COMMUNITY VISITOR PROGRAM

ANNUAL REPORT







2020 / 2021

Respect
Empowerment Courage
Independence
& Integrity

COVER PHOTOS:
CVP 20 YEAR
ANNIVERSARY CELEBRATIONS

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30 September 2021

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

Dear Ministers,

I am pleased to present to you the Annual Report on the activities of the Community Visitor Program for the period 1 July 2020 to 30 June 2021.

This Annual Report has been prepared in accordance with the requirements under section 115 of the *Mental Health and Related Services Act 1998 and* section 66 of the *Disability Services Act 1993.*

Yours sincerely,

Sally Sievers
Principal Community Visitor

REFLECTIONS FROM THE PRINCIPAL COMMUNITY VISITOR

It gives me great pleasure to provide my ninth Annual Report for the Community Visitor Program (CVP) as the Principal Community Visitor (PCV).

The CVP maintains an ongoing dialogue with mental health and forensic disability services throughout the year. There are weekly CVP visits and follow up conversations to resolve matters raised by consumers and their supports. Trimester reports focus on thematic issues / trends throughout the year and are discussed with the service. No matter is raised for the first time in the Annual Report, however a number of ongoing matters have been raised over many years, including infrastructure that is aging and not fit for purpose, consumer safety, and work force capacity issues in the public mental health service.

The CVP monitoring of forensic disability services highlights the ongoing need for specialist forensic disability services to be provided by the government, even in a National Disability Insurance Scheme (NDIS) environment.

"The CVP conducted 134 visits and 5 inspections during this financial year

There has been continuous improvement of the Specialist Support Forensic Disability Unit (SSFDU), developing policy and procedural frameworks, and engaging with multi-disciplinary experts this year.

Providing a quality service, however, is an ongoing and continuous journey. It is now clear, that the NDIS Quality & Safety Commission does not provide oversight for people in the residences monitored by the CVP under the *Disability Services Act 1993* (DSA), their behaviour support plans and the use of restrictive practices. Since 2012, the Act has provided for an oversight mechanism, the behaviour support plan - review panel (review panel), which has never been established. The implementation of the review panel has been a CVP Panel, recommendation since November 2017.

It is now well over 12 months since the commitment to establish the review panel was made. Currently, there is still no concrete outcome of establishing the review panel, which is an important safeguard for people and their families.

People held in closed environments are at far greater risk of neglect and abuse. The review and oversight provided by the review panel is a crucial piece of the protection, prevention and safeguarding, which is urgently needed but currently missing.

This year in CVP's monitoring we have increasingly seen a public mental health system under significant pressure and stress. Long term solutions including construction of a new facility are still pending. Community based initiatives, such as the Adult Mental Health Centre in Darwin are due to come on line in October 2021. As stated in last year's Annual Report there needed to be planning for the immediate pressures that endanger patient safety until the long term initiatives are in place.

Safety on mental health wards, particularly in the Top End, has been raised repeatedly in CVP Annual Reports since 2016.

This year it has been a continuous area of enquiry and complaint particularly at the Joan Ridley Unit (JRU) and Cowdy Ward where consumers report feeling unsafe. The safety concerns have been amplified by overcrowding occurring since late 2020.

For consumers accommodated in other hospital wards, including the Emergency Department, consumers have been negatively impacted by prolonged admissions, reduced quality of care and treatment, stigmatisation and other “push consequences”.

Another long standing area of concern revisited this year, is the very limited improvement in the documentation explaining rights to consumers. Involuntary admission is a very serious incursion on a person’s freedom. It is different from other types of hospital admissions for care and treatment, it is compulsive and services are provided without a person’s informed consent. It is vital that the type of admission and a person’s rights (such as an early review, being involved in their care, leave entitlements etc.), are explained. The assessment and admission process is the start of the therapeutic relationship which underpins a person’s recovery.

Consumers, their family, supporters, and the community generally, do not have assurance that these basic protections and rights have been explained and safeguarded. The completion of this admission documentation is a legislated requirement and a vital protection. If it is not completed there is an assumption that these consumers’ rights have not been provided.

Positively throughout the year despite the many challenges mentioned in this report, mental health staff on the wards and in the community setting generally have worked tirelessly and are dedicated to improving the health and wellbeing of consumers in very difficult circumstances.

In the governance of mental health, the CVP continues to advocate for strong leadership, clear planning and accountability to Territorians who access public mental health services. In particular a legislated role such as the Chief Psychiatrist that provides clinical leadership and has responsibility for ensuring quality and safety should improve the services provided and public confidence.

As has been the case for the last nine years, this was another very busy year for the CVP. The strength of the program has always been in the leadership and teamwork of the very small team, ably led throughout this whole period by Claudia Manu Preston. The CVP team is testament to what can be achieved by an independent and dedicated team of employed community visitors supplemented by sessional and multi-disciplinary panel members.

In late 2020 Claudia Manu Preston was awarded the 2020 NT Mental Health Coalition Phil Dempster Award. This award recognises an individual working in the mental health sector who has made an outstanding contribution to the sector in the Northern Territory, shown a commitment to improving the quality of life of Territorians living with mental health challenges, and has advocated for their inclusion in the community.

The achievements of the CVP program were recently celebrated at the 20 year anniversary event generously hosted by Her Honour the Honourable Vicki O'Halloran AO Administrator of the Northern Territory (NT). The event was attended by the many people who have worked with and supported the program over many years. Former staff, and a consumer travelled from Alice Springs and spoke of the valued assistance provided by the CVP.

I thank all people who have utilised the CVP and have had the courage to raise their concerns both to improve their own experience of access to services, but also to improve systems for others - thank you.

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CONTENTS

INTRODUCTION

The Northern Territory Community Visitor Program provides a valuable service that works to protect the rights of people in health and disability facilities by raising important issues at both an individual and systemic level.

The CVP visits are provided within the legislative frameworks of the *Mental Health and Related Services Act 1998* (MHRSA) and the DSA.

CVP values and practices are grounded in a human rights approach,[1] supporting principles of person-centred care, empowerment and contemporary evidence-based practice. This approach supports people to live the life they want and receive services they need in the least restrictive way possible.

Community Visitors (CV) assist people who may be struggling to have their needs met and to help them be heard. The CV seeks, where possible, to engage people in their treatment, and enable or facilitate the building of therapeutic relationships by resolving issues at the lowest possible level.

[1] The International Covenant on Economic, Social and Cultural Rights (1975); The United Nations Convention on the Rights of Persons with Disabilities (2006) (CRPD); The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care; The Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT); Mental Health and Related Services Act 1998 (NT) MHRSA.

The CVs engage directly with vulnerable people receiving specialist mental health and disability services by visiting facilities on a regular basis. Visits to mental health facilities in Darwin and Alice Springs occur weekly, and to the SSFDU, and Secure Care Facility monthly and Appropriate Places biannually. In addition, visits are conducted twice a year by multi-disciplinary CVP Panels and periodic CV agency inspections on rotation each year.

After the visits and inspections, the CVs or CVP Panel members reflect on systemic 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.

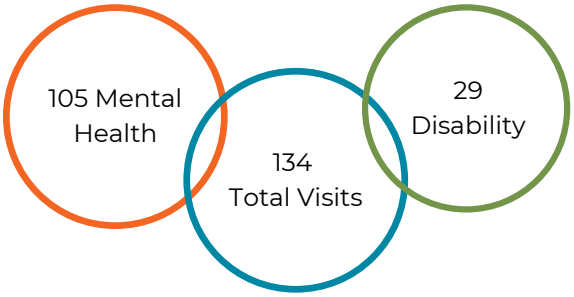
The CVP Annual Report is an opportunity to report and comment on the significant issues for the public mental health and specialist disability services in the NT. This Annual Report lists in the body all CVP recommendations from both the Panel and CVs, open and closed, including recommendations for agencies not visited this year.

VISITS

The CVP visiting role is unique. Other complaint organisations do not provide this type of service to the level provided by the CVP.

The visiting role helps those who may not feel comfortable or empowered to phone or write to someone for help. CVs have a regular presence at the facilities which enables them to build relationships of trust and understanding with both the services and the people receiving care or treatment. It is the CVP's experience that bringing people together at this low level helps to resolve issues in a way which strengthens therapeutic relationships and the way people understand each other.

This year the CVP made 134 visits to specialist mental health or disability facilities. This number is slightly less than last year due to a number of factors including COVID-19 restrictions and CVP capacity.



COMPLAINTS AND ENQUIRIES CASE WORK

This year there was a total of 36 complaints and 298 enquiries for both Mental Health and Disability. This comprised of, 35 complaints and 284 enquiries in Mental Health and 1 complaint and 14 enquiries for SSFDU. Refer to the Appendix – Data table on page 97 for more detailed information regarding the areas of complaint and enquiries.

As an independent, external complaint service the role of the CVP is to listen closely and respect the experience of people who access the service. CVs worked on **334 individual cases**, a similar number to last year. While the overall number of cases is useful, it does not fully illustrate the scope and challenges of some cases dealt with by the CVP.

Issues raised with the CVP in 2020/21 were generally more complex than the previous year involving 650 issues compared 548 in 2019/20. The CVP is a small responsive program and this year has responded to 99% of enquiries within one working day. Over 66% of cases were raised by people receiving services or treatment.

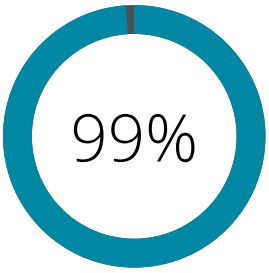
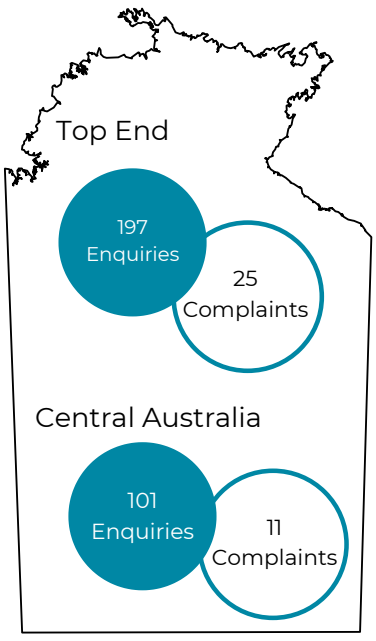


CHART 1 - SAME DAY RESPONSE



COMPLAINTS AND ENQUIRIES IN THE NT

There have been short periods when the permanent CV role was vacant. As the CVP is very small, these changes and any unplanned leave can have an amplified impact on the service.

The high number of issues raised with the CVP by services and staff (39) demonstrates confidence in the CVP's service.

There are some common themes raised with the CV including quality of service, rights, least restrictive alternative, discharge planning, safety, physical and mental health, and relationships with staff.

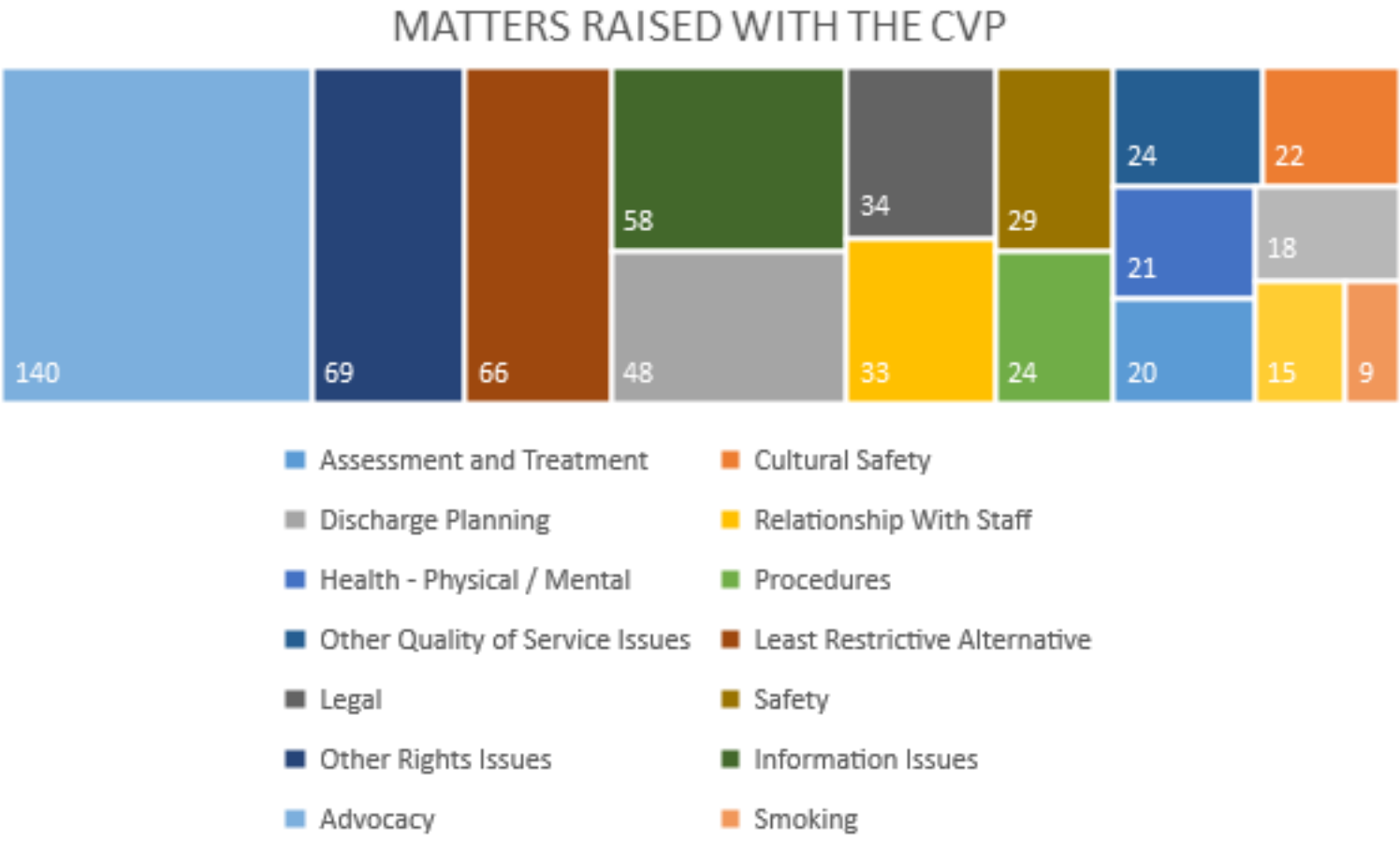


CHART 2 - MATTERS RAISED WITH CVP

At visits the CVs seek to identify issues early and resolve them at the lowest level before they escalate to complaints.This year the CVP have resolved almost 64% of cases raised by complainants.

Many issues 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.

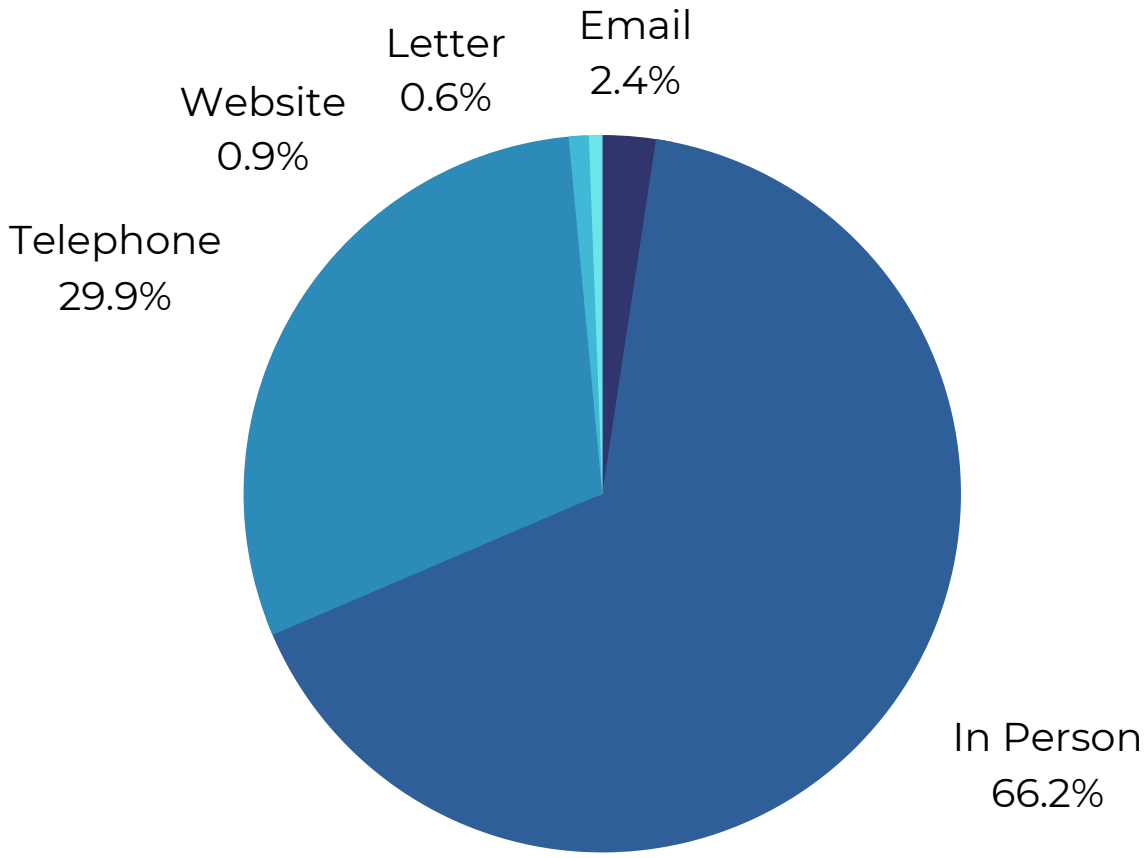


CHART 3 - HOW ARE PEOPLE CONTACTING CVP

At the end of 2020/21 the CVP has 41 cases open for ongoing monitoring. A number of longstanding CVP issues, cases and recommendations have been resolved in this period. Worryingly however, complaints and enquiries that have remained open for an extended period for ongoing monitoring are frequently issues that involve client safety.

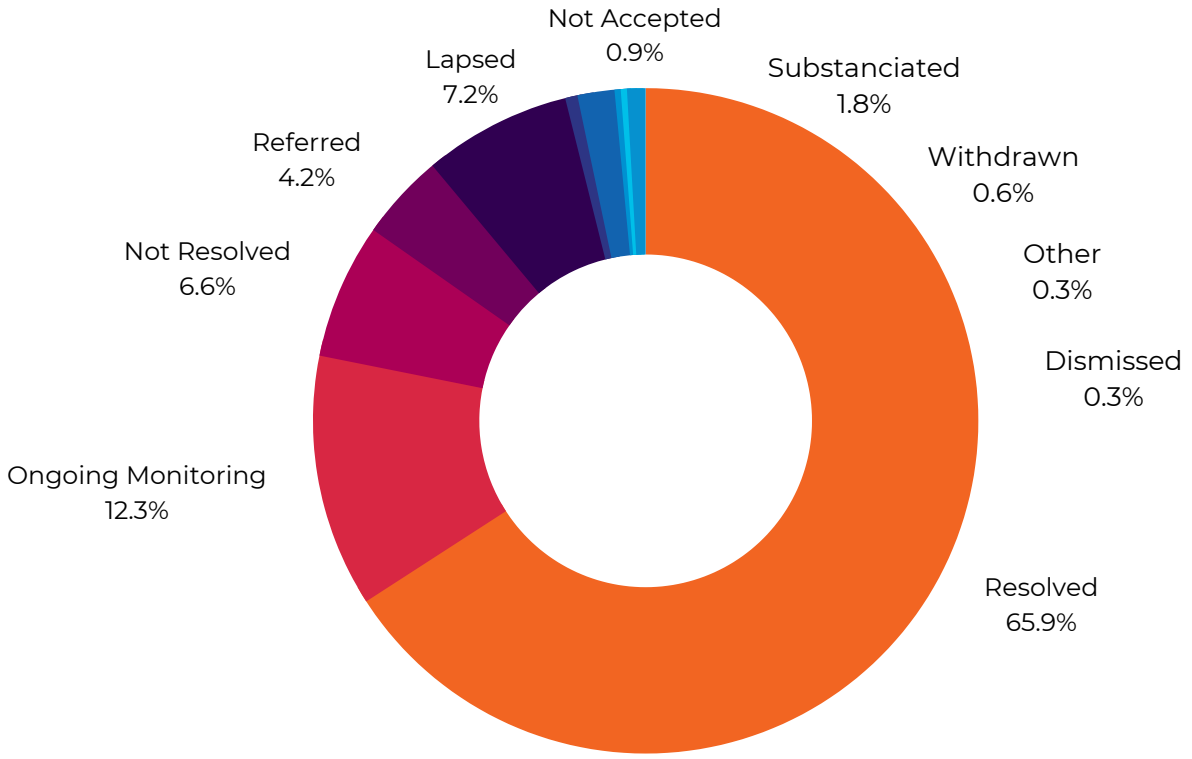


CHART 4 - OUTCOMES

INDIVIDUAL AND SYSTEMIC ADVOCACY

The CVP's statutory oversight function encompasses a preventive, service reform role to provide independent analysis of matters including systemic issues. The complaints and enquiries resolution work is reactive and responds to incidents that have already occurred. The CVP function therefore inherently requires both individual and systemic advocacy in order to effectively improve the quality and safety of services.

The CVP recognises that there is a power imbalance that exists between the clients and services. It can be very hard, even when people are empowered, for them to raise issues with services.

The CVP helps people to actively participate in decision-making processes and conversations that impact upon their lives. Individual advocacy encourages the person to talk to the agency and to feel supported to know the best way to obtain assistance. The CV may advocate directly for individuals, or at other times on behalf of the person but guided by the person's wills and preferences.

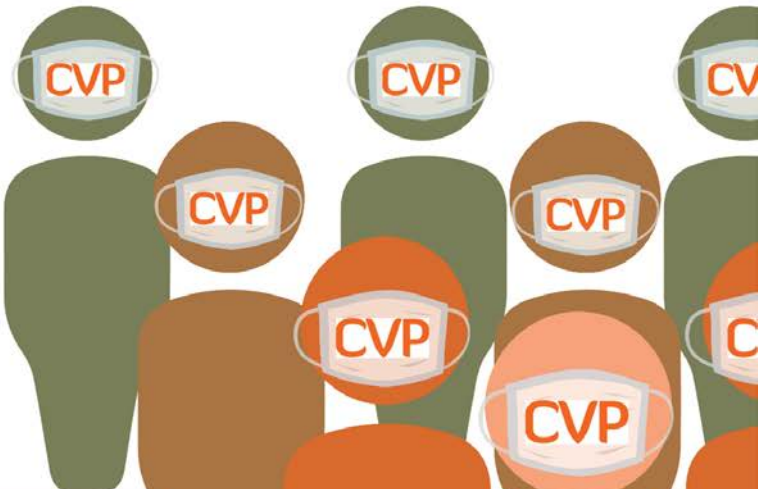
Importantly, advocacy for individuals together with information gathered on visits and inspections informs the CVP's systemic work. The CVs contact with consumers and direct observations helps to identify areas that need further focus and contributes to a process of continuous improvement.

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

A good example of this has been that last year the CVP raised the likelihood that community-based and acute mental health services would experience increased demand as a result of COVID-19 impacts and that there were known gaps and capacity issues in the NT. This has proven to be the case.

COVID-19 PANDEMIC

In 2020/21 the COVID-19 pandemic continued to affect services in a range of ways: from the threat of infection, ongoing restrictions in both the inpatient unit and disability facilities, and the impact on workforce capacity. For people in closed facilities, the pandemic poses considerable risks and challenges.



In the annual reporting period the NT was twice placed into lockdown. The CVP conducted virtual visits while the lockdowns occurred in both Top End Mental Health Service (TEMHS) and Mental Health Central Australia Region (MH-CAR).

Ongoing restrictions throughout this period shortened visit times and limited how many people could visit facilities. Services had to reconsider a range of issues such as how food was provided. All visitors, including CVs have had to comply with restrictions such as being encouraged to sanitize often and keeping the 1.5 physical distance as much as possible. These restrictions can be difficult to manage for staff when the people supported have less capacity and are in closed environments. In the Top End, there is ongoing temperature screening, and periodically visitors have had to wear masks.

The CVP acknowledges the dedication and professionalism of staff in safeguarding the welfare of consumers and residents at a time of great uncertainty. Some mental health consumers were required to quarantine within the mental health in-patient units until early 2021. This is a substantial commitment and achievement for the mental health services.
Due to the highly infectious Delta variant, the MH-CAR made changes that would see the Mental Health Unit not admit consumers with a positive or suspected infection. The MH-CAR advised that there would be no way to contain the virus, with a high risk of spread to everyone in the mental health unit.

At the time of writing there was no change from TEMHS regarding their approach of admitting positive or suspected cases into the separate area of the ward.

The CVP considers that for the most part, restrictions were necessary, reasonable, and proportionate to the circumstances. They were time-limited and have now been reviewed. Given that the pandemic is still a current concern, ongoing vigilance and commitment is required.

FOCUS ON QUALITY AND SAFETY

Mental health services, particularly in the Top End, are experiencing significant stress. In 2018/19 the NT had the highest national average of patients receiving services from community mental health services[2] and in 2019/20 had the highest rate of mental health related Emergency Department (ED) presentations.[3]

Consumers' rights to quality services that are safe are being affected by high demand for services and infrastructure restraints. These issues appear to be compromising confidence in the system for both consumers and potentially the broader community.

A continued broad focus on investment and evidence based strategies including clinical governance, risk management, quality and safety, will be required to address these issues.

CLINICAL GOVERNANCE

With respect to mental health services, the CVP has advocated for the Chief Psychiatrist position to be recruited as a fulltime position and that its functions be embedded within legislation. The CVP submission to the MHRSA review in May 2021 provided detailed commentary about the

[2] National Community Mental Health Care database; Table CMHC.1. Mental health services in Australia, Community mental health care services - Australian Institute of Health and Welfare (aihw.gov.au)
[3] Mental health services in Australia, Hospital emergency services - Australian Institute of Health and Welfare (aihw.gov.au)

legislative functions and reporting of this role to ensure clinical leadership in contemporary mental health practice. The CVP believes that if these suggestions are adopted in full they will strengthen clinical governance and ensure that public mental health services are more transparent and accountable.

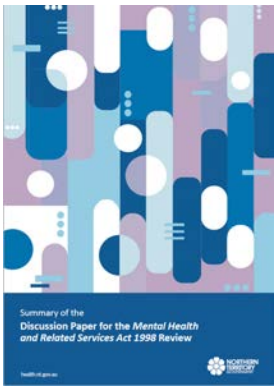
CONTRIBUTING TO REFORM

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 committees and submissions:

- Mental Health Approved Procedures Quality Assurance Committee
- *Mental Health and Related Services Act 1998* review (Submission)
- Expanded submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability submission (April 2021). [4]

The CVP submissions are a significant body of work and an achievement for such a small program.[5]

REVIEW OF THE MENTAL HEALTH AND RELATED SERVICES ACT 1998



The Review of the MHRSA has been pending since 2014 and formal consultation was commenced in December 2020. The review is an opportunity to improve the MHRSA in various ways to bring it into line with contemporary concepts and practices.

The CVP submission highlighted the need to embed the concept of recovery and social and emotional wellbeing using person-centred and wills and preferences principles. This is a fundamental principle and obligation in mental health recovery; that the person and their key stakeholders are included and directing their care and treatment.

[4] Refer to public submission.
[5] Refer to CVP website: www.cvp.nt.gov.au for 2021 submissions and MHRSA Review.

The CVP's strong advocacy starts with ensuring people are aware of their rights and how to use them. When services demonstrate this in practice, they are upholding and ensuring that consumers human and legal rights are being met. The CVP's submission stated that current rights should not be eroded in the current reforms, including ensuring the least restrictive principles were applied in general.

As noted in the CVP submission, the current ongoing challenges are in the CVP's view, related to quality and safety issues. A Chief Psychiatrist role as noted above should assist in these areas by providing clinical leadership to services to operationalise contemporary mental health practices and the requirements of the MHRSA. It is expected that they will have a lead role in developing a NT wide Clinical Mental Health Service Plan.[6]

ROYAL COMMISSION INTO VIOLENCE, ABUSE, NEGLECT AND EXPLOITATION OF PEOPLE WITH DISABILITY (RCD) SUBMISSION

The CVP provided an expanded submission to the RCD in April 2021 addressing the Safety and Quality Issues Paper. The CVP has advocated for improved safeguards and protections to cover people living with disabilities that reside in supported accommodation. At present the safeguard offered by the CVP is only available to a very small number of people with disabilities on a supervision order under the *Criminal Code Act 1983*.

A national review of official visitor programs was conducted[7] and this report found the CVP provides a valuable service in upholding people's human rights and strengthens the protections and safeguards that prevent violence, abuse and exploitation of people with disabilities.[8]

[6] CVP MHRSA submission May 2021, CVP website.
[7] https://www.dss.gov.au/disability-and-carers-publications-articles-policy-research/community-visitors-schemes-review.
[8] Westwood Spice, Community Visitor Scheme Review Report, Department of Social Services for the Disability Reform Council, Council of Australian Governments, December 2018.

The CVP raised in the RCD submission the need to identify 'at risk' individuals and situations. Further, that relying on complaints alone does not recognise the level of vulnerability, NT context, and range of reasons why people don't complain.

The CVP provides the 'missing piece' in the middle of the safeguards continuum. The NDIS Quality & Safety Commission does not routinely gather on the ground information, provide relationship based visiting or ensure early resolution of concerns. Better results in these areas are achieved by local initiatives such as Community Visitors.[9]

The CVP is aware that the DSA is currently under review and looks forward to being consulted and/or being able to provide a submission that reviews the scope and effectiveness of the legislation.

PARTICIPATE IN STEERING GROUPS, FORUMS AND POLICY WORK

This year the Approved Procedures and Quality Assurance Committee (APQAC) committee continued to review and finalised three Approved Procedures (AP), AP 18 - CVP, AP 10 - Mechanical Restraint and AP 11 – Seclusion. There were also four updated patient flyers developed that are available in printed format and online within the services: Referral to hospital for an examination, Voluntary treatment in hospital, Involuntary treatment in hospital, and Receiving treatment for a mental illness.

4 *UPDATED PATIENT FLYERS*

While the CVP is pleased to participate in steering groups, forums and policy work, as a small team, it does place pressure on staff to fulfil its statutory obligations. This year the CVP elected not to continue to participate in the NT Regional Area Mental Health and Emergency Service Committee due to the CVP capacity and volume of work.

[9] Royal Commission Issues Paper, Overview of responses to the Safeguards and quality Issues paper, September 2021

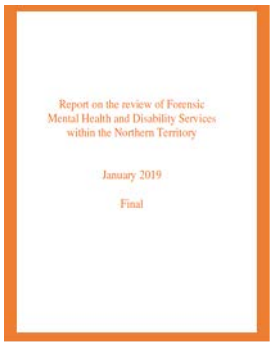
COMMUNITY BASED INITIATIVES FOCUS

The CVP is aware of numerous reforms that were highlighted last year that positively expand the range of community services, and should alleviate to some degree the strained public mental health system. It is positive that the Adult Mental Health centre is anticipated to be operational in October 2021. this is a significant achievement.

The CVP supports a reform agenda that invests in community based recovery models and the Government's current initiatives in this regard. This approach applies a prevention and early intervention focus. This is in line with the concept that good mental health happens and is sustained in the settings and circumstances of everyday life, not in institutions. This is contemporary mental health practice.

The CVP will monitor the impact of the initiatives however is concerned that the proposals may not be commensurate with the demand and that current issues in inpatient facilities also need urgent actions until these new initiatives are fully operational.

FORENSIC SERVICES REFORM


Report on the review of Forensic Mental Health and Disability Services within the Northern Territory

January 2019

Final

Forensic consumers are among the most marginalised and powerless people in our society.[10] Forensic mental health and disability services perform some of the most complex and specialised work in the NT.

The CVP is seriously concerned that little to no progress has been made to implement the recommendations from the Report on the review of Forensic Mental Health and Disability Services within the NT.[11] This report was released on January 2019 and the CVP has reported for the past two years about the Government commitment to this area.

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

The CVP awaits concrete funded proposals being publicly announced with timelines for implementation of the review's recommendations.

COLLABORATION WITH AND RESPECT FOR THE CVP

The CVP monitors laws that restrict the rights of vulnerable people receiving health and disability services. These laws authorise the restriction of individual's rights, such as their right to choose where they live, their right to consent to treatment and their right to freedom of movement. Where government is limiting rights by law, the services and treatment must be open to independent oversight.

The CVP 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. Positively there have been significant longstanding recommendations closed this year.

This tension means, at times, there are varying levels of co-operation and collaboration with the CVP. 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.

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.

The CVP is always looking for better ways to work, to ensure continuous improvement of our processes and the way we work with the services. This year to improve communication processes for inspections, a template questionnaire setting out information, was proposed to reduce the time and work required by both services and the CVP. This was not taken up and a limited number of inspections conducted were adversely impacted and prolonged, requiring multiple versions as relevant information was provided over a prolonged period to the CVP. We look forward to continuing to work towards upfront information sharing, to avoid these frustrations over the next year.

A fundamental value of the CVP's approach is that of respect. The CVP respects the services, and equally the CVP expects respect for its statutory role.

The CVP is proud of its key role of walking alongside people receiving specialist services from the NT public mental health and disability services. This role is a privilege.

The program has significant achievements in safeguarding the rights of people in public facilities receiving voluntary and involuntary services. The CVP upholds that protecting the human rights of individuals contributes also to protecting the dignity and humanity of us all.

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 service.

CVP 20 YEAR ANNIVERSARY CELEBRATIONS

The CVP celebrated the achievements and importance of the role in protecting and safeguarding the rights of people receiving treatment and care under the *MHRSA* and *DSA*.

Thank you to Her Honour the Honourable Vicki O'Halloran AO Administrator of the Northern Territory for hosting the event and the Nemarluk School Choir for entertaining all who were present.

'My name is Padma Andrews and I live in Alice Springs, I am a mother, a friend and I am a proud participant and Peer Worker at the Mental Health Association of Central Australia.

I have lived with a mental illness for many years and have needed to get help from the public Mental Health Services to help me with my recovery.

The Community Visitor (Sophie Staughton) helped me when I was distressed about my treatment. I didn't know what my rights were and I was feeling very alone and powerless.

It was a lot to make a complaint but I didn't want my experience to happen to anyone else.

I didn't feel like I was being listened to and my views were not being respected. I was upset and unable to get my thoughts clear to express my experience and what I thought was important in my recovery.

I had a CV come and see me and come to a meeting with my Psychiatrist. They helped me to sort out all the issues I wanted to raise. They sat with me and advocated for me when I needed help.

I felt like I was listened to because the CV was there and I received an apology from the service. That meant alot to me.

I want to say how important a service like the CVP is, I am very thankful for their help and think this is a really important service and there needs to be more CV's, particularly on the mental health ward.'

CVP 20th ANNIVERSARY

MENTAL HEALTH

MENTAL HEALTH THE FOCUS

- Pending the construction of a new facility, urgent action is required to ensure access, safety and wellbeing of people receiving mental health assessment and treatment at the Royal Darwin Hospital, including 'Cowdy and JRU'.
- Substantial improvements are needed to facilitate the rights of consumers under the MHRSA.
- Documentation and the accuracy of record keeping related to involuntary admission to hospital must be improved.
- The use of interpreters must be improved to ensure effective two way communication.

Public mental health services are a valued and critical specialist service that are established for some of the most vulnerable Territorians.

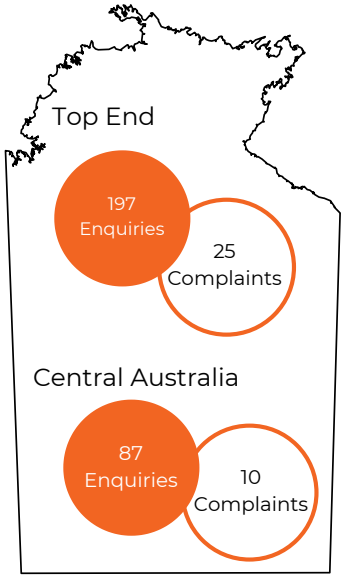
A strong mental health system prevents and detects mental illness early, promotes recovery, and delivers services in the least restrictive way possible.

These services are governed by the MHRSA. The legislation alone cannot improve the effectiveness and accessibility of services or change cultures within services. The MHRSA does however, establish a mandatory framework for the mental health system that supports the recovery of people by promoting and protecting rights and providing a framework for quality assessment, treatment and care.

Positively, in line with the principle of least restrictive practice, most people who access the public mental health services do so on a voluntary basis. Due to the greater level of restriction posed to a person's liberty and increased vulnerability to potential abuse, neglect and violence by virtue of being detained in a closed environment, the CVP oversight is focused on involuntary admission.

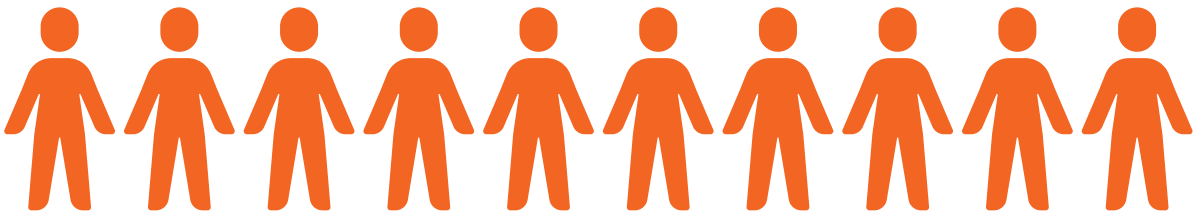
The CVP statutory role is broader than advocacy and complaints resolution. The role also pertains to review of systemic issues including quality and safety of services.[12]

The CVP acknowledges that many staff work tirelessly with care and compassion in a system that is significantly overstretched.



MENTAL HEALTH COMPLAINTS AND ENQUIRIES IN THE NT

The CVP has observed the public mental health system and workforce struggling under a lack of leadership, increasing complex demands of patient care, reduced workforce capacity and capability (some related to COVID-19), a limited range of community based models of care, a lack of appropriate resources commensurate to the demand for services and infrastructure that is out dated and not fit for purpose. Dealing with these challenges appears to have led to low staff morale and high staff turnover.



[12] Section 3(q) of the MHRSA provides for a principal community visitor, community visitors and community visitor panels with inquiry, complaints, investigation, visiting, inspection, advocacy and reporting powers and functions.

CHALLENGES TO PROVIDING CARE AND TREATMENT

The NT has unique challenges that impact on the provision of high quality mental health services including: vast geographic distance, small population, and the level of disadvantage and trauma and other social disadvantage experienced by a large number of Aboriginal Territorians.

An ever present factor, in the past year, looming over the provision of mental health services in the NT has been the threat of COVID-19.

In addition to these challenges the NT public mental health system is functioning in the context of a structural review of the NT Department of Health, a newly appointed Chief Executive Officer, review of the MHRSA and Acacia,[13] the new NT Health's core clinical electronic health record system being implemented. Despite these challenges both TEMHS and MH-CAR have done well to remain responsive and flexible in providing services.

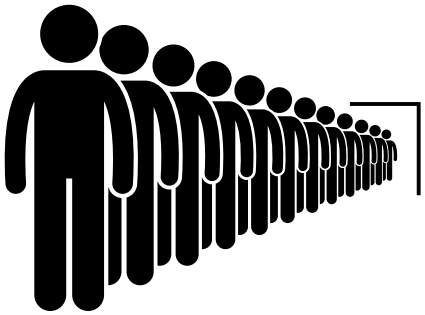
Last year the CVP observed an emerging trend of increased mental health inpatient admissions in the Top End. This phenomenon has continued, with Top End inpatient units running at 120% of capacity. There was a period when 18 people were waiting for admission at the ED and other hospital wards. The CVP hold serious concerns that people requiring urgent mental health assistance are waiting for extended periods in inappropriate facilities most evident since mid-2020.

The broader context is that throughout Royal Darwin Hospital in this reporting period there are current serious bed and workforce issues. The situation of waiting for admission into the inpatient unit for prolonged

[13] Acacia is NT Health's new core clinical system, delivering a single, secure, Territory-wide electronic health record across NT Health services in hospitals, primary health care centres and community health services see; Acacia Home (nt.gov.au).

periods, is likely to exacerbate a consumer's mental health distress and the subsequent restrictive practices employed. The likely therapeutic impact is that people take longer to recover and may require longer admissions. The potential long-term impact could be that the negative experience affects help-seeking behaviour in the future, meaning people do not end up receiving the help they need.

Within the mental health facilities, overcrowding impacts the therapeutic environment and quality of service provided. The ward at times has been described as a 'pressure cooker like'[14] environment. When people present at mental health facilities, they are most often requiring a 'low stimuli' environment, where consumers feel safe.



High numbers of admissions further impact the functioning of the ward as the CVP has observed and have been advised by staff. At times, there has been enormous pressures to admit, manage and discharge, to relieve the backlog of people waiting for admission.

The CVP acknowledges that there are currently limited prevention, early intervention and community care options to help alleviate and prevent admissions. While this is the situation at present, the CVP welcomes the significant work being undertaken on new reform initiatives designed to relieve the pressures being placed on the public mental health system.

When admitted involuntarily to mental health facilities that are struggling with the above challenges, people do not have the choice to leave. Consumers who are admitted involuntarily are effectively under the care of the 'government' and are vulnerable when mental health wards are over capacity.

[14] CVP C/2021/00116 Right to Safety and quality treatment and care for patients

The issue of capacity of Royal Darwin Hospital mental health facilities and outliers on other wards has entered the public domain with divisive and stereotyping language. People with a mental illness seeking help at ED and other wards have been described as 'violent' or 'a burden to the health system'. The CVP is concerned vulnerable consumers are being blamed for issues that are the result of infrastructure limitation and lack of planning.

Valued, experienced and skilled staff are the greatest asset of any service. For some time it has been apparent that the NT mental health system is experiencing significant workforce issues. The tenure of key leadership roles have been acting or vacant for long periods. Additionally there have been various vacancies across public mental health services. Work force issues, appear to be amplified by COVID-19, with gaps in nursing skills and experience of most concern as these affect direct inpatient care. These issues have been acknowledged by both services and require focused and innovative solutions to improve recruitment and retention of staff.

> *'Safety means the absence of preventable harm to people during the process of health care, and reduction of unnecessary harm associated with health care to an acceptable minimum. Safety includes adhering to clinical and work standards for health and safety, and ensuring that people don't get hurt. It also includes emotional safety: creating a welcoming environment free from stigma and judgement, and ensuring that people feel comfortable, validated and respected.'*
>
> National Mental Health Commission, Mental Health and Quality Engagement Guide P.5.

Strong leadership for mental health across the NT is needed given the significant mental health reforms that are taking place, workforce challenges, and resource demands that also require clinical leadership. The position created to provide this leadership, the role of Chief Psychiatrist, has been vacant for over two years. The delay in the legislative reform to create this position and define the roles and powers is likely to have contributed to the difficulties in filling this position.

The CVP has serious concerns that the mental health system in the NT is under significant stress, most obviously in the Top End, and that this is unlikely to change in the short term. The CVP appreciates that there are no quick fix solutions to the current phenomenon, even though many of the issues are not new. Until these issues are addressed, they pose serious risks for consumers and their families accessing services.

ACHIEVEMENTS

- Despite the inherent challenges, staff work tirelessly and are dedicated to improving the health and wellbeing of their clients in difficult and restrictive circumstances.
- Over the long term, seclusion rates are reducing.
- Mechanical Restraint is now being recorded throughout the NT.
- Evidence of commitment and progress towards Aboriginal cultural safety in some areas. Cultural competence training was completed for most staff in the Top End and in Central Australia the results of numerous Aboriginal cultural safety initiatives are being seen.
- 15 closed CVP open recommendations, 12 in TEMHS, three in MH-CAR.
- Ward activities when occurring are significantly improving people's recovery. The CVP has observed a range of special events held throughout the year for clients to enjoy, which normalises the inpatient environment such as Christmas, birthdays, and NAIDOC week.
- COVID-19 planning and service provision model to accommodate COVID-19 positive acute admissions within mental health ward, prioritising the mental health treatment.
- TEMHS was re-accredited in April 2021 under the National Safety and Quality Health Service (NSQHS) Standards, as part of the wider Top End Health Service accreditation.

TERRITORY WIDE ISSUES

The issues raised by people talking to the CVs are the foundation on which the CVP's commentary in this report is built. The mental health case data shows that consumers are concerned about assessment and treatment, which ward they are placed on, discharge planning, procedures and relationships with staff featured in matters raised with CVs. Cultural safety, 'least restrictive' alternatives, legal rights and consumer safety were also identified as significant issues.

CVs enter the acute mental health in-patient facilities in Darwin and Alice Springs on a weekly basis. The CVs ensure that people 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.

As in previous years, the CVs often hear from consumers and carers that they are not adequately consulted or involved in their care (which is inconsistent with therapeutic care and treatment principles). Advocating for consumers' needs, wills and preferences to be heard, is a central part of the CVs work.

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 NT's publicly funded mental health services that operate in the community. This year, the CVP has completed less inspections of community-based treatment teams. This is in part due to CVP staff capacity and biosecurity requirements to address the risks of COVID-19 infections. Nevertheless, the CVP achieved 134 visits and five inspections this year.

RIGHT TO ACCESS MENTAL HEALTH TREATMENT AND CARE IN AN APPROPRIATE, SAFE PLACE

CVP RECOMMENDATIONS:

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

That TEHMS 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 retraumatising clients.(Reworded February 2019)
TEMHS CV, July 2017

All persons receiving care and treatment have the right to be safe. The focus of any public mental health service is to provide assessment and treatment that is therapeutic, safe and does no harm. Last year in the CVP Annual Report the CVP raised that 'until the new facility is built, there is still an ongoing need for attention and vigilance about consumer safety'.

29 Safety Matters Raised

This year the CVP received numerous enquiries and complaints about safety, particularly in the Top End. In all CV Trimester reports, safety on the wards has been raised. People admitted to the JRU and now in Cowdy often report feeling unsafe. Serious allegations of verbal, physical and even sexual assault have been reported. Unfortunately, this year the incidents are not confined to the JRU and these allegations and incidents are on the rise across all wards.

Women continue to be concerned about being accommodated alongside men. On occasion, young people have reported feeling unsafe while admitted.

The presence of prisoners and uniformed corrections officers in JRU inevitably gives a 'prison like feel' to the unit and affects the ward environment.

In late 2020, the CVP observed overcrowding of inpatient units due to bed shortages and in early 2021 unit numbers were capped. The CV reported to the service about the impact of this, as it appeared the ward environment was calmer and anecdotally admissions were of shorter duration for some consumers. Subsequently issues arose with people being detained in the ED and other wards. As previously noted, this surge of demand at its highest was 18 people waiting for a bed in the mental health unit and many people remaining on these wards outside the mental health unit (referred to as outliers) for excessive periods including in ED for over a week.[15]

The level of restriction for outliers is usually higher. Incidents of restrictive practices, seclusion and even intubation are used due to an inability to manage some people's distress and behaviour. The CVP contends that the functional requirements of ED and some other wards are not suitable places for people to remain in for prolonged periods, who are experiencing psychosis or who are exhibiting suicidal ideation for both therapeutic and safety reasons. It appears that both ED and mental health services staff are genuinely trying to provide adequate treatment and care however the solutions are broader than what the mental health service or ED can reasonably address.

[15] VIS/2021/00056, TEMHS s.109 Visit report 13-14/04/21, 11 outliers reported.

In the Top End, the policy of having a security guard present in ED for all people who are detained under the MHRSA means they often feel they are not being treated with dignity and respect. The CVP accepts that there are occasions where this may be necessary, however this approach is stigmatising and a blanket approach which is not in line with the least restrictive alternative.

Another issue raised with the CVP in relation to mental health consumers being held in ED is that patient privacy and confidentiality are compromised when there is only a material partition. This issue is of particular pertinence to mental health patients who need to speak to their treating team about issues that have led to their admission.

The CVP reported workforce issues including skill and capacity gaps to the service this year. The CVP observed at times increased use of personal care assistants (PCA) and security staff on units because of the acuity needs of people and the nursing gaps. The MH-CAR notably has reduced the use of security guards because their new duress alarm system is now in place. TEMHS have also introduced some changes to the ward. To ensure consumer safety, the CVP suggests appropriate staffing, improved supervision and interim strategies continue to be a focus.

Renovations have started on JRU to separate prisoners, and women from men; however the Cowdy renovations have not yet commenced. The CVP have been advised that JRU renovations will be complete by the end of 2021. Queries have arisen as to whether plans comply with national standards.[16] These renovations to the existing wards will not meet the current need, based on the surge in demand discussed previously.

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

At the time of writing this report, a Mental Health Task Force has been formed to address these problems and a communique of proposals has been provided.

All of these factors affect a consumer's experience including their psychological, physical safety and the quality of the service they receive.

The CVP request that urgent action is taken with clear proposals appropriately resourced to meet the current and evolving mental health needs for people in the Top End.

Case Study - Legal Rights: Complaint process & Safety

A consumer and their carer made an internal complaint to the MHS. They were not satisfied with the outcome and raised the matter with the CVP to look at independently. The CVP found that the complaint process had not been followed adequately. The matter related to safety and being treated with dignity and respect. The complainant's allegations were substantiated. The matter was resolved insofar as the MHS acknowledged and agreed to address a range of issues. The complainant was pleased that they were believed and that they should not have been treated the way they were.

LEGAL RIGHTS UPHELD

LEGAL COMPLIANCE

CVP RECOMMENDATIONS:

That the service provide evidence that in the process of involuntary admission that there is adequate explanation of the rights to people, including legal status on admission, offering of interpreters and early access to the Mental Health Review Tribunal. (Reworded 2016)
TEMHS Panel 2011

That within 60 days, TEMHS will provide the PCV with a comprehensive strategy to address the systemic non-completion of all sections of the Form 10 for every person detained at the ATF.
TEMHS Community Visitor 2020

That MH-CAR 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.
MH-CAR CV 2020

That the service provides evidence that staff explain rights under the MHRSA to clients on admission or soon as they are able to understand them, in a manner that they can understand and in a language that they are used to communicating in. In particular:

- *The service implement practices and procedures to ensure that Form 10s are completed in their entirety for each consumer.*

The service 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.
MH-CAR Panel 2020

UNDERSTANDING LEGAL RIGHTS ON INVOLUNTARY ADMISSION

The CVP remains seriously concerned about the absence, inconsistency or ambiguity of information received and recorded about consumer rights. Consumer and carer rights are enshrined in the MHRSA. The obligation is on the mental health service to provide those rights to the consumer and their carer.

People must be supported to know about their legal rights, including the basis of their admission, how to exercise their rights, and the right to be involved in their treatment. This is part of the therapeutic process, which empowers the person's self-efficacy and autonomy.

Review of the data demonstrates that a Form 10 was received for 87% of the admissions in Central Australia and only 30% of admissions in the Top End. The PCV is not receiving all the Form 10s as required by the MHRSA.

Of the 804 Form 10's received only 48% for people in Central Australia, and 52% for those in the Top End, were received within the legislated period of one day.

Form 10s received by the PCV indicate that up to 27% of people detained in the NT were not advised of their legal status at the time of admission.[17] Further, only 68% of all persons were recorded as being told they had the right to early review of their admission by an independent tribunal.[18]

[17] 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'.

[18] 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.

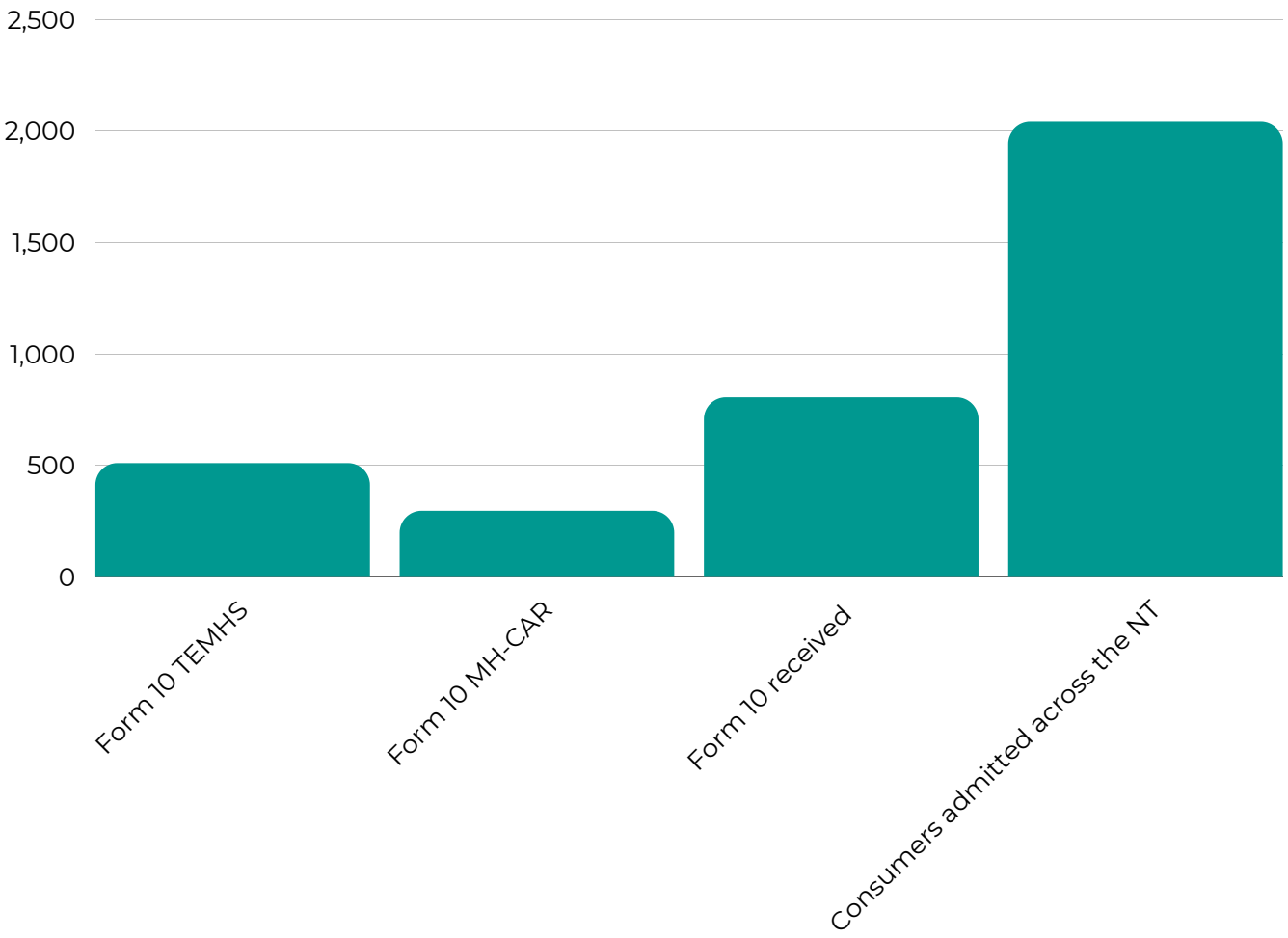


CHART 5 - FORM 10 DATA RECEIVED

It is not clear whether the need for an interpreter during psychiatric assessment was considered as 66% of Form 10 in the Top End and 58% in Central Australia did not have this question completed.

The section to indicate that an interpreter was needed at Mental Health Review Tribunal hearings was completed at a rate of 75% in the Top End and 66% in Central Australia.

For many years the CVP has raised poor compliance regarding the provision of information about rights and compliance with the MHRSA as critically important for people who have been involuntarily detained.

KEEPING ACCURATE RECORDS OF FORM 10

Individual or systemic concerns arise from analysis of Form 10 data. These concerns are raised with the service each trimester.

Reviews include whether people have been made aware of their legal status, if a consumer requested an early tribunal hearing, that carers and guardians are informed about the admission, and that people are receiving information in their preferred language. This information evidences that people are being included in their care and treatment and that their preferences are considered.

The CVP supports efforts to streamline administrative processes that comply with the legislation particularly where proposals ultimately benefit clients and ensure transparency and accountability. However, repeatedly the CVP have been told by mental health services that there is limited operational capacity to meet the growing complex service demands and compliance with legislative protections.

Positively, MH-CAR has implemented the 'yellow form' system recommended by the CVP panel to assist in situations where the person at the admission point is unable to be provided or conveyed their rights. Staff will proactively follow-up to ensure through the consumer signing that rights have been conveyed. There is emerging evidence that the 'yellow form' system is improving the conveying of rights to consumers.

The TEMHS have implemented a new process where doctors send Form 10s directly to the CVP. Despite minor improvements in the completion of some sections and the timeliness in which Form 10s are sent to the PCV this system has not been effective in addressing the lack of compliance. There are serious concerns as discussed above that a significant amount of form 10 have not been provided to the PCV. These issues bring into question the accuracy and efficacy of the TEMHS data system.

Reinforcing the CVP findings in regard to consumers being conveyed and understanding their rights was also addressed in the findings of the recent TEMHS accreditation. The CVP have been told that the service is considering how to incorporate this recommendation into the current Form 10s.

Both TEMHS and MH-CAR are not fully complying with their legislative obligations for involuntary admissions. It is clear that rights are not being upheld for both consumers and carers. This raises serious questions regarding procedural fairness and in some cases whether people are being detained for periods longer than prescribed under the MHRSA.

RIGHT TO CULTURALLY SAFE SERVICES

CVP RECOMMENDATIONS:

It is recommended that the Mental Health Service ensure that interpreters are present at assessment for all people whose first language is not English.

It is further recommended that interpreter assistance is then arranged for all further assessments and to assist the consumer at any hearing before the Mental Health Review Tribunal.
TEMHS Panel, May 2007

TEMHS ensure that Aboriginal Mental Health Workers (AMHW) are available outside of business hours and on weekends.
TEMHS CV, August 2021

That the Palmerston Community Mental Health Team improve access to an AMHWs and use of interpreters.
Palmerston Community Mental Health Team CV, August 2021

TEMHS ensure that interpreters are utilised pre and post seclusion and during:

- *Client debriefing*
- *The development of clinical management plans*
- *Seclusion reviews*

TEMHS CV, August 2011

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

That MH-CAR improve the use of interpreters for the provision of information about legal rights on admission and in reviews to people who do not have English as their first language. (Reworded October 2020).
MH-CAR CV, June 2019

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

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

That significant efforts are made to recruit to the AMHW position within the Forensic Mental Health Team, including any development required to upskill a suitable applicant.
MH-CAR Forensic Mental Health Team, CV, August 2014

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

It is of vital importance that Aboriginal cultural safety is a priority issue for NT public mental health services. In the area serviced at least 30% of the population identify as Aboriginal. According to the NT Government there are more than 100 Aboriginal languages in the NT.[19] The CVP shares the vision of the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Strategy 2020/2021 of patient safety for Aboriginal and Torres Strait Peoples being the norm.[20]

[19] https://nt.gov.au/community/interpreting-and-translatingnt#:~:text=More%20than%20100%20Aboriginal%20languages,grammatical%20structures%2C%20concepts%20and%20vocabulary
[20] As such, this is a priority issue for the Northern Territory public mental health services.

The NT mental health services have continued progress to becoming a culturally safe service for Aboriginal people. TEMHS has implemented a cultural competency program that was well received and attended by staff. There have been positive developments such as the Ngangkari attending the mental health unit in Central Australia as part of a partnership between Aboriginal organisations and the MH-CAR. Despite this progress, there is still more to do.

USE OF INTERPRETERS

The inadequate use of interpreters has been an issue raised many times over many years with the service. While interpreter use relates to all languages other than English, it is most evident in the provision of services in Aboriginal languages.

Too often, CVs will be told reasons why accredited independent interpreters were not used. This can include the time of day the person was admitted, that the person 'speaks English' (despite there being no capacity assessment on their understanding of complex matters), that a family member was used (which raises serious privacy and assessment issues).

There are also operational difficulties the CVP are aware of including difficulties in getting an interpreter sometimes because there is no interpreter for that language group, that the Aboriginal Interpreter Service (AIS) does not have capacity to provide the interpreter, or the interpreter does not attend.

There are also instances in which CVs or the CVP Panel members have identified a lack of awareness of the need for an interpreter.

Over the period covered by this report, the CVP has observed that the low level of interpreter use at mental health facilities is increasing the number of Aboriginal consumers seeking advocacy with enquiries and complaints.

In particular CVs have found that due to low interpreter use Aboriginal consumers may feel unsure of their rights, confused about why they are detained, disempowered, unable to participate in treatment, disconnected from family and not confident that discharge planning is occurring.

While there is evidence that the in-patient facilities are starting to grapple with these issues, the effective use of interpreters for community-based teams remains largely unaddressed. CVP inspection reports of community mental health teams have raised these issues and will continue to do so until there is improvements to interpreter use.

It is relevant to note that previously the Central Australian Mark Sheldon Remote Mental Health Team actively worked to ensure accredited interpreters were part of the team during visits to remote communities. The positive benefits flowing to consumers, family members and staff of the mental health service was highlighted in the previous inspection report.

Case Study - Cultural Safety – Interpreter Use:
The father of a young consumer came from a remote community to support his son who was an involuntary consumer. A father told the CV (with an interpreter), that he had been attending medical reviews but didn't understand what the doctors had been saying. The father explained that it was very important he understand his son's assessment and treatment because on discharge they would be travelling to their home in a remote community which was a long distance from the hospital and medical support.

The CV raised with the treating team, the father's concerns about not being able to participate fully in his son's treatment, and that continuation of care on discharge would rely on the family understanding the young man's support needs. The matter was resolved as an interpreter was organised by the Aboriginal Cultural Advisor that allowed two way communication. C/2021/00085

This is relevant insofar as they are one of the only agencies that the CVP has inspected where there is no open recommendation to improve interpreter use. While this is a positive development, it was only clearly evident in one mental health team. This proactive approach needs to be widespread across all teams in the NT public mental health services.

There is a professional obligation for effective communication that requires widespread interpreter use across NT public mental health services.

At present, there is not enough evidence that NT public mental health services are meeting the challenge of using accredited interpreters as a matter of course. This action needs to occur at all levels, from senior leaders addressing systemic issues through to individual staff completing booking requests.

Increased interpreter use across the mental health services is a must for effective communication and a crucial component of being a culturally safe and competent service.

ABORIGINAL STAFF

A further foundation of Aboriginal culturally competent service is effective cross-cultural communication and AMHW are key partners in ensuring Aboriginal consumers are able to access and use mental health services that meet their needs.

The Top End and Central Australia mental health services have maintained a focus on AMHW positions being an integral part of the staffing profile (in both the in-patient facilities and in some community-based teams). The staff in these positions often face considerable challenges in undertaking their roles, negotiating and supporting cultural dimensions of mental health care.

Inspections of community-based teams, and visits to in-patient facilities, have highlighted the challenges in staffing these positions (both recruitment and retention). Positively MH-CAR has been able to staff some positions. Some teams have not been able to successfully retain staff or put in place succession plans. Other community-based teams have had long-standing vacancies such as the AMHW position in the Forensic Mental Health Team.

The CVP supports the efforts of the NT public mental health services to increase the number of AMHWs. The CVP encourages further workforce development strategies targeted towards this goal.

The NT public mental health services requires a systemic focus and supportive approach to the recruitment and retention of Aboriginal staff. This needs to go beyond the individual efforts of team leaders and managers. Having a stable, well-supported Aboriginal workforce is critical to providing a culturally safe and competent public mental health service. The ongoing workforce issues need to be addressed systemically as a priority.

RIGHT TO LEAST RESTRICTIVE PRACTICES

CVP RECOMMENDATIONS:

The PIC, TEMHS, ensure that the mechanical restraint register contains:

- *A Form 21*
- *A Form 56 where appropriate*
- *The mechanical restraint observation sheet*

And a record of:

- *the form of mechanical restraint applied; and*
- *the reasons why mechanical restraint was applied; and*
- *the name of the person who approved the mechanical restraint being applied; and*
- *the name of the person who applied the mechanical restraint; and*
- *the period of time the mechanical restraint was applied.*

For every instance of mechanical restraint under s.61 MHRSA at the Approved Treatment Facility (ATF).
CV, 2021

That TEMHS implement strategies to ensure the cultural safety of clients, with a particular focus on the needs of Aboriginal clients in line with TEMHS values and objectives.
CV, 2013

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

The PIC, TEMHS, urgently implement procedures for recording seclusions occurring in the ATF, (outside the IPU), and ensure that all seclusions occurring under s.62 MHRSA are recorded in a seclusion register maintained and monitored by the Legislative and Reporting Compliance Officer.
CV, 2021

TEMHS ensure that interpreters are utilised pre and post seclusion and during; Client debriefing, The development of clinical management plans, and; seclusion reviews.
CV, 2021

TEMHS ensure that AMHWs are available outside of business hours and on weekends.
CV, 2021

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

The use of restrictive practices in mental health settings significantly impacts a person's human rights and exposes them to increased risk of further physical and psychological trauma or injury. Research estimates an incidence of post-traumatic stress disorder rate of 25 - 47% following the use of seclusion or restraint.[21]

Reducing, and where possible eliminating, restrictive practices in mental health services is a key national mental health safety and quality priority[22] and the mental health services in the NT have committed to working towards eliminating the use of restrictive practices.

The CVP has observed that the annual rate of seclusion in the NT continues to be is significantly lower (36%) than those recorded prior to 2017/18.[23] While the downward trend in longitudinal data is positive caution must be observed as the seclusion data for both the Top End and Central Australia increased this year.

'Maximising people's self-determination requires continued efforts to reduce coercion, seclusion and restraint'.

A National Framework for Recovery-Oriented Mental Health Services, Australian Health Ministers Advisory Council P.17.

[21] Chieze M, Hurst S, Kaiser S, Sentissi O. Effects of seclusion and restraint in adult psychiatry: a systematic review. Front Psychol. 2019;10:491. https://doi.org/10.3389/fpsyt.2019.00491.
[22] National mental health Commission X, Reducing restrictive Practices, Australian Government. Reducing Restrictive Practices - National Mental Health Commission
[23] 2017/2018 recorded 284 seclusions for the NT

In 2020/21 the CVP have highlighted serious concerns related to the continued disproportionate number of Aboriginal consumers experiencing seclusion during their admission. This over representation is not unique to the NT[24] and cannot be explained by inordinate admission numbers for Aboriginal people.[25] A similar disproportionate rate is observed in the use of mechanical restraint.

Based on past government policies, which have caused significant harm many Aboriginal people have genuine fear when engaging with government services. Mental health services and clinicians who work with Aboriginal people must be cognisant of Aboriginal history and the effects of transgenerational trauma on social and emotional wellbeing particularly when the use of restrictive practices is considered.

In the past 12 months, significant efforts have been made in the Top End to provide cultural competency training across the workforce to increase knowledge of historical and contemporary trauma. It is anticipated that this training will compliment continued policy development, in line with legislation and peoples' rights, and the implementation of a range of trauma informed strategies targeting the reduction of restrictive practices.

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.

In previous years, the CVP has reported serious concerns about the accuracy of record keeping of restrictive practices. This year the inspections demonstrated improvements in record keeping where records are kept but identified that not all instances of seclusion and mechanical restraint are recorded in the register.

[24] Queensland Health 2016, Mental Health Strategy 2016 – 2021, Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2021
[25] TEMHS S&Q data indicated

In April 2021, NT Health approved a policy underpinning the Department of Health's 'efforts to minimise, prevent and, where safe and possible, eliminate the use of seclusion and restraint in NT health settings'.[26] This policy contains a description of the minimum requirements to be included in the register. In response, TEMHS implemented a procedure[27] requiring that any use of mechanical restraint, regardless of who initiates the restraint,[28] must be recorded. This is a significant improvement.

SECLUSION

Seclusion[29] events have increased across the NT. In Central Australia this is the third consecutive year where an increase is recorded. The number of seclusion events has increased by 31% in Alice Springs and 12% in the Top End from the previous year.

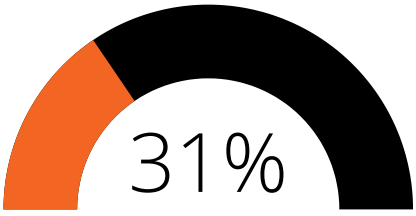


CHART 6 - INCREASE OF SECLUSION EVENTS ALICE SPRINGS

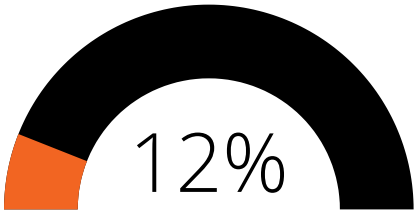


CHART 7 - INCREASE OF SECLUSION EVENTS TOP END

Across the NT 80 people were secluded in Approved Treatment Facilities (ATF). 53% of all seclusions were of people aged under 24 years. This year saw a significant rise of 300% in the number of children being secluded, with twelve children under 18 years secluded. All of these children were Aboriginal.

[26] Seclusion and Restraint NT Health Policy, Version 18.0
[27] Mechanical Restraint TEHS Procedure, Version 1.0, 01 July 2021.
[28] Typically in the Top End persons are mechanically restrained by one of three authorities; The Approved Treatment facility (Department of Health), Department of Corrections or NT Police.
[29] Mental Health and Related Services Act 1998 Section 62

84% *OF PEOPLE WHO WERE SECLUDED THIS YEAR ARE ABORIGINAL*

The CVP is concerned that 84% of people who were secluded this year are Aboriginal. This disparity has progressively increased over the past three years.[30] The CVP have continued to raise the disproportionate number of Aboriginal people secluded as unacceptable with both the Top End and Central Australian mental health services. To the CVP's knowledge, there has been no major inquiry by mental health services into the contributing factors for this over representation and gap in Aboriginal cultural security.

The NT Health Service has many documents underpinning service delivery to Aboriginal people including the Aboriginal Cultural Security Policy.[31] This document in particular identifies that the health system must be free from discriminatory practices and that 'cultural security is necessary to closing the gap in health outcomes for Aboriginal Territorians'.

On the surface, it is evident that there is a commitment to improving Aboriginal cultural security on paper but in regards to restrictive practices the data infers that something is missing between policy development and intent, and procedural implementation.

One of the most obvious gaps in Aboriginal cultural security when considering restrictive practices is language. The MHRSA upholds that a person has a right to receive information in a manner, form and language that they are used to communicating in, with the assistance of an interpreter and with consideration of their culture.

[30] 66% in 2017/18, 67% in 2018/19, 72% in 2019/20 and 84% in 2020/21.
[31] Northern Territory Health Aboriginal Cultural Security Policy 2021, Version 2.0, NT Health Aboriginal Health Policy Unit.

Despite this, the CVP inspection of the registers and subsequent clinical file reviews indicate that Aboriginal interpreters are rarely used for pre seclusion interventions or for post seclusion debriefing.

There is evidence to support AMHW involvement, both before and after seclusion events. Capacity for AMHWs to do this, however, this is limited to Monday to Friday during standard business hours. The CVP has recommended that the availability of AMHWs be increased.

RESTRICTIVE PRACTICES ON CHILDREN

THE USE OF RESTRICTIVE PRACTICES ON CHILDREN SHOULD BE AVOIDED WHEREVER POSSIBLE AND IS PROHIBITED FOR ANY REASON OTHER THAN THOSE AUTHORISED IN THE MHRSA.

Restrictive practices cannot be used as a behaviour management tool or for punishment and must only be considered where imminent risk exists, and all therapeutic interventions have been exhausted. The long-term harm and need for the elimination of restrictive practises is amplified for children and young people.

15% *OF SECLUSIONS IN THE NT INVOLVED CHILDREN AGED UNDER 18*

Unfortunately the reduction in the seclusion of children and young people under the age of 18 years noted in 2019/20 has not continued.[32] 15% of all seclusions that occurred in the NT in 2020/21 involved children and young people aged under 18. All of the children and young people were Aboriginal, with the youngest being 14 years of age.

[32] In 2018/19, 15% of all seclusions were on children aged under 18 years; this decreased to 4% in 2019/20 but the rate has again increased to 15% in 2020/21.

As noted in previous Annual Reports, the Royal Commission into the Protection and Detention of Children in the Northern Territory found that the isolation of a child or young person in detention causes 'suffering' and in some cases enduring 'psychological damage'.[33]

Children and young people have reported to the CVP that seclusion has caused them to remember previous trauma, and caused them to feel unsafe, scared, sad and angry. Significantly, children and young people have reported feeling as though they were being punished. The impact of seclusion on a child or young person is evident when speaking to them and they recall their fear.

The CVP encourages further efforts to eliminate the use of restrictive practices on children in the ATFs and notes that while seclusion of children with disabilities with NDIS plans is unlawful in the NT[34] it is permissible under mental health legislation. This inconsistency does not protect the rights of vulnerable children and young people.

MECHANICAL RESTRAINT

It is positive that both TEMHS and MH-CAR are recording the use of mechanical restraint. According to the registers there has been a decrease in use in the Top End and an increase in Central Australia. Overall mechanical restraint events have decreased significantly across the NT.

17 *PEOPLE WERE MECHANICALLY RESTRAINED*

71% *WERE ABORIGINAL PEOPLE*

[33] Royal Commission into the Protection and Detention of Children in the Northern Territory Report.
[34] Section 17(g), Prohibited Restrictive Practices, National Disability Insurance Scheme (Authorisations) Act 2019.

This year 17 people were mechanically restrained a total of 20 times, 71% were Aboriginal. One female was mechanically restrained twice and the remaining 18 mechanical restraints are attributed to men ranging in age from 19 to 49 years.

The rights and protections of the legislation apply to all people receiving care and treatment under the MHRSA. This includes a person who may be a prisoner at the time of admission to hospital for a mental illness or disturbance.[35]

The Approved Procedures stipulates a person must not apply mechanical restraint to a person unless they are being assessed or receiving treatment, under this MHRSA and that any such mechanical restraint must be applied in accordance with s.61 of the MHRSA.

The use of mechanical restraint on a person treated in hospital under the MHRSA (on a mental health ward or elsewhere) must be authorised by a psychiatrist and be recorded in the mechanical restraint register.

There has been a sharp decrease in the number of mechanical restraints recorded. The integrity of record-keeping and uncertainty about whether all restraints occurring in the approved treatment facilities are being recorded were raised by the CVP throughout the year.

The lack of clarity about roles, responsibilities and recording obligations under mental health and corrections legislation continued this year. This confusion was more evident in Central Australia where mental health services committed to recording mechanical restraints in January 2021 however when the register was requested for inspection in July 2021 MH-CAR management advised the CVP that there was no register as mechanical restraint does not occur in the ATF.

[35] 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.

Subsequently a register was provided which contained seventeen mechanical restraints, eleven of which occurred during 2020/21.

The CVP has a strong view that mechanical restraints are likely to be much higher than those recorded in the registers in both the Top End and Central Australia. This suspicion is based largely on that, until recently, there was no procedure in place that required documentation to be completed and sent to the Person in Charge (PIC) when agencies other than Health applied mechanical restraint to a person.

TEMHS now have a robust procedure in place which clearly articulates the management of mechanical restraint for persons under the MHRSA in different situations.

MH-CAR updated the restraint policy at the time this report was being written however unlike the TEMHS Procedure, there is no specific reference to the recording of mechanical restraints applied by agencies other than the Department of Health. Rather, the policy says, 'Documentation in the restraint register is mandatory following any restraint: planned or emergency, physical or mechanical'.

Based upon these improvements in procedure/policy documents and the fact that both mental health services provided a mechanical restraint register in mid-2021, the CVP acknowledge that moving forward both TEMHS and MH-CAR have implemented mechanical restraint registers. There is an expectation that they will be recording every instance of mechanical restraint applied to a person under the MHRSA regardless of who applies the restraint, and; the register will be consistent with the Seclusion and Restraint NT Health Policy and legislative requirements.

The significant work done by mental health services to improve the procedures related to mechanical restraint is commended.[36]

[36] Mechanical Restraint TEHS Procedure, Version 1.0, Approved 01/07/2021.

However despite TEMHS[37] and MH-CAR[38] assertion that, 'Mechanical restraint is not to be used in Northern Territory Mental Health Inpatient Facilities', the use of mechanical restraint in both Top End and Central Australia's inpatient wards continues.

The onus is on both mental health services to ensure that all staff are aware of relevant procedures as they are implemented. It is expected that next year the registers will have all instances of mechanical restraint recorded including those applied by Youth Justice, NT Correctional Services and NT Police.

The number of mechanical restraints applied by mental health services has increased with 43% of mechanical restraints applied to persons not in custody at the time of the restraint.

Further, the registers in the Top End and Central Australia did not contain the minimum information required by the MHRSA which has been raised by the CVP. This will be a matter monitored more closely next year.

[37] Restraint TEMHS Procedures, Version 4.0, Approved 23/04/2021
[38] Restraint MH-CAR Policy, Version 14.0, Approved 02/09/2021

RIGHT TO QUALITY OF SERVICE PROVISION

CVP RECOMMENDATIONS:

That the 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.
CV, August 2020

TEMHS 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.
CV, January 2019

TEMHS to 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.
CVP Panel, March 2019

That MH-CAR 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 National Disability Insurance Agency (NDIA), Territory Families, Office of Disability.
CV, June 2019

In general, staff in the public mental health system support consumers in a positive and compassionate manner. The CVP has received consumer feedback that has described facilities as therapeutic and thanking staff for their work. When clinicians have opportunity to engage consumers effectively in therapeutic communication, comprehensive clinical assessment, psycho education and collaboration with consumers in care planning, there is a high degree of consumer satisfaction.

However evidence suggests, that when facilities are at or over capacity and come under bed pressure clinicians become stretched and consumers

experience issues related to the quality of service provision. Over the past year the most commonly raised issues have been enquiries and complaints related to discharge planning, relationship with staff, least restrictive care and procedures not being followed.

> *'The CVP have an important role not only in safeguarding consumer's rights but also by supporting inpatient unit work with different skills and perspectives that are valuable. The CV has a job and makes an important contribution'.* ***Consultant***

LEAST RESTRICTIVE CARE

The issue of least restrictive care has been the largest category of enquiry and complaint raised with the CVP. The MHRSA affords consumers the right to receive the least restrictive treatment and care possible. Issues such as consumer's status voluntary/involuntary, ability to take leave and access to possessions, have all been common issues raised with the CVP.

There is concern that these enquiries are the result of staff not explaining consumer's rights on admission and services own policies related to restrictions. The low use of interpreters at services is also a contributing factor to consumers not understanding rights.

Another least restrictive care issue raised with the CVP is consumer's placement at JRU in the Top End. In JRU, consumers reported not having access to possessions, a lack of access to the activities centre and programs to keep them active. Significantly, consumers also reported JRU having a 'punitive feel' and that they feared for their safety after being exposed to intimidation, bullying, verbal abuse and physical assaults.[39]

[39] CVP Trimester Report Top End 07.04.2021

Consumers told the CVP that when they raised these issues staff had minimised their concerns saying they should 'ignore' or 'stay away' from people who are 'unwell'. The CVP does not believe these are effective strategies to maintain safety in such an environment. It is vital that clinicians provide adequate support and supervision to ensure safety at JRU.

DISCHARGE PLANNING

For people detained against their will discharge planning is an important issue. It is a fundamental principle of the MHRSA that consumers are involved in discharge planning. Consumers want to know discharge planning is occurring and they want to be part of the process. Most consumers want to know that family and other significant people are also being consulted and involved in the discharge process. The CVP has found that often discharge planning is being progressed without the consumer's knowledge or involvement.[40]

The majority of consumers who raised discharge planning as an issue have been Aboriginal people from remote communities. They identify a lack of confidence in discharge planning may reflect the low levels of interpreter support during their admissions.[41]

> *'Please accept my heartfelt thanks for the tremendous work you do for your clients. You really are appreciated for how you make things work in difficult and challenging situations and I really have appreciated getting the best outcome for clients when working with you'.*
> ***TEMHS Adult Team Leader***

[40] Top End Trimester Report 07.04.2021
[41] TEMHS MHU interpreter register

RELATIONSHIPS WITH STAFF

The CVP has observed and received reports of therapeutic relationships and respectful communication between staff and consumers. It is widely accepted that 'being respected by staff' is the most significant factor in consumer satisfaction with the care and treatment they have received.[42, 43] Respect and the therapeutic relationship are built on trust, effective communication, good listening skills and transparency in decision-making.

Despite the majority of staff, consumer interactions being positive relationships with staff has been the third highest category of issues in matters raised with the CVP. Consumers report these negative experiences have impacted their ongoing engagement with the service, including the confidence they have in seeking help in the future.

Consumer said *'being a patient at a mental health facility is a huge block on believability'. C/2021/00069*

COMPLAINT PROCESSES

The CVP has received feedback from consumers that complaint processes used in both the Top End and Central Australia are not being followed, are slow, lack transparency and are not procedurally fair.

The CVP notes that while some complaints may be difficult to substantiate, complaints do speak to the experience of consumers with the service. The investigation of these issues can be important to identify and address issues, rebuild relationships and be a learning experience for both the service and the individual. In order to garner these benefits from an effective complaints process it is important that processes are followed.

[42] MacInnes D. etal., 2014, A Cross Sectional Survey Examining the Association Between Therapeutic Relationships and Service User Satisfaction in Forensic Mental Health Settings, BMC Res Notes 7. 657. https://doi.org/10.1756-0500-7-657

[43] [1] Hartley S., etal., 2019, Effective Nurse-Patient Relationship in Mental Health Care: A Systemic Review of Interventions to Improve the Therapeutic Alliance, International Journal of Nursing Studies, Vol. 102, February2020, https://doi.org/10.1016/j.ijnurstu.2019.103490

Consumers reported feeling ignored, intimidated, frustrated and disrespected[44] by the process used to investigate complaints and a lack of communication from the service. A complaint process should be seen as an opportunity to constructively resolve issues in a way which avoids consumers walking away with negative feelings about the way they have been treated. The complaints process is a reflective time when the service can be seen to affirm their values and reaffirm standards of care.

CONSUMERS WITH COMPLEX COGNITIVE IMPAIRMENT

Over the year, the CVP has observed a high number of consumers with cognitive impairments being admitted involuntarily. This issue has been of particular significance in Central Australia. The CVP understands that a wide range of precipitating factors contribute to this issue and that these issues cannot be addressed by organisations working in silos. The CVP believes, however that these complex issues can be progressed and improved through formal agreements and processes that guide interagency coordination and support.[45]

Many of these consumers do not have supports in the community commensurate to their needs. A lack of preventive support means these consumers are sometimes readmitted several times a year. This issue could be significantly progressed by the provision of further coordination and cooperation of services with the NDIS.

'Many people using public mental health services live with other forms of disability. This includes people with intellectual disability, neuro-diverse people and people with sensory impairments... public services for mental health and disability support must be well coordinated to ensure good communication and easy transition between services.'
National Mental Health Commission, Mental Health Safety and Quality Engagement Guide P.19.

[44] Central Australia Trimester Report April 2021.
[45] Central Australia Trimester Report June 2021.

RIGHT TO COMMUNITY TREATMENT

FORENSIC MENTAL HEALTH SERVICES

CVP RECOMMENDATIONS:

That significant efforts are made to recruit to the AMHW position within the MH-CAR Forensic Mental Health Team, including any development required to upskill a suitable applicant.
CV, 2014

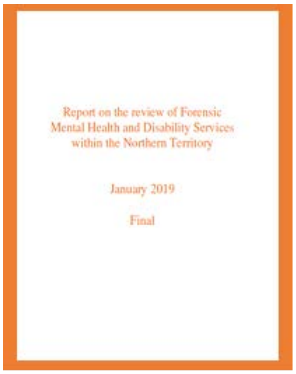
That the Central Australia and Top End mental health services urgently resolve resourcing issues affecting inequitable medical support for forensic mental health clients of Central Australia. (Reworded March 2019).
CV, 2016

That MH-CAR and TEMHS urgently provide integrated mental health services to youth detainees in the NT, supported by child and adolescent psychiatrists or forensic psychiatrists with adolescent experience.
CV, 2016

That 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 to their needs on transition. (Reworded August 2021)
CV, 2019

That TEMHS 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.
CV, 2019

Over the years, the CVP has continued to raise the need for significant reform of the NT's forensic mental health services. Unfortunately, services to forensic clients appear to have declined in the five years since the previous joint TEMHS/MH-CAR inspection report with no significant progress on the open CVP recommendations.


Report on the review of Forensic Mental Health and Disability Services within the Northern Territory

January 2019

Final

The CVP consider that there remains gaps in services for forensic clients in the NT, in particular for children and young people in youth justice settings. The NT public mental health system retains responsibility for crisis assessment and inpatient treatment. The CVP is concerned that services for this group are fragmented and inconsistent with regional inequalities.

The ongoing unacceptable gap in services for children and young people in youth justice to the detriment of vulnerable children and young people detained in government facilities needs to be addressed. 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 must be urgently prioritised in particular in Central Australia, where there currently are no community health providers in this area.

Frequently children and young people in youth detention have experienced a long history of complex trauma prior to entry into the youth justice system. These children and young people require specialist mental health services equipped to provide high quality evidence based care.

The lack of progress in co-operative and efficient clinical governance of the forensic mental health services in the NT remains an ongoing area of serious concern for the CVP. As does the lack of a fulltime, Forensic Consultant Psychiatrist allocated for Central Australia.

The CVP were advised that the ‘visiting’ arrangement of a psychiatrist from Darwin visiting Alice Springs two days a month, with two hours telehealth support each week, continues in Central Australia.

Registrars also provide five hours telehealth support each week. This arrangement, however, appears grossly inadequate for the safe provision of highly specialised mental health services to people within the forensic system in Alice Springs.

'Recovery-oriented practice and service delivery acknowledges that many people in criminal justice, youth justice and forensic settings have experienced considerable social disadvantage and childhood adversity and trauma. Many have been in some form of care for significant periods. Their health is often poorer than other people with mental health issues. They may suffer from intellectual disability, acquired brain injury, alcohol and drug use and physical disabilities. Their involvement in the criminal justice system may compound an already poor sense of self-worth and efficacy. Responses need to be multidisciplinary, multiagency, cross-sectoral, and collaborative. Services need to reach out to the community and provide opportunities for community services to reach in.'

A National Framework for Recovery-Oriented Mental Health Services, Australian Health Ministers Advisory Council P.42.

Despite the NT Government's commitment to implement the recommendations of the independent Review of Forensic Mental Health and Disability Report[46] there has been limited progress on some of the most critical aspects contained within the report. The CVP has been told that a range of reforms have been undertaken and that as projects develop they will be implemented. No detail of these reforms were provided at the MH-CAR inspection or when requested for the Annual Report.

The Department of Health have highlighted that many of the recommendations from the review require considerable investment in both human and capital resources.[47]

[46] David McGrath Consulting (January 2019), Review of Forensic Mental Health and Disability Services
[47] NT Health Position on Review of Forensic Mental Health and Disability Services in the Northern Territory 2019.

The CVP acknowledges that the serious level of under resourcing impact significantly on the improvement of the Forensic Mental Health Services in the NT. The CVP continues to look forward to progress on the implementation of the CVP recommendations as well as the recommendations of various other reviews.

ACUTE CARE FOR PRISONERS

Last year the CVP highlighted a lack of clarity surrounding the use of restrictive practices on prisoners, and the roles and responsibilities of relevant agencies to ensure that all prisoners receive an equitable, recovery-oriented and therapeutic service.

The CVP respects that risk assessments and therapeutic needs are fluid, and at times there are challenging and dynamic situations for mental health service and NT Correctional Services to manage.

However a prisoner admitted for mental health assessment and treatment should always receive treatment that is consistent with MHRSA, standards and practice. As noted in the restrictive practices commentary significant progress has been made with the commitment to record their use on prisoners.

For the past two years, TEMHS have been collaborating with NT Correctional Services on a revised policy document outlining the roles and responsibilities of both organisations consistent with the relevant legislation.

The CVP anticipate that the policy will address broader issues related to therapeutic care and treatment of people who are also prisoners. It is not clear to the CVP why a document as important as this, is experiencing such lengthy delays. The Central Australian CVP Panel have also strongly urged that a resolution of the issue be sought by way of a Memorandum of Understanding or a legislative amendment.[48]

[48] Final CVP s.112 MHU Panel Report 150721

In Darwin, prisoners are restricted from access to the fenced outdoor area despite each prisoner being under the supervision of two Corrections Officers at all times. The restriction to the outdoors and the use of mechanical restraints is higher at the mental health units than it is in the prison. Prisoners have the right to be treated with humanity, dignity and respect while in detention, whether it be at a correctional facility or in a health facility.[49] The Top End Panel maintain that prisoners should have the same access as other people to the open courtyard and will continue to monitor the rights of forensic clients.[50]

[49] Article 10 - 1. All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.
[50] CVP s.112 TEMHS Panel Report 12022021.

RRIGHT TO BETTER SUPPORT FOR CHILDREN AND YOUNG PEOPLE

CVP RECOMMENDATIONS:

That MH-CAR Child and Youth, together with the Remote team, considers how they can respond to the gap in mental health services for young clients living in remote areas. The CVP recommends the model the service currently delivered in the Barkly as an effective framework for remote mental health service delivery. (Reworded July 2021)
CV, 2017

That TEMHS 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.
CV, 2018

That MH-CAR consider how young clients detained at the Youth Detention Centre can be better supported by the service.
CV, 2019

That TEMHS 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.
CV, 2018

That TEMHS 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.
CV, 2019

'Early intervention is key to preventing mental illness later in life. Investing in early intervention and prevention strategies will reduce the likelihood of consumers needing costly supports... including the child protection and justice systems.'

National Mental Health Commission National Report

This year the CVP inspected Child and Adolescent Mental Health Services in Central Australia. The CVP found that there have been positive developments since the previous inspection. The developments include the incorporation of the Barkly Child & Youth services located in Tennant Creek within the Child and Adolescent Mental Health Services in Central Australia. The introduction of the Corrective and Preventative Action (CAPA) case management system and the elimination of waitlist. A recommendation was closed in recognition of established formal mechanisms to improve coordination and case management for youth with complex needs who are accessing mental health services.

However gaps and issues for mental health services for children and young people are well known and ongoing.

This is particularly true for children and young people in remote locations and those in youth detention. Children and young people living in rural and remote areas of the NT 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 Child and Adolescent Mental Health Services in Central Australia located in the Barkly Mental Health Service, based in Tennant Creek.

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. There is a justified community expectation that mental health services deliver high quality care to vulnerable children experiencing mental health issues.

The CVP continues to advocate strongly for the rights of all Territory children and young people, who require access to high quality specialist mental health services, regardless of their geographic location or whether they are in youth detention.

COMMUNITY TREATMENT

CVP RECOMMENDATIONS:

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

That TEMHS in conjunction with 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.
CV, May 2018

That TTEMHS conducts a review of its current Electronic Medical Record (EMR) systems for Remote Health Services and Mental Health Services and consider how to implement an EMR system that can be used for all TEMHS.
CV, May 2018

That the Palmerston Community Mental Health Team improve access to an Aboriginal Mental Health Workers and use of interpreters.
Community Visitor, 2021

That the Palmerston Community Mental Health Team ensure that Individual Care Plans and Risk Assessments are updated and completed in line with current requirements.
CV, 2021

Community mental health care is care that is provided by mental health services to people in their home, community or at an outpatient mental health facility. It is the least restrictive[51] environment for delivery of care and there is evidence to suggest that people experience improved overall symptoms, less inpatient admissions and reduced impact on their family when receiving quality care in their home.[52, 53]

The role of community mental health services is to promote recovery by empowering people to maintain control of their life, engage meaningfully with their community and improve their quality of life and assist them to stay well and achieve their goals with their support networks. That is the basis for quality care and it is evident to the CVP that, despite resourcing and workforce issues, the majority of community mental health workers/case managers in the NT are committed to providing a recovery model of care.

This year the CVP inspected the Palmerston Adult Community Mental Health Team (PMHT) in the Top End. This team provides services to the Palmerston and surrounding area.

Palmerston Regional Hospital is the closest public hospital to the site of the PMHT however there is no mental health ward at this hospital and it is not a gazetted ATF. People living in Palmerston and the rural areas serviced by the PMHT requiring acute inpatient care and treatment must be admitted to Royal Darwin Hospital situated in Tiwi.

[51] Some people receiving care and treatment in the community may be subject to a community management order which obligates them to participate in treatment and therefor carries a level of restriction.
[52] Technical_commentary_home-based-care-1.pdf (neura.edu.au)
[53] Klug, G., Gallunder, M., Hermann, G. et al. Effectiveness of multidisciplinary psychiatric home treatment for elderly patients with mental illness: a systematic review of empirical studies. BMC Psychiatry 19, 382 (2019). https://doi.org/10.1186/s12888-019-2369-z

The inspection identified a gap in services for those people living outside the Palmerston rural area within the Litchfield region. This region encompasses smaller residential areas such as Marrakai, Dundee Beach and Acacia. People in these locations, and other similar outer rural locations, are not seen by the PMHT and are not able to receive care from the Remote Mental Health Team. These areas do not have a local clinic available and are required to travel significant distances to access specialist mental health care and treatment if required.

Based on the high predicted population growth of both Palmerston and Litchfield the CVP raise the need for NT mental health services to do forward planning for resourcing the provision of mental health services for people living within this region. Like other mental health teams PMHT servicing is already limited by resource availability.

OTHER RECOMMENDATIONS

CVP RECOMMENDATIONS:

That 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.
CVP Panel, November 2019

That the Central Australia Mental Health Service address the need for more longer-term supported accommodation and care for consumers requiring sub-acute mental health services.
CV, July 2018

CLOSED RECOMMENDATIONS

CVP RECOMMENDATIONS

That the teacher vacancy in the Youth Inpatient Program be addressed to help ensure access for youth to support to maintain their education. TEMHS ATF
Closed July 2020, Panel

TEMHS develop and provide a CCTV policy, procedures and guidelines that comply with Commonwealth and NT Laws in relation to the surveillance and recording of consumers including the storage and use of recordings and access and destruction of historical footage with consideration given to the legal rights of patients.
Closed August 2020, CV

The TEMHS review and improve processes related to the service's applications to the Mental Health Review Tribunal, in particular to ensure client access to information consistent with the expectation of natural justice and in line with s132 MHRSA.
Closed December 2020, CV

That TEMHS raise the need for significant new infrastructure in JRU to address the requirements for all clients but particularly women with high care needs to have a safe and therapeutic hospital environment.
Closed December 2020, CV

That 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.
Closed December 2020, CV

That 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.
Closed December 2020, CV

TEMHS will review the use of interpreters within the Inpatient Mental Health Unit to determine why interpreters are not routinely being used during assessment, review and tribunal for all consumers where English is not their first language.
Closed December 2020, CV

It is recommended that a comprehensive accommodation and support model is developed, adequately resourced and provided in the Top End of the Northern Territory (in addition to the accommodation currently provided through the Manse).
It is further recommended that the model takes into account the varied and diverse circumstances of consumers in the NT, and is developed collaboratively with consumer groups and mental health professionals. (Reworded, 2018)
Closed July 2020, Panel

TEMHS, who are responsible for a therapeutic environment, should negotiate access to fresh air for forensic consumers while they are under guard supervision.
Closed February 2021, Panel

That 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.
Closed March 2021, CV

That TEMHS Seclusion policy wording urgently be updated to accurately reflect the definition of 'seclusion' as stated in the MHRSA; 'Seclusion of a patient means the confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented'.
Closed March 2021, CV

That TEMHS 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'. (Reworded August 2020)
Closed March 2021, CV

That the TEMHS PIC 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.

Closed March 2021, CV

MH-CAR That a new policy be developed in accordance with professionally accepted standards and the least restrictive principles as required by the MHRSA to ensure that adopted practices comply with the fundamental principles of the Act when a prisoner becomes a mental health patient.

Closed July 2021, Panel

That MH-CAR 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.

Closed July 2021, CV

That MH-CAR provide information as to any specific procedures that may exist in relation to the management of minors admitted to the mental health unit. Specifically and procedures to ensure the rights of young consumers are upheld; that their particular needs and vulnerabilities are responded to; and to assist staff in meeting the challenges that may arise in the rare event that there is a minor admitted to the ward.

Closed August 2021, CV

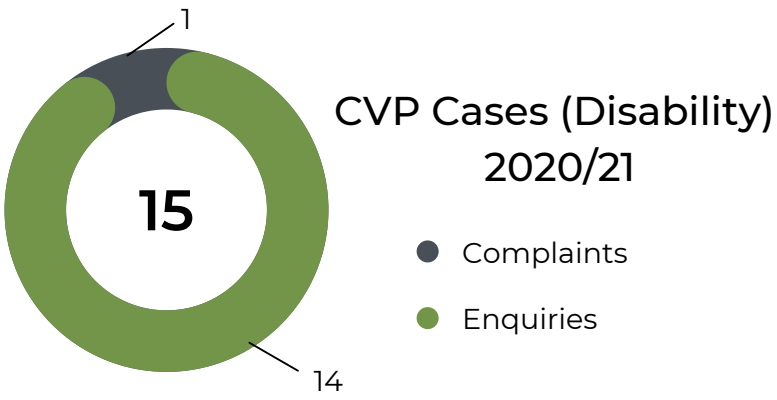
That MH-CAR review processes to improve effectiveness of the internal complaints process. (Reworded)

Closed August 2021, CV

DISABILITY

DISABILITY THE FOCUS

- Contrary to requirement of the *DSA* restrictive practice review rights are not in place.
- Positive developments in Aboriginal cultural safety for residents in Central Australia, however this is not reflected in the Top End.
- Publication of policy and guiding documents that support the provision of quality care.

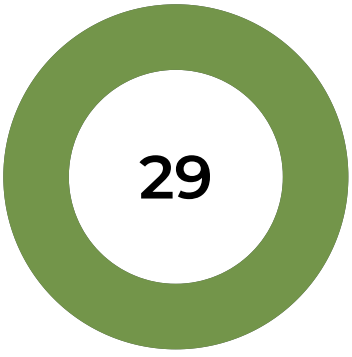


The CVP provides an oversight role for people on Supreme Court supervision orders under the DSA. People are supported by the SSFDU in both community and institutional settings. All residents have complex cognitive impairments, high needs and have come into contact with the justice system. The majority of residents supported by the SSFDU reside in houses in the community, or in facilities adjacent to the Darwin and Alice Springs Correctional Centres. SSFDU facilities include Secure Care Facility (SCF) in Alice Springs, four appropriate places in Alice Springs and two appropriate places in Darwin.

The CVP provides oversight through conducting in person visits to residential facilities. Visits are conducted by both CVs and expert panel. The CVs and CVP Panel members engage directly with residents and ask if there are any concerns or complaints to raise. When matters are raised the CV provides assistance to resolve concerns. The facility and documents relating to the resident's treatment and care are also inspected. As an external, independent visitor, the CVP also monitors overall standards of care and treatment in line with the legislated principles of treatment and care.[54] This includes the use of restrictive practices and progress towards community transitions.

Addressing resident's complaints and enquiries is an important part of the CVP role. People, such as Forensic Disability Unit (FDU) residents, with a disability can feel vulnerable to abuse, neglect and exploitation. They are often reluctant to raise issues about their care due to a factors including:

- Lack of knowledge or understanding of their rights
- Worry that complaining will make things worse
- Shame and negative complaints experience
- Service cultures that do not value feedback and complaints, and a fear of being targeted or perceived as a trouble maker.



CVP Visits (Disability)
2020/21

Currently, the CVP oversights nine residents and conducts the majority of disability visits in Central Australia. As required by the DSA, the SCF is visited on a monthly basis.

[54] *Disability Services Act 1993*, s.2A.

CHALLENGES OF PROVIDING TREATMENT AND CARE

A Supreme Court Order requiring a person to live at a disability facility operated by the NT Government is a serious restriction on a person's freedoms. The purpose of a care and treatment plan accompanying an order is to help the person learn new skills, manage their behaviour, avoid offending and be reintegrated back into the community. It also assists the clinical team establish the best environment for individuals to reduce behaviours of concern and build the person's capacities for their transition to mainstream disability supports.

The process of learning new skills for an individual with complex needs requires an in-depth understanding of the person, their history, forensic risk, environmental needs and disability. It requires a comprehensive and evidence-based approach to their care and treatment. Care and treatment needs to be provided consistent with the contemporary 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 is responding to planned changes in their environment.

The CVP also acknowledges that these environments can be dynamic and unpredictable. That risks and behaviours of concern will arise and need to be managed appropriately. Where the service is taking a person-centred clinically informed approach to service delivery, incidents are an opportunity to learn and improve. Effective critical incident review processes, therefore, are an important component of delivering high quality supports.

Despite the inherent challenges in providing care and treatment at the

disability facilities managed by the SSFDU, the CVP has observed that the vast majority of staff at the service are caring, compassionate and concerned for the wellbeing of residents in their care. Even in the face of sometimes aggressive behaviours directed towards them, most staff across the service have responded professionally and sought to protect the dignity of the residents.

There has been evidence over the reporting period that the SSFDU has experienced significant turnover of staff. Staff turnover can negatively impact various aspects of service delivery, including resident supervision, staff/resident relationship and rapport, and professional skills and experience. The response of the service to these workforce challenges has been positive.

Currently the CVP has been advised that all SSFDU staff have completed induction and required trainings. In Central Australia the CVP is advised that there are currently Disability Support Worker vacancies at the SCF. Given the availability of agency staff who are already familiar with SCF residents and work practices, three of the vacancies will be filled quickly. The CVP acknowledge that staffing can quickly change and consider that developing long term workforce strategies to attract, retain and respond to changes in the known gaps in both disability and NT Health workforce sectors needs ongoing attention and planning.

ACHIEVEMENTS

The SSFDU continues to offer a specialised service for people with complex, forensic disability needs in the NT. It is a necessary and valued service, which aims to safeguard the rights of the individual and the broader community by providing specialist case management and the least restrictive treatment and care to people with significant complex cognitive impairments, who come into contact with the criminal justice system.

Even with the introduction of NDIS, this type of service is necessary in the NT due to the skills and specialist focus required. The CVP consider the ongoing investment to maintain the specialist service, is important.

The CVP commends staff and management on the significant improvements and achievements in the quality of care and treatment of residents observed this year. Positively, for the second consecutive year the CVP has not received a complaint from the Top End. It is important to note, as described earlier, that residents are vulnerable people and lack of complaint should not be the only measure of continuously improving service.

In the majority of instances, senior staff have been accessible and responsive to CVP requests and enquiries. The CVP has observed that senior staff at the service have demonstrated a continued commitment to quality improvement in the action taken to address longstanding concerns raised by the CVP.

Other achievements have included:

- Improved cultural safety practices.
- Re-established communication between senior SSFDU staff and guardians regarding matters of treatment and care arising from a specific complaint matter.
- The development of important policy frameworks that support quality care.
- Significant progress transitioning residents to less restrictive settings.
- Evidence that the SSFDU is focusing on a process of continual. improvement which includes engaging with expertise in the disability sector to improve care and support the health of residents
- SSFDU residents engaging in meaningful programs.
- Six open recommendations closed in this reporting period.

ENGAGING WITH LEADERS IN THE SECTOR

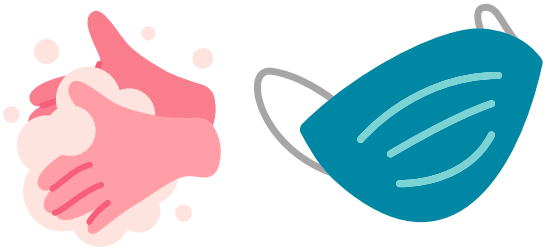
Over this past year there has been significant evidence that SSFDU management are engaging multi-disciplinary expertise in health, disability sector and implementing evidenced based programs to help improve outcomes for residents. The service has sought medical input from expert professionals to inform planning and policy at both a system and individual case level.

The service has consulted and engaged senior Ngangkari (traditional healers), well known Neurologists, senior Psychiatrists, Pharmacists, other Medical Practitioners, the NT Senior Practitioner and a wide variety of NDIS funded services such as Speech and Occupational therapists. The involvement of these professionals provides confidence not only that quality programs are being provided to residents but also that SSFDU facilities are welcoming to scrutiny and residents are not being closeted away from community.

COVID-19 RESPONSE

The SSFDU response to the COVID-19 pandemic in the facilities they directly operate has been appropriate and effective. The SSFDU has worked to ensure the recommended precautions have been embedded in the day to day running of facilities, including appropriate hygiene measures and social distancing.

Planning for COVID-19 has occurred at an overarching, service-wide level and specifically for individual residents. This has been underpinned by the principles of least restrictive practice and that any restrictions imposed are necessary, reasonable, proportionate, accountable and time limited.



LEAST RESTRICTIVE CARE AND TREATMENT

TRANSITIONS (MOVING TO A LESS RESTRICTIVE ENVIRONMENT)

The planning and facilitation of a resident's transition to less restrictive environments is a complex and often lengthy process. The transition of a resident is not without challenge and the CVP acknowledges the process will not always occur as planned and often not without setbacks.

Positively there has been evidence this year that the SSFDU is beginning the transition process for residents as soon as they come into the service. These plans are staged and detailed to include important information relating to culture, family, communication, skill development, community access and support required outside the agency. The CVP has observed in this reporting period that the SSFDU has achieved significant progress on the transition of most residents.

In order to plan, progress and facilitate these transitions the SSFDU has needed to provide purposeful care, support residents in their acquisition of skills, and negotiate NDIS package supports commensurate to the needs of residents.

CASE STUDY

In 2021, the CV visited a resident of an appropriate place supported by an NDIS provider and received an enquiry about safety and the relationship between cotenants. The CVP investigated the matter, and found that the resident was reluctant to spend time at his residence due to safety concerns. The NDIS provider was receptive to these concerns and undertook actions to move the cotenant. The CVP considers this to be a positive example of cooperative advocacy that has helped ensure the safety of residents.

The SSFDU is commended on the considerable progress made towards the transitions of several residents. Significantly this year SSFDU was able to transition one resident back to country where he now resides with a community based NDIS provider. In the case of a SCF resident the SSFDU management has re-established communication to re-engage family and Guardians. This has resulted in positive progress towards community access and transition planning for the resident.

The CVP acknowledges the significant work that has been undertaken to support residents to move towards mainstream supports by the SSFDU and other stakeholders.

FOCUS ON CONTINUOUS IMPROVEMENT

As an oversight body, it is the role of the CVP to identify both achievements and areas for improvement. 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 an independent restrictive practice review mechanism, crisis response and interpreter use.

THE RIGHT TO CULTURAL SAFETY

CVP RECOMMENDATIONS:

That the SCF provide evidence of a systemic approach to ensure that cultural safety is given primacy when providing services to Aboriginal & Torres Strait Islander residents.
July 2020, Panel

That SCF ensure that accredited interpreters are used in line with systemic approach to cultural safety for Aboriginal and Torres Strait Islander residents.
October 2014, Panel

IMPROVEMENTS IN ABORIGINAL CULTURAL SAFETY

Aboriginal cultural safety is the learning and application of knowledge of cultural values, principles and norms for people who receive services. A culturally safe environment allows Aboriginal people to feel safe and draw strength from their identity, culture and community.[55] Aboriginal cultural safety is critically important to the work undertaken by the SSFDU. All SSFDU residents are Aboriginal and the SCF has never had a resident who is not an Aboriginal person. In this reporting period the CVP has observed the SSFDU has made significant steps towards improving the service's cultural safety in Alice Springs.

[55] Australian Human Rights Commission Social Justice Report 2011.

The employment of the Aboriginal Liaison Officer (ALO) at the SCF has had wide ranging benefits to the resident's care and quality of life. The CVP has witnessed the ALO's positive contribution in relation to cultural safety for SSFDU residents including leading resident's community access, staff acquisition of language, providing cultural knowledge and advice and an overall significant improvement in resident's wellbeing. The ALO has played a significant role in engaging families, providing a cultural perspective at staff debriefs and assisting interpreters.

Significantly the recruitment of the ALO position has also helped the SSFDU connect residents with Ngangkari (traditional healers). The CVP notes that cultural safety issues in the Top End would be significantly progressed with recruitment of Aboriginal staff.

The CVP has positively observed SSFDU actively promoting resident family contact and engagement. In the Top End family have regularly visit the Cottages and appropriate places.

CASE STUDY

In 2021, the CVP received an enquiry from a resident saying they missed their interstate family and asking if the CV could advocate their behalf. The CV spoke to the case manager and explored various ways contact could be facilitated. This conversation resulted in the resident seeing family when they visited and also by video call.

Similarly in Central Australia SSFDU is actively facilitating family engagement for residents and in some cases residents have formally structured family contact which occurs as part of their normal routine. Residents' value time with family and have spoken to CVs of their excitement about upcoming family contact.

NORTHERN TERRITORY HEALTH ABORIGINAL CULTURAL SECURITY FRAMEWORK 2016-2026

Providing culturally secure services requires recognition and respect for the cultural rights, views and values of Aboriginal people and communities, and that services reflect the communities they serve.

https://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/730/8/Northern%20Territory%20Health%20Aboriginal%20Cultural%20Security%20Framework%202016-2026.pdf

INTERPRETER USE

Meaningful two way communication is integral to both quality care and the development of relationships that facilitate growth and learning. The CVP maintains that for people for whom English is an additional language the use of qualified, independent interpreters is vital to the process of listening deeply and talking effectively.

Over this past year the SSFDU use of qualified, independent interpreters while initially quite good subsequently fell well below an acceptable level. On one visit, review of the interpreter register showed the ALO was use for 20 out of 21 interpreter engagements.[56] While the recruitment of an ALO that speaks the resident's language is a positive development, the CVP maintains that they do not replace the use of qualified and independent interpreters. If residents have a complaint about the SSFDU they may not feel able to use an in-house SSFDU ALO to voice concerns.

[56] CVP Visit Report June 2021.

Positively, at the time of writing recurrent weekly Aboriginal Interpreter Service bookings have recommenced. A SSFDU staff member goes through a standard list of welfare questions with interpreter support. Unfortunately due to capacity issues these appointments have typically been facilitated by phone. Currently the phone being used for interpreter bookings is old and its speaker sound quality is not good enough to ensure engagement and clear communication. In the absence of in person independent, qualified interpreters the CVP has suggested that the SCF video conference facilities are used.

THE RIGHT TO QUALITY SERVICES

CVP RECOMMENDATIONS:

That 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, Panel

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

That the Office of Disability ensure prompt review by a GP or Psychiatrist when a deterioration in behaviour occurs as documented by frequent PRN usage.
November 2017, Panel

DEVELOPMENT OF IMPORTANT POLICY FRAMEWORKS THAT SUPPORT QUALITY CARE

The SSFDU has demonstrated a focus on continuing quality improvement this year as evidenced by the development of policy documents that support the provision of quality care. New guiding documents the CVP has seen actioned this year include:

- Complaint Process[57]
- Clinical Governance Framework[58]
- SSFDU Practice Guide[59]
- Interpreter Booking Policy[60]
- Use of Interpreters within the SSFDU Policy[61]
- Medication safety systems.

Positively the CVP has observed evidence of staff being trained in the use of these systems and them being used to improve practice.[62]

QUALITY OF MEANINGFUL PROGRAMS FOR RESIDENTS

On visits the CVP has spoken to residents who have reported enjoying a busy and meaningful program. CVP has seen photographs and heard stories about residents supported by SSFDU engaging in fulfilling lives with activities and community access that include:

- Family visits (both at facilities and in community)
- Volunteer work
- Art – including sale of artwork
- Football
- Museum visits

[57] CVP Panel Report March 2021 p.4.
[58] CVP Panel Report March 2021 p.6.
[59] CVP Trimester Report July – Oct 2020 p.1.
[60] CVP Panel Report March p.3.
[61] CVP Panel Report March p.3.
[62] CVP Panel Reports December 2020 p.5 & March 2021 pp.5-6.

- Camping and other bush trips
- Swimming
- Social engagements
- Various NGO programs.

On one Top End visit, a resident told the CV how much he enjoyed going to the local kennel to feed the dogs and cats. He said this was 'Animal Therapy'.

The SSFDU supports several talented artists and CVs have heard stories of residents selling paintings. The pride taken in being able to engage in this work is obvious. This year a guardian organised an art exhibition in Melbourne to show case the resident work. Unfortunately, a lockdown occurred that prevented the exhibition from taking place. The efforts of both the SSFDU staff and guardians should be commended in the work they do to engage residents in meaningful activities.

In addition to the various community and social engagements SSFDU clinical staff develop and deliver therapeutic programs such as the Stepping Stones program which was developed in New Zealand specifically to support adults with an intellectual disabilities.

Programs are a crucial element of quality of services. The CVP is pleased that incremental steps have been taken to extend and improve these options with residents, guardians and the SSFDU.

CRISIS RESPONSE

Over the year there have been several periods where the frequency of critical incidents has been significantly high. Early in the current reporting period there were incidents that raised concerns about SSFDU's crisis response capacity including the involvement of police in a serious incident. [63]

[63] C/2020/00206.

The Panel Trimester Report in October 2020[64] raised concerns about resident supervision.

The CVP has consistently raised concerns about the documentation of crisis events and staff knowledge about reporting obligations.[65] Poorly written incident reports with insufficient detail means, often, the sequence of events and how staff have responded is not clear. The CVP has raised concerns about the consistency of how restricted practices are used and how their use relates to Positive Behaviour Support Plans (PBSP) in an objective way.[66]

Specifically the CVP does not see critical incident severity rating (ISR) scales aligning with behaviour scales in PBSPs.[67] A clear, consistent and objective approach to the use of restricted practice and the recording of incidents ensures data collection is accurate and meaningful. The CVP notes that quality improvements, safety and the protection of rights is driven by comprehensive data and reporting.

The CVP has also raised the issue of how crisis incidents are categorised. During a period with a high frequency of critical incidents[68] a review of the current policy documents indicate incidents are categorised and escalated based on several criteria including frequency. Policies indicate that after three incidents of the same classification a subsequent incident should be classified at the next highest level.

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[64]CVP Panel Report July-October 2020 p.5.
[65] Reporting of pain relief medication as Chemical Restraint. CV Visit Report to Appropriate Place 21.05.2021.
[66] In making this statement the CVP has noted a range of information including: 1. Preparing a Positive Behaviour Plan – Guidelines and Model Plan, Queensland Government, https://www.dsdsatsip.qld.gov.au/, 2. Behaviour Support and the Use of Medicine; a Guide for Practitioners, University of New South Wales 3. Sarah Nicol National Disability Services, Interim Response –Debriefing, Dignity and Risk, https://www.nds.org.au/images/resources/BSP3_interim.pdf.
[67] CVP Trimester Report June 2021 p.8.
[68] CVP Trimester Report June 2021 pp.7-8.

This policy also prescribes the SSFDU response, including which level of management that need to be informed, incidents based on the incident categorisation.

Given the high frequency of critical incidents at the time it was clear this policy was not being followed. In the absence of an independent review panel for PBSPs and restricted practice this policy is of particular importance to help guide practice changes. This policy also helps give families and other stakeholders the confidence that the service is giving incidents the appropriate level of management support.

MONASH UNIVERSITY

'PBS is designed to support staff to select and adopt evidence-based interventions to achieve goals determined through processes of person-centred planning, with these interventions informed by subsequent data collection and data decision making.'

Monash University Submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.
https://disability.royalcommission.gov.au/system/files/submission/ISS.001.00434.PDF

The CVP understands that SSFDU have undertaken significant work completed, in consultation with medical professionals, to balance the health and behavioural effects of medication. While it is important to note that this work is ongoing, the CVP have observed that currently residents are benefiting from reduced behavioural incidents and increased quality of life and ability to engage in their programs.

FEEDBACK AND COMPLAINTS PROCESS

Positively the CVP has received a new FDU complaint procedure. The establishment of an effective complaints process is in accordance with Part 5 of the DSA. There are considerable barriers to FDU residents providing feedback and complaints. The residents are vulnerable people and a complaints process needs to reflect this by being proactive in the way they are implemented.

The current CVP Panel recommendation regarding complaint processes remains open pending evidence of its effective implementation.

THE RIGHT TO INDEPENDENT RESTRICTIVE PRACTICE REVIEW MECHANISM

CVP RECOMMENDATIONS:

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

That the Forensic Disability Unit as appropriate, ensure that PBSP are submitted to the Senior Practitioner to enable the resident's rights to independent restrictive practice review occurs.
December 2019, CV

In November 2017 the CVP Panel[69] recommended SSFDU establish a review panel as required by Section 40 of the DSA. The purpose of the review panel is to provide residents access to an independent review and authorisation process for restricted practice and PBSPs. The SSFDU have advised residents' PBSPs do not come under the legislative provisions of the *National Disability Insurance Scheme Act 2013*.

[69] CVP Panel Report November 2017.

This means the SSFDU are not provided the same quality and safe guarding mechanisms that are provided to other people with a disability.

NORTHERN TERRITORY OFFICE OF THE PUBLIC GUARDIAN

'It is the view of the Office of the Public Guardian that the significant interference with a person's human rights through the use of restrictive practices (unless clearly for health purposes) demands a robust and transparent authorization process by a specialized independent authority.'

Northern Territory Office of the Public Guardian Submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. https://disability.royalcommission.gov.au/system/files/submission/ISS.001.00133_1.PDF

The CVP welcomes updates that SSFDU is seeking interstate advice in setting up the review panel and that it is planned for the NT Senior Practitioner to chair reviews. At the time of writing, however, it is almost four years since the CV Panel recommendation and little substantive progress has been made towards convening the review panel.

It is clear that establishment of the review panel has not been prioritised. The CVP maintains that without the independent assessment mechanism provided by the review panel residents do not have access to a restricted practice review mechanism to protect their rights. The absence of this protection is an ongoing breach of the DSA.

THE RIGHT TO LEAST RESTRICTIVE PRACTICE

CVP RECOMMENDATIONS:

That the Office of Disability develop a Memorandum of Understanding with the Department of Corrections to ensure a collaborative and least restrictive approach to shared clients.
December 2016, CV

That the service 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 & Safety Commission Framework for SSSSFDU residents.
June 2020, CV

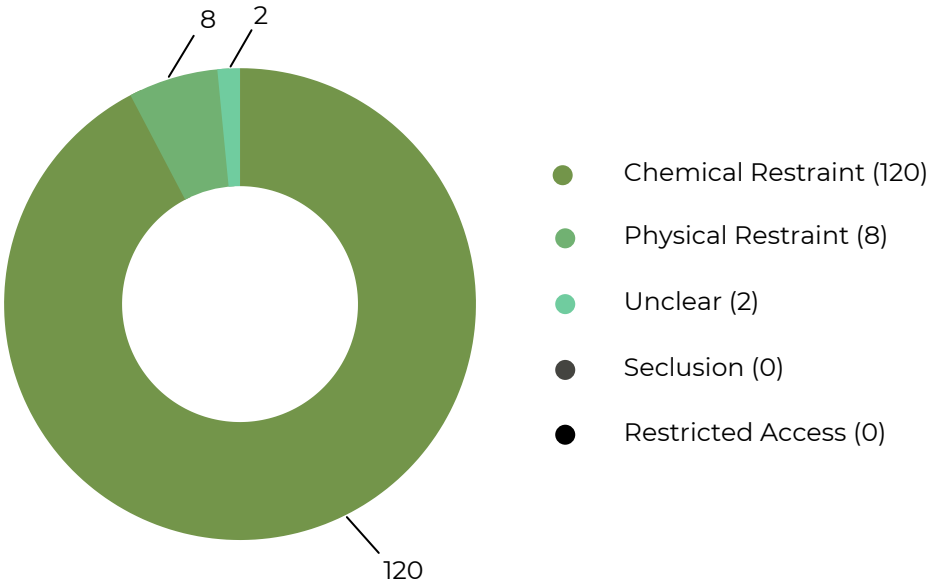
USE OF RESTRICTED PRACTICES [70]

The number of restrictive practices used in this year continues the upward trend observed in last year's report. While the use of restricted practice has fluctuated throughout the year an increase from 105 uses of restricted practice to 130 is substantial. The majority of restricted practices used have been chemical restraint (120) the majority for one resident. As stated previously the FDU have sought expert advice and completed significant work for this resident.

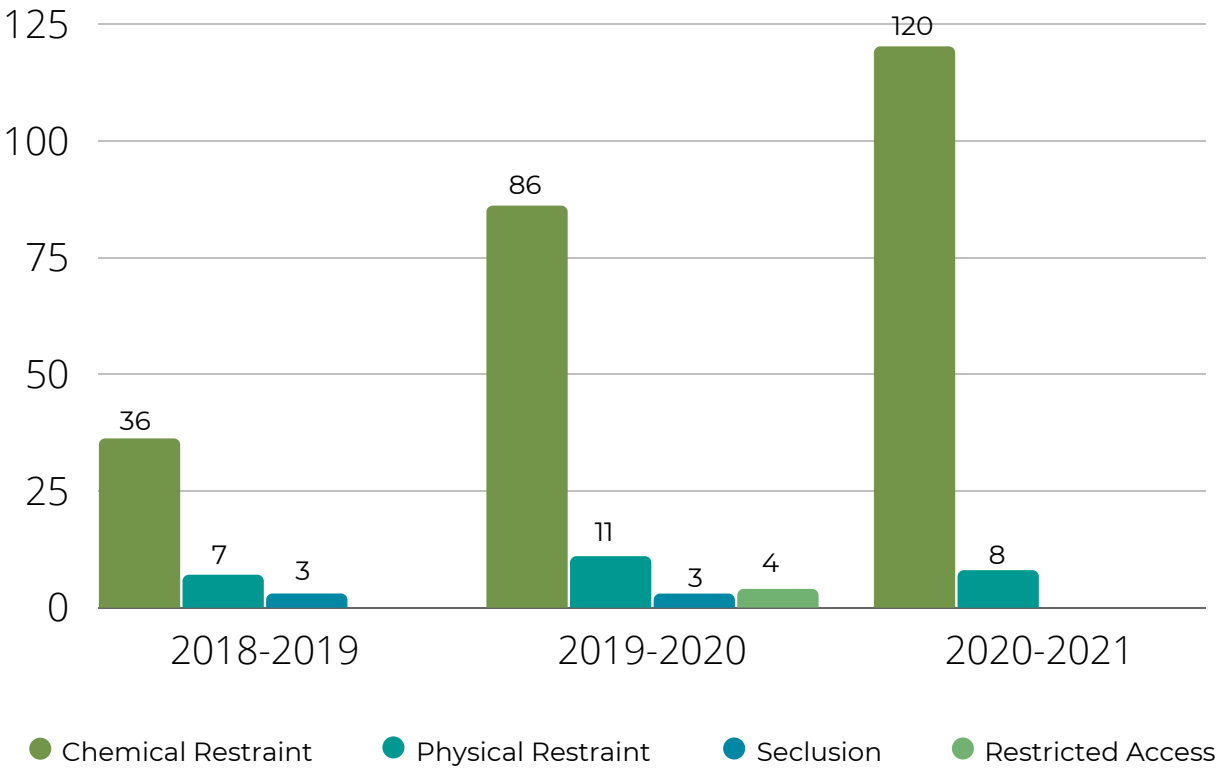
While the CVP is concerned about an increase in the use of chemical restraint the CVP has recently observed lower levels of restricted practice than in earlier parts of the year. Given the complex nature of balancing health, quality of life and behaviour concerns the FDU will need to continue their work in this area and a reduction in the use of restricted practices will continue to be a focus for the CVP.

[70] Unlike the NDIS Quality and Safeguarding Commission there is currently no independent mechanism which authorises restricted practices for forensic residents. The review panel provided for under Section 40 in the DSA has not yet been convened.

USE OF RESTRICTIVE PRACTICES (SPECIALIST DISABILITY) 2020/21



FREQUENCY OF RESTRICTIVE PRACTICES



FORMALISING AGREEMENTS WITH AGENCIES

The CVP believes that formal agreements between agencies who deliver services to mutual clients ensures the continuity and improvement of service. Agreements help ensure services are complementary and that each service is able to respond to their partner agency's needs effectively.

Overall formal agreements ensure good working arrangements are not affected by staff turnover.

Currently the CVP has been advised Department of Health and NT Correctional Services have developed a Memorandum of Understanding. This document, however, does not include an agreement about the use of restrictive practices. The CVP believes this document requires amendment to govern restrictive practices and transitions from the prison to the cottages and other less restrictive environments.

"... THINGS GO WRONG WHEN PROVIDERS FAIL TO TAKE RESPONSIBILITY FOR ISSUES, WHEN INFORMATION IS NOT SHARED, WHERE THERE IS NO LEAD AGENCY THAT TAKES RESPONSIBILITY FOR THE COLLABORATION..."

University of New South Wales (2017), Intellectual Disability Behaviour Support Program, Discussion Paper: Responding to Behaviour Support Needs in the Disability Services Future.

As noted previously the transition of SSFDU residents is complex and during the process SSFDU remains the agency that reports to the Supreme Court on resident care and treatment.

The CVP note the volume of work completed by FDU on the negotiation and development of resident's NDIS plans to help facilitate transitions.

These achievements demonstrate a commitment to realising service delivery that provides opportunity for skill development and personal growth in a least restrictive environment. There are also examples this year where resident have been relocated back to the SCF because of risk arising from the resident change in behaviour. If and how this happens if residents have transitioned to NDIS provider, remains less clear. A further factor that needs to be planned for is changes, in particular reductions in NDIS funding.

Positively the SSFDU have instituted fortnightly case management meetings for stakeholders to guide transitions. In order to maintain this progress, however, the CVP recommend a formal agreement be developed between the SSFDU and NDIS providers and others to provide consistency and govern how the services interact.

CLOSED RECOMMENDATIONS

CVP 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 medication.
Closed February 2021, 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.
Closed October 2020, CV

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.
Closed February 2021, Panel

That the Office of Disability implement a quality data analysis and measurement process related to each client's therapeutic program, including improved process for individual resident review.
Closed December 2020, CV

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.
Closed December 2020, CV

That the Office of Disability provide evidence of the systematic implementation of strategies described in the Positive Behaviour Support Plan (PBSP) and evidence-based changes to the PBSPs.
Closed June 2021, CV

	Mental Health			Disability				
	CAHS	TEHS	Sub Total	Secure Care	Appropriate Places	Other (DSA)	Sub Total	TOTAL
VISITS	**52**	**53**	**105**	**11**	**18**	**0**	**29**	**134**
Community Visitor	49	47	96	9	18	0	27	123
Inspection	1	4	5	0	0	0	0	5
CV Panel	2	2	4	2	0	0	2	6
CASES	**97**	**220**	**319**	**11**	**0**	**4**	**15**	**334**
Complaints	10	25	35	1	0	0	1	36
Enquiries	87	197	284	10	0	4	14	298
Cases – Raised by								
Person receiving treatment	81	172	253		8		8	261
Carer	1	8	9		0		0	9
Case Manager	2	1	3		0		0	3
Service Provider	5	11	16		1		1	17
Nurse/Doctor	3	16	19		0		0	19
Guardian	3	0	3		5		5	8
Friend	0	1	1		0		0	1
Relative	1	11	12		1		1	13
ISSUES RAISED	**198**	**414**	**612**		**38**		**38**	**650**
Quality of Service Provider	68	126	194		11		11	205
Assessment & Treatment	3	16	19		1		1	20
Cultural Safety	11	9	20		2		2	22
Management Plan	1	2	3		0		0	3
Facilities	4	6	10		2		2	12
Discharge Planning	19	29	48		0		0	48
Relationship with Staff	15	17	32		1		1	33
Food	1	2	3		0		0	3
Health – Physical / Mental	10	10	20		1		1	21
Procedures	2	22	24		0		0	24
Consultation Carers/Consumers	1	2	3		3		3	6
Aftercare	0	2	2		0		0	2
Other	1	4	5		0		0	5
Rights	59	128	187		11		11	198
Least Restrictive Alternative	30	33	63		3		3	66
Legal	6	28	34		0		0	34
CV Information on Rights	0	6	6		0		0	6
Early Review of Detention	0	6	6		0		0	6
Restrictive Practices	1	3	4		1		1	5
Respect for Dignity	1	4	5		1		1	6
Safety	5	20	25		4		4	29
Voluntary/ Involuntary	9	4	13		0		0	13
Transport / Transport by Police	0	2	2		0		0	2
Location of Admission	2	8	10		0		0	10
Detention	1	6	7		0		0	7
Community Accommodation	1	2	3		0		0	3
Forensic	2	1	3		2		2	5
ECT	0	1	1		0		0	1
Other	1	4	5		0		0	5

	Mental Health			Disability				
	CAHS	TEHS	Sub Total	Secure Care	Appropriate Places	Other (DSA)	Sub Total	TOTAL
Other Issues Raised								
Information	10	46	56		*3*		3	59
Advocacy	53	76	129		*11*		11	140
Smoking	0	9	9		*0*		0	9
Visit/Support	3	3	6		*0*		0	6
Other	3	12	15		*0*		0	15
Medication	2	14	16		*2*		2	18
OUTCOMES								
Resolved	64	151	215		*5*		5	220
Ongoing Monitoring	17	15	32		*9*		9	41
Not Resolved	7	15	22		*0*		0	22
Referred	0	14	14		*0*		0	14
Lapsed	8	15	23		*1*		1	24
Withdrawn	0	2	2		*0*		0	2
Substantiated	0	6	6		*0*		0	6
Other	0	1	1		*0*		0	1
Dismissed	1	0	1		*0*		0	1
Not accepted	0	3	3		*0*		0	3
TOTAL ISSUES RAISED								**334**

How was contact with the CVP made – communication conduit

	Central	Top End	TOTAL
Aftercare	2	6	**8**
Other	79	123	**202**
Least Restrictive Alternative	18	82	**100**
Legal	0	2	**3**
CV Information on Rights	2	0	**2**
Early Review of Detention	9	8	**19**
TOTAL CONTACTS RECIEVED			**334**

VALUES

Respect

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

Empowerment

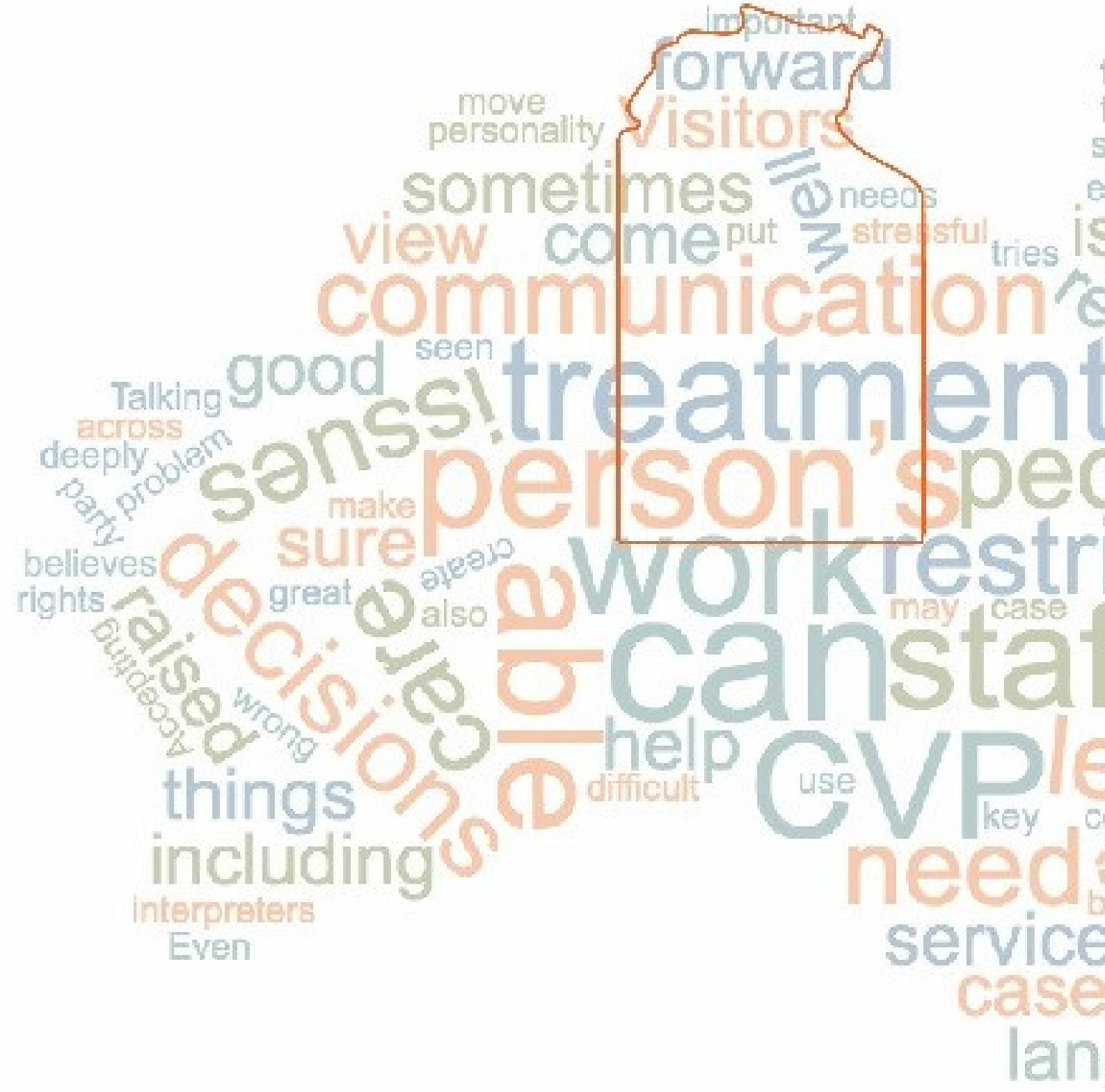
We walk alongside our clients, seeing the situation from their perspective, appreciating that all points of view are valid, striving to understand their journey and maintaining hope at all times.

Courage

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

Independence & Integrity

We act ethically, openly, honestly and fairly by identifying and avoiding any conflict of interest, maintaining confidentiality, resolving complaints impartially and fairly and being accountable.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accepting
wrong
things
including
help
difficult
use
key
CVP
need
service
case
interpreters
Even

COMMUNITY VISITOR PROGRAM

TOP END
NT House
Level 9, 22 Mitchell Street
Darwin NT 0800

CENTRAL AUSTRALIA
Alice Springs Plaza
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Alice Springs NT 0870

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