CVP

NT Community Visitor Program

ANNUAL REPORT

2019-2020

30 September 2020

The Hon. Natasha Fyles, Minister for Health &
The Hon. Kate Worden, Minister for Disabilities
Parliament House
State Square
DARWIN NT 0800

Dear Ministers,

Re: Community Visitor Program Annual Report 2019-20

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 1998* and section 66 of the *Disability Services Act 1993*.

I commend the report to you.

Yours sincerely,

Sally Sievers
Principal Community Visitor

TOP END
Level 9 22 Mitchell Street
Darwin NT 0800

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

INTRODUCTION

The Community Visitor Program (CVP) is a program which is crucial to protecting the human rights of Territorians who are involuntarily detained or accessing publically funded mental health and forensic disability services. With it's visiting, monitoring and advocacy functions, the CVP aims to resolve matters at the lowest possible level. This is a goal we often achieve, leading to positive outcomes for a person's quality of life on a day to day level by addressing their immediate issues of concern.

The CVP is a small and committed team. Our permanent staff include the Principal Community Visitor, NT Manager, and two CVP Coordinators based in Darwin and Alice Springs respectively. We work alongside committed CVP Panel members, and sessional (casual) Community Visitors. These members assist with meeting our statutory duties when staff are unavailable or on leave.

There were some changes of personnel this year. We welcomed Lauren Macaulay as the CVP Coordinator for Central Australia. We have also been pleased to welcome new Panel members and sessional Community Visitors to our dedicated team.

The COVID-19 pandemic has loomed as a dominant theme during this reporting period. It has meant numerous restrictions have been put in place for the wellbeing and protection of the whole community.

For the safety of residents and consumers, further restrictions have had to be implemented in the mental health and disability facilities operated by the NT Government. These are the facilities which are regularly visited by the CVP. The CVP observed that the services responded quickly to the unprecedented challenges presented by COVID-19. The services engaged in robust planning to ensure the safety of residents and consumers.

The CVP also had to adapt to the risks to residents and consumers posed by COVID-19. We negotiated with the services to establish procedures to enable 'virtual' visiting, in the event of community transmission in the Northern Territory. In March 2020, we visited all relevant facilities to ensure technology was in place for virtual visits. These visits were also to ensure that the recommended safety and hygiene measures were in place and accessible to consumers.

We reviewed COVID-19 risk management plans. As circumstances changed, the CVP undertook advocacy to ensure any additional COVID-19 restrictions imposed by the services

were necessary, reasonable, proportionate, subject to oversight, and in place for the shortest possible time.

The pandemic has highlighted the importance of maintaining mental health and wellbeing for all members of our community. The CVP welcomes the announcement of additional funding for mental health in the Northern Territory.

The CVP continues to highlight that day to day safety concerns remain current and are impacting on consumers detained in the Joan Ridley Unit at the Royal Darwin Hospital. The temporary measures introduced to mitigate these concerns do not adequately address the harms caused by that environment.

The Joan Ridley Unit provides specialist care for some of the most vulnerable and unwell members of our community. It has aged and inappropriate infrastructure. Regularly, there are forensic patients (prisoners with acute mental illness) and correctional officers present on the ward. The ward environment impacts significantly on women, children and non-forensic consumers. Sustained pressure is required to ensure that action is taken to address the dangers presented by this facility.

In the forensic disability space, the CVP has observed some positive achievements. This includes a long term resident achieving their goal of returning home, and other residents transitioning to less restrictive environments with familiar staff. There still remains substantial concerns about aspects of the care and treatment provided to the resident of the Secure Care Facility in Alice Springs. These concerns relate to cultural competency, quality and safety, and critical incident management.

We have spent time preparing to participate in the Royal Commission into Violence, Abuse, Neglect and Exploitation of people with Disability. Independent official visitor programs like the CVP are crucial agencies to prevent, detect and deter abuse and neglect.

Official visiting programs are needed for more vulnerable members of our community, such as those living with a disability in residential settings, often without informal support networks. The CVP looks forward to further discussion in the Northern Territory about an expanded role for the CVP in the disability sector to ensure this vital service is available to Territorians who need it most.

As Principal Community Visitor, I express my thanks to the team who are ably led by Claudia Manu-Preston, who brings a wealth of experience to the role and a genuine passion for the protection of people's human rights in healthcare settings. Also to Community Visitors and all Panel members.

I want to express my thanks and admiration to all of you who took the opportunity to raise matters with us this year. Your shared concerns and personal experiences in what was very difficult circumstances. Often, the motivation to do so was the hope that others would experience improved services in the future. This willingness to share, including also when things have worked well, enables the CVP's advocacy and oversight role to be effective.

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OVERVIEW

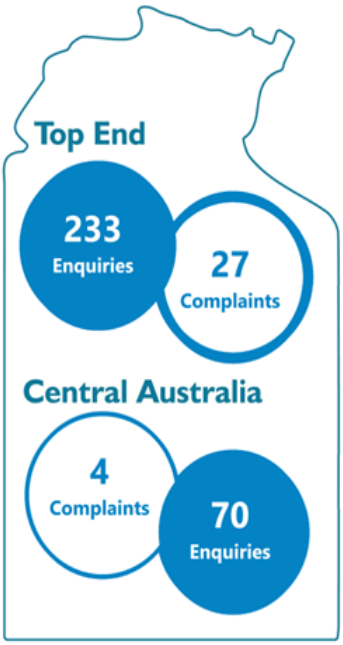
The work of the Northern Territory Community Visitor Program (CVP) to protect the rights of people in health facilities continues to raise important issues at both an individual and systemic level.

Community Visitors regularly visit people receiving specialist mental health and disability services, especially those in involuntary detention and treatment. Community Visitors assist people[1] who may be struggling to have their needs met and help them to have a voice.

Our Case Work

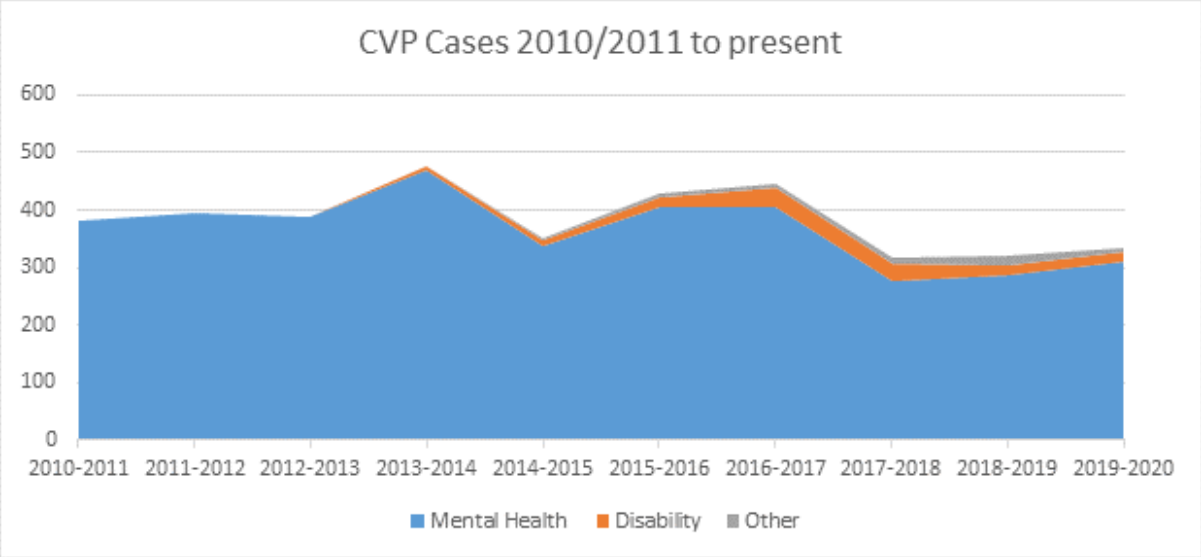
The CVP visits and case work are provided within a legislative framework, being the *Mental Health and Related Services Act 1998* and the *Disability Services Act 1993*. Visits are conducted regularly by Community Visitors, and twice a year by specialist multi-disciplinary CV Panels.[2]

This year, the CVP made 150 visits to specialist health facilities (slightly less than last year). Community Visitors worked on 334 individual cases that encompassed 579 issues. This was a small increase in cases compared to last year.



[1] Terminology: Mental Health referred to as Consumer, Disability, as Resident, People & client – of both services.

[2] CV Panels are a multi-disciplinary panel with a legal, medical/health professional, and community member. The exact composition of a CV Panel is provided for in the relevant legislation. Community Visitors can attend a facility at any time, however visits are usually arranged weekly (for mental health in-patient units), monthly or quarterly (for specialist disability facilities).



The work of the CVP is to listen and honour the experience of all who access the CVP service. The role is also to provide independent, external enquiries and complaints resolution. In general, people contact the CVP when issues of concern arise.

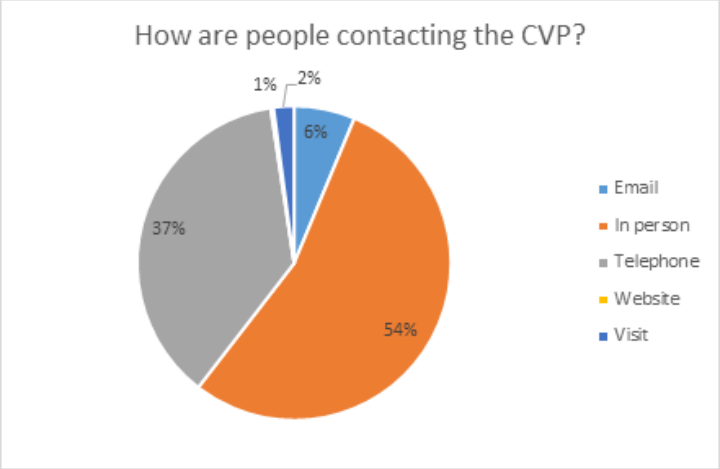
This year there is a marked reduction in the number of complaints (60 to 31) compared to last year. The reduced number of complaints is understood to be due to a number of factors set out below.

The COVID-19 pandemic meant less people were detained in mental health facilities in 2020. Improved weekly reporting processes between the CVP and the mental health service may have contributed to matters being resolved more quickly and potential improvements in facility management and services. There have also been short periods when the permanent Community Visitor role was vacant. As the CVP is very small, these changes and unplanned leave can have an amplified impact on the CVP services.

The number of individual enquiries raised with Community Visitors increased slightly, with some matters being very complex. While the overall number of cases is useful, it does not fully illuminate the scope and challenges of some cases dealt with by the CVP.

Many issues that are raised on visits can be resolved quickly and informally. If the matter is raised as a general enquiry rather than a formal complaint, this 'low level' approach focuses on timely resolution. It avoids issues of concern becoming enmeshed in a formal process.

Of the cases raised with the CVP, just over half (56%) were raised in person or on a visit. The majority of the remaining cases were raised by direct phone contact (37%) and via the CVP website and email (7%).



Importantly, for the second year in a row, the CVP has fully met its statutory commitment to responding to requests for assistance within one working day (100% response rate). Additional CVP data is provided at the end of this report on page 52.

Visiting Commitments

Through the visiting role, the Community Visitor can get to know a person, build trust, and provide reassurance that the person has an independent advocate. The CVP visiting role is unique; other complaints organisations do not provide this service to the level provided by the CVP.

Visiting and inspections also focus on systemic issues. This is particularly the case for visits by CV Panel members. After the visits and inspections, the Community Visitors or Panel members reflect on the issues and formally report to the service about matters of concern.

When the issues are serious or cannot be addressed or resolved quickly, the CVP will open an action item. If required, a formal recommendation may be made to ensure the CVP's concerns are actively addressed. This annual report has a new format that includes listing all of the open recommendations in the body of the report, highlighting those that have not yet been fully addressed by the services. There have been five new open recommendations made, five closed in Mental Health and in Disability there was one recommendation closed and two new recommendations opened.

Most of the significant issues in both the mental health and specialist disability facilities, remain the same as last year. Ensuring people's legal rights are upheld, their right to communicate using an interpreter if required, having the ability to access the community and spend time with their loved ones, and having 'least restrictive' decisions made about their treatment and care.

Individual and Systemic Advocacy

A strong health system provides early detection, prevention and provides supports that are clinically informed. It respects people's rights and freedoms as much as possible. In general, treatment and care occurs in the community. For mental health consumers, the service is mostly voluntary (by agreement).

The goal of the services is to promote and practice 'person centred' care that helps the person live a meaningful and healthy life. Good health and wellbeing needs to happen and be sustained in everyday life, not institutions.

Although acute and involuntary care is necessary, in general, systems and processes should be primarily directed towards community-based services. These services need to be well funded and supported to work effectively and empower people to maintain their health and wellbeing.

Even when people are empowered, it can be very difficult to raise issues with services. The CVP recognises the power imbalance that exists between the clients and services. This means that an advocacy function is inherently required for the CVP to be effective (both at an individual or systems-wide level).

The CVP helps people to actively participate in decision-making processes and conversations that impact upon their lives. Individual advocacy helps people by encouraging the person to take agency and to feel supported to know the best way to get help. In some cases, the Community Visitor may advocate directly, on behalf of the person, guided by the person's wishes.

Importantly, this individual advocacy work informs the CVP's systemic work. This work is part of all visits and inspections. It reviews continuous improvements and identifies areas that need further attention.

On 5 June 2020, announcements of significant investment in mental health for the Northern Territory by the Federal government were made.[3] This includes a new mental health facility and new community mental health centre in Darwin. The CVP has been told of other initiatives being explored, new service models with lesser restrictive places of care that will help keep people out of acute care, as well as a trial housing program.

[3] http://newsroom.nt.gov.au/mediaRelease/33379

"… A mental Health system that meets the needs of consumers & carers is accessible, acknowledges a consumers' dignity, provides care that is relevant to the person's needs, and achieves the desired outcome for consumers…"

National Mental Health Commission National Report 2019.

The new range of mental health services and initiatives are thought to strengthen the continuum of care options and offer consumers more choice. Consequently, it is likely to eleviate admission pressures on a already strained public mental health service. This approach is in line with contemporary mental health practice, supporting recovery using a preventative focus model of mental health service delivery across the spectrum of care. These are significant investments and achievements that are welcomed.

The CVP annual report is an opportunity to reflect on the significant issues and achievements for the Northern Territory mental health and specialist disability services.

COVID-19 Pandemic

This year, the COVID-19 pandemic has had an unprecedented impact on the provision of mental health and specialist disability services. For people in closed facilities, the pandemic poses considerable risks and challenges.

In March 2020, the CVP liaised with services about plans and actions in place to respond to the pandemic. The CVP raised questions of how services would be affected, including proposed measures and additional restrictions to prevent the spread of COVID-19.

The CVP saw evidence of proactive efforts that ensured continuity and risk management plans were in place to ensure safe services. These plans also addressed how services would be provided in the event of COVID-19 spreading within the relevant facilities, as has occurred in other States. Information available to consumers and residents was also scrutinised to ensure it was accessible.

The CVP was impressed at the dedication and professionalism of staff in safeguarding the welfare of consumers and residents at a time of great uncertainty. Some in-patient mental health consumers were required to quarantine and this was able to be arranged on the mental health units which enabled consumers to continue receiving specialist care. This is a substantial commitment and achievement.

The service with the largest number of clients in closed facilities, the Top End Mental Health Service, had extensive plans in place to keep consumers and staff safe while also balancing 'least restrictive' principles. An example of their success was that visitors and leave access remained available, with reasonable restrictions, throughout March to May 2020.

The CVP had to adapt its visiting arrangements. The CVP collaborated with the services to enable 'virtual visits'. This was a significant and extensive body of work by the services at a demanding time. The CVP appreciated the efforts of the service to enable these virtual visits to occur.

In general, the CVP considers that both mental health and specialist disability services were reasonable and proportionate in their response to the pandemic. Changes were time limited and were openly scrutinised, internally by the services and externally by the CVP. The CVP commends the services for their commitment to ensuring specialist mental health and disability services could continue to be provided in a safe way.

Given that the pandemic is still a current concern, ongoing vigilance and commitment is required. The CVP also has some concerns that community-based and acute mental health services are likely to experience increased demand as a result of COVID-19. There are known gaps and capacity issues in the Northern Territory. The CVP will monitor this in the coming year.

Focus on Quality and Safety

The CVP is one of the few organisations able to go into a facility and speak to people receiving services. The CVP can go in at any time, without the need for an invitation from the service or a person in the facility.

The CVP has access to records. The CVP can also request and receive information and reports created by the service's own quality and safety teams. Open recommendations and action items in CVP reports are part of the broader quality and safeguards framework.

Complaints and enquiries raised with Community Visitors are considered alongside broader quality and safety issues. The cases raised by people in facilities, including the frequency or severity of issues, guide the CVP's systemic advocacy.

There are a number of areas where the CVP has and will continue to maintain a strong systemic advocacy focus. This includes ensuring people's legal and human rights are upheld, that decisions and interventions are as 'least restrictive' as possible, and that services are culturally safe. Accessible and appropriate services for children and people in remote areas is another significant area of advocacy.

While change is slow, the CVP is also reassured that this systemic advocacy is effective. A CVP internal review of the last 10 years of open recommendations showed that 66 % of Mental Health recommendations were able to be closed.

The CVP will continue to consider what reports and data recording changes are required and are most effective to ensure the important work of the CVP is documented for complainants, the services and the broader community. Accurate and open reporting of abuse, neglect, violence and exploitation is part of ensuring Australia meets its international and national obligations to people in mental health facilities and those with disabilities.

Clinical Governance

The Central Australia Health Service and Top End Health Service each have their own clinical governance processes for the provision of mental health services. The Forensic Disability Unit also has its own clinical governance processes. The CVP considers that more detail and rigour for clinical assessment and treatment processes is required.

With respect to mental health services, the CVP has advocated for the Chief Psychiatrist position to be staffed. The position needs to be fulltime and its functions embedded within the legislation as it provides an additional oversight of the quality and safety of services. The CVP is pleased that the position has been recently advertised and will be considered in the mental health legislative review.

For disability services, the CVP has highlighted for many years the need for a robust clinical governance framework to guide the clinical work of the Forensic Disability Unit. At the time of writing, the CVP has received a Clinical Governance Framework and Service Practice Guide. This sets out the philosophies of practice and guidelines for the service. The CVP commends the service on the development of these cornerstone policy documents.

The CVP continues to support the Northern Territory having a Clinical Service Plan for public mental health services as an evidence based approach. The need for such a plan was articulated in the 2019 review of the Northern Territory's forensic mental health and disability services.[4] The CVP was provided the plans in early 2020 which will be reviewed in more detail by the CVP in the year ahead.

[4] Report on the Review of Forensic Mental Health and Disability Services within the Northern Territory, January 2019, recommendation 13, page 14.

Contributing to Reform

As part of its systemic advocacy role, the CVP actively contributes to broader policy and reforms. This past year, the CVP has been involved in the following consultations, committees and reviews:

- Mental Health Approved Procedures Quality Assurance Committee
- Northern Territory Regional Area Mental Health AOD and Emergency Service Committee
- *Mental Health and Related Services Act* review (consultation)
- Northern Territory Mental Health Coalition, Consumer/Carer Rights Guide update project (consultation)
- Mental Health Productivity Commission (submission)
- Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (sign post submission)
- NDIS & CVP Information sharing (agreement).

> 'There is a range of evidence which suggest people with disability are more vulnerable to violence, exploitation and neglect than others in the community. People with disability fare worse in institutional contexts where violence may be more common.'
>
> *National Disability Strategy, 2010-2020*

With respect to mental health, the CVP is a member of the Approved Procedures Quality Assurance Committee (APQAC). There continues to be progress on updating approved procedures, albeit slowly but diligently. The CVP welcomes the secretariat's positive initiative that these policies are available on line for services and the public.[5]

While the CVP is pleased to participate in steering groups, forums and policy work, as a small team, it does place pressure on staff capacity to fulfil its statutory obligations.

Official Visitor Reforms for People with Disabilities

The CVP has been advocating for improved safeguards and protections to cover people who have disabilities that reside in supported residences. At present, the safeguard offered by a Community Visitor is only available to a very small number of people with disabilities on a supervision order under the *Criminal Code Act 1983*.

The Northern Territory has high numbers of people under adult guardianship. Many have very limited informal support networks to advocate for their needs. Sometimes they are disconnected from family, having moved away from their remote homelands in order to receive services that are only available in regional towns or Darwin.

[5] https://health.nt.gov.au/professionals/mental-health-information-for-health-professional

In the context of national reforms to the disability sector related to the NDIS rollout, a national review of official visitor programs has been concluded. The final report has been released. [6] This report makes clear that the CVP provides a valuable service in upholding people's human rights and strengthens the protections and safeguards that prevent violence, abuse, neglect and exploitation of people with disabilities.[7]

The CVP has been told that a senior practitioner and restrictive practice clinical specialist were employed by the Department of Health. The CVP looks forward to being provided details of the role beyond the *National Disability Insurance Scheme (Authorisations) Act* 2019. The CVP is unclear regarding the processes for the residents that the CVP oversight. In particular, how and who can access the senior practitioner's independent involvement, transparency about findings and recommendations of the restrictive practices reviews and whether these recommendations have been implemented.

The CVP acknowledges the Northern Territory Government's continued commitment to the CVP role. The CVP appreciates work being done together on models for furthering the scope of the CVP, similar to that available in other States and Territories.

It is anticipated that this work will be reflected in the upcoming review of the *Disability Services Act* 1993, including the transition to the NDIS and other changes in disability services. This is a welcome and positive direction for disability services in the Northern Territory.

Forensic Services Reform

Forensic clients are among the most marginalised and powerless people in our society.[8] Forensic mental health and disability services are tasked with some of the most complex and specialised work in the Northern Territory.

Over the past few years, the CVP has been involved in numerous consultations and advocated for improvements in the adequacy and quality of services provided to forensic clients.

The CVP commends the Northern Territory Government's commitment to implement the recommendations of the 2019 independent review of forensic mental health and disability

[6] https://www.dss.gov.au/disability-and-carers-publications-articles-policy-research/community-visitors-schemes-review
[7] Westwood Spice, Community Visitor Scheme Review Report, Department of Social Services for the Disability Reform Council, Council of Australian Governments, December 2018
[8] McGrath David Consulting, Report on the Review of Forensic Mental Health and Disability Services within the NT, 2019, p 18.

services. The CVP continues to look forward to being provided with timeframes and priorities for implementation of the review's recommendations.

Collaboration and Mutual Respect

Much of the effectiveness of the CVP role comes from the cooperation and collaboration provided by the services over which the CVP has oversight.

The CVP and services are all working towards quality mental health and specialist disability care and treatment. This work is sometimes difficult. There will be differences of perspective and views. There may be differences of interpretation or priorities. This is the inherent tension that exists in the work.

This tension means at times there are varying levels of cooperation and collaboration with the CVP. As noted above, the services worked cooperatively and productively with the CVP to address impacts of the COVID-19 pandemic.

This year, the Mental Health Secretariat helped to facilitate CVP access to electronic records held by the services (CCIS). This has been outstanding for many years. This allows the CVP to conduct its statutory role as envisioned in the mental health legislation.

In general, interactions and liaison with front line staff have been responded to in a courteous and prompt manner. This professional respect and courtesy is acknowledged and appreciated.

At times, however, a lack of collaboration or cooperation with the CVP has been evident.

The CVP understands that relationships with the services may go through periods of tension when challenging issues are raised. When responsiveness declines and matters are not resolved or attended to in a timely manner, it affects the reputation of both the service and the CVP. This in turn reduces the quality of services to vulnerable people in the community.

This year the CVP will be seeking to improve communication processes, in particular, to ensure formal responses are provided to CVP statutory reports. A fundamental value of the CVP's approach is that of respect. The CVP respects the services' important work & clinical expertise, and equally the CVP expects respect for its statutory role.

With a collaborative and respectful working relationship with the CVP, services can improve the quality and responsiveness of their services. This approach safeguards the human rights of individuals who may be subject to restrictive practices in a health context, or who have specialist needs that require specialist care.

Walking alongside people receiving specialist services from the Northern Territory public mental health and disability services is a privilege.

The CVP is proud of the key role it has in safeguarding the rights of people in facilities receiving voluntary and involuntary services from the government.

By protecting the human rights of individuals, it is work that protects the dignity and humanity of us all.

> "I felt isolated, outnumbered and unheard… you stood up for me, in my experience that is rare, Your Great."
>
> Mental Health Carer

Notes on Reading the Annual Report

'Quotes' used in the Annual Report faithfully represent the issues and matters raised by people in facilities and are approved for use by these people. By including the 'quotes', the CVP does not imply that there were errors or failings in the service in response to any matters raised or represented.

The CVP notes that it is unable to report on some significant cases addressed this year. This is in recognition that the NT is a small jurisdiction and details of some cases may identify the person and/or the service.

MENTAL HEALTH

- Substantial improvements to facilitating consumers' legal rights are needed.
- Accredited interpreters need to be consistently used to ensure effective two-way communication.
- Ongoing vigilance to ensure the safety and wellbeing of consumers in the Royal Darwin Hospital's 'Joan Ridley Unit' is required.
- Accurate record keeping of restrictive practices and paperwork related to involuntary admission to hospital must be improved.

The Northern Territory (NT) public mental health services provide for assessment, treatment, care and protection of people with mental illness, whilst protecting their human rights. The services are governed by the *Mental Health Related Services Act* 1998 (the Act). These services are critical and valued services.

The NT has unique challenges that impact on the provision of high quality mental health services. This includes the Northern Territory's vast geographic land mass, small population, and level of disadvantage and trauma experienced by a large number of Aboriginal Territorians. While there have been improvements in the public mental health services this year, there remains some way to go.

The CVP acknowledges however, that even though there are improvements needed, many staff have shown considerable dedication and care to consumers and their recovery. This was highlighted in the considerable commitment of the services to respond to COVID-19 in order to protect consumers.

The CVP understands that staff of the public mental health services in the Northern Territory work in difficult environments. At times, they are working with outdated infrastructure and insufficient resources. As with many organisations, the service grapples with workforce capacity and retention issues.

> "Staff are wonderful and kind, very professional."
>
> C/2020/00198

Community Visitors enter the acute mental health in-patient facilities in Darwin and Alice Springs on a weekly basis. The Community Visitors ensure that consumers in the most restrictive environments are able to talk with an independent person and raise their concerns. A multi-disciplinary panel visits the in-patient facilities twice a year. The panels provide a 'systemic' focus to the CVP oversight role.

In addition to individual consumer feedback, weekly visits, and systemic panel visits, the CVP conducts inspections of community-based mental health teams throughout the year.

Inspections provide a broader perspective on the quality and effectiveness of the Northern Territory's publicly funded mental health services that operate in the community.

This year, the Community Visitor Program has completed fewer inspections of community-based treatment teams than previous years. This is in part due to changes in staff and the biosecurity requirements to address the risks of COVID-19 infections. Nevertheless, the CVP achieved 118 visits and inspections over the year.

Case Study – Advocacy

A consumer called distressed that they did not think they were receiving enough support and as a result may become unwell.

The CV encouraged the consumer to consider what supports they needed and then spoke to the team on their behalf. The service organised a meeting for the person for a review and discuss their concerns.

The consumer called back after the meeting and said a care plan had been developed that included all the support they felt they needed. They thanked the CV for the help and expressed how happy they were that the issue was resolved.

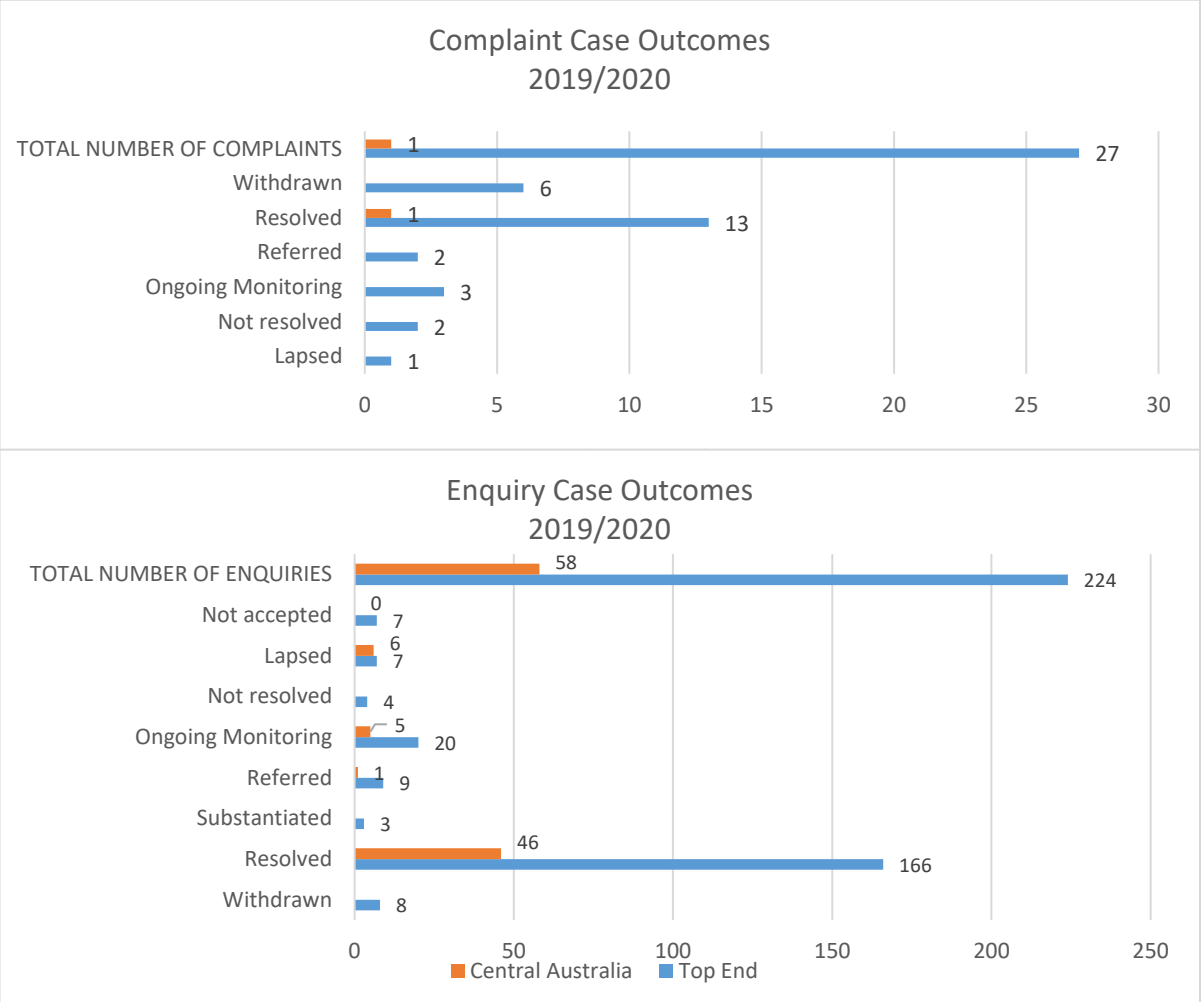
C/2020/00045

Territory-Wide Issues

310 CASES			
COMPLAINTS		ENQUIRIES	
TEHS	27	TEHS	224
CAHS	1	CAHS	58
543 INDIVIDUAL ISSUES RAISED			

Consistent with previous years, issues related to the quality of service provision and consumer rights featured strongly in matters raised with Community Visitors. Cultural safety, 'least restrictive' alternatives, legal rights and consumer safety were also identified as significant issues. Community Visitors and the Community Visitor Panel closed five recommendations. Five new recommendations were raised, arising from visits, inspections, and consumer and carer feedback. Recommendations often span two or more primary issue groups.

67%
issues resolved



Legal Compliance

Understanding Legal Rights on Involuntary Admission

Outstanding Open Recommendations:

TEMHS *provide evidence that in the process of involuntary admissions that there is adequate explanation of rights to consumers, including legal status on admission, offering of interpreters and early access to the Northern Territory Civil and Administrative Tribunal*. (Reworded, 2016)* **November 2011, CVP Panel**

TEMHS *review and improve processes related to the service's applications to the Northern Territory Civil and Administrative Tribunal* in particular to ensure client access to information consistent with the expectation of natural justice and section 132 of the Mental Health and Related Services Act.* **November 2016, CV**

TEMHS *- A review be conducted to determine the reason for non-completion of each section of the Form 10 to determine the rationale for systemic non-completion of certain elements of the form, and that feedback on this review is provided to the CVP.* **April 2018, CV**

MH-CAHS *urgently address ongoing systemic issues in relation to completion of Form 10s to ensure compliance with sections 38, 41, 42, 43 and 55 of the MHRSA.* **May 2020, CV**

MH-CAHS *provide evidence that staff explain rights under the Act to clients on admission or, as soon as they are able to understand them, and in a manner that they can understand and in a language that they are used to communicating in. In particular; (i) Implement practices and procedures to ensure that Form 10 are completed in their entirety for each involuntary consumer. (ii) Amend the Client Information Agreement (yellow form) to include whether the consumer requires an interpreter and whether the information contained in the form has been provided to the consumer with the assistance of an interpreter.* **June 2020, CVP Panel**

The right of consumers and carers to participate in their care and treatment is fundamental to quality mental health services. Consumer and carer participation provides a therapeutic benefit to the consumer, enabling the consumer's self-determination as appropriate.

It is essential therefore, that services must support consumers to know and ensure their legal rights are facilitated.

For many years, the CVP has noted a range of concerns regarding legal rights, in particular for consumers who are made 'involuntary' and have to be admitted to hospital. On admission, a consumer must be told about and assisted to understand in their own language, if needed, that they are involuntary and that they can request an early review by a tribunal. Carers and guardians must also be informed about the admission.

Data reviewed by the CVP indicates that up to 26% of people detained were not advised of their legal status at the time of admission.[9] Further, only half of all persons were recorded as being told they had the right to early review of their hospital admission by an independent tribunal.[10]

Case Study

A consumer on the inpatient unit contacted the CVP distressed and angry about having to have injections that they did not want or approve of.

The CV advised the consumer of their rights under the Act and that the treating team were able to administer treatment without consent, in specific circumstances. After discussion, the CV advised the consumer that they could apply to the Tribunal for a review of their involuntary admission and treatment.

The consumer did apply for an early review to the Tribunal. Following the process, the consumer expressed satisfaction to the CV, that they better understood their rights and that there was an independent Tribunal.

C/2020/00212

Fundamentally, the 'Form 10' paperwork evidences that a person has been lawfully detained under the mental health legislation. The CVP is concerned that in addition to the issues raised above, at times this paperwork also does not demonstrate that all the required oversight requirements for the serious decision of detaining someone in hospital are met.

The CVP considers that the ongoing absence, inconsistency or ambiguity of information recorded to evidence lawful detention and enabling of consumer rights is a serious failing of the Northern Territory mental health services. These concerns are amplified for consumer who speak a language other than English and require an interpreter to understand their legal rights and be involved in their care and treatment. The CVP review disclosed that there is insufficient evidence that consumer legal rights have been facilitated sufficiently.

The Community Visitor Program has regularly reported these findings to the mental health services over many years and there are three open recommendations in relation to this. The most recent recommendation follows an inspection by the Panel in June 2020.

On a positive note, the Director of Psychiatry in the TEMHS advised the CVP that there will be increased internal oversight of the completion of Form 10's and direct distribution to the CVP and Tribunal. TEMHS believe that this will increase compliance significantly.

[9] Of the 924 'Form 10' (paperwork related to involuntary admission to hospital) received, 244 were either not completed or had 'no' selected for Part C in the section stating 'informed of the legal status of admission'.
[10] Of the 924 Form 10 received, 466 demonstrated that the person was advised of this right to early review by the Mental Health Review Tribunal.

Right to Culturally Safe Services

Outstanding Open Recommendations:

TEMHS *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 Northern Territory Civil and Administrative Tribunal*.* **May 2007, CVP Panel**

Significant efforts are made to recruit to the Aboriginal Mental Health Worker position within the ***MH-CAHS Forensic Mental Health Team****, including any development required to upskill a suitable applicant.* **August 2014, CV**

TEHS - Katherine Mental Health Team *recruit an Aboriginal Mental Health Worker so that it can better provide evidence based, culturally safe, and confidential clinical service delivery to Aboriginal consumers and their families.* **January 2019, CV**

Barkly Mental Health Service *work with the* ***MH-CAHS*** *cultural consultant to develop strategies to improve access to accredited interpreter services and access AIS training for all staff.* **June 2019, CV**

TEMHS *implement 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.* **May 2013, CV**

TEMHS *urgently consider the introduction of a 1.0 FTE position for the recruitment of an Aboriginal Mental Health Worker / Practitioner to the* ***Adult Mental Health Team****.* **August 2020, CV**

MH-CAHS - Community Mental Health Team *improve the access and use of accredited interpreters.* **June 2019, CV**

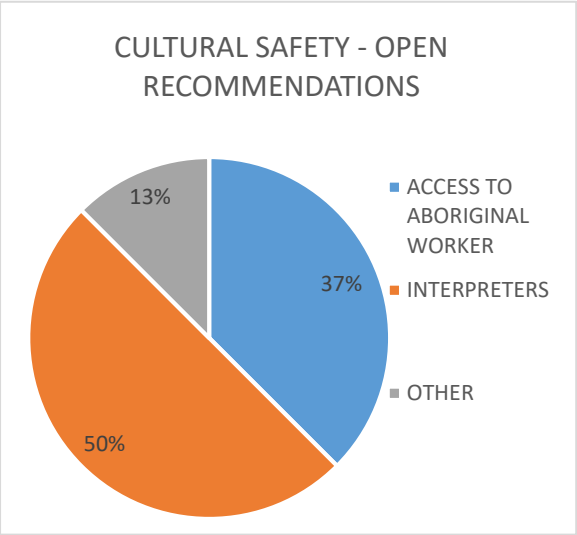
MH-CAHS - ATF *improve the use of interpreters for the provision of information about legal rights on admission to consumers who do not have English as their first language.* **June 2019, CV**

Each year, the CVP raises the importance of culturally safe treatment and care. Aboriginal people are approximately 30% of the population of the Northern Territory[11] and two of the top three languages (other than English) spoken in the Northern Territory are Aboriginal languages (Kriol, and Djambarrpuyngu).[12]

A fundamental principle of the mental health legislation is that, as far as possible[13], involuntary treatment and care should be tailored to an individual's needs. This includes care being provided in the person's preferred language.

If the consumer is Aboriginal, treatment and care must be appropriate to and consistent with the person's cultural beliefs. It must take into account the views of the person's family and community.

[11] Department of Treasury and Finance, NT Population Projections (2019 Release).
[12] Languages Spoken at Home (Top 4), 2016 Census: Northern Territory Media Release, Australian Bureau of Statistics, 27 June 2017.
[13] *MHRSA,* s.9(m), s.9(n)



The Northern Territory public mental health services have shown sustained progress in their efforts to achieve culturally safe services in line with the Department of Health strategic objectives and the Aboriginal Cultural Security Framework 2016-2026.

Top End and Central Australia mental health services have maintained a focus on Aboriginal Mental Health Worker positions within the in-patient facilities and have further strengthened the skill level of some of these professionals by supporting them to further their education and become Aboriginal Health Practitioners.

There is currently one Aboriginal Health Practitioner employed at the Top End in-patient unit with another two undergoing the further training. In Central Australia, the in-patient unit has an Aboriginal Health Practitioner, an Aboriginal Mental Health Worker, and a senior *ngangkari* who works two hours per week providing culturally informed mental health treatment. Central Australia mental health services also have an Aboriginal Cultural Advisor role. This position has strengthened and provided leadership in ensuring culturally safe treatment.

Aboriginal Health Workers and Aboriginal Mental Health Practitioners are also present in many of Central Australian community-based mental health teams. Previous inspections of the community-based teams in the Top End has generally evidenced an absence of Aboriginal Mental Health Workers and Aboriginal Health Practitioners.

Case Study

An Aboriginal male consumer asked the CV for help with concerns about family problems. They had been unable to contact family, were highly distressed but did not want to go into detail. The CV referred the person to the AMHW and he facilitated family contact.

When the CV met with the consumer the following week, he was grateful to CV and said that the AMHW helped him.

C/2020/00229

These proactive efforts of the Central Australian mental health services to employ Aboriginal Mental Health Workers and Aboriginal Health Practitioners across both in-patient and community teams is commended. Continuous improvement is required in this area across the Northern Territory. Doing so strengthens the ability of the mental health services to deliver culturally safe care to Aboriginal people, as the majority of people receiving services are living in the community.

The CVP encourages further strategies and workforce development targeted towards increasing the number of Aboriginal professionals across all service levels.

Use of Interpreters

In all teams, there were concerns about insufficient use of accredited interpreters. The concerns relating to interpreter use are most notably in relation to people understanding their admission and legal rights in their preferred language.

> "My cultural needs were not considered or respected."
>
> C/2020/00024

The CVP acknowledges that there are known challenges to identifying and using interpreters in the Northern Territory. Nonetheless the quality of two way communication is genuinely compromised if independent, accredited interpreters are not used.

The CVP has seen evidence of some improvements however this will continue to be monitored closely.

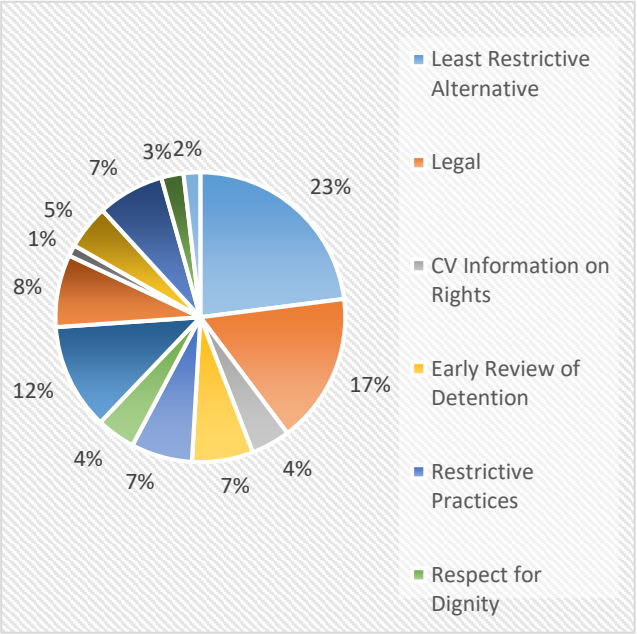
Rights in Language

The right to receive information in a language and form that an individual is used to communicating in, in a culturally appropriate manner and through the use of interpreters is underpinned by the mental health legislation. This not only affords the individual their right to be fully informed, it empowers them to be involved in their care and assert their rights.

The CVP encourages services to continue to develop tools such as the Rights in language boards that support consumers to understand their rights in language.

Rights

	CAHS	TEHS	Total
Rights	**28**	**133**	**161**
Least Restrictive Alternative	7	30	37
Legal	4	23	27
CV Information on Rights	2	5	7
Early Review of Detention	0	11	11
Restrictive Practices	1	10	11
Respect for Dignity	0	7	7
Safety	2	17	19
Voluntary/ Involuntary	9	4	13
Transport / Transport by Police	2	0	2
Location of Admission	0	8	8
Detention	0	12	12
Community Accommodation	0	4	4
Other	1	2	3



Right to the 'Least Restrictive' Care and Treatment

Admission to an in-patient facility for treatment and care is generally only for consumers with acute needs that cannot be met in the community. In most cases, the wards will be locked. Admission and treatment decisions made while in the facility must be based on the principle of 'least restrictive' care and treatment.

> "The ward has improved so much after all these years."
>
> C/2020/00198

Nearly one quarter (23%) of primary issues raised with Community Visitor were about 'least restrictive' care and treatment. The most frequent enquiry from consumers related to the reasons for being involuntarily detained, and why they cannot be treated in the community or admitted as a voluntary patient. Some consumers raised enquiries about the ward they were initially admitted to, which is often the more restrictive 'high dependency unit'. Many consumers also raised questions about discharge.

There were numerous enquiries related to access to outdoor spaces, in both Cowdy Ward and the Joan Ridley Unit in Royal Darwin Hospital. Outdoor space allows consumers to breathe fresh air, see the sky and feel the sun on their skin. These spaces are valued, therapeutic spaces for consumers, particularly given the restrictions that inevitably are part of involuntary

admission. Outdoor spaces are generally accepted as being integral to good mental and physical health.[14]

Consumers raised concerns about restrictions to access the Cowdy Ward outdoor area in Royal Darwin Hospital, particularly in the late afternoon and evenings. This was due to new procedures that required a staff member to be present at all times, until the courtyard was renovated and fully secured.

The CVP is aware that planning is well underway regarding the renovation of the Cowdy courtyard. The CVP has raised the need for the courtyard to comply with national standards.[15] There also needs to be a contingency plan while renovations are taking place, to ensure consumers can continue to access fresh air and outdoor spaces.

On the Joan Ridley Unit, there are two outdoor spaces, one that has access to the natural outdoor courtyard, and the second being fully enclosed courtyard. The fully enclosed courtyard has a concrete floor and walls, with a closed roof and no natural light. It is prison-like, stark and unwelcoming. More often, the natural outdoor courtyard is not in use as it requires staff to be continuously present.

In the Joan Ridley Unit, the lack of appropriate outdoor spaces is made worse by limited access to the main activity centre on Cowdy ward. While there are some activities available on the Joan Ridley Unit, there is a more comprehensive structured activity program on Cowdy that can be freely accessed.

> "Activity centre should be opened for longer hours and all day on the weekends."
>
> C/2019/00226

Voluntary Patients' Consent to Treatment

The mental health legislation establishes the general principle that treatment and care is on a voluntary basis (where the consumer is able to give informed consent). Voluntary consumers have legally protected rights; one of these is the right to request discharge and then leave the facility 'at any time'.[16]

[14] Aerts R, Honnay O, Van Nieuwenhuyse A. Biodiversity and human health: mechanisms and evidence of the positive health effects of diversity in nature and green spaces. Br Med Bull (2018) 127(1):5–22. Viewed https://pubmed.ncbi.nlm.nih.gov/30007287

[15] Australasian Health Facility Guidelines, HPU 131 Mental Health – Overarching Guideline and HPU 132 – HPU 137, 14 March 2018.

[16] Section 29(1) *Mental Health and Related Services Act* 1998

This year there has been a reduced number of consumers raising concerns regarding requests for discharge or leave. This may indicate a greater awareness of the rights of voluntary patients. However the CVP has received some reports from consumers that they were made involuntary after requesting to be discharged.

> "I was also not informed of the reasoning behind my change from voluntary to involuntary, since it seemed rather abrupt and almost controlling in a sense… My only understanding of the abrupt change from voluntary to involuntary was because I said "well as a voluntary patient, I can just leave" (which was met with 'well we'll change it)"
>
> C/2020/00015

A new operational policy has been developed that makes the process clearer. The CVP continues to monitor this issue to ensure that voluntary consumers are not subject to the same restrictions as involuntary consumers.

The CVP considers that requests for leave from the ward for voluntary consumers should comply with the principles of 'least restrictive alternative' and have different criteria.

While the CVP acknowledges that the service has a duty of care for all consumers, it is inconsistent that if the person is able to give informed consent and participate in care voluntarily, they must follow the same procedures for leave as someone who is involuntarily detained. This blurs the important distinction between a voluntary and involuntary legal status. Service responses to consumer requests for leave should more appropriately reflect the capacities of voluntary consumers to participate in their own care and treatment.

The Right to a Safe Facility

Outstanding Open Recommendation:

*To improve the care of acutely unwell consumers in the **Joan Ridley Unit (TEMHS)** and ensure safety for all vulnerable JRU consumers especially women it is recommended that the facility be improved to allow the separation of consumers and that safe practices be documented.* **March 2016, CVP Panel**

All persons receiving care and treatment have the right to be safe. The announcement of a purpose-built new facility for Darwin is welcomed and is a very positive step forward.

Until this new facility is built, there is still an ongoing need for attention and vigilance about consumer safety. The Top End mental health service has introduced some changes to the ward. Improved supervision and the use of interim strategies to ensure consumer safety.

This year the CVP received numerous enquiries and complaints about safety, particularly in the Top End. Consumers admitted to the Joan Ridley Unit often report feeling unsafe.

Some people expressed concern about being detained in a secure unit with prisoners. The presence of prisoners and uniformed corrections officers on the Joan Ridley Unit contributed to some consumers feeling unsafe. Some reported that they felt like they were in a prison and had done something wrong. The CVP have observed the presence of up to six uniformed corrections officers and three prisoners with prison clothing on the JRU at any one time. Inevitably, this affects the ward environment.

Case Study – Mental Health

A young person admitted to the Joan Ridley Unit told the CV during a visit, "I felt scared and unsafe". In this instance the CVP continued supporting the young person while liaising with the treating team regularly to ensure that the location of the admission was reviewed daily in efforts to transfer the young person as soon as the team assessed him as clinically suitable.

C/2020/00109

Women are concerned about being accommodated alongside men. On occasion, young people have reported feeling unsafe while admitted. There were a number of instances of violence on the Joan Ridley Unit that evidence these fears. Serious allegations of verbal, physical and even sexual assault have been reported. These incidents are not confined to the Joan Ridley Unit but more commonly occur here.

The CVP continues to assert strongly that more needs to be done by the mental health services to ensure the safety of all consumers, particularly women and children. All of these factors impact on a consumer's perspective of their psychological and physical safety.

Restrictive Practices

Outstanding Open Recommendations:

***TEMHS** provide evidence of improvement in processes to ensure compliance with the Act in relation to recording information about the seclusion of clients.* **April 2018, CVP Panel**

***TEMHS** provide to the CVP the terms of reference/performance indicators how current seclusion reviews and analysis contribute to seclusion reduction, both for individuals and systemically.* **August 2017, CV**

***TEHS** urgently initiate the recording of mechanical restraint and seclusion of clients under the MHRSA in other areas of the Royal Darwin Hospital 'approved treatment facility' and the Palmerston Regional Hospital.* **August 2018, CV**

***TEMHS** strengthen the Approved Procedures and policy suite to ensure that family members and carers are consistently advised of seclusions and, where appropriate, participate in the development of care plans aimed at reducing restrictive practices or the impact thereof.* **August 2018, CV**

*The Person-in-Charge (PIC) of the **Top End Approved Treatment Facility** (ATF) ensure that; All instances of mechanical restraint at the ATF are contemporaneously recorded in the register and that a Form 21 and a Mechanical Restraint Observation Form are placed in the register for each event. Where the person has an Adult Guardian the Form 56 should also be in the register,*

And,

All staff are made aware of their legal obligations when applying mechanical restraint and the requirement to fully document the restraint in the client's clinical notes. **August 2019, CV**

***TEMHS** seclusion policy wording urgently be updated to accurately reflect the definition of 'seclusion' as stated in the Mental Health and Related Services Act: 'Seclusion of a consumer means the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented'.* **August 2019, CV**

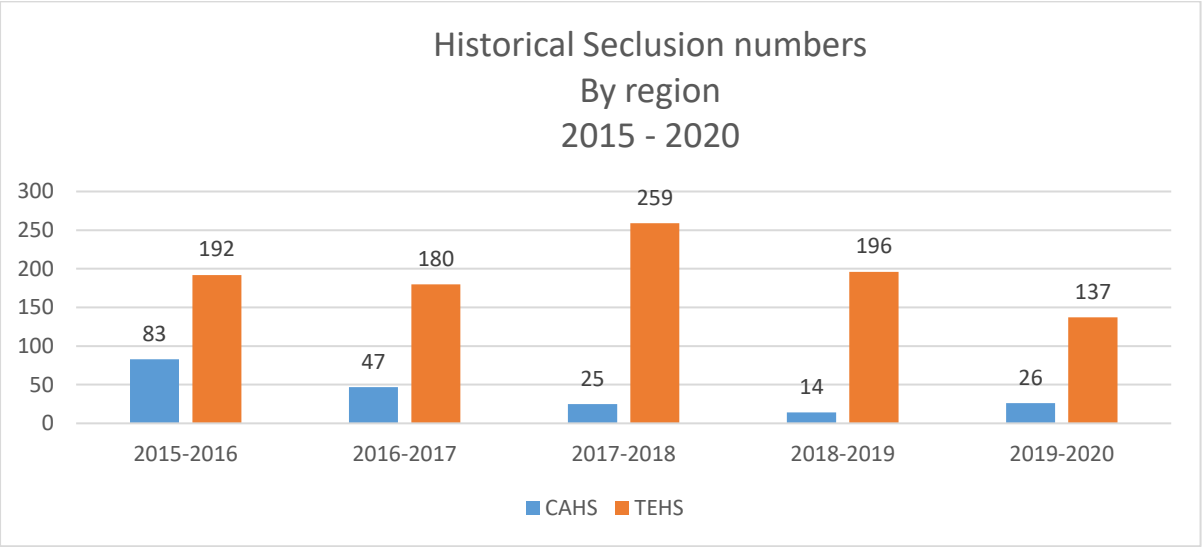
The use of restrictive practices in mental health settings significantly impacts on a consumer's human rights. These practices may cause trauma or injury, are not therapeutic, and compromise the therapeutic relationship between the person and the clinicians involved.

The CVP has observed that, consistent with the rest of Australia, mental health services in the Northern Territory are committed to working towards eliminating the use of restrictive practices. In the past twelve months significant efforts have been made to review and update the relevant policy so that it is in line with legislation and peoples' rights. This work is still ongoing and progress to date is commended.

The CVP inspects all instances of seclusion and mechanical restraint that occur within the Royal Darwin and Alice Springs Hospitals. The CVP reports in detail to the mental health services on its findings.

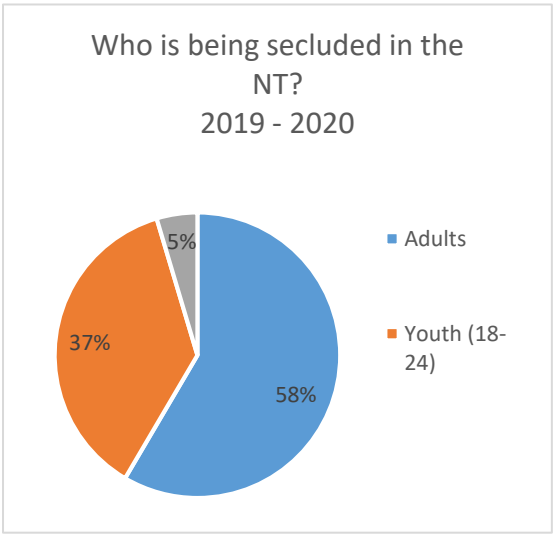
For the past two years of inspections, the CVP has held serious concerns about the accuracy of record keeping of restrictive practices. This includes retrospective recording, which is more frequently noted to occur in the Top End.

Keeping accurate records at the time of an event is not only required by law, but it is also an essential part of monitoring the provision of quality and safe services for consumers. This area of documentation needs to be vastly improved.



Seclusion

While the number of seclusion events have continued to decrease in the Top End, numbers have increased in Central Australia despite the efforts of the service. The number of seclusion events in Alice Springs has increased 86% from the previous year. Some incidents may relate to higher aquity of consumers where multiple seclusions events occurred.



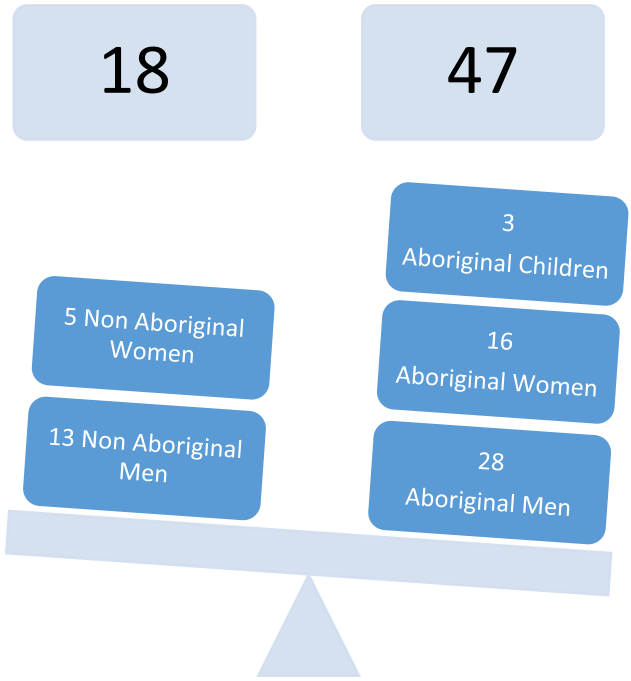
In the past year in the Northern Territory, sixty five people were secluded. Over a third (37%) were young people aged 18 – 24 years. In Darwin, three children under 18 years were secluded.

In the Northern Territory, 72% of people who were secluded were Aboriginal. This rate has progressively increased over the past three years.[17]

The CVP has raised this concern with both the Top End and Central Australia mental health services.

[17] 66% in 2017/18, 67% in 2018/19 and 72% in 2019/20.

Cultural Background of People Secluded



It is difficult for the CVP to analyse the meaning of this data without reliable information from the services on the number of Aboriginal people admitted for treatment. Nevertheless, the disproportionately high number of Aboriginal people (many who speak a language other than English) compared to the broader population is very concerning.

On a more positive note, there was evidence of increased involvement of Aboriginal Mental Health Workers to support Aboriginal consumers who are acutely unwell and escalating in their behaviour, both before and after seclusion events.

> "People speak to me of being scared during seclusion, of being re-traumatized by the experience."
>
> CV Top End

Despite this, the CVP continues to find little evidence on the use of interpreters for consumers who speak a language other than English and who were subject to one or more seclusion events.

Case Study – Mental Health

An Aboriginal woman contacted the CVP reporting that she was left 'traumatised after being physically restrained and secluded by male staff members in the Joan Ridley Unit'. The individual reported that she was left feeling 'totally humiliated and degraded' by her treatment during the seclusion event. She said the event had a 'devastating impact' on her emotional and mental health. The woman was upset that her cultural needs were not considered or respected. The CVP provided support to the woman and assisted her to lodge a complaint with the service. A response was provided from the mental health service that addressed the concerns raised. The service provided the complainant with an opportunity to review the CCTV footage of the event in an effort to allay concerns about her treatment in seclusion.

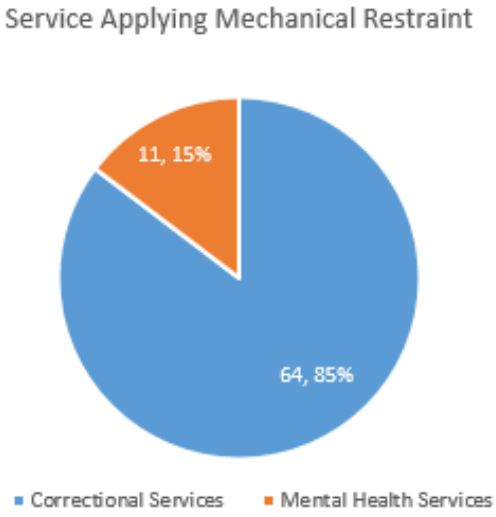
C/2020/00024

Mechanical Restraint

The definition of mechanical restraint in the Northern Territory mental health legislation is clear. The rights and protections of the legislation apply to all people receiving care and treatment under the MHRSA.

This means that every use of mechanical restraint on a person treated in hospital under the NT mental health legislation must be authorised by a psychiatrist. It must be recorded as restraint by the NT mental health services in the mechanical restraint register.

Mechanical restraints are most often applied by correctional officers on prisoners admitted as patients. The CVP consider that the rights and protections of the legislation apply also to a patient who is a prisoner.[18]



This year, the number of recorded instances of mechanical restraint has significantly increased in the Top End. Events of mechanical restraint have decreased in Central Australia. The progressive increase in the number of restraint events in the Top End has been noted since 2018.

The data on mechanical restraint events needs to be viewed with some caution. This is due to concerns about the integrity of record-keeping. The CVP considers that mechanical restraints are likely to be much higher in number. There remains considerable uncertainty about whether all restraints occurring in the approved treatment facilities (not just the mental health wards) are being recorded.

At the time of writing, the Central Australian mental health service has confirmed that from July 2020, it will be recording all mechanical restraints such as those applied by Corrections officers. This will assist both services in their quality and safety analysis, to understand the extent of these interventions and put in place strategies to reduce these practices.

For those events that are recorded on the register, the CVP has also raised concerns about the quality of the information recorded. Often events on the register do not contain enough information. This includes an absence of the most basic data, such as duration for which the person was restrained and what form of restraint was used.

[18] Section 81(3) Part 6 applies to the prisoner as if the recommendation were a recommendation under section 34(1), and; Part 12 Mental Health and Related Services Act.

The CVP restates that legislative obligations to record mechanical restraint must be met. Work is still required to provide clarity about roles, responsibilities and reporting obligations under mental health and corrections legislation. There also needs to be improvements in record keeping overall.

Restrictive Practices on Children

Outstanding Open Recommendations:

*That **MH-CAHS** existing seclusion policies and procedures include detailed strategies to reduce the use and impact of seclusion on minors.* **July 2017, CV.**

The use of restrictive practices on children should be avoided wherever possible and only used as a last resort. It must only be considered where imminent risk exists, and all therapeutic interventions have been exhausted.

6

seclusion events of children

This year there has been a marked reduction in the seclusion of children under the age of 18 years compared to last year (30) and no seclusion incidents in MH-CAHS.[19] This is very positive.

The Royal Commission into the Protection and Detention of Children in the Northern Territory found that the isolation of a child in detention causes 'suffering' and in some cases enduring 'psychological damage'.[20]

The CVP notes the inconsistency that while seclusion of children with disabilities with an NDIS plan is unlawful in the Northern Territory,[21] the seclusion of a child in acute mental health crisis is authorised under the mental health legislation. The CVP encourages further efforts to reduce and eliminate seclusion of children in an institutional setting including hospitals.

[19] In 2018/19, 15% of all seclusions were on children aged under 18 years; this decreased to 4% in 2019/20.
[20] NT Royal Commission, Report Overview, Royal Commission into the Protection and Detention of Children in the Northern Territory , https://www.royalcommission.gov.au/sites/default/files/2019-01/rcnt-royal-commission-nt-report-overview.pdf
[21] Section 17(g), Prohibited Restrictive Practices, *National Disability Insurance Scheme (Authorisations) Act 2019*

Right to better Support for Children and Young People

Outstanding Open Recommendations:

TEMHS - East Arnhem Community Mental Health Team *improve access to specialist child and adolescent mental health services for children and young people living in rural and remote locations, including the re-introduction of clinics based in these communities.* **May 2018, CV**

MH-CAHS - Child and Youth team *establish with other key stakeholders a case management mechanism to improve coordination and case management of youth clients with complex high needs who are accessing youth mental health services.* **December 2017, CV**

TEMHS - Child & Adolescent Mental Health Team *develop a working protocol with the Department of Territory Families that enhances the outcomes for vulnerable children and young people in the joint care and treatment in line with each agency's statutory obligations their human rights of children to safety and quality therapeutic healthcare.* **May 2019, CV**

Children and young people have a right to specialist mental health services. In the Northern Territory, children and young people aged 15-24 years have high rates of mental illness.[22]

The CVP has not been able to complete inspections of the Northern Territory's Child and Adolescent Mental Health Services in this reporting period. The gaps and issues for mental health services for children and young people however are well known and ongoing.

Children and young people living in rural and remote areas of the Northern Territory are further disadvantaged by inequitable access to services. There remains only one mental team that provides child and youth mental health outreach appropriate to the needs of remote communities. This is the Barkly Mental Health Service, based in Tennant Creek.

Of note, the CVP was recently advised that, this year Katherine Mental Health team has a new consulation and liaison role (Psychologist) that supports children in remote regions by telehealth. While this is a welcomed update, there is still no capacity for regular visits to surrounding communities.

Both Central Australia and the Top End specialist child and adolescent mental health services continue to provide services in a context of high demand and limited resources. The CVP continues to advocate strongly for Territory children and youth to receive the specialist mental health services they need and deserve.

[22] Northern Territory Department of Health (2015), *Mental Health Service Strategic Plan 2015-2921,* p9; specifically that young people aged 15-24 years are 15% of the NT population however were one quarter of all community-based mental health clients in the NT. Accessed at: digitallibrary.health.net.gov.au

Youth in Detention

Outstanding Open Recommendations:

***CAHS** and **TEHS - Forensic Mental Health Teams** urgently provide integrated mental health services to youth detainees in the Northern Territory, supported by child and adolescent psychiatrists or forensic psychiatrists with adolescent experience.* **December 2016, CV**

***TEMHS - Child & Adolescent Mental Health Team** in conjunction with other relevant agencies implements the recommendations made within the Royal Commission into the Protection and Detention of Children in the Northern Territory 2017 regarding the provision of initial mental health assessment and ongoing mental health treatment for individuals detained in youth detention.* **May 2018, CV**

***TEHS - Forensic Mental Health Team** urgently prioritise implementing 'at risk' procedures, comprehensive mental health assessments and integrated models of service delivery for youth detainees supported by child and adolescent psychiatrists or forensic psychiatrists with adolescent experience.* **May 2019, CV**

***TEMHS - Child & Adolescent Mental Health Team** finalise in conjunction with other relevant agencies and stakeholders (Working Group) a framework and working agreements for the provision of initial mental health assessment and ongoing mental health treatment for individuals detained in youth detention.* **May 2019, CV**

There has been little progress in the area of mental health assessment and treatment for children in youth detention by the NT Mental Health Services in 2019/2020.

The Royal Commission into the Protection and Detention of Children in the Northern Territory identified that an increase in therapeutic approaches and early intervention is required for youth in detention in the NT.[23] Often children in youth detention have experienced a long history of complex trauma and require specialist services.

There remains no integrated service delivery model, led or coordinated by Northern Territory public mental health services, for children in youth detention during the reporting period. This is required to provide quality mental health assessments on admission to the youth detention facility. The CVP understands in the next financial year, there will be some improvement in social and emotional wellbeing services being provided in youth detention facilities. These are to be provided by Aboriginal health services. The CVP also received advice from TEMHS that there will be significant work undertaken in this space in the coming year.

This is a positive step forward for young people in youth detention.

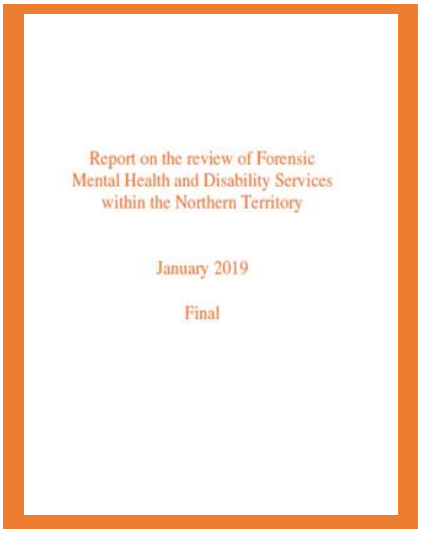
The aim is for quality mental health screening and assessment for children, and the development of a mental health care plan that includes psychiatric assessment and treatment as required. Similarly, there needs to be continuation of treatment after release[24] and

[23] NT Royal Commission, Report Overview, Royal Commission into the Protection and Detention of Children in the Northern Territory , https://www.royalcommission.gov.au/sites/default/files/2019-01/rcnt-royal-commission-nt-report-overview.pdf

[24] Recommendation 15.1(2)(b), Chapter 15 – Health, mental health and children at risk, Royal Commission and Board Inquiry into the Protection and Detention of Children in the Northern Territory Findings and Recommendations.

improved interagency collaboration. The CVP will continue to monitor the public mental health provision of these services.

Forensic Mental Health Rights



Over the years, the CVP has raised the need for reform of the Northern Territory's forensic mental health services.

The forensic mental health review report finalised in March 2019 echoed some of the concerns raised by the CVP. The report highlights that consumers who are in prison are among the most marginalised and powerless people in our society.[25]

Considerable work has been done in Australia to ensure that the states and territories have in place legislation that recognises the special needs of people with mental illness who are prisoners. Queensland, New South Wales and Victoria have reported that national and international standards and principles for forensic mental health services were taken into account in legislative review in their jurisdictions.

The CVP expects that the Northern Territory will demonstrate the same commitment in its current review of the mental health legislation.

https://www.royalcommission.gov.au/sites/default/files/2019-01/rcnt-royal-commission-nt-findings-and-recommendations.pdf

[25] McGrath David Consulting, Report on the Review of Forensic Mental Health and Disability Services within the NT 2019, p 18.

Prisoner Rights

Acute Care for Prisoners

Outstanding Open Recommendations:

*The **Top End Mental Health Service**, who are responsible for a therapeutic environment, should negotiate access to fresh air for forensic consumers while they are under guard supervision.* **August 2019, CVP Panel**

***MH-CAHS** A new policy be developed in accordance with professionally accepted standards and the least restrictive principles as required by the Mental Health and Related Services Act to ensure that adopted practices comply with the fundamental principles of the Act when a prisoner becomes a mental health consumer (Reworded 2017).* **June 2016, CVP Panel**

*The **Central Australia** and **Top End** mental health services urgently resolve resourcing issues affecting inequitable medical support for forensic mental health clients of Central Australia. (Reworded March 2019)* **December 2016, CV**

*The **NT Mental Health Services** develop a clear pathway for forensic mental health clients to transition to least restrictive community-based placements with appropriate supervision on transition.* **March 2019, CV**

A prisoner admitted for mental health assessment and treatment should always receive treatment that is consistent with mental health legislation, standards and practice.[26]

The CVP has observed the use of restrictive practices on prisoners for many years. These practices impact on the person's therapeutic care and right to receive an equitable, recovery-oriented service. Over the past two years, it has become evident during weekly visits and CVP inspections of restrictive practices that there was a lack of clarity around roles and responsibilities of the different agencies. This has affected the care and treatment being provided in practice for prisoners in mental health in-patient facilities. In Darwin, prisoners on the Joan Ridley Unit are not permitted the same supervised access to a fenced, grassed outdoor courtyard as other consumers. This is despite the prisoners having at least two correctional officers supervising them at all times. A recommendation was made by the CV Panel (Top End) with this in mind.

The CVP inspections found that the use of mechanical restraint for prisoners was not always supported by clinicians, and in some cases is seen as contra-therapeutic. The CVP considers that the purpose for any admission is to treat a mental health episode and interventions should reflect this intention.

The CVP respects that risk assessments and therapeutic needs are fluid, and at times there are challenging and dynamic situations for the public mental health service and Corrections services to manage. Nonetheless, the CVP restates that restrictive practices should be proportionate, and in line with the person's individual assessment.

[26]Section 81(3) Part 6 applies to the prisoner as if the recommendation were a recommendation under section 34(1), and; Part 12 *Mental Health and Related Services Act 1998*.

The Top End mental health service is currently collaborating with the Department of Corrections on a revised policy and protocol to clearly outline the roles and responsibilities of both organisations, consistent with the relevant legislation. It is anticipated that the policy and protocol will address broader issues related to therapeutic care and treatment of consumers who are also prisoners and mechanical restraint of prisoners in the mental health in-patient unit. The CVP welcomes this planned work.

Other Outstanding Open Recommendations

TEMHS *revise forms and practices to ensure that they are consistent with the NT Department of Health Intersex, Differences of Sex Development (DSD) and Transgender NT Health Policy.* **March 2019, Panel**

TEMHS *provide advice to the CVP on current trauma informed care work practices that have been implemented across the service and are currently being used by staff to improve trauma-informed care and decrease the potential for re-traumatising clients.* **July 2017, Reworded 2019, CV**

TEHS *conducts a review of its current electronic medical record systems for* ***East Arnhem Remote Health Services*** *and* ***Mental Health Services*** *and consider how to implement an EMR system that can be used for all* ***TEHS****.* **May 2018, CV**

TEMHS *in conjunction with* ***East Arnhem Remote Health Services*** *consider ways to build the capacity of their staff, community members, families and individuals to provide support to those experiencing emotional distress in relation to acute psychosocial issues such as grief and loss, relationship issues and the effects of interpersonal violence and trauma.* **May 2018, CV**

MH-CAHS *review processes to improve effectiveness of the internal complaints process.* ***June*** **2017, CV**

MH-CAHS *address the need for more long-term supported accommodation and care for consumers requiring sub-acute mental health services.* **July 2018, CV**

TEMHS *endeavour to improve access to housing by partnering with NGO's who provide housing and formalise relationships and procedures for referral, discharge planning and access to staff training.* **February 2020, CVP Panel**

TEMHS *improves access of psychiatric review in remote locations* ***(East Arnhem)*** *through providing regular routine review for all consumers accessing mental health services.* **May 2018, CV**

TEMHS - Adult Mental Health Team *review the current model of care to ensure strategies that engage consumers and carers more extensively in care planning and the delivery of psychosocial interventions are developed and implemented.* **August 2020, CV**

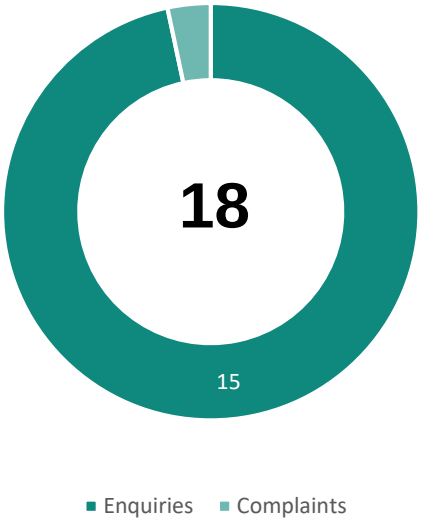
TEMHS – Katherine Mental Health Team *conduct a risk assessment in relation to the administration of intramuscular medications in the absence of both a resuscitation trolley / equipment and staff knowledge as to the whereabouts of a defibrillator.* **January 2019, CV**

MH-CAHS *proactively identify strategies to avoid inappropriate in-patient admission for clients with cognitive impairments and/or behaviours of concern presenting for mental health assessment, including through protocols with key agencies such as NDIA, Territory Families, and Office of Disability.* **June 2019, CV**

DISABILITY

- Cultural safety needs to be improved as all residents are Aboriginal
- Restrictive Practice review rights are not yet in place
- Greater attention to quality and safety, particularly workforce development and supervision

CVP Cases (Disability) 2019 – 20



CVP Visits (Disability) 2019 – 20

Alice Springs – **25**

Darwin – **7**

The CVP visits disability residential facilities covered by the *Disability Services Act 1993*, being facilities or houses directly operated by the Office of Disability. The majority of the residents supported by the Office of Disability reside in houses in the community, or in facilities adjacent to the Darwin and Alice Springs Correctional Centres.

Community Visitors provide support for residents with high needs and complex cognitive impairments who have come into contact with the justice system. Residents are on Supreme Court supervision orders. All are Aboriginal.

18 CASES	
TOP END ENQURIES = 3	CENTRAL AUS ENQUIRIES = 12 COMPLAINTS = 3

The CVP visits residents where they live and engages directly with them. The Community Visitor will ask if they have concerns or complaints that need to be raised. When matters are raised, the Community Visitor provides assistance to resolve their concerns. As an external, independent visitor, the CVP also monitors overall standard of care and treatment. This includes the use of any restrictive practices.

Currently, the CVP undertakes a higher number of disability visits in Central Australia due to particular statutory responsibilities set out in the *Disability Services Act 1993*, requiring that visits to the Secure Care Facility occur on a monthly basis.[27]

Challenges of Providing Care and Treatment

Being required to live in a disability facility operated by the NT government is a serious matter. It restricts the person's freedom of liberty. It is ordered by the Supreme Court in order to help the person learn skills to enhance their quality of life.

The process to learn new skills for an individual with complex needs requires a sophisticated understanding of the person, their history, forensic risk, environmental needs and disability. It requires a comprehensive and contemporary evidence-based approach to their care and treatment.

Care and treatment needs to be provided consistent with the principle of 'dignity of risk', being that the person has the right to take reasonable risks as they live and learn. This means that at times there may be expected increases in 'behaviours of concern', such as when a resident is being supported to develop new skills or responding to planned changes in their environment.

The CVP also acknowledges that these environments can be dynamic and unpredictable. When behaviours occur, or risks arise, the CVP takes the view that blaming the client or blaming the service are not helpful ways to respond to a complex environment. Where the service is taking a responsible, clinically informed approach to service delivery, that is person-centred in its approach, any incidents are an opportunity to learn and improve. Effective review processes are therefore an important component of high quality supports.

Despite the inherent challenges in providing care and treatment in the disability facilities managed by the Office of Disability, the CVP has observed that most staff of the service are caring, compassionate and concerned for the resident and their wellbeing. Even in the face of sometimes aggressive behaviours directed towards them, the CVP acknowledges that most staff across the service have done their best to respond professionally and sought to protect the dignity of the residents.

Achievements

Overall, the CVP is optimistic that the service is on a positive trajectory, in terms of improvements and achievements seen this year in the care and treatment of residents.

The Office of Disability's response to the COVID-19 pandemic in the facilities they directly operate has been effective and professional. There was evidence of COVID-19 planning at

[27] *Disability Services Act 1993*, s54(d)(i)

both a service-wide and individual level. The principles underpinning the response were that the restrictions imposed were necessary, reasonable, proportionate, accountable and time limited.

The CVP has continued to observe progressive improvements in the quality of Positive Behaviour Support Plans (PBSPs) for residents, including a greater level of individualisation. These plans are the key tools by which residents are supported to learn new skills, and manage or reduce their behaviours.

In most instances, senior staff are responsive to CVP requests and enquiries, and demonstrate a continued commitment to quality improvement. This year there has been action to address some longstanding concerns raised by the CVP. A recommendation relating to the installation of adequate duress alarms at the Secure Care Facility has been closed. A request to close a number of further recommendations was received on 24 September 2020, evidencing a commitment to continuous improvement. This material will be analysed and considered in the next reporting period.

Most residents usually speak favourably of the support provided by the Office of Disability. For example, during the CVP visit to the Cottages in mid-2020, both residents stated that they were happy with their current activities and appeared to be involved in the planning of activity schedules that were meaningful to them as individuals.[28] During a visit to a house in Alice Springs, the Community Visitor was impressed by the resident's dedicated music room, and was fortunate to see a drum solo being played.[29]

For many years, the CVP has highlighted the need for a robust clinical governance framework to guide the work of the service, with relevant recommendations on this at a Community Visitor and CV Panel level. At the time of writing, the CVP has received a Clinical Governance Framework and Service Practice Guide. This sets out the philosophies of practice and guidelines for the service. The CVP commends the service on the development of these cornerstone policy documents. The CVP will be reviewing these documents within the next reporting period.

This year, for three residents, the Office of Disability has facilitated successful transitions to NDIS service providers. Supporting residents to access mainstream disability support in the community is significant. Whilst there are areas of improvement that need to occur, as new processes are being established, the CVP acknowledges the significant work that has been undertaken to support these residents to move to mainstream supports. The CVP also notes that two residents were transitioned out of Corrections and into less restrictive environments.

The CVP has also long advocated for the development of a medication policy that clearly articulates the service's responsibility to safe administration of medication (including PRN 'as needed' medication when behaviours of concern occur). The CVP is pleased to report that during this reporting period, significant progress has been made. A Medication Management

[28] CVP Visit Report – Visit to Residential Disability Facility, 22 June 2020
[29] CVP Visit Report – Visit to Appropriate Place, 23 June 2020

Practice Guide has now been developed and finalised. The process included substantial engagement with the CVP. A solid policy foundation is crucial to supporting best practice, and the CVP will continue to closely monitor how well policies are implemented in practice in the coming years.

More broadly, the CVP was advised that a comprehensive Orientation and Induction program has been implemented with direct support staff to support improved understanding of client needs and evidence based disability support practices. We look forward to seeing the flow on effects of this program on the frontline.

For many years, the CVP has emphasised the importance of regularly communicating with residents in their first language. At the time of writing, a weekly interpreter booking for the resident at the Secure Care Facility has been made. Each week, the resident is taken through a question sheet that includes topics such as his relationship with his support workers, physical health, activities, food, temperature of the facility, and so on. The CVP welcomes this proactive approach to seeking feedback and identifying issues – unless someone is directly asked, they, the residents may not feel comfortable independently raising the issue.

Focus on Continuous Improvement

As an oversight body, it is the role of the CVP to identify both achievements and areas for improvement. The service offered by the Office of Disability is specialised, and is provided for people with complex, forensic disability needs in the Northern Territory. It is a necessary and valued service to safeguard rights of the individual and the community more generally.

Alongside the positive observations above, serious concerns remain in some areas.

These are described in more detail in the areas for change below. In summary, however, the areas where more work is required relate to cultural safety, workforce (including staffing levels and expertise) and safety (specifically, critical incident reporting, emergency response, management and investigation). In addition to this, the CVP continues to advocate for the need for an independent review mechanism of restrictive practices. This review mechanism is set out in the *Disability Services Act 1993* but has never been constituted, thereby removing the rights of residents to independent review of Positive Behaviour Support Plans and the authorisation process for restrictive practices.

Areas for Change

Right to Provide Feedback and Complain

Outstanding Open Recommendation:

Office of Disability - Specialist Support and Forensic Disability Unit *establish and implement an effective complaints procedure in accordance with Part 5 of the Disability Services Act* 1993. **November 2017, CV Panel**

A key function for the CVP is that Community Visitors review complaints processes and assist residents and other stakeholders to exercise their right to participate in their care and treatment, provide feedback and/or make complaints.

While the CVP has observed positive evidence of matters being put in the register that have a broad definition of 'complaint', this is a relatively recent development.

Working together by valuing feedback and complaints from all stakeholders should be encouraged and facilitated. In particular, family members and guardians who have legal rights and are likely to have intimate knowledge and understanding of the person and their history. The process of how to achieve this in regards to the 'best interest' of the residents individual care and the broader services development requires further consideration. This needs to be facilitated by the Forensic Disability Service.

The panel's open recommendation will remain until the CVP sees sufficient evidence that there is robust complaint and feedback systems for all residents in place.

Right to Cultural Safety

Outstanding Open Recommendations:

Office of Disability - Specialist Support and Forensic Disability Unit *ensure accredited interpreters are used to assist in communicating with non-English speaking residents.* **May 2014, CVP Panel**

Office of Disability - Specialist Support and Forensic Disability Unit - *Clear individualised transition plan be established for each resident at the facility upon admission, showing steps achieved towards exit.* **May 2015, CVP Panel**

The CVP has observed ongoing evidence of good engagement by the Office of Disability with residents' families and communities. This includes facilitating visits to country for contact with family and meeting cultural obligations. A recent example of this was a 5 day trip to a remote community. The service overcame many challenges presented by the complex health concerns of the resident and the significant staff resources required. The trip was reported to be a success.

Despite the efforts of the service, the CVP frequently receives feedback from residents that they are feeling lonely, missing family, and that they would like to spend more time on country. Resident isolation from their families has been further impacted by COVID-19 restrictions.

Case Study

In 2018, the CVP received an enquiry from a resident asking to be relocated to their home community. The CVP advocated for the resident on this issue, and kept the enquiry open to ensure it was followed up. Over time, the CVP expressed concerns as to whether the service was progressing and prioritising the transition plan in a timely way. In mid 2020, the outcome was achieved. The resident is pleased to be finally relocating back to country.

C/2018/00007

Throughout the Northern Territory, there is limited evidence of consistent, routine access to interpreters for residents. This year, an initiative at the Secure Care Facility to engage interpreters on a weekly basis has improved communication. At the time of writing, there are renewed efforts to employ Aboriginal staff at the Secure Care Facility.

It is critical that all services provided, and efforts to improve residents' quality of life is made through a cultural lens. All residents in facilities managed by the Office of Disability are Aboriginal. Despite this, there are no Aboriginal staff or language speakers employed by service. This inevitably compromises the ability of the service to meet the resident's needs.

Case Study

In 2020, the CVP received an anonymous complaint regarding aspects of the care and treatment of a resident. One aspect of the complaint related to cultural safety, specifically that personal care arrangements for the resident involved a staff member of the opposite gender being present on some occasions, to provide direction. The CVP investigated the matter, and found that the practice was culturally unsafe and compromised the dignity of the resident. The service was ultimately receptive to these concerns and undertook to immediately discontinue the practice. The CVP considers this to be an example of a lack of cultural safety, albeit unintentional, that would have been less likely to occur had insight and expertise of Aboriginal staff been available.

C/2020/00128

The CVP has recently received the Aboriginal Cultural Security Framework for NT Health, however this did not appear to have provided assistance in adequately addresseing or progressing the cultural safety issues in a complaint that was raised with the CVP.

The CVP has been advised that a cultural framework is being developed for residents. Whilst this would be a positive development, the CVP notes that Aboriginal culture is varied and diverse across the Northern Territory. In addition to this framework, detailed and well informed individual cultural plans are required for residents. This will ensure that residents' individual needs are identified in planning and service delivery.

At the time of writing, the CV Panel raised an open recommendation about the need for a systemic approach to the primacy of cultural safety for Aboriginal residents. The Office of Disability has advised that a self-audit of the service would be undertaken, with the aim of developing a cultural safety action plan. This plan would be a welcome and necessary step in improving cultural safety for residents.

Right to Quality Services

Outstanding Open Recommendations:

Office of Disability - Specialist Support and Forensic Disability Unit *undertake an urgent and major review of its adherence to the basic principles of clinical governance.* **November 2017, CVP Panel**

Office of Disability - Specialist Support and Forensic Disability Unit *provide the quality assurance framework documentation and process that underpin quality assurance for the Secure Care Facility and appropriate places.* **August 2014, CV**

The CVP continues to hold significant concerns about understaffing, high staff turnover, and the reliance on agency staff in Central Australia. These concerns are held because of the impact on resident care and safety.

The CVP is of the view that these issues contribute to a situation where staff may not be suitably qualified, skilled, motivated or supported to meet their responsibilities to residents. These include upholding resident rights, and ensuring resident dignity and safety.

The CVP recognises that the disability workforce issues are a sector-wide challenge. Some agency staff work at numerous sites, and this is a situation over which the service has limited control.

Staff turnover, however, impacts the quality of service in many ways. This includes impacting on staff knowledge of the resident, relationships and rapport, understanding of the service's legislative and procedural context, and experience and confidence in challenging and high risk situations. High staff turnover also increases the need for training and close supervision in the workplace. This in turn places demands on management time and resources.

Supervision helps support staff to be empowered and equipped in their role through training, regular coaching and clear service guidelines. The CVP has seen some evidence that processes are being established, however high staff turnover erodes confidence that this is being successfully maintained. The overall impact on a quality service by poor staff retention cannot be understated.

The CVP is of the view that there is some distinction between the staffing and workplace issues in Central Australia, as opposed to the Top End. It has been observed that many staff in the Top End have a longer history of service, and longer term relationships with residents. This makes a significant difference to the nature of care received.

By contrast, during this period the CVP observed large scale recruitment in Central Australia. Whilst it is positive that a large number of vacant positions have been filled, there is a level of risk attached to having an influx of new staff at the one time. Central Australian residents of the service are also impacted in terms of clinical governance arrangements, as clinical supervision and monitoring of fidelity to treatment plans occurs remotely.

The CVP will continue to monitor staffing and workforce capacity issues, noting the significant impact this has on residents and quality care received.

Right to Effective Treatment and Care

Outstanding Open Recommendations:

The **Office of Disability - Specialist Support and Forensic Disability Unit** *provide evidence of the systematic implementation of the strategies described in the Positive Behaviour Support Plan (PBSP) and evidence-based changes to PBSPs.* **December 2016, CV**

The **Office of Disability - Specialist Support and Forensic Disability Unit** *ensure prompt review by a General Practitioner or psychiatrist when deterioration in behaviour occurs as documented by frequent PRN usage.* **November 2017, CVP Panel**

The **Office of Disability - Specialist Support and Forensic Disability Unit** *to ensure proper consideration of biological and/or psychiatric causes of significant incidents which result from extreme or out of character behaviour, a clear procedure should be developed for notifying the General Practitioner and psychiatrists of such incidents and of subsequent actions taken by both.* **June 2016, CVP Panel**

Implementation of Plans

Positive Behaviour Support Plans are a crucial mechanism for the regulation, reduction and elimination of restrictive practices over time. While the CVP has observed improvements in the overall quality of PBSPs, there remain areas where more work is required.

In some instances, the CVP has questioned the level of involvement of the resident in the development of their PBSP. Effective treatment requires the active engagement and participation of the person being supported. To the extent of their capacities, the person must be supported to be involved in their plan development and implementation.

Another area of concern identified by the CVP has been an apparent lack of familiarity with the PBSPs demonstrated by frontline staff. Each PBSP is developed individually for the resident, including their behaviours of concern and strategies to develop new skills and improve the environment. The PBSP should be the key document assisting frontline workers to understand what is required of them as support workers.

Whilst a skilfully drafted PBSP is an excellent platform for the service's work with the resident, the value of a PBSP rests upon the frontline staff effectively implementing the plan with the resident on a daily basis. The CVP has not seen sufficient evidence that PBSPs are understood by frontline staff, even to the extent of the plans being signed as read and training having occurred in relation to the plan.

Right to Safety

Outstanding Open Recommendations:

Office of Disability *ensure that all disability support workers received required training to safely monitor and respond to the needs of residents who receive PRN.*
November 2017, CVP Panel

Office of Disability - Specialist Support and Forensic Disability Unit *finalise a medication policy that clearly articulates the service's responsibility to ensure that residents are safely administered medications, including PRN medication in response to behavioural incidents.*
July 2019, CV

Medication

The Medication Management Practice Guide was finalised (see commentary on Page 41) and there is evidence of support staff training occurring which partially addresses the open recommendations.

As was the case during the last reporting period, the CVP continued to raise a number of concerns this year relating to the use and administration of medication for residents. Errors in medication administration have been recorded in incident management documents reviewed by the Community Visitor. Whilst these instances are not frequent, any medication error is a serious 'near miss.'

The current service model relies on non-clinical staff to accurately observe, assess and action the use of medication for medical or behavioural needs of residents. It remains that PRN 'as needed' medication is able to be authorised by non-medically trained staff.

The CVP consider that this presents risks for residents and staff, especially for complex forensic residents with complex co-morbidities who may be taking a range of medication on a daily basis. When given for behavioural reasons, the use of PRN medication is 'chemical restraint', a restrictive intervention that is prohibited by the *Disability Services Act 1993* except in specific circumstances.[30] Accordingly, it is essential that matters concerning the use of PRN 'as needed' medication be informed by the necessary clinical expertise.

The CVP received the Forensic Disability Unit response[31] to the open recommendatons including the above medication recommendation on 24 September 2020, which was too close to the finalisation of this report for the services position to be included in this report. The CVP accepts that there is no mandate to observe a medicalised model of behavioural support, however the broader clinical governance systems need to be well established. The CVP will continue to monitor these systems closely in the coming year.

[30] *Disability Services Act 1993,* s41.
[31] Forensic Disability Unit Response to the Trimester report dated 21 August 2020, received 24 September 2020

Critical Incident Management

The CVP has expressed ongoing concerns about critical incident reporting anomalies during this period. Visits and inspections have identified instances where discrepancies in incident reporting have been noted between the service and residential staff, and instances where highly pertinent information included in debrief notes has not been reflected in the critical incident report.

Case Study

A resident engaged in a prolonged episode of persistent self-harm. Due to the seriousness of the incident, the CVP conducted an own motion investigation and reviewed the CCTV footage. The CVP determined that the resident actively harmed themselves in a forceful, high frequency manner for approximately 45 minutes. The critical incident report included a far lower estimate as to the frequency and number of self harm acts. The resident was taken to hospital by ambulance due to the sustained length of the incident and the injuries that resulted. In the CVP's view, the Critical Incident Report did not accurately reflect the severity of the incident. The CVP considered that the incident raised serious questions about the adequate supervision of the resident and the lack of preparedness to implement reactive strategies (including emergency interventions) in the event of known self-harming behaviour.

C/2020/00008

The CVP is concerned that in some instances critical incident reports do not always reflect the seriousness of the incident. The lack of timely updates, responses and feedback from the service about serious incidents has also raised concerns that these matters may not be receiving the appropriate level of attention.

The reporting of serious escalations in behaviour raises questions regarding the accuracy of the information relied upon to inform clinical decision-making. Reliable, accurate information affects the quality of assessments and interventions, including risk management. It's lack can also compromise the safety of residents. Ongoing issues and queries remain regarding emergency response processes being clear and implemented proportionately to the critical incident circumstances.

The CVP will continue to monitor the issue of critical incident management, including data, reporting integrity and emergency response protocols.

Right to the Least Restrictive Practice

Outstanding Open Recommendations:

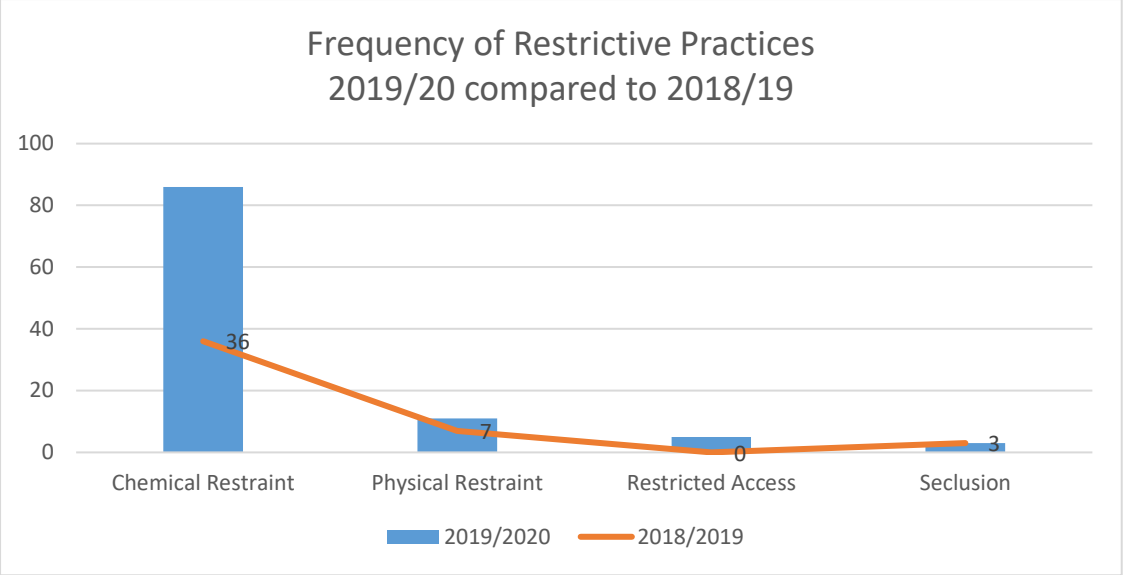
Office of Disability - Specialist Support and Forensic Disability Unit *develop a Memorandum of Understanding with the Department of Corrections to ensure a collaborative and 'least restrictive' approach to shared clients.* **December 2016, CV**

Office of Disability - Specialist Support and Forensic Disability Unit *establish a behaviour support plan review panel as required by the* Disability Services Act 1993. **November 2017, CVP Panel**

Office of Disability - Specialist Support and Forensic Disability Unit *as appropriate, ensure that PBSP are submitted to the Senior Practitioner and/or NDIS National Quality and Safety Commission to enable the resident's rights to independent restrictive practice review occurs.* **December 2019, CV**

Office of Disability - Specialist Support and Forensic Disability Unit *provide the CVP advice of how protections and rights can be accommodated in a manner that is equivalent to NDIS participants under the NDIS Quality and Safeguards Commission framework for service residents.* **June 2020, CV**

The number of restrictive practices – being mostly chemical restraint – used in this year has substantially increased compared to last year. These chemical restraint incidents are mainly attributed to one individual resident, where a range of complex factors were evident.



The CVP has observed a general trend of restrictive practices decreasing for other residents throughout the year. Nonetheless, the CVP holds a number of concerns relating to the use and review of restrictive practices.

Independent Review of Plans with Restrictive Practices

There is no independent process for review of PBSPs in facilities operated by the Office of Disability. By contrast, any person with a disability in the Northern Territory who is subject to restrictive practices implemented by an NDIS provider must have their plan reviewed by the NT Senior Practitioner and the practices authorised under Northern Territory legislation.

The *Disability Services Act 1993* includes provision for an independent Review Panel. The Review Panel can review a resident's PBSP, including what restrictive practices are authorised to be used. The Review Panel, however, has never been constituted.

The Office of Disability could have implemented a process of establishing this Review Panel at any time as a protection for its residents. The CVP considers that the lack of a legislated, independent Review Panel being established in the past 5 years is an ongoing breach of the *Disability Services Act 1993*.

At present, residents who have restrictive practices in their PBSP do not have equivalent protections and rights to those available to NDIS participants. This is despite those residents also being participants in the NDIS (but not receiving their day to day supports by an NDIS provider).

Considering that the Northern Territory now has a mandatory authorisation process for NDIS participants, it is concerning that forensic residents of the Office of Disability service do not have access to similar protections available to them under the law.

The residents in Office of Disability's residence are some of the most vulnerable and marginalised people in the Northern Territory. It is unclear to the CVP why the rights and protections afforded to other persons with a disability are not being recognised or enabled within the forensic disability space operated by the Office of Disability.

The CVP has expressed concerns about this inequity in safeguards over many reporting periods and whilst we welcome the recent advice that Review Panel is to be established, we will monitor the implementation of this development.

Transition to the NDIS

The CVP recognises that the role of the service in supporting residents to transition to mainstream disability supports needs to be carefully managed. Careful, planned transition is important to ensure NDIS providers can meet their obligations and provide safe services to high risk clients.

The CVP has noted positively the successful transition of three Office of Disability clients to NDIS service providers. The CVP continues to observe that there is a need for greater clarity around the ongoing clinical obligations of the Office of Disability when residents are transitioning to NDIS supports. The Office of Disability is the responsible party for reporting to the Supreme Court on a resident's care and treatment. The CVP has noted however that there are gaps in the NDIS transition process for some forensic clients in terms of clinical responsibility, particulalrly when the Forensic Disability Unit is not the Specialist Behaviour Support Practitioner. These gaps expose the clients and the community to potential vulnerability and risk.

The CVP has also identified some uncertainty in relation to how the *Disability Services Act 1993* interacts with the *National Disability Insurance Scheme (Authorisations) Act 2019*. Specifically, the obligations relating to authorisation of restrictive practices for residents who are transitioning between services. The CVP has sought advice on this matter.

During this period, the CVP met with the Office of Disability and separately with the NDIS Quality and Safeguards Commission to discuss the issues of NDIS transition and Office of Disability ongoing responsibilities. The CVP anticipates that more discussions will occur regarding the emerging issues, so that residents are not left vulnerable or with lesser protections during the NDIS transition process.

DATA TABLE 2019 - 2020

	Mental Health			Disability				
	MH-CAHS	TEHS	Total	Secure Care	Appropriate Place	Other (DSA)	Total	TOTAL
VISITS	57	61	118	10	19	3	32	150
Community Visitor	52	52	104	10	19	3	32	136
Inspection	4	7	11					11
CV Panel	1	2	3	0			0	3

	CAHS	TEHS	Total	Secure	Appropriate Place	Other (DSA)	Total	Other	TOTAL
CASES	59	251	310	2	1	15	18	6	334
Complaints	1	27	28	0	0	3	3	0	31
Enquiries	58	224	282	2	1	12	15	6	303
Cases – Raised by									
Person receiving treatment	47	174	221	7			7	5	228
Carer	3	13	16	0			0	0	16
Friend/Relative	0	9	9	0			0	0	9
Service Provider	7	22	29	8			8	1	37
Nurse/Doctor	1	32	33	0			0	0	33
Guardian	0	1	1	3			3	0	4
Blank	1	0	1	0			0	0	1

	MH-CAHS	TEHS	Total	Secure Care	Appropriate Place	Other (DSA)	Total	TOTAL
ISSUES RAISED	117	426	543	4	2	30	36	579
Quality of Service Provider	37	133	170	14			14	184
Assessment & Treatment	3	15	18	1			1	19
Cultural Safety	2	8	10	4			4	14
Management Plan	1	6	7	0			0	7
Facilities	1	10	11	1			1	12
Discharge Planning	10	20	30	1			1	31
Relationship with Staff	3	34	37	1			1	38
Food	1	2	3	0			0	3
Health – Physical / Mental	3	8	11	1			1	12
Procedures	1	17	18	3			3	21
Consultation Carers/Consumers	10	4	14	0			0	14
Activities	0	2	2	1			1	3
Aftercare	0	2	2	0			0	2
Other	2	5	7	1			1	8
Rights	28	133	161	9			9	170
Least Restrictive Alternative	7	30	37	0			0	37
Legal	4	23	27	0			0	27
CV Information on Rights	2	5	7	0			0	7
Early Review of Detention	0	11	11	0			0	11
Restrictive Practices	1	10	11	0			0	11
Respect for Dignity	0	7	7	2			2	9
Safety	2	17	19	4			4	23
Voluntary/ Involuntary	9	4	13	0			0	13
Transport / Transport by Police	2	0	2	0			0	2
Location of Admission	0	8	8	1			1	9
Detention	0	12	12	0			0	12
Community Accommodation	0	4	4	0			0	4
Forensic	0	0	0	1			1	1
Other	1	2	3	1			1	4
Information	8	43	51	4			4	55
Advocacy	31	68	99	7			7	106
Smoking	1	9	10	0			0	10
Visit/Support	1	12	13	0			0	13
Other	1	10	11	0			0	11
Medication	10	18	28	2			2	30

	CAHS	TEHS	Total	Secure Care	Appropriate Place	Other (DSA)	Total	TOTAL
CASE ISSUE OUTCOMES								
Resolved	88	277	365		10		10	375
Ongoing Monitoring	14	68	82		18		18	100
Not Resolved	2	7	9		2		2	11
Referred	0	18	18		0		0	18
Lapsed	9	18	27		0		0	27
Withdrawn	1	14	15		0		0	15
Substantiated	0	8	8		0		0	8
Other	1	0	1		6		6	7
Dismissed	0	2	2		0		0	2
Not accepted	2	14	16		0		0	16
							TOTAL ISSUES RAISED	**579**

HOW WAS CONTACT WITH THE CVP MADE			
	Central Australia	Top End	TOTAL
Email	6	15	21
In person	43	138	181
Telephone	22	102	124
Website	0	1	1
TOTAL CONTACTS RECEIVED			334

TOP END

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Level 9, 22 Mitchell Street
Darwin NT 0800

CENTRAL AUSTRALIA

Alice Springs Plaza
Level 1, 36 Todd Mall
Alice Springs NT 0870

General Enquiries

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