach their full potential, and to live active and healthy lives in a safer community. Through this, the person can achieve their right to full participation in the community, and maximise control of their own lives.

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OVERVIEW OF CVP ACTIVITIES

The performance of the CVP is measured against its legislative requirements in the *Mental Health and Related Services Act*, the *Disability Services Act*, and the *Alcohol Mandatory Treatment Act.*

The following tables and graphs illustrate the key performance indicators for the CVP overall. The data for each area (mental health, disability and alcohol mandatory treatment) is analysed in greater depth in the relevant chapter.

> "it is great to know there is an advocate here, as you can feel very powerless in the system; it has been helpful to talk with a community visitor"
>
> C/2014/46

Report Structure and Approach

The Annual Report has been divided into sections relating to the areas of CVP activities, highlighting the significant issues for each area. Each chapter includes a 'report card' on the work of agencies and facilities visited by the CVP.

The order of chapters reflects the length of time that the CVP has been operating in each jurisdiction.

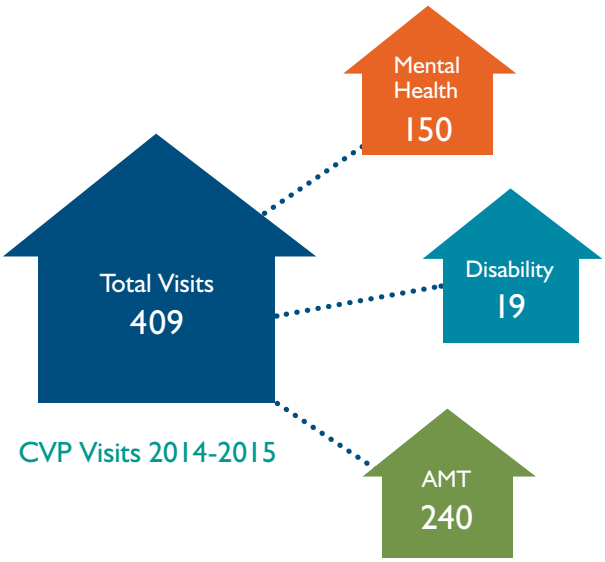
In the Annual Report, people who are visited by the CVP, or who can make enquiries or complaints, have been referred to by different terms. The terminology is consistent with that used in the relevant legislation, or is a commonly used term (such as 'consumer' for mental health).

The report includes an overview of the nature of the CVP work. The CVP is not involved in all issues and complaints that arise in each of the areas of service provision; only those where people have requested or chosen to talk to the Community Visitor or the CV Panel member.

Often, the Community Visitor will talk to individuals who say that they have had positive experiences with the service and have no concerns. This is a positive aspect of the CVP's work and the Community Visitors try to ensure that this feedback is also passed on to the service and acknowledged in the reporting.

There are times, however, that concerns arise or even very serious incidents occur. This is the main purpose of the CVP work – to assist clients and to help services improve the quality of the services. For this reason, these issues tend to be the focus of the CVP's work and also of the reporting.

In this Annual Report, the CVP has sought to identify the systemic issues of most concern without going into unnecessary detail, and risk breaching a client's privacy or unfairly criticising



CVP Visits 2014-2015

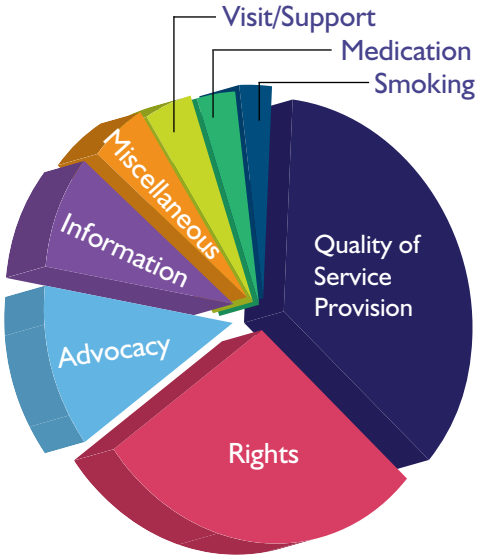
CVP Complaints & Enquiries 2014-2015

the service. All interactions with the CVP, from the positive through to the serious incidents, assist the CVP to identify areas for the service to improve or that demonstrate good practice.

The Annual Report includes case studies illustrating how the CVP assists people throughout their engagement with a service or in a facility. The report also includes some reflections from a Community Visitor and a Panel member on the meaning of the work at a person level.

Most importantly, the report includes the words of people who have talked to the CVP. These words are as faithful as possible to what was said, based on the records of conversations kept by the Community Visitors. The people's voices highlight that every issue raised in this report comes from someone affected by the legislation, including sometimes their family, carers or loved ones.

With their words, the Community Visitors stand beside each individual; the people's words breathe life to this report.



CVP Complaints & Enquiries - Issues Raised 2014-2015

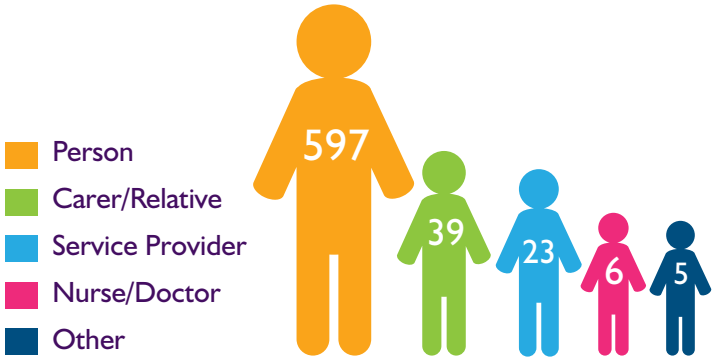
	Complaint	Enquiry	Total
Mental Health	58	280	**338**
Disability	-	11	**11**
AMT	52	268	**320**
Other	-	1	**1**
Total	**110**	**560**	**670**

CVP Complaints and Enquiries 2014-2015

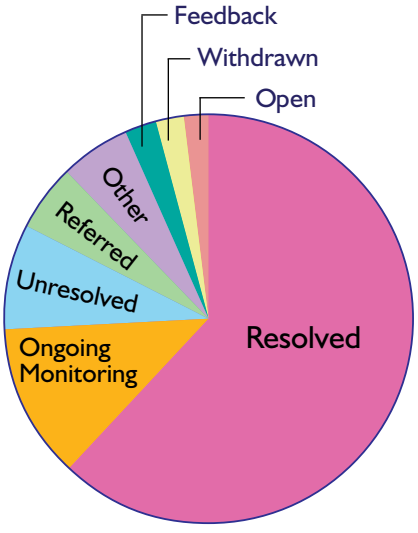
More detailed information on the data collected by the CVP in 2014-2015 is in the Appendix.

	Mental Health	Disability	AMT
% of requests contacted within one working day	99%	(no requests)	100%

Requests to Contact CVP 2014-2015



CVP Complaints & Enquiries - Sources 2014-2015



CVP Complaints & Enquiries - Outcomes 2014-2015

I have been with the CVP since early 2012 and it is a very challenging, but also very rewarding role.

The Annual Report is an opportunity to make the voices of people who are treated in these systems, heard loud and clear: with decision-makers and politicians, the public and whoever has an interest in the well being of people living with mental illness and disabilities.

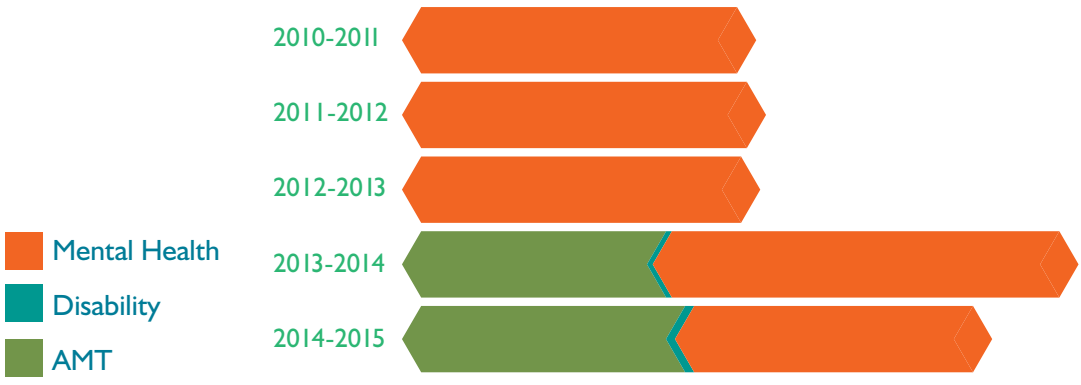
This report cannot do justice to the depth and variety of experiences people have shared with us. Although it may seem to some that their pleas and concerns go unacknowledged, I would like to assure all of them, that each and every issue is noted and informs us and the services.

Without these issues raised, big and small, we would not have such a deep understanding of the need for change and improvement in certain areas, and also what is helpful and supportive.

I would like to thank all staff in the services who work with us and assist us, even though we often challenge the status quo.

Most importantly, I would like to express my deepest respect for the courage and tenacity people show in raising the issues that concern them and thank them for their trust in our work. They often deeply affect us and they always keep us inspired and dedicated to the task.

CVP Coordinator



CVP Complaints & Enquiries - Historical Overview

Chapter 2: Who We Are and What We Do

WHO WE ARE AND WHAT WE DO

The Community Visitor Program (CVP) is a legislated means of protecting the legal and human rights of people receiving mental health, disability and alcohol mandatory treatment services in the Northern Territory.[1]

The CVP provides a specialist complaints resolution and advocacy service. It is one of the systemic 'checks and balances' to ensure that the standard of the services provided under the relevant Acts is of a high quality and that people's rights are protected.

The CVP is located in the Anti-Discrimination Commission (ADC). The Anti-Discrimination Commissioner is appointed as the Principal Community Visitor (PCV). This guarantees the CVP's independence from the providers of the services. The services are the responsibility of the Department of Health.

FRAMEWORK FOR THE COMMUNITY VISITOR PROGRAM

Principal Community Visitor

The Principal Community Visitor has overall responsibility for the CVP. The Principal Community Visitor is required to do a number of activities under each of the Acts mentioned above. These include establishing standards, principles and protocols for the program, circulating information about the program and reporting on its activities to the Minister for Health.

Community Visitors Panels

A Community Visitors Panel (CV Panel) is established for each approved facility or agency covered by the legislation. For AMT facilities, the CV Panel only visits AMT treatment facilities (that is, they do not visit AMT assessment facilities).

Each CV Panel is appointed by the Minister for Health and has three members. The CV Panel members are comprised of a medical practitioner or registered health practitioner, a legal practitioner and a community member with an interest and experience in the relevant field.

Panel members are required, as a group, to visit the facility to which they are appointed at least once every six months.[2]

During visits, CV Panel members inquire into a range of matters that are more systemic in nature. These matters include opportunities and facilities for recreation and rehabilitation, the application of the 'least restrictive alternative' principle,

I have been a Community Visitor for mental health since 2007 and a Panel member for AMT since 2013. People are often at a dark time in their lives when they are being treated by the relevant service, feel very vulnerable, and without power and control.

It has been a privilege to be invited by them to assist them in exercising their rights.

In the main, my experience of staff in these services is that they are dedicated and motivated by the best interests of the clients. A lot of the CVP work has been facilitating communication between clients and staff, helping the client's voice be heard by an already open and willing audience.

Community Visitor and CV Panel Chair

the quality of treatment and care, and the adequacy of information provided about complaints and legal rights.

The CV Panel may also inquire into any matter referred by the Minister or the Principal Community Visitor, or any other matter that the Panel may consider appropriate.

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

"This is the first time I have really felt listened to and been able to tell the full story, thank you."

C/2015/142

Community Visitors

Community Visitors are appointed by the Minister for Health for a three-year term. They have inquiry, inspection, complaints resolution and advocacy functions.

The Community Visitors respond quickly. If a person asks to see the Community Visitor, the CVP has to make contact or follow up with the person by the end of the next working day. Often a Community Visitor responds on the same day.

The Community Visitor will seek to address any issue at the lowest possible level.

Community Visitors may help a person make a complaint using internal complaints processes, or by accessing external complaints bodies such as the Health and Community Services Complaints Commission (HCSCC). For mental health and disability functions, the Community Visitor can help the person to use the legislated review mechanisms.[3]

CASE STUDY — COLLABORATION WITH CARERS (MENTAL HEALTH)

Robert's family rang the Community Visitor, unsure if the CVP could help them. The family had recently moved to the Northern Territory from Victoria. Robert's behaviour had become erratic and his family wanted Robert's medication reviewed.

The family had tried to talk to the crisis assessment team, but the family felt like they did not really understand the depth of the family's concern. The family were not able to encourage Robert to go to the emergency department because of negative experiences in other hospitals.

The Community Visitor spoke to Robert's psychiatrist and the community team leader. The psychiatrist agreed to review Robert's medication. The team leader noticed that Robert's case had not been re-assigned when a staff member had left.

With a change in medication, a new case manager, and better engagement with the family, Robert's health began to improve. Robert's family felt more confident about the help that was available.

For mental health and AMT facilities in Darwin and Alice Springs, the Community Visitors generally visit on a weekly basis. This is so that as many clients as possible have access to a Community Visitor.

In the disability area, visits to the Secure Care Facility are required monthly and, for 'appropriate' places, at least once every three months (as the residents usually remain there for a longer period). The Community Visitor can also visit other residential facilities covered by the *Disability Services Act.*

After every visit, or quarterly as agreed with the service, the Community Visitor forwards a report of the visit to the Principal Community Visitor. Every three months, a report is forwarded to the person-in-charge of the relevant facility or agency.

If a matter is urgent or important, the person-in-charge will be contacted as soon as possible.

The Community Visitor may look into a broad range of matters. This includes the adequacy and standard of services and facilities, the failure of persons employed to comply with the relevant law, or any other matter referred to the Community Visitor by the Minister or the Principal Community Visitor.

"I have no doubt that my complaint and my issues are taken seriously because of the CVP's involvement. Because you are there, you are advocating for the issue and you keep following up, that's why they are listening to me."

C/2015/66

CASE STUDY — USE OF POWERS (AMT)

During a visit to the facility, Jackson talked to the Community Visitor about a search that had been undertaken the previous week. Jackson was upset about the search, especially around matters of personal dignity, and wanted to make a formal complaint.

At Jackson's request, the Community Visitor organised a meeting with the manager of the facility, and attended the meeting with Jackson. The manager acknowledged Jackson's concerns, heard his feedback about possible improvements to searches in the future, and also apologised directly to Jackson about some communication issues which had arisen during his admission.

Jackson was happy with the outcome of the meeting. With Jackson's consent, the Community Visitor also reviewed his file and noted that documentation about the search was not present. This was subsequently fixed by the facility.

Requests for clarification about legal issues relating to search powers were raised in the next CVP quarterly report and included in the CVP recommendations to the agency. The agency advised the CVP that legal advice is being sought to clarify the powers under the Act.

VALUES AND APPROACH OF THE CVP

The values, mission and strategic objectives of the CVP are detailed in full at the conclusion of this report. This section illustrates how the CVP brings these values to life in the work. The work of the Community Visitors and the CV Panel members is challenging but also rewarding.

The CVP works in a way that respects and values the voice of people receiving services, their family members and carers. The CVP also respects the skills, knowledge and expertise of staff working in the services.

It is important to Community Visitors and CV Panel members to act courteously but always courageously. Sometimes this can be a difficult tension. The CVP honours the importance of open communication, and how this can help achieve high quality services.

The CVP role includes advocating, or 'talking up', for both individuals and also changes needed at a broader level. Community Visitors support individuals to actively participate in decision making processes and conversations that impact upon their lives.

The CVP appreciates that there is a power imbalance between the service and clients and works with services to address this for clients. The goal is services that work better for the people who are using them.

> "I am so glad you were at the meeting. You understood what was important to me… Before that, they just didn't really take notice of what me and my family were saying. But the way you put it, I think they understood it."
>
> C/2015/8

CASE STUDY – LEAST RESTRICTIVE ALTERNATIVE (MENTAL HEALTH)

Tamara met the Community Visitor during a routine visit to the ward. The Community Visitor provided Tamara with her contact details.

A few weeks later, Tamara rang the Community Visitor, crying and frightened. She said she felt like killing herself but was too anxious to go to the hospital.

Tamara said that she was told that if she felt suicidal again, she would be admitted directly to the Joan Ridley Unit (JRU). Last time Tamara had been in JRU, she had felt like the ward was a punishment.

The Community Visitor rang the community mental health team, and Tamara's psychiatrist, and asked if the advice given to Tamara was true. Both assured the Community Visitor this was not the case.

After hearing back from the Community Visitor, Tamara went to the hospital and was supported to get better without the need for admission to JRU.

The Community Visitor listens and acts to support the individual, helping them to be aware of the different ways they can have a say. The Community Visitor will also help them to represent their own interests.

The Community Visitor also works with the person to decide the best way forward. In practice this may involve the person speaking to staff with or without the Community Visitor present. Or, with the person's permission, the Community Visitor might speak to staff on the person's behalf.

The Community Visitor always tries to talk to staff immediately. This is because staff may already be trying to address the issues. This is consistent with raising any issue at the lowest possible level.

Often, talking to staff about what is happening, and then discussing this further with the person concerned, is all that is needed. Regardless, the Community Visitor will remain involved until the issue is resolved.

CASE STUDY — WANTING TO GO HOME (DISABILITY)

When the Community Visitor went to see Tobias, he said that he was feeling okay but he wanted to go home. Tobias is on a supervision order that requires him to live there.

The Community Visitor talked to the house manager, to find out where Tobias's family lives and how often he is able to visit. The house manager said that Tobias's home community was three hours away, and he had not visited anytime that year.

With the Community Visitor's advocacy, including with Tobias's adult guardian, a visit home around Christmas time was arranged and plans were put in place for more regular visits next year.

The CVP strives to work in a culturally safe manner, especially as there are many clients who are Indigenous Australians or who come from other culturally and linguistically diverse backgrounds.

Continuing to develop the skills of Community Visitors in this area is a priority for the CVP. In the coming year, the team will be exploring ways to improve cultural advice and mentoring from Indigenous Australians in particular.

In every interaction, the Community Visitors try to walk alongside clients. The work requires the Community Visitors to be very careful to maintain people's privacy and their confidences. However, the Community Visitors approach each situation with the knowledge that all points of view are valid and that maintaining hope for positive change is important.

There is an inherent tension in the roles of advocacy and complaints resolution. The CVP understands that the work can sometimes be challenging for the services involved. The CVP values robust, frank discussions. Even when what is being communicated is not welcome or accepted, the Community Visitors will continue to fulfil their statutory role and promote the rights of clients and their right to quality services.

The CVP is committed to being accountable, for their own work just as the service also has to be accountable. The CVP actively welcomes feedback about how Community Visitors and CV Panel members are doing.

Professional supervision for the Community Visitors is planned for next year. This is part of a broader strategy to ensure that Community Visitors can remain resilient and strong in the face of often very personally challenging work.

CASE STUDY — AFTERCARE (AMT)

Bill was due for discharge from the AMT treatment facility when he spoke with the Community Visitor. He said that he didn't think the aftercare process was well handled. Bill felt like he was being 'thrown out' into a short term accommodation option, and he was anxious about what would happen when he left.

Bill and the Community Visitor met with Bill's case manager to review his aftercare plan together. In the meeting, Bill's case manager talked in more detail about referrals that had been made and how Bill would be supported once he had left the facility.

Bill said that he was happy to stay with his family member, as had been arranged, but he still wanted more follow up with local hostels. Bill's case manager agreed to assist Bill with this on the day.

Later on, the Community Visitor raised issues about aftercare planning and engagement in the next quarterly report to the agency due to a number of issues which had arisen in that area.

[1] The program is formally established under the Mental Health and Related Services Act, the Disability Services Act and the Alcohol Mandatory Treatment Act (the AMT Act).

[2] Under the Mental Health and Related Services Act, the Principal Community Visitor may establish a special CV Panel to investigate and report on a matter. In 2014-2015, no such special CV Panel was constituted.

[3] Refer to Part 15 of the Mental Health and Related Services Act, being the Mental Health Review Tribunal; and Part 7 of the Disability Services Act, the Review Panel.

CVP ORGANISATIONAL STRUCTURE

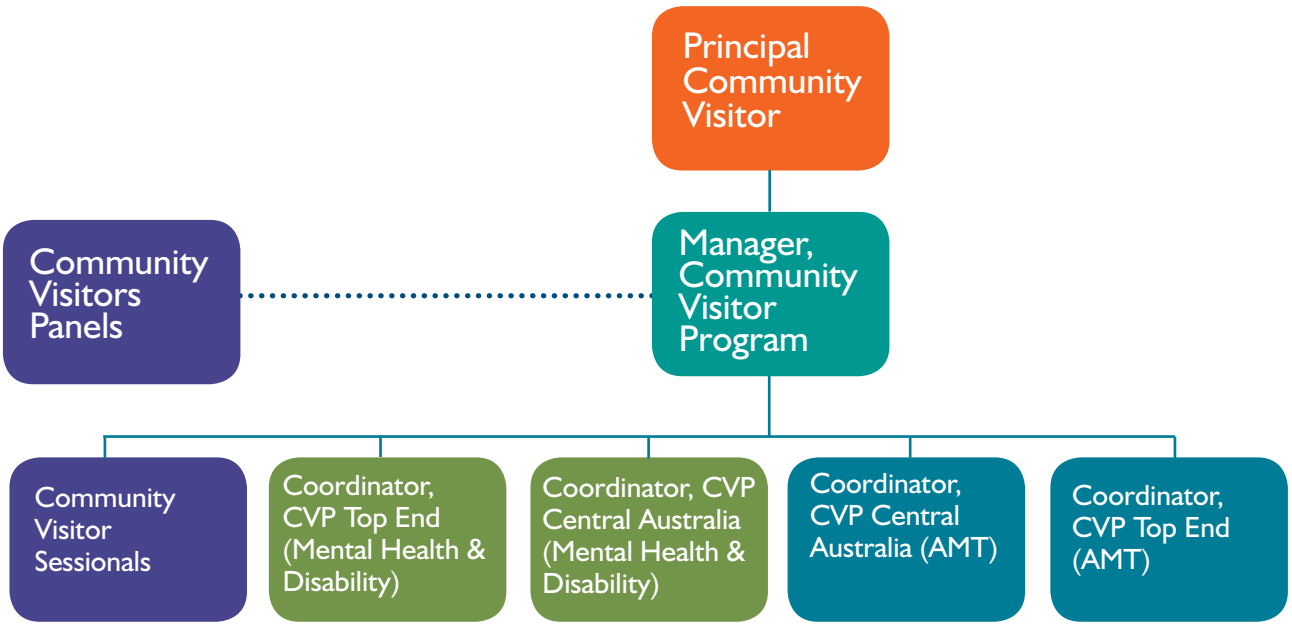
The CVP team is comprised of:

- The CVP Manager (this role does not have a statutory function, although the Manager is appointed as a Community Visitor);
- Four CVP Coordinators, who are appointed as Community Visitors under relevant legislation;
- One administrative support person; and
- Sessional Community Visitors and CV Panel members as required.

The CVP Manager is responsible for the overall direction and management of the program. The CVP Manager also ensures that Community Visitors and CV Panel members are properly appointed and aware of their statutory responsibilities.

The CVP Coordinators are responsible for ensuring regular visits occur at facilities, and coordinating the work of sessional Community Visitors as required. At times, sessional Community Visitors are employed to ensure that the visits occur as regularly as required and to cover Community Visitors' leave and other commitments.

The CVP Coordinators respond to complaints and enquiries, liaise with the service, and prepare quarterly reports on the work of the CVP.



CVP STAFF, COMMUNITY VISITORS AND CV PANEL MEMBERS

CVP Team

Sally Sievers
Principal Community Visitor

Claudia Manu-Preston
CVP Manager

Hiltrud Kivelitz
Coordinator,
Top End
(Mental Health and Disability)

Sophie Staughton
Coordinator,
Central Australia
(Mental Health and Disability)

Elizabeth Keith,
Coordinator,
Top End (AMT)

Graeme Berryman,
Coordinator,
Central Australia (AMT)

Loene Wilson,
CVP Administration

Tessie Reinsch,
Coordinator,
Central Australia
(Resigned)

Kaylene Arnell,
CVP Advocate (AMT)
(Resigned)

CV Panel Members

Carly Ingles
Panel Chair,
Central Australia
(AMT)

Maya Cifali
Panel Chair,
Central Australia
(Mental Health and Disability)

Georgia McMaster,
Panel Chair,
Top End (AMT)

Alison Hanley
Panel Chair,
Top End
(Mental Health)

Dr Sarah Giles
Central Australia,
(Disability) and Top End
(Mental Health)

Dr Kate Lloyd
Central Australia,
(Mental Health)

Jared Sharp
Top End,
(Mental Health)

Caisley Sinclair
Central Australia,
(AMT)

Toni Smith
Central Australia,
(AMT)

Julian Robinson
Top End,
(AMT)

Elizabeth Stubbs
Top End,
(AMT)

Mark O'Reilly
Central Australia,
(Mental Health and Disability)

Community Visitor – Sessionals

Michelle Alleman

John Duguid

Traci Keys

Lauren Macauley

Pamela Trotman

Denise Taylor (Resigned)

Sara Baggley

Gabrielle Jess

Ken Lechleitner

Claire Pirrett

Marion Wells

Emily Webster **Kathryn Broadbent**

Chapter 3: Mental Health

CVP MAIN CONCERNS

1. Ongoing lack of systematic partnership with consumers and carers to enable well informed, recovery-focused care and planning
2. Seclusion of young people, in particular minors under 18 years of age, and some seclusion events for very long periods (such as many days)
3. The need for a range of accommodation options, including intensive supported care for consumers with complex impairments and other vulnerable consumers, to enable safe discharge from mental health in-patient facilities

At the outset, the CVP would like to acknowledge the staff who work in mental health in the Central Australia and Top End Health Services. The work is challenging and requires a high level of focus on the individual, their family, and their personal circumstances. Often the CVP hears stories of the positive relationships forged between staff and consumers. These stories are honoured as much as the challenges of the work.

	Community Visitor	Inspection	CV Panel	Total
Central Australia	59	2	2	63
Top End	83	2	2	87
Total	**142**	**4**	**4**	**150**

Mental Health Visits 2014-2015

SIGNIFICANT ISSUES

Early Intervention and Services for Young People

The CVP has consistently raised systemic concerns regarding the lack of early intervention and youth-specific services for young people with a mental illness in the Northern Territory. A recent survey indicated that more than one fifth of adolescents (aged 15-19 years) in Australia meet the criteria for 'probable serious mental illness' and these figures were higher for Indigenous young people.[1]

Young people with mental health challenges are also more likely to disengage from education, training and employment.[2] At a national level, the need to more effectively target interventions for families with children was the subject of a specific recommendation of the National Mental Health Commission in its most recent national review of mental health services.[3]

It is widely recognised that early intervention can prevent episodes of mental illness and reduce the severity of episodes. The Northern Territory *Mental Health Services Strategic Plan 2015-2021* acknowledges the importance of early intervention.[4] It is crucial therefore that effective early intervention services are in place in the Northern Territory and, where young people need to access acute mental health services, these services are appropriate and responsive to their needs.

The Department of Health has advised that both Central Australia and the Top End Health Services work collaboratively with the 'Headspace' service. Headspace provides early

	Complaint	Enquiry	Total
Central Australia	13	99	112
Top End	45	181	226
Total	**58**	**280**	**338**

Mental Health Complaints & Enquiries 2014-2015

intervention services for youth in the community, and referral pathways are in place between the services.

Unfortunately, there remain a number of concerns for the quality and responsiveness of early intervention services provided to young people with mental illness or disorders in the Northern Territory. These concerns are based on Community Visitors and Panel members visiting in-patient facilities, enquiries and complaints to the CVP (in particular from carers), inspections of community treatment agencies, and the evidence of restrictive interventions used on young people.

Acute Mental Health Services for Young People

Young people and their families have particularly raised with the CVP the lack of support when they are in crisis, including potential crisis management in the community or admission to the in-patient facilities.

The CVP has consistently stated that treating young people, including minors, in the same ward as adults is not acceptable.[5] While the service provides a 1:1 'special' nurse for minors, and there may be options for further support of youth in the Top End through a youth worker and different facility options, the CVP does not regard these measures as fully mitigating the risks or concerns for young people and minors at in-patient facilities.

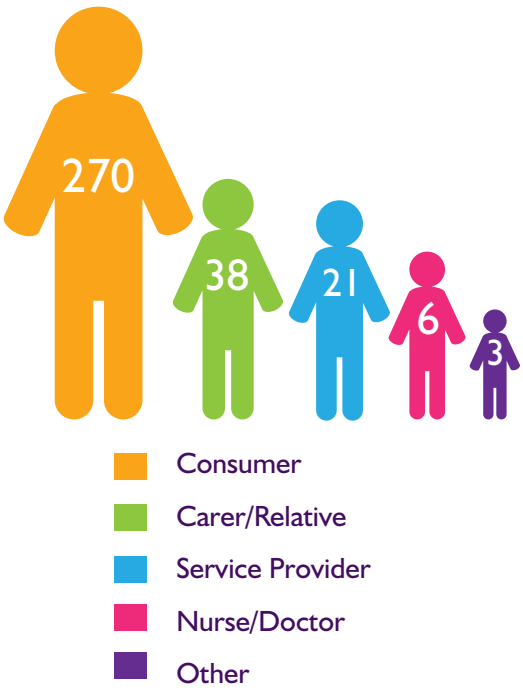
For young people admitted to the Joan Ridley Unit (JRU) in Darwin, in particular, there has been ongoing feedback that the facility is 'prison-like' and some people have indicated that they would avoid accessing crisis support if this means being admitted to this facility again. Further to this, in 2014-2015, the CVP inspection of seclusion registers indicated that 37 young people (those aged 25 or under) were placed in seclusion in Northern Territory in-patient facilities, the majority of whom were in Darwin.[6] Of those, 7 were minors (under 18 years of age).[7] The use of seclusion is known to be traumatic and non-therapeutic.[8] More information on the CVP concerns relating to seclusion of youth is outlined in the relevant section below.

Research evidence indicates that young people are uncomfortable accessing support for mental health problems.[9] If individuals and their families in the Northern Territory come away from acute episodes with an aversion to accessing future support this is concerning. Similarly, if those services are difficult to access or inappropriate for young people who are mentally unwell in the community, this impacts negatively on both the individual and the broader community.

Earlier in this reporting period, the Top End CV Panel took the unprecedented step of making a formal request under section 112 of the *Mental Health and Related Services Act*. This is the formal mechanism under the legislation to escalate, through the Principal Community Visitor, concerns about a lack of responsiveness to Panel recommendations. The Top End CV Panel formed the view that its recommendation relating to the need for a youth-specific framework,

> "We didn't know what to do anymore, he was totally out of control. They didn't want to give us any medication, because they said it's behavioural. After seeing the case manager two times, she said she was going on leave and someone else would take over the case. But nobody ever contacted us. We have been ringing … so many times."
>
> C/2015/1

> "I was told that he would have to stay here [JRU] at least until Tuesday, because Monday was a public holiday... We had called for help and then he was stuck in there, he is not a criminal."
>
> CVP060814



Mental Health Complaints & Enquiries Sources 2014-2015

open since 2007, had not been adequately addressed by the service. Since then, the CVP has been advised that the Top End Health Service is now developing a youth-specific framework for mental health services consistent with best practice guidelines. A very positive development is that additional funding has been secured to enable a specialist youth in-patient service in Darwin to commence in early 2016.

> "I just want to know what's happening for her, is she getting help?"
>
> C/2015/224

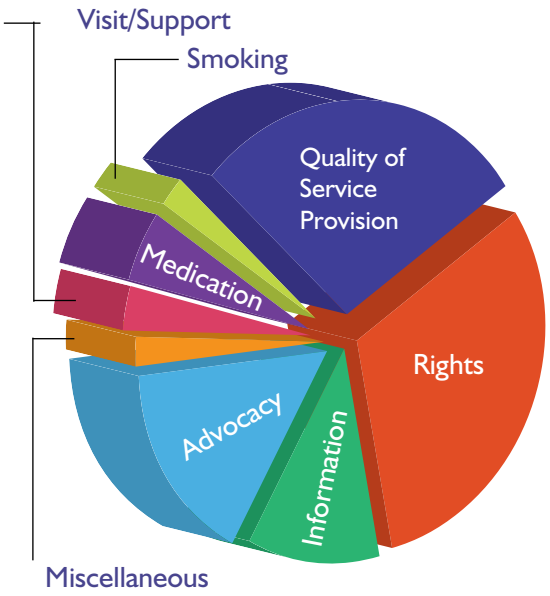
Youth Forensic Mental Health

The CVP has also seen from its inspections of community treatment agencies that there is a significant gap in the provision of mental health services to young people in correctional facilities ('youth forensic mental health'). The CVP understands that only urgent mental health assessments (that is, of suicide risk) are provided to young people from forensic mental health teams in both the Top End and Central Australia.

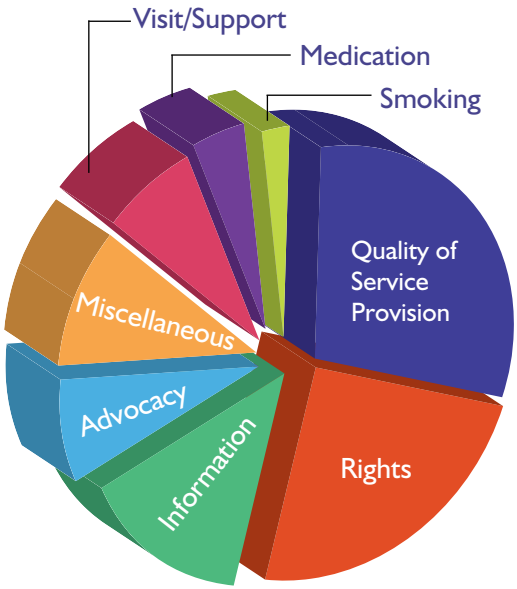
Young people who were previously accessing mental health services from the specialist 'child and adolescent' teams can continue to receive services if incarcerated, however not within the detention centre. This means that there can be issues of privacy and dignity for young people who have to attend outpatient clinics accompanied by correctional officers. Once a young person with mental health issues is incarcerated, their needs are more complex. There are no specialist youth forensic mental health staff in the Northern Territory.

The Northern Territory has the highest rate of young people in detention in Australia, with the majority being Indigenous youth (96% of youth detainees are Indigenous Australians).[10] The average number of days that a young person spends in detention in the Northern Territory is 64 days.[11] The gap in youth forensic mental health services presents a considerable risk for the health and wellbeing of youth detainees in the Northern Territory.

While there are positive changes for youth mental health services flagged for the Top End, the need for such a framework exists across the Northern Territory. The CVP is of the view that the Department of Health, and the Health Service Boards, need to ensure that a Territory-wide approach is taken to improve youth-specific mental health services. This approach needs to focus in particular on early interventions for young people, seclusion cessation, and urgently allocating additional resources to fill the gap in youth forensic mental health services.



Complaints & Enquiries Central Australia Health Service (Mental Health) - Issues Raised 2014-2015



Complaints & Enquiries Top End Health Service (Mental Health) - Issues Raised 2014-2015

Seclusion Reduction

'Seclusion' is confinement alone in a locked room. The *Mental Health and Related Services Act* establishes in section 62 that a person must not be kept in seclusion. The Act and associated Approved

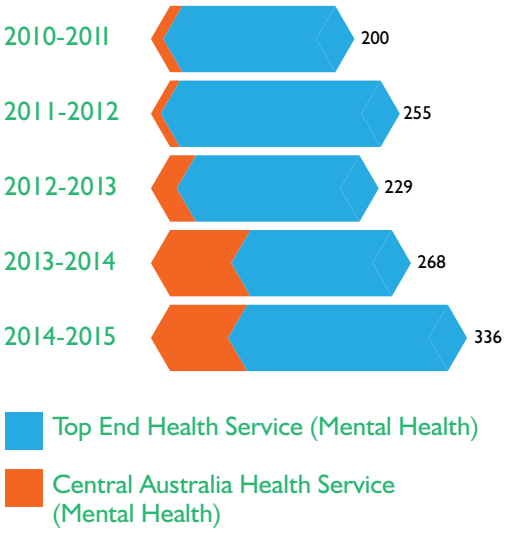
Procedures then specify in detail the only lawful means by which a person may be kept in seclusion. The level of seriousness with which seclusion is viewed by the legislature is clearly evident in the detail provided in section 62 and the additional protections afforded for consumer safety, care and oversight in the Approved Procedures. The CVP has a statutory obligation to review the seclusion registers at least every six months, providing external scrutiny to all seclusion events in Northern Territory in-patient facilities.

Seclusion reduction has been a national mental health priority since 2005. The National Mental Health Commission regards seclusion as a human rights issue, a 'sign of a system under stress', and lacking in international evidence to support its use.[12] The National Mental Health Commission has made recommendations for driving action to reduce seclusion. The CVP notes in particular the need for interventions relating to improving organisational culture, leadership and the physical environment of in-patient facilities. These interventions also need to be informed by a focus on recovery, trauma-informed care and consumer participation.

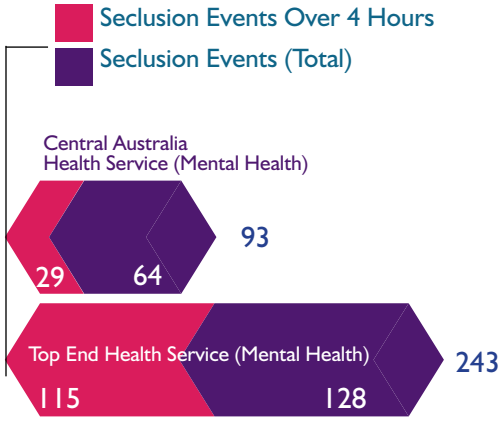
The data gathered from the review of the seclusion registers is provided in this report, and highlights that there is a concerning increase in the number of seclusion events in the Northern Territory.[13] The CVP is also concerned about the length of some seclusion events that have occurred in the Northern Territory, for both youth and adults. Of the total 336 events in 2014-2015, 144 (43%) went for longer than four hours. A concerning number (9) of seclusion events in Darwin went for longer than two days. Some consumers also experienced multiple shorter seclusion events over a number of days, bringing their total number of hours in seclusion over a relatively short period to a concerning level.

The seclusion data alone does not illustrate the whole picture of CVP concerns. Detailed review of the seclusion events in the Northern Territory highlights that there are concerning incidences of seclusion of young people, in particular Indigenous youth, and some very long seclusion events. For the first half of this reporting period in the Darwin in-patient facilities, just over half of seclusion events were for young people and the majority of those people were Indigenous Australians.[14] The most concerning example was a seclusion event for a minor that extended over 7 days.

Without minimising the traumatic effect of seclusion, and especially for long periods, on consumers there is also an impact on staff of seclusion practices. The Top End CV Panel commented that during its visit in late 2014, it was apparent that there had been a 'traumatic number of weeks' with high numbers of youth admitted to the in-patient facility, including a significant number of seclusions of youth. The Top End CV Panel noted that there did not appear to be evidence of any procedures or policies for youth seclusions. The same observation was made by the CVP in Central Australia. As a result of this concerning practice of secluding minors, the CVP recommended that the Department of Health develop policies



Review of Seclusion Register Events - Historical Overview



Review of Seclusion Register 2014-2015

"It felt like a punishment, I should have been warned that they were thinking about putting me in seclusion. I told myself 'you've really got to play this game if you want to get out of here'… that seclusion was like a 'first resort' not a 'last resort!'"

C/2015/142

and procedures relating to the seclusion of minors. The CVP also recommends that these be included in the Approved Procedures and in the developing youth-specific framework.

The CVP has observed that both the Top End and Central Australian Health Services have implemented initiatives in 2015 to reduce seclusion events. The Top End Health Service in particular has established the 'SafeCare project' that appears to have had some positive effect on reducing the length of seclusion events since January 2015. It seems that the service initiatives in seclusion reduction primarily focus on the quality of holistic nursing care.

The CVP is of the view that senior clinicians and organisational leaders in the Northern Territory mental health services will need to more actively drive the seclusion reduction initiatives for there to be sustained positive impact on the seclusion rates over time. Considerable efforts will need to be made by both mental health services to maintain a focus on seclusion reduction, and ideally cessation, in Northern Territory in-patient facilities.

(Consumer crying): "I missed that funeral. I gonna get a hiding for this when I get back. I needed to go to that funeral."

CVP031014

"I'm not really sure why I'm here… I want to go home and I don't know why they are holding me here for so long" (CV advocated for an interpreter; consumer was discharged three days later)

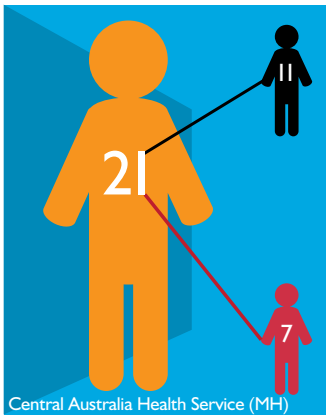
C/2015/82

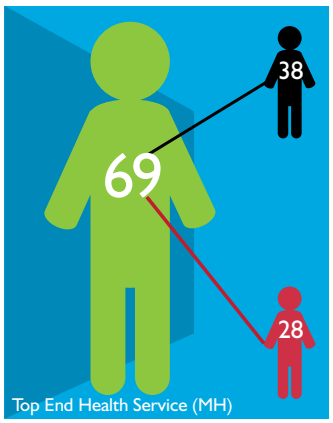
Cultural Safety

A significant proportion of consumers of mental health services in the Northern Territory are Indigenous Australians. This reflects both the high proportion of Indigenous people in the Northern Territory population, and the greater incidence of mental health concerns among Indigenous Australians in general.[15] Indigenous Australians are proportionally over-represented in mental health-related hospitalisations.[16] Indigenous people in the Northern Territory, in general, face a number of disadvantages and for individuals with a mental illness this is further complicated by the predominance of Western cultural values in health settings. The predominantly non-Indigenous composition of the workforce further complicates the delivery of a culturally safe service.

The CVP has heard and read many difficult stories from Indigenous consumers who are struggling to communicate their situation and needs, and have problems understanding details of their treatment plans. The Northern Territory mental health services face considerable challenges in providing a culturally competent and safe service to Indigenous Territorians.

One of the most significant challenges is ensuring that consumers who predominantly speak languages other than English are able to communicate effectively with their treatment teams. The recently released *Mental Health Services Strategic Plan 2015-2021* states that facilitating increased availability and use of interpreters is a planned strategy to improve partnership approaches to recovery in Northern Territory mental health services.[17] The CVP recognises that there have been improvements in the use of interpreters in both in-patient facilities. Despite this, ongoing efforts are required in identifying the





Aboriginal/Torres Strait Islander

25 Years & Younger

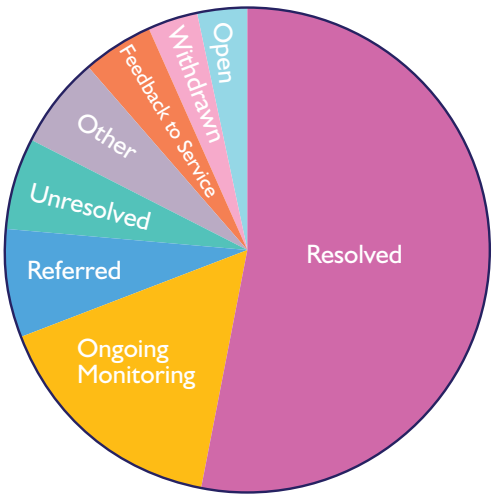
Mental Health Seclusion Data
Review of Seclusion Register
People Secluded 2014-2015

"he's not sick in the head, he was just angry about having no money."
(Carer statement, made soon after admission when no interpreter was available)
C/2015/79

(through interpreter) "I'm unhappy about not getting leave … I'm angry too about the courtyard being shut off – I feel like a prisoner, I want to breathe fresh air."
C/2014/102

"why can't I call my mother?"
C/2015/291

"I need to talk to family."
C/2015/80



Complaints & Enquiries (Mental Health) Outcomes 2014-2015

first language of consumers on admission and consistently engaging interpreters throughout admission, Mental Health Review Tribunal hearings, and discharge planning.

The CVP notes that while there have been improvements in the use of interpreters at the in-patient facilities, the CVP has identified that consumers receiving services from community-based mental health teams may not be as well supported. This will be examined further during annual inspections of community teams in the coming year. The CVP encourages the Top End and Central Australian services to exercise ongoing diligence in the consistent use of interpreters. This includes staff training on identifying the need for an interpreter, and engaging and effectively using interpreters. This training is available through the Aboriginal Interpreter Service.

Another significant challenge for the mental health service in the Northern Territory is ensuring that restrictive interventions for consumer care are culturally safe. Both services have, over time, established good processes to enable cultural safety in the in-patient settings.[18] Nevertheless, based on enquiries, complaints and observations, the CVP notes that ongoing concerns for cultural safety for Indigenous Territorians who are in the more restrictive wards of the in-patient facilities and either at risk of being secluded, or experiencing seclusion.

The CVP inspection of the seclusion register pays close attention to the impact of seclusion events on Indigenous consumers, especially those who require an interpreter. The data on the number of seclusion events that occur for Indigenous Australians in the Northern Territory is included in this Annual Report. The CVP's data does not allow a conclusive interpretation on the rates of Indigenous clients in seclusion compared to the number of Indigenous clients admitted to in-patient facilities. Nevertheless, the Department of Health has advised the CVP that the information has prompted the service to accurately evaluate those rates and review appropriate prevention and responses targeted at Indigenous Australians at in-patient facilities.

The CVP notes that for Indigenous Australians, as for others from culturally and linguistically diverse backgrounds, the ability to communicate effectively is essential for interventions that avoid or reduce seclusion and other restrictive practices. The CVP review of pre- and post-interventions used in seclusion events indicates a low level of Aboriginal Mental Health Worker (AMHW) involvement in managing consumers at risk of seclusion, and in the debriefing afterwards. The services need to use AMHW staff more effectively as part of seclusion reduction initiatives. Despite this, the CVP notes that, in the Top End in particular, there has been an improvement in the engagement of AMHWs with consumers in the high dependency units.

The CVP regularly comments to the service on the need for more Aboriginal Mental Health Workers (AMHWs), timely recruitment to vacant AMHW positions, and appropriate support and training of the

AMHW workforce. A culturally safe workforce however rests with the actions of all staff, not just staff who are Indigenous Australians, and greater attention to the cross-cultural competence skills and training of non-Indigenous staff is required.

Engagement with Carers and Consumers

The CVP considers that the mental health services need to substantially improve engagement with carers and consumers, based on the principles of partnership and a recovery focus. Consumer and carer involvement in services is a key element of the National Mental Health Standards, and the Northern Territory Government's *Mental Health Services Strategic Plan 2015-2021*.[19] A 'person-centred' approach is one of the central recommendations of the recent National Mental Health Commission report on mental health services in Australia. The rights of consumers and carers to actively participate in the mental health care and services are also enshrined in Northern Territory legislation (the *Mental Health and Related Services Act* and the *NT Carers Recognition Act*).

The Department of Health Approved Procedures expand on these principles of consumer and carer participation. The Top End and Central Australian Health Services employ mental health consumer and carer consultants who provide advice and support to consumers and staff. They work to ensure that consumer and carer perspectives are considered in individual and systemic decision-making and policy development.

Despite the resounding breadth of legislative, policy, procedural, and practice guidance, this area consistently remains a key feature of CVP complaints and enquiries. A common concern articulated by consumers, particularly those actively engaged in their care and recovery, is the lack of engagement with them during acute episodes requiring admission. Some consumers express anger and upset about being talked to disrespectfully, talked over or having their concerns and ability to manage their illness ignored or given little weight.

Another issue raised by consumers is how information is documented in their clinical record, including information provided by third parties that might be recorded as factual. The CVP notes that it is important a consumer's clinical record accurately and respectfully reflects the consumer's perspective.

Lack of engagement and partnership with consumers is also evident in the number of concerns raised to the CVP about discharge planning and follow up and support after discharge. The frustration expressed by consumers and carers is echoed by the CVP, as it is regularly observed that there is very little evidence of active involvement of carers and consumers in planning.

It appears that consumers and carers are often given limited information about the detail of their care plans. Relapse prevention plans, which should be promoted in particular by community teams,

"the client is so upset she said that she never wants to see this doctor again."
C/2015/59

"I told two doctors I was allergic to lithium but they ignored me… I know what makes me well and it's not being here."
C/2015/77

"they go on past records, but they judge me on my past, especially my previous drug use."
C/2014/154

"I have this relapse prevention plan, which I did with my case manager. But when I became unwell, nobody in the services followed it. They didn't even know I had it."
C/2015/287

"When we finally found out where they had discharged him to, he was in a mess, scared stiff, cold … how could they have discharged him there, he had no money or anything."
C/2015/257

are under-utilised; if such plans exist, the plan may not be clear about the expectations that consumers and families can have of support that the service will provide them and/or the clinicians may not know or follow what is written in the plan about that support.

Recognition of carers, and creating therapeutic alliances with carers, is another key challenge for the Northern Territory mental health services. According to the Approved Procedures, a partnership approach with carers is required. Effective carer engagement is essential to robust mental health assessments, treatment and discharge. Despite this, the CVP continues to receive a number of enquiries and complaints from carers, frustrated in their attempts to be recognised and involved. A number of concerns have been expressed, in particular, about the quality of service received by carers engaging with the Crisis Assessment and Triage Teams (CATT) and the need for the individual to present at the Emergency Department of the hospital rather than be seen in the community.

CATT is the first point of call for community-based support and assessment in a crisis situation. The CVP acknowledges the challenging nature of CATT work, nevertheless the support that consumers and carers receive in the community is of critical importance to the broader effectiveness of mental health services. Where consumers or carers have negative experiences engaging with CATT, this will inevitably lead to an even greater reduction in help-seeking behaviour.

The CVP recognises that maintaining the privacy of consumers is a right enshrined in the *Mental Health and Related Services Act*. Privacy requests can present particular challenges for the service when consumers are seeking to exclude carers from engagement in their care and planning.

As noted in the Department of Health's Approved Procedures, the service needs to continually encourage consumers to identify their networks of support and involve key people in their care in the interests of their recovery. This is consistent with the requirement in the *Carers Recognition Act* that the role of carers is recognised and their views and needs taken into account when decisions are made. The CVP notes that privacy considerations should not be used to avoid the legislated obligations that all government services have to carers in the community, including in mental health services.

Supported Housing and Community Accommodation

The CVP has made comment in every Annual Report since 2003-2004 on the need for appropriate accommodation options for people living with mental illness in the Northern Territory. This issue is not unique to the Northern Territory; the Australian Institute of Health and Welfare data indicates that 44% of consumers with a current mental health issue reported being homeless in the preceding 12 months.[20] Nationally, Indigenous consumers with a mental health issue access specialist homelessness services at nearly six times the rate of non-Indigenous consumers.[21]

> "I said to the doctor: 'I needed help over the weekend, no one from your department could help me'. The consultant just shut me down… it seemed like she wanted to get rid of us"
>
> C/2015/257

> "My daughter always shuts me out when she is getting unwell. They need to ask her why she suddenly doesn't want me involved. At least they need to hear what my experience is, even if they don't tell me anything. I just want to keep her out of hospital."
>
> C/2015/187

> 'Stable, safe and secure accommodation is the foundation from which people can build a contributing life and recover from mental illness'
>
> (National Mental Health Commission, 2014, Vol. 2).

The need for supported accommodation for people with psychiatric disability is well established; in Australia, psychiatric disability is the second most common disability for those living in disability supported accommodation.[22] The National Mental Health Commission also notes that a 'one size does not fit all' and a range of supported, group and shared arrangements are required.[23]

The Northern Territory is particularly affected, however, by limited accommodation options, high numbers of people who are homeless or at risk of homelessness, and a large Indigenous population.[24] One of the fundamental principles

of the *Mental Health and Related Services Act* is the right to be treated in the community.[25] Any involuntary treatment requiring admission to an in-patient facility is also to be for a brief period.[26]

For Northern Territorians with mental illness, and especially those with other complex needs that affect their capacity to live independently, a range of appropriate supported accommodation models is essential to enable the service to meet the expectation of community-based care.[27] For a small number of consumers, intensive support and supervision is required to enable a safe discharge.

Unfortunately, the CVP has observed that there can be considerable delays in discharge for complex consumers, especially where accommodation options are very limited and/or joint planning with other service providers is required. At present, this is a particularly critical issue for the Central Australian Health Service with one consumer having been involuntarily detained for an unacceptably long period of time pending resolution of safe and supported community accommodation. A whole of government approach is required to achieve change in this area.

The community impact of the lack of support housing and appropriate community accommodation in the Northern Territory is particularly evident in complaints and enquiries made to the CVP. These include concerns expressed by consumers about lengthy in-patient admissions, the heavy burden placed on carers (often ageing carers), and fears expressed by carers and loved ones when inappropriate or poorly managed discharges occur.

"What's happening with my house? Can I live with my [public] guardian?"

C/2015/241

"I've got nowhere to go but that's no reason to keep me locked up here."

C/2015/45

"They knew that I was seeing a psychologist for my trauma issues …when they told me I was sectioned and would be locked up, I freaked out … All the bad memories came back. The whole time in JRU I was on the edge, I was so scared. I understand they wanted me to be safe, but I didn't feel safe in there at all."

C/2015/267

EMERGING ISSUE

Trauma Informed Care

This year, the CVP has identified an emerging issue for the Northern Territory's mental health services related to a lack of trauma-informed care. Acknowledging and effectively responding to the impact of trauma on consumers is increasingly a central feature of national and international mental health policies. Research evidence suggests that significant numbers of people seeking assistance for personality disorders and mental illness have been exposed to trauma.[28] The Northern Territory Government has also recognised the impact of trauma on mental health.[29]

For consumers with a mental illness, trauma can exacerbate the symptoms of a mental illness and/or may precede the onset of a mental disorder; the experiences of trauma also affect how consumers respond to service providers.[30] In particular, ensuring that consumers both are and feel safe is a key element of a trauma informed care; the CVP has indicated to the service on a few occasions in 2014-2015 that consumers have expressed concerns about their safety while at in-patient facilities. Mental health services can, unfortunately, cause additional trauma to individuals and this has been a key driver in the national push to reduce restrictive practices, in particular seclusion and restraint.[31]

The need for trauma-informed mental health care has been particularly identified by the CVP with the Top End Health Service; however the CVP regards this as a Territory-wide issue. The Top End Health Service has acknowledge that trauma-informed care is a gap in their service framework, but has expressed concerns that insufficient resources are available to build trauma-informed approaches into their practice.

Key features of trauma-informed care include avoiding re-traumatising experiences, building respectful relationships, consumer engagement and empowerment, culturally competent services, and a focus on consumer strengths and resilience.[32] Strong clinical leadership is also a key component of successful implementation of trauma-informed approaches.[33] For in-patient facilities, attention

to the amenity of the physical environment and the emotionally-supportive therapeutic relationships (rather than focusing primarily on risk management, assessment and medication) are particularly important.[34]

In the CVP's view, these strategies do not require additional resources, but rather a shift in treatment culture, including in assessments and planning, and prioritising interventions that avoid triggering or causing trauma reactions. The CVP looks forward to constructive discussions about implementing trauma-informed care in the coming year.

COMPLIANCE WITH LEGISLATION

The CVP has continued to observe concerns regarding compliance with legislative requirements, in particular for documentation required when consumers are involuntarily detained. These documents are required to be fully completed and also forwarded to the Principal Community Visitor.

Unfortunately, there continues to remain concerns that forms are not being consistently forwarded to the CVP (in particular from Central Australia). When received, there are often gaps in completion. The documentation for involuntarily admission includes that a consumer has been assessed by two approved psychiatric practitioners, been informed of the right to an early review hearing, whether an interpreter has been requested, and that the client's carer and (as applicable) adult guardian has been notified. These safeguards for consumer rights are very important, and the 'form 10' documentation is evidence that these have been complied with by the service. The Principal Community Visitor is concerned at the failure to demonstrate consistent improvements in the documentation of involuntarily detention, open communication with consumers about their rights and the meaning of their legal status.

The CVP also notes, however, that there is evidence of other provisions in the legislation not being consistently applied. For example, advising adult guardians of their clients who are secluded; and ensuring that restrictions on entitlements to visitor and phone access are documented and provided to the consumer, the Mental Health Review Tribunal and the Principal Community Visitor.

Further, to ensure procedural fairness, the CVP would also like to see greater attention to making sure that consumers are given and have the opportunity to read documents related to upcoming Tribunal hearings. Consumers repeatedly state that this is a concern and that they do not have enough time to prepare for the hearing, even if they do receive the documents.

It is expected that 100% compliance with legislative and procedural requirements is the objective. The CVP understands that, in particular when the service has staff shortages and high turnover, this will impact on capacity to fulfil legislative and procedural obligations. Nevertheless, orientation and professional development needs to remain the focus of senior management to ensure that the rights of consumers under the *Mental Health and Related Services Act* are protected. This issue will remain the subject of ongoing discussions with the Top End and Central Australia mental health services.

"I only knew I was involuntary when I tried to leave!"
C/2015/77

"Even though I'm considered 'voluntary', I feel like I can't really discharge myself if I think I want to, I have to wait for my doctor's approval."
C/2015/43

"This is the first time I am here but I'm really impressed with the care I am getting here and with the healthy rhythm in the day."
VIS/2015/155

Review of Seclusion and Mechanical Restraint Registers

Under the *Mental Health and Related Services Act*, the CVP is required to inspect the seclusion and mechanical restraint registers bi-annually. The CVP reports that there were two (2) incidences of mechanical restraint occurred in 2014-2015.

The graphs in the Annual Report on pages 21 and 22 are from the inspection of the seclusion registers kept at each service.

REPORT CARDS

Top End Health Service – Mental Health – CVP Report Card

The Top End Health Service - Mental Health (TEHS-MH) provides care for people with a mental illness who live in the Top End, extending south of the Katherine region. For consumers with an acute illness, there are three secure in-patient facilities based at the Royal Darwin Hospital. There are eight community-based teams in TEHS-MH.

Achievements:

- Three (3) CVP recommendations closed.
- In Cowdy ward, positive atmosphere of the morning meetings and quality and range of the activities room.
- Consumers and carers often give positive feedback about the care they have received through TEHS-MH and their relationship with staff of the service.
- TEHS-MH initiated a 'SafeCare project' for seclusion reduction, and seclusion events did reduce in the first half of 2015.
- Greater focus on enabling escorted leave arrangements for consumers in the Joan Ridley Unit (JRU), including use of the activity centre, access to the JRU courtyard and leave.
- The increase in Aboriginal Mental Health Workers (AMHWs) to support consumers on JRU.
- Cleanliness of the facilities, in particular in Cowdy ward, improved.
- TEHS-MH allocated a nurse as a dedicated 'CVP Liaison' contact.
- The CVP is pleased to report that, at the time of writing, an activity nurse is now working in the Joan Ridley Unit (JRU) and the service is actively working towards reopening the sensory modulation room as a matter of priority.

Areas for Improvement:

- Open Ward. The CVP continues to request and advocate for an open (unlocked) policy for Cowdy ward. This policy has been consistently applied in Central Australia, and is consistent with the principle of the least restrictive alternative.
- Use of Available Facilities. The Contained Assessment Unit (CAU) space was rarely opened and staffed for young patients. The CAU is acknowledged to be a more amenable environment, and is a safe space for young people to be separate from adults.
- Standard of Amenities. In Cowdy ward, the state of the bathrooms is not at an acceptable standard for a health facility. There have been longstanding concerns with water pressure and temperature. Privacy screens in the bedrooms also need to be renewed.
- Crisis Assessment and Community Engagement. The CVP continues to receive some enquiries and complaints that the CATT service has not been responsive or respectful. There may be a need to consider more broadly the policy framework for CATT services.

Priority Concerns:

- Seclusion Reduction. There have been some alarming instances of very lengthy seclusions. In this reporting period, a 16 year old was secluded for 7 days (181 hours). A further nine seclusion events extended past 2 days. The CVP has serious concerns with seclusion events of this length.
- Youth-Specific Services Framework. In the Top End, in particular, there have been many instances of young people (under the age of 25 years) being detained or nursed with adults. The CVP does not regard this as appropriate, especially for minors. The CV Panel has had outstanding recommendations since November 2007 relating to the need for the TEHS-MH to develop and implement a youth-specific framework for services. The CVP is pleased to report that the Department of Health has made a commitment to positive improvements for youth-specific support and an in-patient facility to be established in 2015-2016. This will be closely monitored by the CVP in the coming year.
- Joan Ridley Unit (JRU) Amenities and Activities. Consumers and their families express a range of negative reactions to JRU. This facility is intended to be a low stimulus area for the most acutely unwell consumers. The CVP has repeatedly commented on the 'prison-like' environment and run-down appearance. Consumers and carers often comment that the standard of hygiene is low, and some female consumers say they feel unsafe. Consumers with acute symptoms are in a severely confined space with little access to meaningful activities, fresh air and limited positive interactions. A room was set aside as a 'sensory modulation' room several years ago; unfortunately in this reporting period, this room was instead used as a bedroom and the equipment previously in the room is no longer available.

Top End Health Service - Mental Health - CVP Recommendations

		Made By	Date	Status
1	That an Electro Convulsive Therapy (ECT) committee be convened and that ECT ward rounds be commenced as per ECT guidelines.	CV Panel	Apr 2013	Closed
2	As the ECT guidelines are being reviewed, that the group reviewing the ECT guidelines should contain an expert, external to the Northern Territory.	CV Panel	Apr 2013	Closed
3	That the Top End Health Service-Mental Health to negotiate additional hours for cleaning to ensure a hygienic and safer hospital environment.	Community Visitor	May 2014	Closed
1	That discharge planning procedures be improved by identifying and referring to preferred ongoing General Practitioners.	CV Panel	Oct 2004	Open
2	That information services to Aboriginal consumers be improved by providing greater access to Aboriginal Health Workers including when admitted out of hours, advocating for improvements to the interpreter service and providing appropriate visual material.	CV Panel	Oct 2004	Open
3	That a comprehensive accommodation and support model is developed, adequately resourced and provided in the Top End of the Northern Territory (in addition to the accommodation currently provided through the Manse). It is further recommended that the model takes into account the varied and diverse circumstances of consumers in the Northern Territory, and is developed collaboratively with consumers groups and mental health professionals.	CV Panel	Nov 2006	Open
4	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
5	That for those under 18 admissions to the in-patient unit that are unavoidable, the Top End Health Service-Mental Health develop with urgency a comprehensive framework for a 'youth-friendly' in-patient service which also ensures youth under 16 have access to expert assessment and management.	CV Panel	May 2007	Open
6	That there are systems to ensure that Aboriginal Mental Health Workers (AMHWs) are integrated into the clinical care of all Aboriginal consumers. There should be documented evidence of their role in individual consumer care.	CV Panel	May 2008	Open
7	That approved psychiatric practitioners (APPs), when involuntarily admitting a person to the Top End Health Service-Mental Health In-patient Unit, complete Parts C and D on the Form 10 to ensure that interpreters are used where required, that the person is informed of his/her right to early review of the admission and that primary carers are notified of the admission where appropriate.	CV Panel	Nov 2011	Open
8	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

Top End Health Service - Mental Health - CVP Recommendations

Continued

		Made By	Date	Status
9	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
10	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
11	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
12	In light of the provisions of the *Mental Health and Related Services Act* and the National Mental Health Standards regarding discharge planning, the Panel recommends that Top End Health Service-Mental Health conduct a review of discharge planning policy and procedures.	CV Panel	Oct 2013	Open
13	That Top End Health Services-Mental Health responds particularly to the needs of young and Indigenous people with pro-active frameworks and policies.	Community Visitor	May 2014	Open
14	The development of a comprehensive action plan with detailed strategies that that attempt to reduce the events of seclusion for the Northern Territory. (Reworded)	CV Panel	Aug 2014	Open
15	That the involvement of clients in their care planning becomes a proactive feature of treatment (Katherine Mental Health).	Community Visitor	Jan 2015	Open
16	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
17	That the sensory modulation room in the Joan Ridley Unit (JRU) is used for its intended purpose.	Community Visitor	Feb 2015	Open
18	It is recommended that TEMHS seriously considers implementing an early psychosis service based on the Australian Clinical Guidelines developed by Orygen Youth Health (Community Team).	Community Visitor	Feb 2014	Open
19	That the Top End Health Service-Mental Health assess the evidence of demand and needs together with the elements of best practice, evidence based model to incorporate into the reviewed CATT model (Crisis Assessment and Triage Team).	Community Visitor	March 2015	Open

"This mob are really good here … I know I could dodge my way out of here but it's not a good idea"

VIS/2015/132

"I know they're looking out for me because if I'm struggling someone will notice and they come up to me and ask me if I'm okay"

VIS/2015/204

Central Australian Health Service - Mental Health - CVP Report Card

The Central Australian Health Service - Mental Health (CAHS-MH) provides care for people with a mental illness who live in the Central Australia region, extending up to the Barkly. For consumers with an acute illness, the Mental Health Unit (MHU) at the Alice Springs Hospital is the secure in-patient facility. There are five community-based teams.

Achievements:

- 5 CVP recommendations were closed.
- A reduction in enquiries and complaints, and an increase in positive comments, from consumers at Mental Health Unit.
- Successful recruitment to the vacant Occupational Therapist position at the Mental Health Unit, with an observed improvement in consumer engagement and activities.
- Maintaining a policy of keeping the main ward of the Mental Health Unit unlocked.
- Initiating a seclusion reduction project at the Mental Health Unit.
- Securing ongoing funding for the 'sub-acute facility' in Alice Springs, which provides residential care for consumers thereby avoiding or limiting hospital admissions.

Areas for Improvement:

- Cultural Safety. A number of Aboriginal mental health worker positions were vacant during 2014-2015, including the 'cultural consultant' leadership role. The service needs to more actively target measures to recruit, retain and support Aboriginal staff.
- Restrictions. The CVP has observed that the provision in the Act regarding restriction or denial on entitlements for telephone use and visitors in the Mental Health Unit has not been consistently or properly applied. Access to telephones and visitors is a right and when restricted, all relevant provisions in the Act need to be observed.
- Respecting Consumers and Carers. A number of enquiries to the CVP related to concerns about a lack of respect for the role of, and respectful engagement with consumer and their carers/family. Consumers who are unwell, and carers and families in stressful circumstances with a loved one, can be highly emotional and their behaviour will reflect this.
- Compliance with Act and Procedures. The CVP continues to make recommendations relating to requirements in the legislation and Approved Procedures. CAHS-MH needs to increase staff skills and knowledge regarding the requirements of the legislation and procedures and work towards full compliance.

Priority Concerns:

- Long-Term Consumer. One young consumer has been involuntarily detained at the Mental Health Unit for a long period of time. The complexity in this consumer's needs requires considerable cooperation, joint planning and commitment. The CVP will continue to raise the matter at the highest levels to advocate for expeditious discharge to appropriate community accommodation with support.
- Minors in Seclusion and Restrained. A minor (16 years old) experienced a large number of seclusion events, including a physical restraint for 1.5 hours at the Mental Health Unit. The CVP has very serious concerns about the need for such restrictive interventions on minors.
- Seclusion Reduction. In January 2015, two acutely unwell and aggressive consumers were placed in seclusion a large number of times. The service needs to develop additional strategies to deal with a similar situation if this were to occur again, if it is to maintain a focus on reducing seclusion events overall.

Central Australian Health Service – Mental Health – CVP Recommendations

		Made By	Date	Status
1	That CAHS-MH management thoroughly investigate the existing limitations to building alterations according to Heritage Listing legislation.	Community Visitor	Jun 2008	Closed (Unresolved)
2	That the Child and Youth Team do a process review of M's case to consider whether, if this client's case was given high priority at the first referral in November 2012 and the ensuing months, the presentations to the emergency department in May/June 2013 may have been resolved.	Community Visitor	Nov 2013	Closed (Unresolved)
3	That the Mental Health Unit arrange a meeting with the Secure Care Facility to establish protocols to ensure an easy transition of appropriate clients from the Mental Health Unit to the Secure Care Facility.	CV Panel	Dec 2013	Closed
4	That the General Manager CAHS-MH and the Clinical Nurse Manager of the Mental Health Unit, with the assistance of the newly established recruitment sub-committee, continue to prioritise the employment of an Occupational Therapist and ensure its sustainability.	CV Panel	May 2014	Closed
5	That the Mental Health Unit continue to closely monitor the issue of interpreter attendance and works with the Aboriginal Interpreter Service to ensure that mental health specific training is available to interpreters.	CV Panel	Nov 2014	Closed

"I don't want to be here, but not because of the staff. They're all good, they really keep an eye out for me."

VIS/2015/204

"They listen to you and it's better than other places I've been in."

VIS/2015/132

"My nurse has been really encouraging and supportive."

VIS/2015/211

Central Australian Health Service – Mental Health – CVP Recommendations

Continued

		Made By	Date	Status
1	The Mental Health Unit address the lack of physical movement and activity programs for clients, including contingency plans to ensure that activities continue irrespective of individual staff availability.	Community Visitor	Jun 2013	Open
2	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
3	That the Remote Team continue to advocate within CAHS-MH to the Department of Health about recording and use of information across electronic databases, including the recording of early psychosis and diagnosis.	Community Visitor	Nov 2013	Open
4	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
5	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
6	That the Mental Health Unit review its seclusion practices and introduce strategies aimed at reducing the rates of seclusion.	CV Panel	Dec 2013	Open
7	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
8	That CAHS-MH address the need for increased psychiatric services [for the Forensic Mental Health Team], including consideration as to whether increased utilisation of psychiatrists based in Alice Springs may assist.	Community Visitor	Aug 2014	Open
9	That CAHS-MH develop and implement an action plan to reduce seclusion incidents.	Community Visitor	Mar 2015	Open
10	That policies and procedures relating to the seclusion of minors are developed and included in the Department of Health's Approved Procedures for Seclusion.	Community Visitor	Mar 2015	Open
11	That the Clinical Director works with the Approved Psychiatric Practitioners to ensure understanding of the importance of all sections of the Form 10 (involuntary detention), and related responsibilities under the Act to inform the Principal Community Visitor and others of involuntary admission.	Community Visitor	Apr 2015	Open
12	That the Clinical Nurse Manager works with the ward clerk to ensure that all Form 10s (involuntary detention) are sent to the CVP after the second Approved Psychiatric Practitioner (APP) assessment has occurred.	Community Visitor	Apr 2015	Open
13	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

[1]Ivancic, L., Perrens, B., Fildes, J., Perry, Y. and Christensen, H. (2014), Youth Mental Health Report, Mission Australia and Black Dog Institute. Accessed from: http://library.bsl.org.au/jspui/bitstream/1/4178/1/mission-australia-youth-survey-mental-health-report-june-2014%20%282%29.pdf.

[2]Australian Government, National Mental Health Commission (2014). Report of the national review of mental health programmes and services (Volume 2, Chapter 3).

[3]Ibid. Recommendation 15: Build resilience and targeted interventions for families with children, both collectively and with those with emerging behavioural issues, distress and mental health difficulties.

[4]Northern Territory Government, Mental Health Service Strategic Plan 2015-2021, priority area 3.

[5]This is particularly a concern for the Top End, which has a higher population base and higher admissions of young people and minors to in-patient facilities. In some cases, acutely unwell young people may also need to be transferred from Alice Springs to Darwin for specialist support that is not available in Central Australia.

[6]The CVP has reviewed all seclusion register data gathered in both the Top End and Central Australia to identify the total number of individual young people secluded in 2014-2015. Thirty-one young people (84%) were secluded in the Top End.

[7]All seven minors were secluded in the Top End; one of those minors was also secluded in Central Australia.

[8]Australian Government, National Mental Health Commission, (2015). A case for change: position paper on seclusion, restraint and restrictive practices in mental health services. Accessed at: http://www.mentalhealthcommission.gov.au/media/123610/Position%20Paper%20-%20FINAL%20ENDORSED%2020%20May%202015%20(D15-676902).PDF.

[9]Ivancic et al, (2014), Youth mental health report. Mission Australia and Black Dog Institute.

[10]Australian Institute of Health and Welfare, Youth justice in Australia 2013-2014.

[11]Australian Institute of Health and Welfare 2015. Northern Territory: youth justice supervision in 2013–14. Youth justice fact sheet, No. 39.

[12]Australian Government, National Mental Health Commission, (2015). A case for change: position paper on seclusion, restraint and restrictive practices in mental health services. Op cit.

[13]The CVP notes that while there are concerns with how national seclusion data is analysed, in particular as it relates to smaller jurisdictions like the Northern Territory with lower ratios of beds per person, at present the Northern Territory has the highest rate of seclusion per patient day in Australia (2013-2014) (Australian Government, Australian Institute of Health and Welfare, (2014). Use of restrictive practices during admitted patient care. Accessed at: http://mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices/).

[14]The CVP notes that since seclusion occurs predominantly in the Joan Ridley Unit (JRU) in the Top End, this calls into question the impact of environment on consumers and the consequent behaviours that might lead to seclusion. More discussion on the JRU is included in the Top End Health Service–Mental Health (TEHS-MH) report card.

[15]Australian Government, National Mental Health Commission (2014). Report of the national review of mental health programmes and services (Summary).

[16]Australian Government, Australian Institute of Health and Welfare (2014). Admitted patient mental health-related care. Accessed at: https://mhsa.aihw.gov.au/services/admitted-patient/.

[17]Northern Territory Government, Mental health services strategic plan 2015-2021, p.17.

[18]The CVP notes that boarders (family members who stay with a person in treatment for all of some of the consumer's admission) are often supported for Indigenous consumers from remote communities. This assists consumers to feel less isolated or intimidated in an often foreign environment. The treatment teams for consumers from remote areas also try to maintain contact with families and key health professionals in the communities, using videoconferencing as available.

[19]Northern Territory Government, Mental health services strategic plan 2015-2021, priority area 4 'enabling participation and engagement' (p.19). Embedding family and community-centred practice is also part of priority area 2 (p.17).

[20]Australian Government, Australian Institute of Health and Welfare (2014). 'Specialist homelessness services', Mental health services in Australia. Accessed at: https://mhsa.aihw.gov.au/services/specialist-homelessness-services/.

[21]Ibid.

[22]Australian Government, Australian Institute of Health and Welfare (2014). 'Psychiatric disability support services', Mental health services in Australia. Accessed at: https://mhsa.aihw.gov.au/services/disability-support/.

[23]Australian Government, National Mental Health Commission (2014). Report of the national review of mental health programmes and services (Volume 2, Chapter 3).

[24]NT Shelter (2015). Factsheet – Homeless Statistics in the NT. Accessed at: http://ntshelter.org.au/uploads/ntshelter/0615%20NT%20Homelessness%20Factsheet.pdf.

[25]Mental Health and Related Services Act, s9.

[26]Mental Health and Related Services Act, s10.

[27]This need has been recognised by the Northern Territory Government in the Mental health services strategic plan 2015-2021, priority area 2, 'creating a more inclusive community environment' (p.17). Housing is also recognised as a social determinant of health on page 8 of this strategic plan.

[28]Muskett, C. (2013). Trauma-informed care in inpatient mental health settings: a review of literature. International Journal of Mental Health Nursing.

[29]Northern Territory Government, Mental health services strategic plan 2015-2021, p.8. The CVP notes that while trauma is mentioned in the context of this strategic plan, there are no priority areas or strategies that specifically address trauma informed care.

[30]Substance Abuse Mental Health Administration (SAMHSA) (2014). Trauma informed care in behaviour health services (including the associated literature review). Accessed at: http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/Most-Popular/SMA14-4816?sortByValue=4.

[31]Australian Government, National Mental Health Commission, (2015). A case for change: position paper on seclusion, restraint and restrictive practices in mental health services. Op cit.

[32]SAMHSA (2014). Trauma informed care in behaviour health services. Op cit.

[33]Muskett, (2013), op cit.

[34]Ibid.

CVP MAIN CONCERNS

1. Improvements in the quality of therapeutic interventions for residents at the Secure Care Facility, in particular objective, measurable evaluation of outcomes
2. Greater attention on transition planning for all residents to enable them to reside with specialised support, as identified and required, in the community

This is the third year that the CVP has reported on issues identified and raised in its visiting, inquiry, complaints and oversight function for residential facilities governed by the *Disability Services Act*.

In practice these facilities are the eight-bed Secure Care Facility in Alice Springs, and two 'appropriate places' for clients with a forensic history (one of which is in a residential location in Alice Springs and the other is a small collection of buildings next to the Darwin Correctional Centre). There are currently three residents in the Secure Care Facility, and one client transitioning into the facility. No clients have been admitted to the facility from a non-forensic setting despite requests to consider this being made to the Office of Disability. No female clients have been admitted to the facility.[1]

The Secure Care Facility is not 'home-like' accommodation; the facility is a purpose-built secure building located adjacent to the Alice Springs Correctional Centre with various levels of security access and a high staff to client ratio.

The CVP notes that the Northern Territory is one of the few jurisdictions in Australia to have a 'group home' secure care facility for clients with a cognitive impairment, requiring specialist interventions to address behaviours of concern. The original intention was to establish a facility in Darwin and Alice Springs, however due to policy changes, only the Alice Springs facility was established.

The focus of this report is principally on the Secure Care Facility in Alice Springs (although the reflections also relate in a general sense to the small number of clients in 'appropriate places'). In 2013-2014, the CVP reported on progress with the operation of the Secure Care Facility and establishment of 'appropriate places' and highlighted that there were issues related to transitioning from the Secure Care Facility into the community.

As the establishment phase for the Secure Care Facility has now passed, the CVP is reflecting in greater depth on the quality of the services and frameworks in place for individuals with a complex cognitive impairment in the Northern Territory.

At the outset, the CVP would like to acknowledge the difficult environment that is specialist disability services. The staff work well with clients. The achievements the staff have made in building positive strong relationships with residents, maintained on a daily basis, is commended by the CVP.

	Community Visitor	CV Panel	Total Visits
Secure Care Facility	9	2	11
Appropriate Places	8	-	8
	17	**2**	**19**

Disability Visits 2014-2015

Secure Care Facility	8
Appropriate Place	3
Total	**11**

Disability Complaints & Enquiries 2014-2015

SIGNIFICANT ISSUES

Transition from Secure Care into Appropriate Community Accommodation

The stated purpose of the Secure Care Facility, evident in policy documents and the *Disability Services Act,* is for clients to benefit from therapeutic services and 'step down into appropriate residential placement or other less restrictive placement options'.[2]

The Office of Disability acknowledges that the length of time that an individual may stay in the facility will vary according to the individual client and that this may be for 'some months' to 'a longer term stay'.[3] The ultimate decision on when an individual can transition into supported community accommodation resides with the Supreme Court of the Northern Territory. However, this decision is informed primarily by information provided to the Court by the Office of Disability.

While no definitive length of stay for each client can be stated, transition planning needs to be a central feature of each resident's care. This is consistent with the principle of 'least restrictive alternative' and the fundamental human rights of people with a disability to achieve maximum independence and participation in all aspects of their life.[4] This is further confirmed in the principles for treatment and care in the *Disability Services Act*.

As with the second CVP Annual Report into disability services for 2013-2014, the CVP continues to remain very concerned about the apparent lack of planning and focus on building skills and modifying behaviour to transition clients from the Secure Care Facility (or other residential facilities) into less restrictive environments suitable to their assessed level of risk. While the Department states that a gradual and incremental approach to introducing less restriction is used, in order to measure risk dynamically over time, the CVP remains concerned that the goal of transitioning to the community is often unclear.

The policy intent and purpose of the *Disability Services Act* and facility is to enable intensive support and intervention, and assessment of risks and ongoing capacity to benefit, for clients to enable them to reside in less restrictive environments. It is not intended to be the ultimate destination for clients who display behaviours of concern.

The progress with each client's therapeutic program at the Secure Care Facility enables an evidence base to be built up. This supports decision making regarding the appropriate levels of support and, as necessary, ongoing restrictive interventions required for clients transitioning into the community.

The CVP acknowledges that exit planning is complicated by the lack of infrastructure and support for clients to return to their family and home communities. However, the CVP is of the view that determining what is required for each client is the starting point and part of the Office of Disability's role is to provide information and recommendations to the Supreme Court to make this occur.

Complaints & Enquiries - Sources 2014-2015

> "I want to be free to return to my community and be with my family."
>
> C/2014/139

The ongoing assessments and interventions provided at the Secure Care Facility help identify the client's capacities and needs, and related strategies that best support the client to achieve the most positive outcome in the community. This information will substantially inform the decision of the Court.

The evidence base gathered while at the Secure Care Facility provides a level of assurance regarding individual and community safety when a client moves to a different environment. The facility is thus available for intensive support for a moving cohort of clients as they pass through the facility, providing a service of value to the Northern Territory as a whole.

Transition Planning

Many of the residents have raised with the CVP their wishes to return to their home community; although some say that they are not unhappy to be at the facility, most do not appear to understand why they have to remain in the facility. The CVP notes that of the six residents who have resided at the Secure Care Facility, only one has transitioned into community-based accommodation. One resident has returned to the Alice Springs Correctional Centre. Recently, two residents have commenced overnight stays in a house in the community.

The CV Panel most recently made a recommendation that exit planning occur for residents on admission, and reworded an existing recommendation to reinforce that exit planning be urgently initiated for the two longest term residents. Those residents have been in the facility for nearly two years. The CV Panel noted that there appears to be no documented planning or milestones for transitioning clients from the facility, nor a systematic approach to pursuing options for community-based accommodation.

The CVP considers that it is unlikely that many residents of the Secure Care Facility will be able to develop a suite of new skills and behaviours that would enable them to return to their family or home community directly from the Secure Care Facility. This is especially the case if the home community is a considerable distance from specialised disability support services. There are also important issues to consider regarding the needs and capacities of carers and communities to support a family member with a complex cognitive impairment.[5]

As noted in last year's Annual Report, there needs to be options available for people to 'step down' into less restrictive supported accommodation. The 'appropriate places' and other residential facilities operated by the Department currently in place in the Northern Territory are an example of more intensive arrangements for supervision in the community, managed by Department of Health and (in the case of one place) under contract with a non-government disability supported accommodation provider. Other options might also be needed to enable supported and safe accommodation in the community.

Whatever models of supported accommodation and support are needed to support clients transitioning from the Secure Care Facility, and other appropriate places, the Department of Health urgently needs to identify and pursue these on an individual needs basis.

Policy Framework for the Secure Care Facility

The CVP has been told that the policies and procedures for specialist disability services are currently being reviewed. The CVP has raised concerns that the policy framework for the Secure Care Facility appears to have shifted, especially as there have been no admissions from non-forensic settings.

Complaints & Enquiries - Issues Raised 2014-2015

> "I want to see my [family]"
>
> C/2015/226

The CVP is concerned that, as all the residents have come from forensic backgrounds, the individuals who are in this most restrictive setting are those for whom services are struggling to manage risks that have resulted from escalation in their behaviours of concern into criminal offences (that is, the criminalisation of vulnerability that can occur with this cohort).[6] The facility could be used to support the broader client group of those who are 'at risk' to themselves and others, but who have not yet come into contact with the criminal justice system.

There also appears to be a 'brokerage' model of care provided by the Office of Disability, with specialised disability support workers managed from the Secure Care Facility providing off-site support to individuals with complex needs residing in other places.

The Office of Disability has indicated verbally that the policy framework is fundamentally the same, however the experience of operationalising the Secure Care Facility needs to be better reflected in the policy and procedures. If the policy context is evolving, as appears to be the case, the CVP is of the view that wider consultation needs to occur.

Any review of the framework for specialist disability support needs to take into account consideration of both best practice and therapeutic benefit for this cohort.

Quality of the Therapeutic Programs

Central to enabling transition from secure facilities is the quality of the therapeutic program being provided. Each resident's Positive Behaviour Support Plan (PBSP) articulates the meaning and function of the individual's behaviour in a 'whole of life' context, their aspirations, and builds on their strengths and abilities as the foundation for their individual therapeutic program.[7]

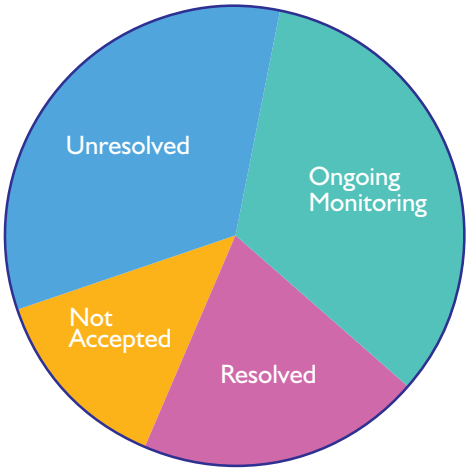
The PBSP is the key document describing the individual's circumstances, cognitive impairment, needs, behaviours of concern and strategies to manage behaviour. The approved PBSP also provides the basis by which restrictive interventions specific to each resident may be lawfully enforced. The PBSP is required to be regularly reviewed.

The CVP considers that the quality of the PBSPs for each resident needs to be substantially improved and individualised, in particular for residents at the Secure Care Facility. The CVP reiterates that a highly individualised approach to each client is central to the effectiveness of the PBSPs as a foundation document for each client's therapeutic program. The CV Panel has also recently recommended that the PBSP incorporate more information about the client's personal circumstances extending back to the client's childhood. The Department of Health (Office of Disability) has indicated that this will occur.

In making this observation about the PBSPs, the CVP notes that the Department of Health (Office of Disability) has not yet established the review panel provided for under section 40 and Part 7 of the *Disability Services Act*. The Department has indicated that it intends to do so, however the CVP remains concerned that this has not occurred in the past two years.

The CVP understands that the purpose of the review panel was to provide professional and independent oversight of the quality of PBSPs, in particular the restrictive interventions, and the timely development and review of professional plans for each client. Review panels provide quality assurance mechanisms for the client's adult guardian and, as required, the Supreme Court. The lack of quality assurance mechanisms and benchmarks is a key issue for the Secure Care Facility. This continues as an open recommendation of the CVP.

Further to the PBSPs, the CVP has continued to observe a lack of evidence regarding systematic structuring, measurement and evaluation of residents' therapeutic outcomes. The CVP notes that there are only very basic tools to record changes in resident's behaviours of concern, and no structured gathering and review of objective data against individual elements of a client's therapeutic plan.



Complaints & Enquiries - Outcomes 2014-2015

> "There needs to be a more client-centred approach"
>
> VIS/2015/206

The level of detail in clinical interventions that would be expected from a facility of this nature is not evident. To illustrate this, the CVP notes that for each person, the therapeutic program does not have the following detail:

- a detailed articulation of client aspirations,
- a hypothesis for the meaning and function of individual behaviours of concern,
- proactive and reactive interventions for individual behaviours of concern,
- measures to ensure procedural reliability of the specialist support workers,
- measures to track durability in interventions over time, and
- evaluation of the social and cultural validity of the interventions.[8]

This is what the CVP understands are key features of contemporary positive behaviour support interventions, consistent with the National Standards for Disability Services.[9] These are not evident to the CVP in the documentation or articulated purpose of daily activities for each resident.

In effect, there is no clear evidence-based framework to inform the annual reviews of client's PBSP and readiness for transition to less secure environments. The approach appears to be more qualitative in nature, based on senior staff reviews and feedback, and risks subjective bias in decision-making processes.

There is a concerning lack of systematic individual client reviews completed by all relevant staff working with each resident, including reviews that involve the residents themselves. Further, there continues to be limited evidence of reflective practices which are systematically incorporated into review of the residents' PBSP and therapeutic outcomes.

> "His health and welfare are doing well, but they're not addressing risk behaviours"
>
> C/2015/266

Quality Assurance and Safety

The CVP has acknowledged previously that this specialist disability service model is new; as could be expected with any emerging model, policies, practices, and quality and safety mechanisms will evolve. It is unclear, however, to the CVP how the broader clinical governance and risk management processes are managed in relation to the residential facilities under the *Disability Services Act.*

In the recent restructuring of health services more broadly in the Northern Territory, towards two health boards, the CVP notes that the Office of Disability does not sit within these arrangements. In that context, greater attention to the depth, breadth and quality of the clinical interventions, risk and quality assurance framework is required. The Department of Health has advised that an external expert has been engaged to assist in the development of a quality assurance framework. The CVP looks forward to reviewing this documentation when it is completed.

The CVP remains of the view that the clinical leadership on-site needs to be strengthened. It appears to the CVP that the Alice Springs-based clinical positions of Senior Clinician and Occupational Therapists were either not recruited to or are no longer part of the current staffing structure. The lack of on-site clinical leadership has been identified by the CVP as a concern. The Department of Health has indicated that the positions have been advertised and recruitment initiatives will continue.

The CVP has observed that the residential accommodation and care services in the Secure Care Facility and appropriate places are at a good standard. Residents appear to feel safe and to have good relationships with staff.

The CVP has observed that residents are generally treated with dignity and respect, and have frequent opportunities for community access. The community access often includes daily contact with family members. Two residents also have regular visits to their home communities.

There is evidence that strategies have been put in place to ensure that the physical health needs of clients, in particular their diet, is monitored and improved. These are important elements of providing quality residential care, and essential for enabling therapeutic work to be undertaken.

Despite this, the CVP continues to note that there are ongoing risks present for physical safety of residents and staff in the Secure Care Facility. In particular, the recommendation relating to duress alarms not being available in the facility remains current. Recent advice from the Office of Disability is that staff do not wear duress alarms during the day (although these are available for visitors), due to the numbers of staff present. Duress alarms have been trialled on the night shift.

The return of one resident to the Alice Springs Correctional Centre illustrates the high risk that some clients can pose both to staff and other residents. While improving the quality of the therapeutic planning and interventions will assist to mitigate these risks, there needs to be further consideration of safety procedures for all people living, visiting and working in the Secure Care Facility and other places.

With respect to cultural safety, all of the residents of the Secure Care Facility and those in appropriate places are Indigenous Australians. The CVP has observed that a number of staff in the Secure Care Facility are from non-English speaking backgrounds, and few staff are Indigenous. There is also very low reported use of interpreters by clinical or specialist support staff.

In light of this, it will be a considerable challenge for staff to ensure that they are both culturally competent and culturally safe in their practice with Indigenous Australians. While resident enquiries to the CVP are low (which can be expected as the nature of CVP's independent inquiry and complaint function is difficult for residents to understand), the most frequent enquiries relate to a desire to see their families and/or return to their home communities (to live or visit).

Maintaining family and cultural connectedness is central to the residents' wellbeing; it is acknowledged that it is extremely difficult to achieve this connectedness for residents in the high security environment of the Secure Care Facility (even with contact during community access).

Achieving cultural safety in disability services therefore rests on prioritising the residents' safe and supported transition to community accommodation and a more normalised environment.

"I'm doing okay here"

VIS/2014/90

COMPLIANCE WITH LEGISLATION

The *Disability Services Act* requires that the CVP be provided with 'reasonable assistance' to perform its statutory role. The CVP has raised ongoing issues with the notification of residents transitioning into the facility or moving into other residential facilities as defined by the *Disability Services Act*.

Confirmation of clients residing in facilities covered by the *Disability Services Act*, and therefore activating the oversight function of the CVP has been requested from the Office of Disability. Unfortunately this confirmation has not been forthcoming in a timely manner. The Principal Community Visitor escalated this matter further to ensure that the CVP can fulfil its statutory obligations and the CVP has recently been advised of some additional residents to commence visiting. The processes to ensure CVP oversight of residential facilities, other than the Secure Care Facility and appropriate places, needs to be clear.

Community Visitors regularly review documentation relating to restrictive interventions used in accordance with section 43 of the *Disability Services Act.* Recommendations to improve the quality of documentation have been made to the Secure Care Facility and this will be monitored in the coming year. There has been a reduction in the use of restrictive interventions in the first half of 2015 and the CVP commends the service for this achievement.

The CVP notes that, as required under section 49, it has not yet received any reports containing details of complaints. These reports are required to be provided bi-annually. As noted above, it is likely that the cohort of residents receiving services under the *Disability Services Act* is not likely to register complaints, either internally with the service or externally with the CVP.

This places a considerable burden on the service to ensure that the complaints procedure is transparent, well known to the resident and promoted to the resident's guardian.

REPORT CARDS

Appropriate Places – CVP Report Card

Note: Information is very general to maintain client confidentiality due to low numbers.

Achievements:

- Both Central Australia and Top End 'appropriate places' provide stable residential care, with evidence of good staff knowledge of client.
- There is evidence of appropriate documentation of the support for, and monitoring of, resident's needs.
- For the Top End in particular, the CVP has seen positive evidence of varied and engaging schedules of activities, and attempts to maintain the resident's connection to family and community.

Areas for Improvement:

- As with the Secure Care Facility, there needs to be improved attention to both the detail and review of residents' Positive Behaviour Support Plans.
- Residents often express their desire to visit their home communities. Greater assistance to facilitate regular visits is required.
- The facilities would benefit from improved amenities, in particular more appealing outdoor spaces and achieving a more home-like environment.
- Where non-government organisations are the main provider of residential care, the organisation needs to be better supported by the Office of Disability to understand how this arrangement varies from other disability supported accommodation, including the CVP role.

Priority Concerns:

- Evidence of documented transition planning for all residents.

Nil Open/Closed Recommendations for Appropriate Places

Secure Care Facility – CVP Report Card

Achievements:

- The Secure Care Facility provides a stable, structured, safe environment for day to day residential care, and staff generally demonstrate a good knowledge of and rapport with residents
- There is an established daily program of community and social access for residents, including contact with their family members where possible.
- There is limited use of restrictive practices, and improvements in other areas (such as diet) to reduce the need for restrictive practices. The facility does not use the seclusion room for this purpose, with no instances of seclusion in this reporting period.

Areas for Improvement:

- There is a need for specialist training and support for staff, in particular in areas specific to development and implementation of a therapeutic program. The CVP notes that one of the most common reasons for therapeutic programs not being implemented is staff not understanding what is expected. [10]
- There needs to be more mechanisms to monitor staff 'procedural reliability' in therapeutic interventions, and involvement of staff in individual client reviews and re-assessments of the therapeutic program.
- Ongoing need to ensure cultural safety, in particular using accredited interpreters and engagement with the Aboriginal Interpreter Service on the unique interpreting requirements for the Secure Care Facility.
- Facilitation of CVP 'read only' access (and training if required) to use of the CCIS system (the Department has advised that this matter is now being progressed).

Priority Concerns:

- Clearer articulation of the policy and procedural framework for admission into the facility, in particular from mental health and forensic pathways and for female clients.
- Improved quality of clinical leadership and supervision, with a particular need identified for the Senior Clinician and Occupational Therapist to be based on-site, and the development of detailed therapeutic plans with measurable evidence-based interventions.
- Evidence of documented transition planning for all residents at the facility, initiated on transfer into the facility but urgently prioritised for long-term residents of the facility.

Secure Care Facility – CVP Recommendations

		Made By	Date	Status
	That complaints mechanisms, such as talking posters, are established in accordance with section 45 of the *Disability Services Act*.	Community Visitor	Aug 2014	Closed
1	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
2	That Kwiyernpe House [Secure Care Facility] management and the Aboriginal Interpreter Service meet to organise an orientation session for interpreters called to have language and cultural contact with the secure care facility residents.	CV Panel	Oct 2014	Open
3	That Kwiyernpe House [Secure Care Facility] management explore options for accommodating women within the facility separate from men.	CV Panel	Oct 2014	Open
4	That exit planning is urgently initiated with the two long term residents. (Reworded)	CV Panel	May 2015	Open
5	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
6	That a clear exit plan be established for each resident at the facility upon admission.	Community Visitor	May 2015	Open
7	That appropriate security features are installed, particularly duress alarms for all staff and visitors.	Community Visitor	May 2013	Open
8	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
9	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
10	That the CVP be granted CCIS access to enable files reviews.	Community Visitor	Aug 2014	Open
11	That the roles of Occupational Therapist and Clinician be located on-site at the Secure Care Facility and recruitment to these positions be prioritised. (Reworded)	Community Visitor	July 2015	Open

[1] The Department of Health (Office of Disability) has advised that available resources are being considered in relation to considering the inclusion of female residents in the Secure Care Facility.

[2] NT Department of Health (2011), Yirra and Kwiyernpe [Secure Care Facility] House Policies and Procedures. Copied supplied to the CVP. The Department of Health has confirmed in its discussions with the CVP that, even though the policies and procedures needs to be updated, there is no substantial shift in the fundamental aims and outcomes of the Secure Care Facility. See also the eligibility criteria for involuntary care and treatment in the NT Disability Services Act, section 8.

[3] NT Department of Health (2014), Secure Care Facilities and Services – Questions and Answers. Accessed at: http://health.nt.gov.au/Aged_and_Disability/Office_of_Disability/Services_for_People_with_Disability/Secure_Care_Services/index.aspx.

[4] UN Convention on the Rights of Persons with Disability, s26.

[5] University of NSW (n.d). Education and advocacy resources, volume 4: Indigenous Australians with mental health disorders and cognitive disability: Alice Springs.

[6] University of NSW (n.d), Education and advocacy resources, volume 3: Servicing and supporting Indigenous clients with mental health disorders and cognitive disability.

[7] NT Department of Health (2011), Yirra and Kwiyernpe [Secure Care Facility] House Policies and Procedures.

[8] An example of a positive behaviour support services framework guiding the CVP's assessment is the 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. The CVP also referred to the applied behavioural analysis approach described by P. Sturmey, South London and Maudsley National Health Service, Treatment interventions for people with aggressive behaviour and intellectual disability (chapter 4), accessed at: http://www.slam.nhs.uk/media/199428/treatment_for_aggression.pdf.

[9] Australian Government, Department of Social Services (2013), National Standards for Disability Services. Accessed at: https://www.dss.gov.au/our-responsibilities/disability-and-carers/standards-and-quality-assurance/national-standards-for-disability-services. The CVP notes in particular the standards and indicators of practice for standard 3 (individual outcomes) and standard 6 (service management).

[10] Victorian Department of Human Services (2011), Positive practice framework.

Chapter 5: Alcohol Mandatory Treatment (AMT)

CVP MAIN CONCERNS

1. Need for an independent evaluation of the effectiveness of the Alcohol Mandatory Treatment (AMT) program
2. Adequacy of quality assurance and safety, in particular the lack of a unified risk management framework
3. Need for a more systematic approach to individual review of Affected Persons to ensure that the 'least restrictive alternatives' are used
4. Improved focus on cultural safety for all Affected Persons in AMT facilities (in light of 97% of Affected Persons being Indigenous Australians)

This is the second report by the CVP under the *Alcohol Mandatory Treatment Act* (the AMT Act), and relates to the first full year of CVP work in this area. The CVP notes that the Alcohol Mandatory Treatment (AMT) scheme is still very new and is a rapidly changing and evolving area of policy and practice for all agencies involved.

During this period there were some significant changes, including new services being established in Tennant Creek, relocations of both assessment and treatment services in Darwin, and the commencement of services by a new treatment provider in Darwin. The proposed service in Nhulunbuy, mentioned in the last Annual Report, did not eventuate. The role of the CVP Advocate was also discontinued during this period.

The CVP would like to thank staff in AMT assessment and treatment facilities for the assistance provided to enable the CVP to perform its functions. The CVP would also like to acknowledge staff working in AMT facilities for the care and support provided to Affected Persons.

The CVP understands that independent statutory oversight may be unfamiliar to some non-government providers and those in the provision of Alcohol and Other Drug services generally. The CVP commends the Department of Health for supporting employees and contracted service providers to understand the role, powers and functions of the CVP. The CVP regards cooperative relationships with agencies as the key to supporting good client outcomes and quality service provision.

Facility	Community Visitor	CV Panel	Total
AMT Assessment	**115**	**-**	**115**
Darwin Alcohol Assessment Service	60	-	60
Katherine Mandatory Rehabilitation Assessment Service	8	-	8
Alice Springs Alcohol Assessment Service	43	-	43
Tennant Creek Alcohol Assessment Service	4	-	4
AMT Treatment	**125**	**4**	**125**
Darwin Alcohol Treatment Service (to 22 March 2015)	47	1	48
Stringybark Treatment Facility, 'Saltbush Mob' (23 March 2015)	17	1	18
Central Australian Aboriginal Alcohol Programmes Unit	53	2	55
Tennant Creek Alcohol Treatment Centre	4	-	4
AMT Total	**236**	**4**	**240**

AMT Visits 2014-2015

Overview of AMT Arrangements

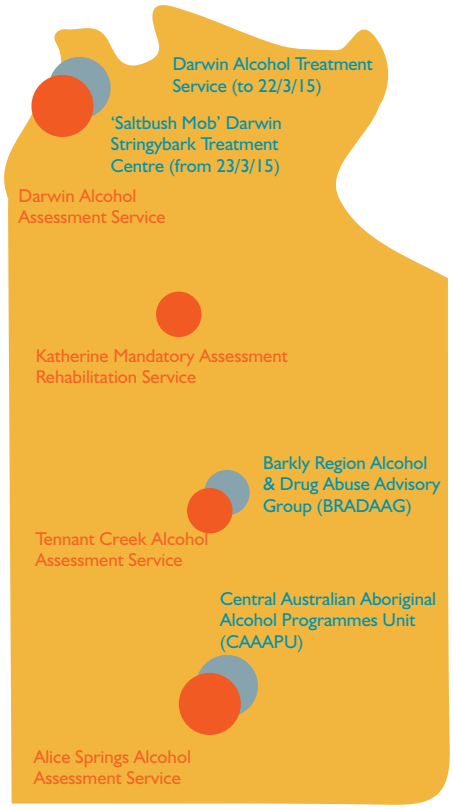
The guiding principles of the AMT program are that involuntary detention and treatment are to be used as a last resort and that least restrictive interventions are to be used. Any interference with a person's rights and dignity are to be kept to a minimum. These principles, outlined in section 6 of the AMT Act, govern the exercise of all functions and powers under the Act. The principles also guide the CVP in its work in the AMT field.

"I was really happy that they helped me see my grandchildren, and visit my mother at the hostel – that made me feel good to see them again."

VIS/2014/29

The structural arrangements for AMT assessment and treatment facilities are outlined below to place the CVP commentary about the AMT program into context. In summary:

- AMT assessment services are managed and operated by the NT Department of Health;
- AMT residential treatment services in Alice Springs and Tennant Creek are outsourced to not-for-profit non-government organisations, namely:
  - Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU) (Alice Springs), and
  - Barkly Region Alcohol and Drug Abuse Advisory Group (BRADAAG) (Tennant Creek);
- Prior to 23 March 2015, the Department of Health had full responsibility for AMT treatment services at the Darwin Alcohol Treatment Service (also known as the Stringybark Centre or 'Stringybark');
- From 23 March 2015, AMT treatment services at Darwin have been provided by Saltbush Mob Pty Ltd ('Saltbush Mob'), a company that forms part of the Karen Sheldon Group of Businesses; and
- Department of Health clinical staff are co-located and involved in the provision of services at each AMT treatment centre (this includes the Senior Treatment Clinicians (STC), who have specified functions and responsibilities under the AMT Act).



Facility	Complaint	Enquiry	Total
AMT Assessment	10	123	133
AMT Treatment	42	145	187
Total	52	268	320

AMT Complaints & Enquiries 2014-2015

It is the CVP's view that the structural arrangements for AMT services are complex, and that this in turn affects oversight, communication and clear lines of responsibility for service delivery.

While the Department of Health does not have carriage of all aspects of program delivery in the AMT treatment centres, the Department is responsible for overall leadership and management of the AMT program. It is the Department's responsibility to develop and set the policy parameters, employ the majority of clinical staff and ensure that an effective and safe clinical governance structure is in place for AMT.

> "It's OK here… we have a good yarn and good tucker."
>
> V/15/280 (2014)

'Saltbush Mob'

The CVP notes that there was a change in AMT treatment providers in Darwin in March 2015. There will be very limited references in the chapter to 'Saltbush Mob', the new Darwin treatment service. This is because the implementation of this new approach is being monitored by the CVP at this stage. The client quotes included in the chapter also do not relate to Saltbush Mob's period of operation.

The CVP notes that initial impressions from the CVP in relation to the Darwin AMT treatment service, run by 'Saltbush Mob', are that there is an improved quality of treatment services being provided. Prior to 'Saltbush Mob' taking on the AMT treatment services, the facility was

operated by the Department of Health. More detailed analysis of the new Darwin AMT treatment arrangements will be made in next year's CVP Annual Report.

SIGNIFICANT ISSUES

The commentary below is a discussion of significant issues for the AMT program. This is followed by a 'report card' identifying specific issues for each AMT facility. This chapter refers to people who come into AMT assessment and treatment facilities as 'Affected Persons'.[1]

Model of Care

In the second half of 2014, the Department of Health finalised a 'Model of Service Delivery, Role and Function' for Northern Territory Alcohol and Other Drugs (AOD) services. This included a model of practice for AMT services, an AMT Clinical Practice Guideline,[2] and an Alcohol and Drug Community Care Clinical Practice Guideline. These documents were noted in the 2013-2014 CVP Annual Report to be a necessary (but at that time absent) part of the framework required to facilitate the delivery of consistent AMT services in the Northern Territory. The Model of Service Delivery and AMT Clinical Practice Guidelines provide greater detail about a range of matters including the treatment and aftercare phases of AMT, and therefore are important documents to operationalise the program.

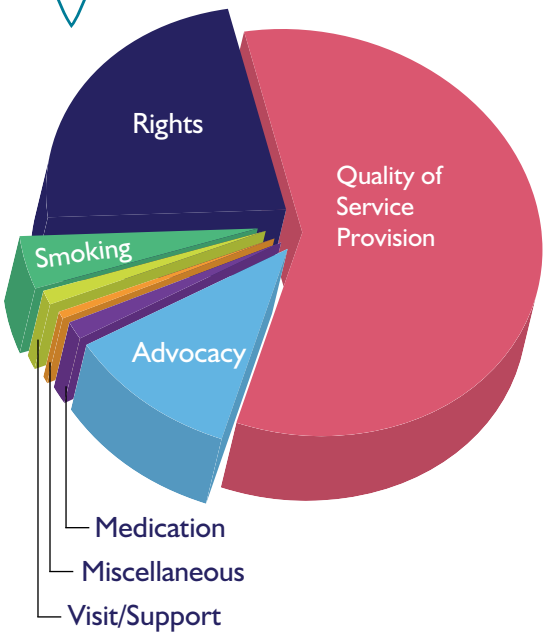
It appears to the CVP that a systematic approach has been taken in AMT assessment facilities to determining whether an Affected Person fulfils the criteria of the AMT Act. The AMT assessment services provided under the model of care appear to provide an environment where detoxification can occur safely, and where the person's primary health care needs can be identified and treated where possible. As acknowledged by the Department of Health, however, the fact that an Affected Person has complex health needs is not the key measure for determining whether mandatory treatment should be imposed under the AMT Act.

Where a mandatory residential treatment order is made by the AMT Tribunal, the 'treatment' phase of AMT commences.[3] It is the view of the CVP that the model of care does not adequately address the responsibilities and interaction of Department of Health staff co-located in AMT treatment centres with non-government AMT treatment providers. This is despite operational protocols being established. The Department of Health recently indicated to the CVP that the AMT Clinical Practice Guideline is being expanded to include a section for the non-government service providers.[4] At present, however, these aspects of the AMT treatment environment remain opaque.

AMT (Assessment Facility) Complaints & Enquiries - Issues Raised 2014-2015

"I'm happy to be here, it feels safe and my husband's here too… I'm able to talk to staff and they listen to me"

VIS/2014/58



AMT (Treatment Centre) Complaints & Enquiries - Issues Raised 2014-2015

Mandatory alcohol treatment is new to the Northern Territory. While the unique contributions of the different treatment providers are potentially valuable, the CVP supports the use of a common practice approach in the AMT facilities. The Department itself has recognised this through the commissioning of a 'treatment and rehabilitation toolkit' for use in AMT services. There also needs to be common understanding of responsibilities and expectations of the treatment providers and the Department in the AMT treatment centres. Without this, there are implications for the quality of service provision, as well as management of risk and the application of 'least restrictive' principles. These matters are discussed further below.

Independent Evaluation of the AMT Program

As indicated in the 2013-2014 Annual Report, the scale of the mandatory alcohol treatment program in the Northern Territory provides an important opportunity for a body of knowledge to be built up on the efficacy of this approach.

The CVP notes for a second year that there is an urgent need for an independent evaluation of the AMT program. It is also concerning that the Central Australia CV Panel has commented in its report that there is no 'consistent, focused, evidence based' approach to the treatment program. The CV Panel has expressed concerns that it would be 'virtually impossible' to do a rigorous evaluation of the program at that site due to the lack of detailed documentation.

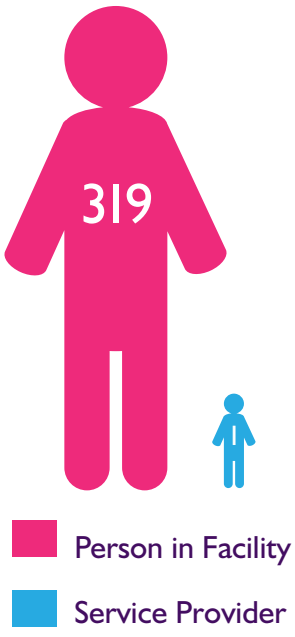
Given the length of time that the program has now been in place, and anecdotal reports of 'repeat entrants' to the AMT facilities, the CVP regards independent evaluation of the AMT program as being of critical importance. An evaluation may also lead to improvements, if required, in the documentation required to be kept in AMT facilities.

Mandatory residential treatment is a restrictive intervention that limits the civil rights of individuals. It is the view of the CVP that the need for evidence regarding the efficacy of a program is particularly acute where detention is a key mechanism for providing treatment.

This view was recently affirmed also by the NT Coroner, who also noted the need for an evaluation of the AMT program:

> *…if the detention process results in therapeutic outcomes that save lives and restores the health of citizens, then arguably the abrogation of [their human] rights may be justified… Without data in relation to the result of the detention process… the community will not know if the process is arguably justified or merely a process to 'warehouse' alcoholics so as to remove them from public eyesight.*[5]

The CVP notes the recent announcement by the Minister of Health that the Department would arrange for an evaluation. The Department of Health has advised that a steering committee has been established



AMT Complaints & Enquiries Sources 2014-2015

"the government is trying to take over our lives… you don't see them doing it to white people… this is history repeating itself… I want to complain about our rights"

VIS/2015/296

and that invitations to tender a proposal have been made to the Department of Health's panel of evaluators. The CVP urges that a fully independent evaluation occur as a matter of priority.

Quality of Treatment Services

Quality of Therapeutic Program

In last year's Annual Report, the CVP noted that there is an inherent conflict that exists for all types of mandated care. The CVP raised the importance of identifying and resolving this conflict using a health promotion approach and evidence based strategies across the whole program. The CVP reiterates that individualised treatment options are critical. This maximises the ability of the services to create an environment whereby Affected Persons may elect to move from a passive phase to the active self-determining phase in the management of their alcohol dependency, use or subsequent cessation.

The CVP had concerns, based on visits to facilities, requests for information, and enquiries raised by Affected Persons, that there was limited time spent in AMT treatment centres on structured programs or individual case management. There is clear evidence available in the Alcohol and Other Drugs field that certain treatment strategies are most likely to be beneficial.[6]

At CAAAPU, the majority of the day appeared to be spent on activities which, while culturally appropriate, did not relate clearly to the purpose of alcohol treatment. At Stringybark (while treatment services were fully provided by the Department of Health), it appeared common for Affected Persons to return to their accommodation blocks after a morning group session which at times lasted for less than an hour.

Individual counselling related to health promotion and alcohol use (such as engagement using a motivational interviewing approach, leading into a personalised action plan) did not appear to be provided as a matter of course.

There appear to have been positive developments in the Darwin AMT treatment centre with 'Saltbush Mob' and these will be closely monitored by the CVP to see how these work in practice. As mentioned, the Department of Health has advised that a 'treatment and rehabilitation toolkit' has been commissioned to further develop practice in this area.

"I watch TV … it's too hot here to walk [to the meeting room]… I just sit, sit, sit"
(Affected Person with disability)
VIS/2015/295

"[the program was] just talking nothing for a while… we're just doing time"
VIS2015/276

"it's a bit boring [here] but still good – they are treating us nice"
V/15/291(2014)

Staff Turnover and Skill Levels

Another issue with the quality of the treatment program is the skill level of the staff to deliver such programs. In the CVP's view, staff providing mandatory alcohol treatment require high level skills to deliver evidence based, culturally appropriate motivational interviewing, Cognitive Behavioural Therapy (CBT), one to one counselling, relapse prevention strategies and group work.

Effective clinical supervision is also required for staff providing key therapeutic modalities. The Department of Health has acknowledged that there are difficulties in recruiting and retaining staff with appropriate levels of skill and knowledge to provide these sorts of interventions.

The most recent CV Panel report on the visit to the Alice Springs AMT treatment provider, CAAAPU, identified that due to staff turnover, attempts to proactively tailor the program were being regularly lost when staff leave. This is of concern to the CVP, however, it is pleasing that CAAAPU has signalled its intention to undertake an independent review of their program.

Regardless of the inherent challenges in staff retention and recruitment, these issues need to be effectively addressed. This further emphasises the need for independent evaluation of the AMT program's efficacy with respect to client outcomes.

"This is like 'kindergarten level'… people want to go shopping and fishing because they're bored, [the program] doesn't keep their minds occupied."

VIS/15/278(2014)

Aftercare

Aftercare is a crucial element of the AMT program, and is more than just the development of an aftercare plan. This is evidenced by detailed attention to aftercare in the Department of Health's model of care. Effective aftercare, while voluntary in terms of client participation, supports the 'harm minimisation' approach that underpins drug and alcohol services available more broadly to all people in the Northern Territory and nationally.

The CVP noted in some complaints and enquiries received from Affected Persons that there was a need for more rigorous engagement of individuals in the development of their aftercare plans. The planning needs to be respectful of their preferred discharge destination. It also needs to be specific and practical with strategies related to relapse prevention. These elements are critical both to the individual's re-integration into the community and, if treatment has had an impact, sustaining any beneficial outcomes from the treatment program.

At the time of writing, the Department of Health advised that in July 2015 funding had been provided to the Central Australian Aboriginal Congress in Alice Springs for aftercare workers. The CVP acknowledges this information but has not been provided with details of how this will work. Aftercare workers were also funded by the Department of Health when 'Saltbush Mob' commenced services at the AMT treatment centre in late March 2015. Prior to March 2015, however, there was limited evidence of specialised aftercare services being provided in any AMT treatment centres.

For the cohort of Affected Persons in AMT treatment, it is evident that there are significant challenges with supporting both effective aftercare planning and implementation. This is due to the complexity

"I'm happy that I've been given the chance to do some training here in the kitchen, it's been good for me."

VIS/2014/29

"I don't want to be forced to go there [home community]… I don't want to be treated like a child… [my case manager] wouldn't listen."

V/2014/71

"It doesn't feel like 'aftercare', it's more like 'throwing you out there'!... I know [people who have been here] who go straight back to drinking on the streets."

VIS/15/289(2014)

of their needs and the known limitations in services and supports available in the community (such as housing). The CVP is of the view that comprehensive aftercare services to Affected Persons need to be provided consistently across the Northern Territory, and well supported beyond the legislative requirements to prepare and lodge an aftercare plan.

Quality Assurance and Safety

As noted in last year's Annual Report, the objectives of quality assurance are to maximise safety of Affected Persons and staff, and to facilitate continual improvement in the quality of services. It safeguards care by creating an environment that strives for clinical and service excellence.

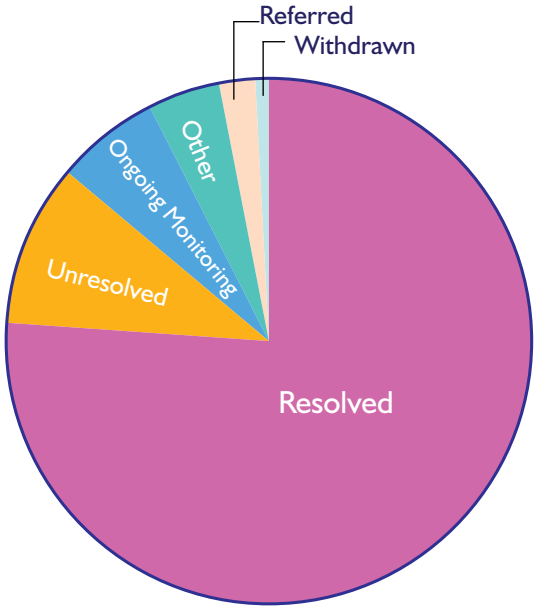
Primary Health Care

People affected by the AMT legislation, namely individuals with chronic alcohol misuse issues, tend to have complex health needs. In practice, Affected Persons under this legislation overwhelmingly have been Indigenous Australians (97%).[7] Indigenous Territorians have higher rates of chronic health conditions compared to non-Indigenous Territorians.[8] AMT assessment and treatment providers need to be able to adequately respond to the primary health care needs, including chronic medical conditions, of Affected Persons.[9]

The inclusion of primary health care nurses in the multi-disciplinary team in the AMT treatment centres appears to have been a very positive improvement in the care and treatment of Affected Persons during the treatment phase. However, the death of an Affected Person at the Alice Springs AMT treatment centre (CAAAPU) illustrates the seriousness of the risks posed when clients with complex medical conditions are residing at mandatory treatment centres.

Given the recognised need for comprehensive primary health care in AMT, the CVP has sought clarification from Department of Health and AMT treatment providers regarding the arrangements made to meet primary health care needs in AMT treatment centres. At present, there are different arrangements for each AMT treatment centre for access to medical officers.[10] In the CVP's view, inconsistencies in these arrangements affect clarity in processes and could create risks with communication and coordination of care.

The Department of Health has ultimate responsibility for the care and wellbeing of Affected Persons detained under the AMT Act. The CVP is concerned about limitations in the Department's oversight of clinical services across all AMT treatment centres. There are risks associated with the complexity of the current arrangements, linked to lack of clarity around areas of responsibility within AMT treatment as



AMT Complaints & Enquiries Outcomes 2014-2015

a whole. This is particularly the case in AMT treatment centres, as the Department has clinicians co-located in those facilities. The Department is therefore operating as both a contract manager and a collaborator in the provision of services (clinical and governance).

The CVP has identified some concerns relating to procedures and training of non-clinical staff to appropriately respond to the health needs of Affected Persons. Under current arrangements, non-clinical staff at AMT treatment centres are sometimes required to manage or identify client health care needs during periods when no clinical staff are on duty. In these circumstances, non-clinical staff would have to make a judgment call about the most appropriate response to presenting symptoms, including whether the on-call medical officer needs to be contacted.

It is imperative that clear risk management processes, together with adequate training and procedures, are in place for 'after-hours' clinical care in AMT treatment centres. The CVP has been advised that Department of Health nursing staff provide support and training to non-clinical staff to enable medication to be safely provided and after hours medical issues to be properly identified. Some written procedures are also in place.

The CVP is concerned that these strategies may not be sufficient to mitigate the risks to Affected Persons after hours. As mentioned earlier, due to the high staff turnover in AMT treatment centres, there needs to be detailed procedures regarding these matters and evidence of regular training and orientation for non-clinical new and ongoing staff in all AMT treatment centres. The CVP will monitor this issue closely.

> "I feel sick, I want to see the doctor and he can take my blood… I don't know what was in those needles I got at that other place [AMT assessment facility]"
>
> VIS/2014/27

Clinical Governance and Risk Registers

The governance arrangements for AMT treatment centres are complex. The model of co-locating Department of Health staff with outsourced AMT treatment providers, who perform separate but connected duties, presents challenges for quality assurance frameworks. It also affects clarity in lines of management and responsibility. It appears to the CVP that there is a fragmented approach to risk management. This carries serious risk implications for Affected Persons and the AMT program.

While quality and safety officers are employed by the Department of Health (Alcohol and Other Drugs Services Directorate), there has been limited information from the Department of Health regarding what is expected in terms of risk registers and risk management plans in general. This information has been requested by the CVP, including by the CV Panel in Central Australia when visiting the Alice Springs AMT treatment centre, but insufficient information has been provided.

In this context, the CVP has also expressed concerns about the use of different record-keeping systems by non-government and Department of Health staff operating within the same AMT treatment centre. This includes clinical record keeping (such as the use of the Department of Health 'PCIS' database) through to management of incidents and complaints.

> "I pressed that [duress] button, but nothing happened"
>
> VIS/2015/75

The CVP understands that incidents are only recorded on the Departmental risk management system ('Riskman') if the incident relates directly to the Department's own service provision. This approach is not comprehensive. It does not capture all matters that relate to quality assurance and safety for the program and for Affected Persons' care. As the risks cannot be adequately determined in the current system,

action plans to mitigate these risks (for each AMT facility) inevitably also will be incomplete. There is still no comprehensive risk register that records all incidents, both of Department of Health and non-government agencies. This is not acceptable and requires urgent attention.

A major issue of concern in terms of clinical governance and risk management is the impact of the high level of staff turnover. Staff turnover places a large burden on management in terms of ongoing training for new staff. The loss of staff also impacts on quality supervision and continuous improvement. While the CVP acknowledges that staffing of Alcohol and Other Drug services is a broader issue for the Northern Territory and nationally, there needs to be improved quality and depth of the policy and procedures to mitigate the risks of staff turnover on client safety.

Cultural Safety and Responsiveness

The overwhelming majority of Affected Persons in AMT assessment and treatment facilities in 2014-2015 were Indigenous Australians (97%).[11] This means that cultural safety and responsiveness is a paramount consideration for the AMT program.

A number of Affected Persons and staff at AMT services have raised concerns with the CVP about the apparently discriminatory impact of the AMT scheme on Indigenous Australians. In response to requests from Affected Persons, where appropriate, information has been provided about options for raising these concerns.

> "you never see them doing to it white backpackers … this is discrimination"
>
> C/2015/237

Cultural diversity gives rise to significant challenges in communication. Considerable distress for Affected Persons can occur when their cultural needs are not fully understood or prioritised. Complaints and enquiries raised with the CVP highlight the complexity and sensitivity involved in cross-cultural communication.

Consistent with last year's Annual Report, the CVP has continued to observe varying degrees of culturally respectful services in the AMT program. For AMT treatment centres in particular, it is unclear how the Department of Health ensures that culturally safe healthcare is consistently provided throughout the AMT program.

While at the current time some facilities appear to have culturally appropriate activities, the CVP notes that the cultural safety of treatment programs is also a feature of broader concerns about the quality of treatment programs. This illustrates the importance of appropriately adapting treatment programs due to the overwhelming numbers of Affected Persons being Indigenous Australians.

Last year, the CVP identified the strategies that could assist in ensuring culturally respectful healthcare.[12] While AMT facilities have provisions for cross-cultural training for staff, the CVP is concerned that high staff turnover complicates the provision of such training in a timely manner.

The CVP encourages efforts made to recruit Indigenous Australians to work in the AMT facilities. Ensuring cultural safety, however, is the work of all staff and attention to cross-cultural competence must remain a high priority in professional development and training.

Interpreter Use

One of the key challenges in effective communication within AMT assessment and treatment facilities is the consistent and systematic use of interpreters. Many Affected Persons in AMT facilities speak a first language other than English. This has the potential to create communication breakdowns during assessment, Tribunal appearances, case management and aftercare planning. It also can affect full participation in therapeutic programs. The level of English required to enable a proper assessment, and to participate effectively while in an AMT facility, is more than conversational.

> "I don't need to be here… I've got a home to go to… I want an interpreter to talk to a lawyer and that Tribunal"
>
> C/2015/235

The CVP has formed the view that interpreters are being requested with greater regularity during the Assessment phase than had been the case during the previous reporting period. While some improvements were noted, concerns still remain regarding the level of interpreter use during the Treatment phase. The CVP noted several cases in which Department of Health AMT staff said interpreters were not required, even though the Affected Person's first language clearly was not English.

The CVP has also expressed concerns regarding the independence of interpreters used at the Alice Springs AMT treatment centre (CAAAPU). The CVP raised these matters directly with CAAAPU in the first instance, and then as part of the regular reporting to the Department of Health. In June 2015, the CVP was advised by the Department of Health that CAAAPU had agreed to access and engage the Aboriginal Interpreter Service for all client planning and assessment during their treatment. At the time of writing, the CVP has since been advised directly by CAAAPU that this is no longer the case. This matter requires further discussion with CAAAPU.

The CVP reiterates the view expressed in the previous Annual Report that the use of independent qualified interpreters at appropriate stages is critical to the success of a person's participation and experience of the AMT Program. More broadly, effective use of interpreters is critical to the success of the AMT program as a whole.

> "we're not treated like adults … we want our mobile phones"
>
> VIS/2015/299

Contact with Family and Other Needs

A common concern that Affected Persons raise with the CVP is the need to ensure cultural connectedness. This includes satisfying obligations to family, attending funerals or other cultural business, and maintaining close contact by phone or in person. In general, the CVP commends efforts made by AMT staff to respond to the concerns of Affected Persons.

During the reporting period, however, there were concerns raised by Affected Persons about visits and telephone use. The policies about use of mobile and landline phones are not consistent across AMT facilities. Despite the uniqueness of each facility, the Department of Health needs to consider the provision of clearer, objective guidelines regarding phone use and access in AMT facilities. The CVP is monitoring these issues closely to ensure that Affected Persons' right to be in contact with their families and loved ones while detained remains protected.

Least Restrictive Alternative

Assessment Phase

Some Affected Persons raised issues about being detained in an AMT assessment facility while Tribunal hearings were being arranged, despite the fact that release orders had been recommended by the Senior Assessment Clinician (SAC). The CVP made recommendations to the Department about considering leave and expediting hearings with the AMT Tribunal in these situations. At the time of writing this report, the Department of Health advised that steps were being taken in relation to these recommendations.

> "The only good thing here is the BBQs… people might love to be here if we could smoke"
>
> VIS/2015/292

Enquiries from some Affected Persons in AMT assessment raised issues about the circumstances in which they had been brought into AMT under the *Police Administration Act*. It was noted by the CVP that in situations where an Affected Person contests the validity of their detention in the AMT assessment phase, they have no opportunity to raise such issues prior to a hearing of the AMT Tribunal (which may be up to nine days after admission).

> "I was with my girlfriend and I didn't have alcohol, they [Police] asked me to move on and I swore at them … they grabbed me and took me to the watch house"
>
> VIS/2015/296

Further, the CVP observed during the reporting period that there appeared to be inconsistent understanding within AMT assessment facilities regarding the time period within which a Senior Assessment Clinician must finalise an assessment report. The AMT Act specifies in section 17 that the Senior Assessment Clinician has 96 hours to conduct an assessment of an Affected Person. Section 20 of the Act provides that the Senior Assessment Clinician has 24 hours after completing the assessment in which to make an application to the AMT Tribunal or request a mental health assessment.

There appears to have been inconsistent interpretation of the '96 hour rule', with some staff expressing the view that the further 24 hours referred in section 20 can be used to finalise the assessment report. The CVP is strongly of the view that the AMT Act provides for 96 hours to conduct the assessment and that this is evidenced by completion of the report within that timeframe.[13] The CVP's view is also consistent with the recommendations on the same issue in the Department of Health's 2014 *Report to the Minister for Alcohol Rehabilitation on the Review of the AMT Act (2013).*

At the time of writing, the CVP received advice from the Department of Health that further legal advice is being sought in relation to this issue. The Department also stated that Senior Assessment Clinicians are completing reports within the 96 hour timeframe. This issue was raised with the Department over six months ago. Clarity in legal requirements needs to be achieved as a priority to avoid the risk of any future inconsistent practice.

Treatment Phase

The CVP had previously raised concerns that applications for variation, replacement or revocation of orders under section 44 of the AMT Act did not seem to be well utilised. At the larger centres in Darwin and Alice Springs, for much of the reporting period there was little evidence of systematic reviews of Affected Persons' progress which would enable the 'least restrictive' alternatives to be used for each Affected Person.

The CVP has observed that there have been improvements in this area at the Darwin AMT treatment centre run by 'Saltbush Mob' since March 2015. These are encouraging developments however these need to be consistently evident across all AMT treatment centres.

The application of the 'least restrictive' principle also applies to leave requests and outings away from the facility. It is noted in particular that there has been a concerning development at the Alice Springs AMT treatment centre (CAAAPU) which has led to a reduction in approval for leave requests, including for outings such as church attendance.

In both the Alice Springs and Darwin AMT treatment centre (the latter, when administered by the Department of Health), it was the general practice not to allow leave during the first few weeks of admission to the facility. While some of the matters relating to leave are complicated by the difficulty of ensuring transport by authorised officers, this is a practical consideration that should not derogate from the overarching principle of the 'least restrictive alternative' enshrined in the AMT Act.

Applying the least restrictive principle needs to be, and remain, a focus of all AMT treatment providers. This needs to be led by the Department of Health, namely, the Senior Treatment Clinician based at AMT treatment centres and the Senior Assessment Clinician at AMT assessment facilities.

> "We want to go to church, but they won't take us."
>
> VIS/2015/136

> "More trips out … get into the environment."
>
> VIS/2015/276

> "[In relation to a search] we're not criminals… we're just people with an alcohol problem"
>
> VIS/15/284(2014)

COMPLIANCE WITH LEGISLATION

'Rights Statement'

The AMT Act requires that a 'Rights Statement' is provided to an Affected Person in an AMT facility (during both the assessment and treatment phases).[14] Section 4 of the Act requires that a number of elements are included in the statement. The CVP has expressed the view to the Department of Health that the current Rights Statement, as amended in April 2015, does not satisfy the legislative requirements in the AMT Act.

The current Rights Statement appears to be more of an 'orientation' document than a comprehensive outline of an Affected Person's rights. The CVP has further suggested that there be separate Rights Statements prepared for the assessment and treatment phases.

Use of Search Powers

The CVP received a complaint about an incident at the Darwin AMT treatment centre in late 2014 in which there was a search of all client rooms, followed by frisk searches of some clients. The facility was run by the Department of Health at this time. The search was apparently due to suspicions about the presence of tobacco and tobacco-related items.

Concerns were raised about the manner in which the search was conducted, in particular regarding

its impact upon the dignity of Affected Persons. The CVP queried whether all aspects of this search fell within the scope of section 77 of the AMT Act, which provides that searches of Affected Persons involve a 'reasonable belief' that the search is necessary to prevent an 'imminent risk of harm'.

A formal response to these legal issues raised above by the CVP has not yet been provided by the Department of Health. This needs to happen as a priority.

REPORT CARDS

The CVP notes that some of the AMT facility report card comments and recommendations raise issues that apply across the AMT program as a whole. The report cards have been written to indicate issues which have arisen at each facility, and include matters that are common across the AMT program.
It is acknowledged that the AMT sector is rapidly evolving and that some issues raised below were being responded to at the time of writing. The CVP maintains recommendations as 'open' until it is clear that the matter has been resolved after a period of monitoring.

Assessment Services

Darwin Alcohol Assessment Service (DAAS) - CVP Report Card

Achievements:

- Ten (10) closed CVP recommendations
- Apparent increased focus on 'least restrictive alternative' in assessments, for example, the use of release orders or community treatment orders (CTO).
- Responsiveness of Indigenous Liaison Officers to requests for assistance by Assessable Persons, and involvement of ILO with release planning on admission.
- Apparent increased use of interpreters subject to availability.
- Increased clarity in policies and procedures regarding transport arrangements on release/transfer of Assessable Persons.
- Timeliness of release and transfer to community treatment providers where relevant orders are made by the Tribunal.
- Facilitating CVP access to 'PCIS' to enable independent file reviews.
- Posters have been put up to indicate how to make a complaint about Police, and staff have been advised to assist Assessable Persons seeking to do so.

Areas for Improvement:

- Clarification of the processes and protocols for return to DAAS and/or AMT Tribunal when Assessable Persons are brought to Assessment by police while subject to Community Treatment Orders (CTOs), or are considered by community treatment providers to no longer meet the criteria for a CTO.
- Liaison between the Department of Health and NT Police and/or NT Ombudsman regarding processes to enable prompt referral of issues raised by Affected Persons involving complaints against Police.
- Improved privacy for clients in their room (via window coverings). The CVP understands that a quote has been sought for this.

Priority Concerns:

- Improvements to the Department of Health Rights Statement (both adequacy and accuracy of the Statement).
- Length of time that Assessable Persons may spend in detention awaiting a Tribunal hearing if assessed as not meeting the criteria for a mandatory treatment order and recommended for release.

Darwin Alcohol Assessment Service (DAAS) - CVP Recommendations

		Made By	Date	Status
1	That DAATS staff attend the 'Appropriate Workplace Behaviour Workshop' and other training as indicated.	Community Visitor	Feb 2014	Closed
2	That staff undertake training in appropriate clinical documentation – to include treatment planning, case notes and discharge planning and to include client participation in formulating plans.	Community Visitor	Feb 2014	Closed
3	That the CVP be involved in the staff orientation program when developed to ensure staff understanding of the CVP, CV and Advocate's role and responsibility.	Community Visitor	Feb 2014	Closed
4	That Assessable Persons have access to phone calls more than once a day and when necessary prior to 3pm so they can contact family and conduct their business.	Community Visitor	Feb 2014	Closed
5	That DAATS consider release options and plans for Assessable Persons at the time of assessment to ensure they are not held longer than necessary should they not be placed on an order.	Community Visitor	Mar 2014	Closed
6	That DAATS staff attend the Aboriginal Interpreter Service training to gain an understanding of the language needs and limitations of Indigenous Assessable Persons.	Community Visitor	Mar 2014	Closed
7	That DAATS develop as a priority a policy to address situations where domestic violence orders exist between Assessable Persons when both parties are at DAATS.	Community Visitor	Jul 2014	Closed
8	That protocols be developed for situations in which release orders are made by the Tribunal, which aim to balance Stringybark's duty of care to locate a safe discharge destination with an Assessable Person's (APs) right to be released promptly.	Community Visitor	Mar 2015	Closed
9	That policies and procedures be clarified in relation to arranging and paying for transport where Assessable Persons (APs) are placed on Community Treatment Orders (CTOs) or released from Assessment. That an Assessable Person's transport costs be covered by the Department of Health: • where the Tribunal makes a CTO requiring the AP to present themselves for admission at a community rehabilitation facility; or • where the Tribunal orders that the AP be released (in which circumstances the Senior Assessment Clinician may arrange for the person to be taken to their usual place of residence or another place which is reasonably believed to be safe, in accordance with section 39 of the AMT Act).	Community Visitor	Mar 2015	Closed
10	That steps be taken to ensure that areas used for washing hands after toileting meet the environmental health standards applying to Department of Health facilities. Attention is drawn to the 'No Germs On Me' campaign promoted by the Department of Health.	Community Visitor	May 2015	Closed

Darwin Alcohol Assessment Service (DAAS) - CVP Recommendations

Continued

		Made By	Date	Status
1	That DAATS ensure that information about Assessable Persons' rights is prominently displayed and that there is a system of checking that Assessable Persons have had their rights explained to them orally and in their own language and that they understand their rights.	Community Visitor	Feb 2014	Open
2	That DAATS 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
3	That when Assessable Persons are identified as having cognitive impairments or other needs beyond DAATS scope of practice timely and appropriate referrals are followed up on.	Community Visitor	Mar 2014	Open
4	That the Aboriginal Interpreter Service be contacted as soon as an Assessable Person arrives at DAATS to ensure that every endeavour is made to provide an interpreter during the assessment.	Community Visitor	Mar 2014	Open
5	That protocols be developed in relation to urgent guardianship applications and referral of Assessable Persons to NT Aged & Disability Services.	Community Visitor	Mar 2015	Open
6	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 SAC.	Community Visitor	Mar 2015	Open
7	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
8	That liaison takes place between Department of Health and NT Police and/or NT Ombudsman to establish processes for the prompt referral of issues raised by Assessable Persons involving complaints against police.	Community Visitor	Jul 2015	Open
9	That all Assessable Persons be offered a copy of their assessment report when completed and that there be provision for client copies to be stored securely.	Community Visitor	Jul 2015	Open
10	That curtains be made available for use in client bedrooms, if it is assessed as safe to do so.	Community Visitor	Jul 2015	Open
11	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
12	That Department of Health provide clarification to Assessment staff in relation to sections 17(2) and 20 of the AMT Act, specifying that assessment reports must be completed within the 96 hour period referred to in section 17(2), with section 20 allowing additional time for lodgement of the report with the Tribunal or the making of a request under the *Mental Health and Related Services Act* (as per the recommendations of the Report to the Minister for Alcohol Rehabilitation on the Review of Alcohol Mandatory Treatment Act (2013).	Community Visitor	Jul 2015	Open

Alice Springs Alcohol Assessment Service (ASAAS) - CVP Report Card

Achievements:

- One closed CVP recommendation.
- Introduction of talking books on Rights Statement in 5 languages.
- Recruitment of an Indigenous Liaison Officer with language skills.
- Use of interpreters when available.
- Staff encouraging and supporting family contact.

Areas for Improvement:

- Rights Statement talking book to be available in Pitjantjatjara.
- Staff turnover, in particular in Senior Assessment Clinicians (SACs) and Nursing Manager positions.
- Recording of referrals and follow up.

Priority Concerns:

- Referral pathways for assessments for Assessable Persons suspected of having a cognitive impairment.
- Staff awareness of procedures for dealing with threatening behaviours, in particular in light of staff turnover issues.

Alice Springs Alcohol Assessment Service (ASAAS) - CVP Recommendations

		Made By	Date	Status
	Department of Health and CAAAPU examine ways in which threatening/ disruptive clients can be more effectively managed.	Community Visitor	Jul 2014	Closed
1	That the Department of Health develops clear policies and procedures for management of Assessable Persons with diagnosed or suspected cognitive impairment within the AMT 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 Department of Health ensures that all staff involved with dealing with Assessable Persons (APs)/clients are aware of the procedures to be followed in managing threatening/disruptive clients.	Community Visitor	Jul 2015	Open
4	That the rights statement includes an explanation of S113 about representation at the Tribunal contained within it and that the new rights statement being used by DoH is amended to include important information that is missing. (Reworded)	Community Visitor	Jul 2015	Open

Katherine Mandatory Assessment Rehabilitation Service (MARS) – CVP Report Card

Achievements:

- One closed CVP recommendation.
- Apparent application of 'least restrictive alternative' in assessment process.
- Improved facility space (however CVP concerns regarding the facility remain and the relevant recommendation has been left open).
- Use of interpreters when available.
- Regular meetings between MARS unit manager and management of Katherine District Hospital regarding service provision issues.
- Enhanced staff awareness regarding only authorised officers restraining and transporting clients (that is, no other parties providing transport, such as security guards).
- Steps taken to include and utilise skills of the Katherine District Hospital social worker and Indigenous Liaison Officer in the provision of services.
- Resolution of the concern regarding automatic locking of the doors in the facility, which had the potential to create a situation where Assessable Persons were in 'seclusion' (which is not authorised under the AMT Act).

Areas for Improvement:

- Finalisation of transport arrangements for Assessable Persons, in light of identified safety and risk concerns in transporting clients over long distances.
- Clinical communication and documentation, including high quality clinical handover and record keeping processes.
- Clarification of the processes and protocols for return to DAAS and/or AMT Tribunal when Assessable Persons are brought to Assessment by police while subject to Community Treatment Orders (CTOs), or are considered by community treatment providers to no longer meet the criteria for a CTO.

Priority Concerns:

- Adequate outdoor space and common room area set aside for Assessable Persons.
- Audio Rights Statement to be made available in Kriol.

Katherine Mandatory Assessment Rehabilitation Service (MARS) – CVP Recommendations

		Made By	Date	Status
	That DoH review and clarify procedures for the restraint and transport of persons detained under the Act and ensure that only authorised persons are used for these functions.	Community Visitor	Dec 2014	Closed
1	That MARS be relocated as a matter of urgency to ensure safety of staff and Assessable Persons. This would allow for office space for staff and provide privacy and confidentiality for Assessable Persons. Relocating the service would also allow for men and women to be at the centre at the same time and provide space for movement and activities to be conducted with Assessable Persons.	Community Visitor	Mar 2014	Open
2	That the Alcohol Mandatory Treatment Program provide the clinical governance framework to the CVP detailing what structures and clinical supervision is in place to ensure there is an environment in which quality care can be provided.	Community Visitor	Mar 2014	Open
3	That steps be taken to provide an accessible and appropriate outdoor area for sole use by MARS clients.	Community Visitor	Jul 2015	Open
4	That the Department of Health finalises arrangements for provision of transport services for MARS clients.	Community Visitor	Jul 2015	Open
5	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
6	That urgent steps be taken by the Department of Health to resolve issues raised by the CVP regarding automatic locking arrangements for MARS patient rooms, to ensure that seclusion situations and safety hazards are not created.	Community Visitor	Jul 2015	Open
7	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
8	That Department of Health review operation of section 62 of the AMT Act, with a view to: • establishing protocols with community treatment providers regarding the contact which must be made with a Senior Assessment Clinician (SAC) where the criteria for an order appear not to be met, and outlining the steps to be taken by SACs in these situations regarding application to the Tribunal under section 44 for revocation of the order; and/or • amending the AMT Act so that section 44 applications can be initiated by community treatment providers where the provider is of the opinion that criteria for a Community Treatment Order (CTO) are no longer met.	Community Visitor	Jul 2015	Open

Tennant Creek Alcohol Assessment Service – CVP Report Card

Achievements:

- Two closed CVP recommendations.
- Separate male and female areas, despite centre being small with low numbers.

Areas for Improvement:

- Staff recruitment and retention, in particular of the Senior Assessment Clinician (SAC); this issue has led to service closures in the reporting period.

Priority Concerns:

- Resolution of issue regarding interaction of AMT with Alcohol Protection Orders, which appears to affect Tennant Creek more than other regions.
- Low intake numbers, which leads to under-utilisation of staff and affects staff retention.

Tennant Creek Alcohol Assessment Service – CVP Recommendations

		Made By	Date	Status
1	Replacement of the beds which could present a safety risk for both Assessable Persons and staff.	Community Visitor	Jan 2015	Closed
2	Improving the quality of Assessable Person files including attempting to gain access to the documents locked on the intranet and putting client files on PCIS.	Community Visitor	Jan 2015	Closed
1	That Department of Health give priority to efforts to implement the amendment to the AMT Act that would allow for persons on Alcohol Protection Orders (APOs) to be admitted to AMT.	Community Visitor	Jan 2015	Open

Treatment Centres

Darwin Alcohol Treatment Service (DATS) - CVP Report Card (to 22 March 2015)

DATS was also known as the 'Stringybark Treatment Centre'. Provision of AMT treatment services transferred to Saltbush Mob (KSC Pty Ltd) in March 2015. Therefore this report card identifies the achievements, areas for improvement and priority concerns that were identified by the CVP prior to 23 March 2015, during the period when the facility was entirely administered by the Department of Health.

Achievements:

- Four resolved and closed CVP recommendations.
- Responsiveness to Affected Persons' practical needs (eg clothing) and attempts to facilitate arrangements to meet cultural obligations.
- Development and implementation of Department of Health 'Persons displaying attributes under the NT Anti-Discrimination Act Clinical Practice Guideline' (this applies across all AMT services but the CVP notes that its development was precipitated by issues at Stringybark Treatment Centre relating to accommodation arrangements and respect for the dignity of an Affected Person).

Areas for Improvement:

- Responsiveness to Affected Persons' concerns, such as banking, shopping, leave, use of mobile phones, arrangements for visitors and phone use, noting the non-punitive nature of AMT treatment and detention.
- High staff turnover and vacancies, with concerns for low morale, and consequent impact on case management and leadership, treatment programs, activities; noting in particular impact on individuals from high client to staff ratios.
- Standard of food, heat levels in bedrooms (noting no air-conditioners available), storage of personal property, and bathroom cleanliness/hand hygiene.
- Numbers of people absconding, and risk of harm resulting from this behaviour (one client injury noted).
- Standard of case management and aftercare provided, in particular for clients with complex needs such as mental health concerns.
- More concrete processes required to ensure prompt and adequate follow up of AMT Affected Persons by the Top End Mental Health Service.

Priority Concerns:

- Quality of treatment program, including short periods of program activities, lack of information about program provided by the Department of Health, and feedback from Affected Persons about being bored.
- Lack of detailed documentation on treatment interventions that would enable a rigorous evaluation of quality and effectiveness.
- CVP observations of limited time spent on therapeutic (group or individual) treatment programs.
- Concerns about the quality, responsiveness and timeliness of case management services.
- Standard and responsiveness of aftercare planning, noting that no aftercare workers were employed by the Department of Health.
- Little evidence of systematic review and pursuit of 'least restrictive' treatment options.
- Concerns about hanging points in facility (raised by CV Panel).
- Approach taken to searches and whether all searches fell within s 77 of the AMT Act.
- Timeliness and frequency of interpreter bookings.

Open/Closed Recommendations:

- The recommendations below relate to the Darwin Alcohol Treatment Service (DATS) as it operated until 22 March 2015. Due to handover of service responsibility to another provider, all recommendations for DATS have been categorised as 'closed' (with the exception of the recommendation regarding external evaluation of the AMT program as this is a sector-wide issue). Where recommendations were unresolved at the time of the handover, this is indicated.

Darwin Alcohol Treatment Service (DATS) - CVP Recommendations (to 22 March 2015)

		Made By	Date	Status
1	That DAATS staff attend the 'Appropriate Workplace Behaviour Workshop' and other training as indicated.	Community Visitor	Feb 2014	Closed
2	That the CVP be involved in the staff orientation program when developed to ensure staff understanding of the CVP, Community Visitor and Advocate's role and responsibility.	Community Visitor	Feb 2014	Closed
3	That staff undertake training in appropriate clinical documentation – to include treatment planning, case notes and discharge planning and to include client participation in formulating plans.	Community Visitor	Feb 2014	Closed (Unresolved)
4	That DAATS ensure that information about Affected Persons' rights is prominently displayed and that there is a system of checking that Affected Persons have had their rights explained to them orally and in their own language both in Assessment and Treatment and that they understand these rights.	Community Visitor	Feb 2014	Closed (Unresolved)
5	That DAATS ensure there is an accessible and obvious complaints process and that Affected Persons know they have the right to complain.	Community Visitor	Feb 2014	Closed (Unresolved)
6	That Affected Persons have access to phone calls more than once a day and when necessary prior to 3pm so they can contact family and conduct their business.	Community Visitor	Feb 2014	Closed (Unresolved)
7	That interpreters be used as a matter of best practice throughout the treatment process but in particular during the formulation of treatment plans and aftercare plans to ensure engagement and understanding by the Affected Persons.	*Community* Visitor	Mar 2014	Closed (Unresolved)
8	That staff attend Aboriginal Interpreter Service training.	Community Visitor	Mar 2014	Closed (Unresolved)
9	Aftercare planning – formal, documented interaction with community, non-government organisations in the continuing care of the Affected Person upon release.	CV Panel	Aug 2014	Closed (Unresolved)
10	Interpreters – use of interpreters is increased significantly in treatment consultations (not just the Tribunal proceedings), especially where English is a second language.	CV Panel	*Aug* 2014	Closed (Unresolved)
11	Safety: • An audit of the facility with a view to minimising risk from hanging points and lethal materials; • All staff receive training in the recording and reporting of 'use of force' incidents and that the policies are re-developed so that they are consistent with each other and the relevant legislation; and • DAATS prioritise the development of a comprehensive suicide/self-harm policy, which may include details of staff training, screening, observations, post-screening management, communication about risk, safe housing and linkages to mental health services.	CV Panel	Aug 2014	Closed (Unresolved)

Darwin Alcohol Treatment Service (DATS) – CVP Recommendations (to 22 March 2015)

Continued

		Made By	Date	Status
12	Policies – it is recommended that all DAATS policies, procedures and like documents include a promulgation date, review date and owner.	CV Panel	Aug 2014	Closed (Unresolved)
13	That staff begin discharge and aftercare planning at the beginning of the treatment process to ensure there is sufficient time for referrals and arrangements to be made (particularly when issues of accommodation are involved).	Community Visitor	Jul 2014	Closed (Unresolved)
14	That where issues of cognitive capacity are identified appropriate referrals and assessments are made in a timely fashion and steps taken to find less restrictive options. (Reworded)	Community Visitor	Dec 2014	Closed
15	That clearer pathways of treatment and referral be developed to ensure appropriate responses for people with cognitive impairments and mental health issues.	Community Visitor	Dec 2014	Closed (Unresolved)
16	That case conferences/discharge planning meetings involving Stringybark case management staff and other relevant service providers be implemented as part of the aftercare planning process, particularly in relation to Affected Persons with co-morbidities.	Community Visitor	Feb 2015	Closed (Unresolved)
17	That performance targets be adopted in relation to the timeliness of interpreter bookings for treatment planning processes.	Community Visitor	Feb 2015	Closed (Unresolved)
18	That protocols be developed in relation to both guardianship applications and referral to NT Government Aged & Disability Services.	Community Visitor	Feb 2015	Closed (Unresolved)
19	That Affected Persons' sleeping conditions be reviewed.	Community Visitor	Feb 2015	Closed (Unresolved)

20	That issues regarding searches be clarified, including:
	• the grounds upon which searches can be undertaken under section 77 of the AMT Act, in particular:
	  • does section 77 authorise searches for tobacco and/or tobacco-related items;
	  • does section 77 permit general searches of the client population, or must there be a 'reasonable belief' in relation to each specific person who is subjected to a search; and
	• whether the NT Government's Alcohol and Other Drugs (AOD) Search and Contraband Policy exceeds the scope of the AMT Act in relation to its provisions regarding searches.
		Community Visitor	Feb 2015	Closed (Unresolved)

21	That practices be developed to ensure that the necessary records of any search of an Affected Person are completed and filed 'as soon as practicable', as required by section 77 of the AMT Act.	Community Visitor	Feb 2015	Closed (Unresolved)

Darwin Alcohol Treatment Service (DATS) – CVP Recommendations (to 22 March 2015)

Continued

		Made By	Date	Status
22	That policies and procedures be clarified in relation to the payment of Affected Persons' travel costs to release destinations.	Community Visitor	Feb 2015	Closed (Unresolved)
23	That consideration is given to allowing Affected Person (APs) to retain their mobile phones for a trial period, to see whether: (a) issues arise in relation to the provision of contraband; and (b) the level of contact by APs with their families, communities and external service providers is improved.	Community Visitor	Feb 2015	Closed (Unresolved)
24	That training about the protocol between Alcohol and Other Drugs (AOD) and Top End Mental Health Service (TEMHS) be provided to both Stringybark and TEMHS staff.	Community Visitor	Feb 2015	Closed (Unresolved)
25	That Stringybark management liaise with community rehabilitation providers to develop streamlined processes for transferring clients assessed as suitable for those facilities.	Community Visitor	May 2015	Closed
26	That the operational protocol between Alcohol and Other Drugs (AOD) and the Top End Mental Health Service (TEMHS) be implemented and its effectiveness reviewed.	Community Visitor	May 2015	Closed (Unresolved)
27	That steps be taken to ensure that bathroom and toilet areas meet the environmental health standards applying to Department of Health facilities.	Community Visitor	May 2015	Closed (Unresolved)
1	That timely arrangements are made for external evaluation of the AMT program.	Community Visitor	May 2015	Open

Stringybark Treatment Centre ('Saltbush Mob') - CVP Report Card (from 23 March 2015)

The CVP notes that that Saltbush Mob had only been involved in provision of treatment services at the Stringybark Centre for a relatively brief period prior to 30 June 2015. This is acknowledged by the CVP and should be taken into account in consideration of the comments below.

Achievements:

- Improvements in food and amenities (noting also improvements from moving to the new site in May 2015).
- Improvements in the ethos of client centred approaches evident in new participant file review policy and participant engagement processes.
- Improvements in range of recreational and social activities for Affected Persons.
- Improvements in flexibility with mobile phone use, and expansion of weekend visiting hours.
- Evidence of improvements in level of case management activity and aftercare planning, including the level of involvement of Affected Persons.
- Provision of information regarding the treatment program ('Footprints'), and the CVP notes that best practice Alcohol and Other Drug models and psychological therapies are evident in the program.
- Apparent improvement in pursuit of 'least restrictive' options for Affected Persons.
- Increased on-site medical coverage, including arrangements for 'on call' assistance through a GP clinic. GP now attends for eight hours per week over three days and on call after hours.

Areas for Improvement:

- Clearer referral pathways and responsiveness of Top End Mental Health Service to AMT Affected Persons with mental health concerns (the CVP has been advised by 'Saltbush Mob' that this issue is being followed up).

Priority Concerns:

- Completion of policy and practice documentation (at the time of writing, a policy and practice manual had been provided and advice received that a case management manual is being developed).
- Clarity of communication processes and procedures involving Saltbush Mob and Department of Health.
- Adequacy of new Rights Statement developed by Department of Health.

Open/Closed Recommendations:

- These are the Open CVP Recommendations that have most recently been communicated to 'Saltbush Mob' by CVP since taking on the AMT treatment service. It does not include recommendations that may have been provided to the service since the end of August 2015.

Stringybark Treatment Centre ('Saltbush Mob') - CVP Recommendations (from 23 March 2015)

		Made By	Date	Status
	That a completed version of the Saltbush Mob Policy and Practice Manual be provided to the CVP and AMT management as a matter of priority.	Community Visitor	Aug 2015	Closed
1	That remote PCIS access be arranged for Saltbush Mob doctors who provide 'on call' assistance for Stringybark clients.	Community Visitor	Aug 2015	Open
2	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
3	That systems be put in place to ensure that all relevant incidents placed on Saltbush Mob registers are notified to Department of Health (via the Senior Treatment Clinician (STC) and/or other appropriate arrangements).	Community Visitor	Aug 2015	Open

Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU) - CVP Report Card

Achievements:

- One CVP recommendation closed.
- Improvements in treatment planning over the reporting period.
- Culturally safe environment with appropriate activities and engagement with families.
- Workers with many years of experience in the field of alcohol and other drug rehabilitation with Indigenous Australians.
- Being proactive in offering and supporting professional development in Certificate III, Certificate IV and Advanced Diploma qualifications for existing staff.
- Finalisation of an Operational Protocol between Department of Health and CAAAPU.
- Return to acceptable staff to Affected Person ratio, following restructure and concerns raised by CVP regarding the impact on care of a higher ratio of Affected Persons to staff.
- AMT practice guidelines workshop with Department of Health (April 2015).

Areas for Improvement:

- Consistently applying the principle of least restrictive alternative, in particular, enabling leave for cultural, social and religious needs and seeking variations or revocations of mandatory treatment orders.
- Improvements in CAAAPU staff's skill level and knowledge regarding AMT program and Affected Persons' needs, in particular breadth of treatment program skills.
- Documentation, in particular integrating electronic and paper recording to a single system, and systematic recording of referrals and outcomes of referrals.
- Reduction in staff turnover and the consequent impact on consistency in treatment services and programs on offer (avoiding 'reinventing the wheel' and risks in documentation and follow up of Affected Persons).
- Improvements in aftercare planning and support.

Priority Concerns:

- Improved quality of treatment programs on offer, in particular program interventions specifically targeting alcohol use (such as evidence-based motivational interviewing and counselling, harm minimisation strategies, and relapse prevention).
- Lack of detailed documentation on treatment interventions that would enable a rigorous evaluation of the effectiveness of the AMT treatment program overall.
- Need for increased use of interpreters, including those independent of CAAAPU.

Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU) - CVP Recommendations

		Made By	Date	Status
1	It is recommended that the Treatment Centre procure a bus for group outings.	Community Visitor	Jun 2014	Closed
2	It is recommended that clear protocols and procedures for the management of clients using threatening/aggressive behaviour be developed by Department of Health.	Community Visitor	Jul 2014	Closed
1	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
2	That the treatment program be reviewed and improved by CAAAPU, in accordance with the Department of Health model-of-care, and include best practice, evidence-based and evidence-informed treatment related directly to alcohol misuse. (Reworded)	CV Panel	Dec 2014	Open
3	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
4	That the Senior Treatment Clinician and CAAAPU implement the Department of Health Model of Care in the treatment program, including documentation of treatment and consent.	CV Panel	Dec 2014	Open
5	That a proper system of review, audit and evaluation of individual Affected Persons treatment and Aftercare planning be developed and carried out by CAAAPU, and that a proper evaluation of the AMT Program as a whole, including Aftercare, be developed and carried out by Department of Health in conjunction with its treatment providers. (Reworded)	CV Panel	Jun 2015	Open
6	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	Jun 2015	Open
7	That the Rights Statement be amended to give a clear explanation of section 113 of the AMT Act.	CV Panel	Jun 2015	Open
8	It is recommended 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
9	It is recommended that trained interpreters are used for critical assessments and planning.	Community Visitor	Jul 2014	Open
10	It is recommended 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
11	That the treatment program be reviewed and improved using the Model of Practice as a guide.	Community Visitor	Dec 2014	Open
12	That an evaluation of the AMT program be undertaken.	Community Visitor	Apr 2015	Open

Tennant Creek Alcohol Treatment Service – CVP Report Card

Achievements:

- Small service providing a high level of staff to Affected Person ratio.
- Facilities are appropriate for service and provide a range of spaces of Affected Persons and staff

Areas for Improvement:

- Resolution of issue regarding interaction of AMT with Alcohol Protection Orders, which appears to affect Tennant Creek more than other regions.
- Low intake numbers, which leads to under-utilisation of staff and affects staff retention.

Priority Concerns:

- Nil

Tennant Creek Alcohol Treatment Service – CVP Recommendations

		Made By	Date	Status
1	That Department of Health give priority to efforts to implement the amendment to the AMT Act that would allow for persons on Alcohol Protection Orders (APOs) to be admitted to AMT.	Community Visitor	Jul 2015	Open

[1] The CVP notes that the correct term under the AMT is 'Assessable Person' for individuals in the AMT Assessment facilities. For readability, the term 'Affected Person' is used consistently throughout this chapter. The correct term of 'Assessable Person' is used in the information specific to AMT Assessment facilities at the end of the chapter (the facility 'report cards').

[2] The CVP has recently been provided the updated AMT Clinical Practice Guideline, as at 19 August 2015. The CVP comments on the clinical practice guidelines in this report take into account any relevant changes made to the updated guidelines, despite these not applying in the reporting period (2014-2015).

[3] The oversight of the CVP also continues into the AMT treatment phase when a mandatory residential treatment order is made. The CVP does not have any role in relation to mandatory community treatment orders that might be made.

[4] The Department of Health has advised that the revised AMT Practice Guideline will be finalised by the end of October 2015. The CVP is pleased that the practice guidelines are being reviewed to clarify guidance for non-government service providers.

[5] Inquest into the death of Virginia (Kumanytjayi) Nabarula Brown, [2015] NTMC 015, 129. Accessed at: http://www.justice.nt.gov.au/courtsupp/coroner/documents/A00462014Brown.pdf.

[6] Heather, N., Wodak, A., Nadelmann, E.A., and O'Hare, P. (Eds). (1993), Psychoactive drugs and harm reduction: From faith to science. Refer also Miller, W.K, and Hester, R.K. (1986), Inpatient alcoholism treatment: Who benefits?, American Psychologist, 41, 794-805.

[7] The total numbers of Indigenous and non-Indigenous 'Affected Persons' in 2014-2015 has been provided to the CVP by the Department of Health.

[8] Australian Government, Australian Institute of Health and Welfare, Aboriginal and Torres Strait Islander Health Performance Framework data. Accessed at http://www.aihw.gov.au/indigenous-data/health-performance-framework/.

[9] The foundation of primary health care for the delivery of AMT programs is also strongly articulated in the overarching model of practice (Northern Territory Government, Alcohol and Other Drugs Services, (2014), Model of service delivery, role and function, pp7-8.)

[10] In Alice Springs, Department of Health medical officers (who also cover the AMT assessment service) attend the AMT treatment centre at CAAAPU. In Tennant Creek, Affected Persons are taken to a local Aboriginal Medical Service or the hospital as appropriate. In Darwin, the contracted service provider ('Saltbush Mob') is required to arrange medical coverage. With respect to nursing care, the Department of Health provides nurses in Alice Springs and Darwin AMT treatment centres, but not in Tennant Creek.

[11] This data was provided to the CVP by the Department of Health.

[12] NT Community Visitor Program, (2014), Annual Report 2013-2014, p.69. The elements described in the report were: cross cultural training for staff that supports cultural competency skills; policies and processes that enhance cultural safety; Indigenous staff, whose skillsets demonstrate cultural knowledge and competencies; and culturally appropriate activities and therapies.

[13] To support this view, the CVP also draws attention to Part 5.5 of the AMT Clinical Practice Guideline, which states that the AMT Act requires Assessable Persons to be assessed 'and the report written' within the first 96 hours of admission to an AMT assessment facility.

[14] The Senior Assessment Clinician must provide the rights statement to an Affected Person in an AMT assessment facility (section 15, AMT Act) and the Senior Treatment Clinician must provide it in an AMT treatment centre (section 55, AMT Act).

DATA TABLE 2014-2015

	Mental Health			Disability			AMT			Other	TOTAL
	Central Australia	Top End	Total	Secure Care	Appropriate Place	Total	Assessment	Treatment	Total	Total	
Visits	**63**	**87**	**150**	**11**	**8**	**19**	**115**	**125**	**240**		**409**
Community Visitor	59	83	142	9	8	17	115	121	236		395
Inspection	2	2	4	-	-	-	-	-	-		4
CV Panel	2	2	4	2	-	2	-	4	4		10
Complaints & Enquiries	**112**	**226**	**338**	**8**	**3**	**11**	**133**	**187**	**320**	**1**	**670**
Complaints	*13*	*45*	*58*	-	-	-	*10*	*42*	*52*	-	*110*
Enquiries	*99*	*181*	*280*	*8*	*3*	*11*	*123*	*145*	*268*	*1*	*560*
Sources											
Person (eg Consumer, Person in Facility)	*90*	*180*	*270*	*5*	*3*	*8*	*51*	*268*	*319*	-	*597*
Carer/Relative	*5*	*33*	*38*	-	-	-	-	-	-	*1*	*39*
Service Provider	*11*	*10*	*21*	*1*	-	*1*	*1*	-	*1*	-	*23*
Nurse/Doctor	*4*	*2*	*6*	-	-	-	-	-	-	-	*6*
Other	*2*	*1*	*3*	*2*	-	*2*	-	-	-	-	*5*
Outcomes											
Resolved	*84*	*140*	*224*	*2*	*1*	*3*	*114*	*130*	*244*	-	*471*
Ongoing Monitoring	*62*	*6*	*68*	*3*	*2*	*5*	*3*	*17*	*20*	-	*93*
Unresolved	*8*	*18*	*26*	*3*	*2*	*5*	*5*	*27*	*32*	-	*63*
Referred	*14*	*17*	*31*	-	-	-	*4*	*3*	*7*	*1*	*39*
Other	*14*	*12*	*26*	*2*	-	*2*	*5*	*10*	*15*	-	*43*
Feedback	*6*	*13*	*19*	-	-	-	-	-	-	-	*19*
Withdrawn	*2*	*13*	*15*	-	-	-	*2*	-	*2*		*17*
Open	5	8	13	-	-	-	-	-	-		13

Complaints & Enquiries	Mental Health			Disability			AMT			Other	TOTAL
	Central Australia	Top End	Total	Secure Care	Appropriate Place	Total	Assessment	Treatment	Total	Total	
Issues Raised	**187**	**303**	**490**	**9**	**5**	**14**	**140**	**194**	**334**	**1**	**839**
Quality of Service Provision	54	91	145	4	-	4	34	113	147	-	**296**
Assessment and treatment	7	29	36	2	-	2	4	6	10	-	48
Cultural safety	7	1	8	1	-	1	19	17	36	-	45
Management plan	2	10	12	1	-	1	-	16	16	-	29
Activities	9	4	13	-	-	-	-	13	13	-	26
Discharge planning	9	14	23	-	-	-	1	1	2	-	25
Facilities	3	6	9	-	-	-	2	7	9	-	18
Relationship with staff	7	10	17	-	-	-	-	-	-	-	17
Aftercare	-	-	-	-	-	-	-	15	15	-	15
Health - Physical	-	-	-	-	-	-	2	13	15	-	15
Other	10	17	27	-	-	-	6	25	31	-	58
Rights	58	72	130	4	1	5	60	45	105	-	**240**
Least restrictive alternative	21	15	36	-	1	1	13	26	39	-	76
Legal	7	8	15	1	-	1	29	10	39	-	55
CV Information on rights	3	10	13	-	-	-	-	-	-	-	13
Detention	1	4	5	-	-	-	8	-	8	-	13
Community accommodation	6	4	10	2	-	2	-	-	-	-	12
Other	20	31	51	1	-	1	10	9	19	-	71
Information	21	44	65	-	-	-	8	-	8	-	73
Request information from CVP	3	15	18	-	-	-	6	-	6	-	24
Information provided	9	10	19	-	-	-	1	-	1	-	20
Access to files; inaccurate info	2	11	13	-	-	-	-	-	-	-	13
Other	7	8	15	-	-	-	1	-	1	-	16
Advocacy	30	24	54	1	1	2	24	22	46	-	**102**
Miscellaneous	4	31	35	-	-	-	6	1	7	1	**43**
Visit/Support	6	22	28	-	-	-	6	2	8	-	**36**
Medication	10	13	23	-	2	2	-	3	3	-	**28**
Smoking	4	6	10	-	1	1	2	8	10	-	**21**


service
health
information
Community
consumer
alcohol
report
program
quality
support
involuntary
disability
client
Accessible
complaint
resolved
accountable
confidential
feedback
outcome
visit
detention
referred
respectful
independent
Panel
person
enquiry
Visitor
rights
impartial
mental
Mandatory
advocacy
treatment
monitoring
informed

VISION

The human rights and dignity of people affected by mental illness or cognitive impairment and people receiving Alcohol Mandatory Treatment services in the NT are respected and protected.

MISSION

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

- Its response to the voice of people in the NT receiving services visited by the CVP under the *Mental Health and Related Services Act*, *Disability Services Act* and *Alcohol Mandatory Treatment Act*; and
- Promoting the rights of people in these circumstances through advocacy, complaints resolution, monitoring and reporting.

VALUES

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

Empowerment: We walk alongside our clients, seeing the situation from their perspective, appreciating that all points of view are valid, striving to understand their journey and maintaining hope at all times.

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

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

STRATEGIC OBJECTIVES

1. Operate the CVP in accordance with requirements of the Mental Health and Related Services Act, Disability Services Act and Alcohol Mandatory Treatment Act.
2. Improve CVP governance and capacity to encompass the expanded role under the Disability Services and Alcohol Mandatory Treatment legislation.
3. Increase recognition of the CVP and its role throughout the Territory.