Annual Report

2016/2017

CVP

NT Community Visitor Program

"The CVP is the independent voice that makes the experience of consumers and carers heard to service providers and the public. In my experience, this way of improving services is unique and indispensable."

Hiltrud Kivelitz

CVP Coordinator
(February 2012 - September 2017)

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29 September 2017

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

Dear Minister,

Re: Community Visitor Program Annual Report 2016-2017

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

This Annual Report has been prepared in accordance with section 115 of the *Mental Health and Related Services Act*, section 66 of the *Disability Services Act*, and section 101 of the *Alcohol Mandatory Treatment Act* (repealed 1 September 2017).

Yours sincerely,

Sally Sievers
Principal Community Visitor

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

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

SALLY SIEVERS

PRINCIPAL COMMUNITY VISITOR

REFLECTIONS FROM THE PRINCIPAL COMMUNITY VISITOR

This year has been a busy one for the Community Visitor Program (CVP). The focus of the CVP has remained on meeting our statutory obligations to visit facilities and raising matters of concern in an independent, respectful manner.

In my role as the Principal Community Visitor, I am often reminded about the value of an independent visiting service reaching out directly to people in facilities. A visiting program ensures that people's rights are protected and reduces barriers to accessing independent assistance.

Importantly, a service such as the CVP assists people to resolve concerns at the lowest possible level. This avoids matters escalating into complaints, and focuses the attention on people receiving high quality treatment and returning to the community.

Some people will not feel empowered to speak up unless supported to do so. When people have English as an additional language, or have had negative experiences with services in the past, it can be especially difficult to raise matters.

This is where the work of the CVP is particularly valuable in supporting the services to provide quality care and treatment.

The CVP also takes a broader look at the service delivery context. Moving from the individual to the systemic in its advocacy for the rights and needs of people receiving services.

There are a number of areas in which the CVP has been a strong advocate for many years. The two highest priority areas for systemic change in the Northern Territory remain constant: greater use of accredited interpreters (such as the Aboriginal Interpreter Service) and reducing the use of seclusion in mental health in-patient facilities.

Part of the benefit of a visiting service is the independent perspective that comes from having an external party

involved. This is especially the case when the places being visited are otherwise 'closed', such as mental health facilities and disability residences. It is even more important when people in facilities do not often receive visits from friends or family (which may occur for a number of reasons).

Our regular reporting to the services enables multiple views on their work to be considered. Sometimes, the CVP will highlight areas where change is needed. Or where additional investment in facilities may be required. Or how a policy framework has shifted from its original intent when implemented.

This year, the CVP has made comment along those lines to each of the services we visited. For example, the shift in the use of specialist disability facilities as supervised places for people on orders under the Criminal Code; and the need for more investment in facilities that support the most acutely unwell mental health consumers in Darwin.

This year has been a significant one of change. There were changes in leadership and governance at the highest levels in the Department of Health and the area health services. The Alcohol Mandatory Treatment (AMT) program was repealed on 1 September 2017.

While the CVP maintained its role in the facilities until the end of the program, the CVP team also decreased in size as a substantial proportion of CVP funding came from AMT work. The additional support provided under the AMT program provided economies of scale that enabled the CVP to meet its statutory functions across all areas of the service. There is now additional pressure on the CVP to sustain our current level of service, including the statutory visiting requirements and maintaining the high quality and integrity of our work.

The work of the CVP is challenging and complex. The Northern Territory has invested in a professional, paid visiting service. This is essential for a small region such as the Northern Territory, where securing the right person for the job is important.

The CVP provides an essential service to people in facilities or receiving services who may be vulnerable or have barriers to accessing help. It provides independent eyes into what can otherwise be closed spaces. It protects the human rights of people receiving treatment and care, including those experiencing restrictive practices. It is a valuable service that continues to play a very important role in our community.

The CVP will need to refocus on meeting statutory obligations, while also being available and accessible to the many people who raise matters with the CVP for advocacy or complaints resolution. This work to support consumers, residents, carers, guardians and others with a genuine interest is at the heart of the CVP's work.

I would like to acknowledge that it is the people who raise issues with a Community Visitor or CV Panel who take the first courageous step. To trust another party. To seek their support to bridge a gap across to the service. To avoid errors or mistakes happening for them, or sometimes, for those who come after them. To all the people who raised matters with the CVP this year, I thank them for their courage and trust in our service.

CONTENTS

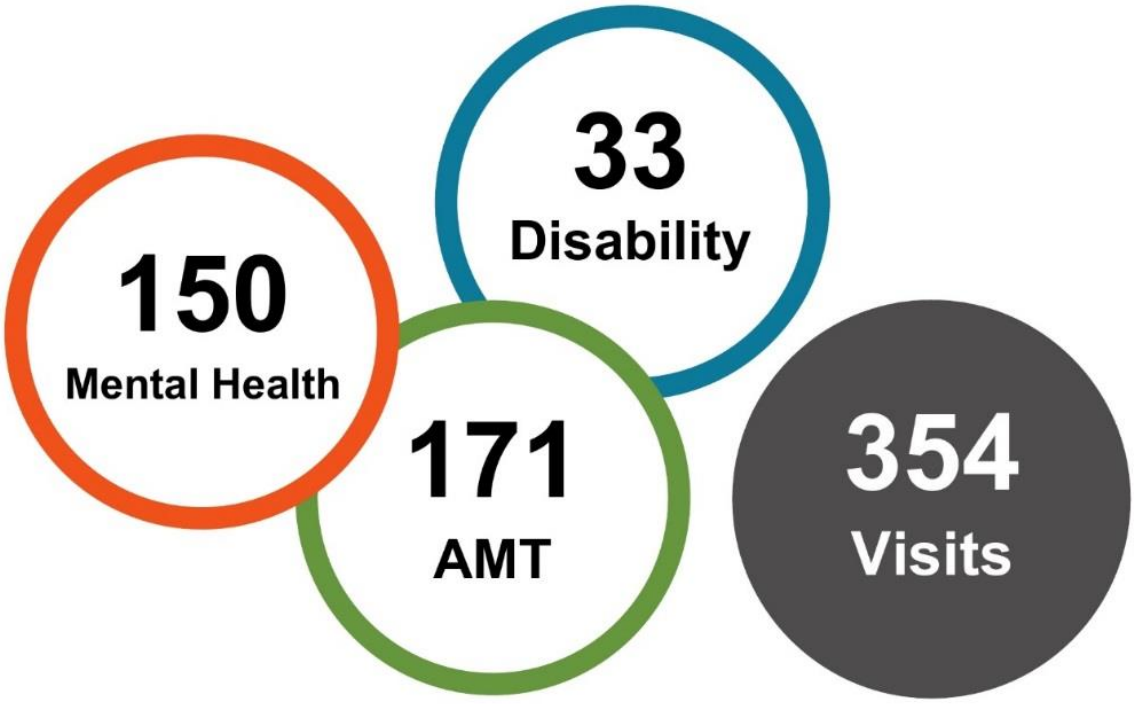
CHAPTER 1: OVERVIEW

Key Messages

1. A visiting service assists people to raise issues early, to resolve concerns at the lowest possible level and improve services.
2. Independence is essential to a quality visiting service, providing confidence to people in facilities and ensuring integrity in the process to resolve issues.
3. Community visitors support the protection of human rights and continuous improvement in service delivery for the most vulnerable.

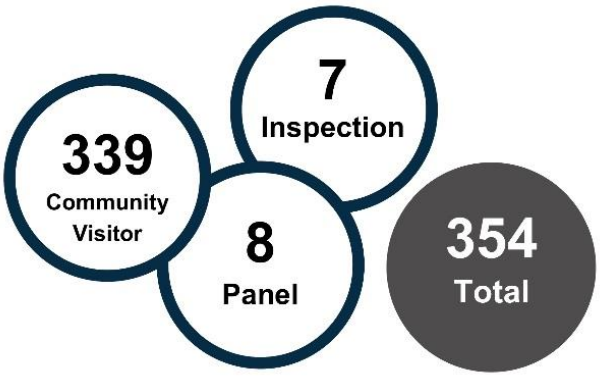
The Northern Territory Community Visitor Program continued to deliver on its main responsibility to visit people at involuntary facilities, working to resolve enquiries and complaints and inspecting registers of restrictive practices.

Respect
Empowerment Courage
Independence
& Integrity



REACHING OUT THROUGH VISITS

This year, the CVP completed 354 visits to mental health in-patient units, specialist disability facilities and AMT facilities.



The CVP visited as part of its statutory obligation under three pieces of legislation: the *Mental Health and Related Services Act*, the *Disability Services Act*, and the *Alcohol Mandatory Treatment Act*.[1]

The visits were by Community Visitors and Community Visitor (CV) Panels.[2] Some visits were for the purpose of inspecting registers of restrictive practices (seclusion and restraint).

The Community Visitors and CV Panels ensure that any restrictive practices are used and documented consistent with the relevant legislation. This is a very important safeguard in the legislation for the use of restrictive practices on people. The CVP reports on the inspections of seclusion and restraint registers in mental health services (see chapter 2).

Community Visitors generally arrange to visit facilities once a week or fortnightly. People in facilities can also request that a Community Visitor make contact with them. The CVP has a statutory obligation to ensure that when this occurs, the CVP makes contact with that person by the next working day.

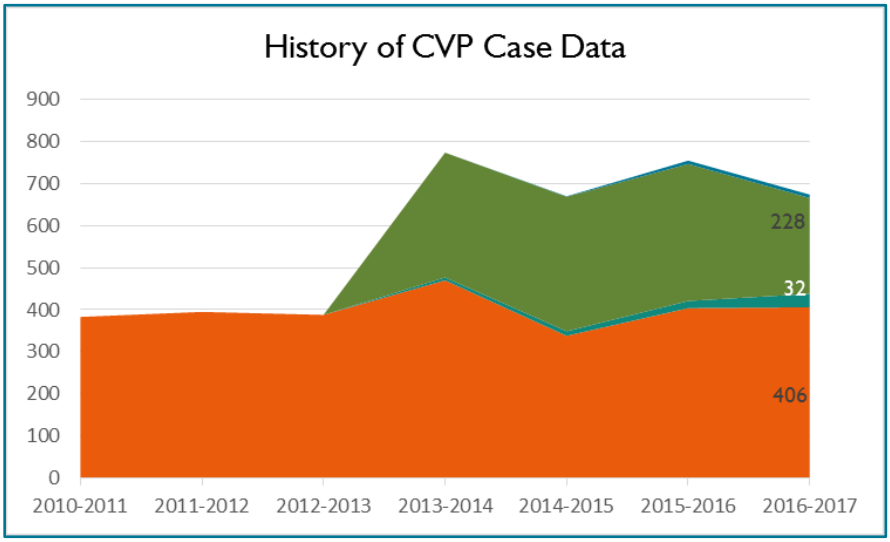
Requested CVP	Mental Health	Disability	AMT
Number of people	151	1	16
% Contacted Next Working Day	**97%**	**100%**	**100%**

PEOPLE WHO USE THE CVP

The Community Visitors are the main way by which the CVP is accessible to vulnerable residents. Visiting is a core responsibility of the program.

[1] The *Alcohol Mandatory Treatment Act* was repealed by the NT Legislative Assembly on 1 September 2017.

[2] CV Panels are a multi-disciplinary panel of members, comprised of a legal, medical/health professional, and community member. The exact composition of a CV Panel is provided for in the relevant legislation. CV Panels visit relevant facilities twice a year.



2016/2017 Cases: Mental Health (406) Disability (32) AMT (228)

674

cases raised in 2016/2017

89%

were enquiries

The CVP is available to people in relevant facilities providing involuntary care and treatment. The CVP is also able to provide support to people receiving services in the community from the Northern Territory mental health services. The CVP is available to carers, guardians or other people with a genuine interest in someone's care and treatment.

However, the CVP knows from experience and caseload data that people feel more comfortable raising issues with someone in person. For this reason, the CVP visits as often as possible to relevant facilities in Darwin and Alice Springs where people are receiving involuntary care and treatment.

This year, the CVP received 674 cases across the Northern Territory. As can be seen, the majority of cases are raised from people in the Top End. The work of the CVP in the mental health field has remained strong and steady.

This year, there has been a slight increase in the number of cases from the disability area, and a decrease in cases from the AMT area. This is discussed in more detail in the relevant chapters.

WHAT PEOPLE SAY TO US

For all the 674 cases raised, the CVP records the main issues raised within a case (sometimes more than one issue is raised) and the outcome for each issue.

545

cases from people receiving services

80%

raised in person

When reviewed at its highest level, this data is a voice to and about the service from the people who use the relevant health services, or are affected by it in some way.

Issues are recorded in the CVP database under the major headings of quality of service provision, rights, information, advocacy, visit/support and smoking. The majority of issues raised are in the areas of quality services and rights.

Issues Raised

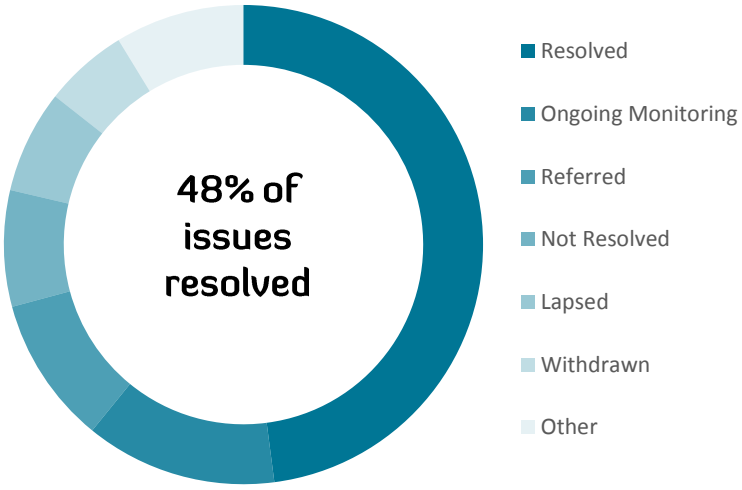
In 2016/2017, there were 1237 issues raised in all cases with the CVP. The main issues raised this year highlight the important work of the CVP in providing advocacy and information to people, promoting their right to the 'least restrictive' care and treatment and culturally safe healthcare.

The above four issues were 44% of the total issues raised this year, and represent the core of the work of the Community Visitors and the CV Panels.

Outcomes of Cases

A central part of how the CVP works is to seek to resolve matters at the lowest possible level.

The work aims to resolve matters before they escalate into complaints or serious concerns about quality or safety, rights or misunderstandings.



It is pleasing for the CVP that the outcome of cases continues to be heavily focused on resolution. The issues that more frequently record an outcome of 'ongoing monitoring' or 'not resolved' were those related to cultural safety and the least restrictive alternative.

Many of the cases where the issue was 'smoking' were also not able to be resolved due to the Northern Territory Department of Health policy that all facilities are smoke-free. People held in involuntary facilities who are not able to smoke often raised this as an issue of concern. This concern is not raised in specialist disability facilities, where the Office of Disability has flexible policies enabling residents to smoke outdoors.

AREAS OF FOCUS

The unique perspective of the CVP provides a window into the Territory-wide areas for ongoing improvement for the Department of Health. Services vary across the Northern Territory. Each field of practice that the CVP visits is different. What is common, however, is the ongoing stated commitment of the services to improve.

Stronger Internal Complaints

"A complaint is always going to start with two stories. That is the beginning of the complaint process. But in the end it's just their word against mine. I feel like there's no point."

C/2016/489

Complaints and enquiries raised with an independent body are an important part of quality assurance. Building a strong, positive culture of welcoming feedback is a challenge.

People receiving services, and their loved ones, need to feel confident that their concerns are dealt with in a prompt and respectful way.

In each of the relevant Acts establishing the CVP, an important role is to inquire into and comment on the service's own 'internal' complaints procedures. This assists services to improve their own processes. Reviewing the internal complaints procedures of the services has been a strong feature of the CVP's work this year, and is evident in some new recommendations for services.

Use of Interpreters

"Often people don't get to speak their own language when they are here ... that's really difficult for them. When you speak their language, it just opens up so many doors. You find out so much."

VIS/2016/266

Another strong area of focus for the CVP that has continued this year is culturally safe healthcare. The CVP has a specific interest in the use of accredited interpreters. This is a critically important issue for the Department of Health and area health services.

Clear communication between both parties, and understanding of cultural needs and values, are essential aspects of quality health care.

Nearly all of the people in AMT facilities were Aboriginal Territorians. All of the people in specialist disability residences visited by the CVP are Aboriginal Territorians. Many people in mental health facilities are Aboriginal Territorians. The Aboriginal Interpreter Service (AIS) therefore is a key partner for the health services.

62%

CVP cases were raised by Aboriginal Territorians

In the CVP's work this year, the majority of cases were raised by Aboriginal Territorians.[3] The CVP database shows that half of these cases were raised by people needing an interpreter. This demonstrates the significant proportion of cases raised by people who have English as an additional language.

The Community Visitors and CV Panels have conducted visits and inspections, reviewing any registers of interpreter use, enquiring about staff training, and promoting liaison with the Aboriginal Interpreter Service.

> [Staff]: "That's your [CVP] interpreter. We don't really need interpreters so much. We know how to talk to them."
>
> VIS/2016/266

Overall, while there are some instances of good practice, the CVP still does not see a culture of consistent commitment to and use of interpreters across the Northern Territory. This needs to change.

Safety First

The safety of people in involuntary facilities remains a top priority for the CVP. The Community Visitors and CV Panels ensure that issues related to safety are prioritised in matters raised with the service and, if necessary, raised at a senior level.

Safety issues that are discussed include the availability of medical staff, the authorisation of medication, transport to other places or services, absconding, duress alarms and risk management systems. If necessary, the CVP will move directly to formal recommendations if the safety concerns need urgent attention.

This year, the CVP kept a close eye on issues related to safety in the AMT program as it moved towards closure. Understandably, there were challenges for the services in maintaining staffing levels. High turnover of staff and gaps in staffing while positions are being recruited creates risks to safety. It was pleasing to see that there were no significant safety issues arise in the AMT field at this challenging time.

[3] The CVP notes that the percentage of cases raised by Aboriginal Territorians varies across the three areas. In AMT, 94% of cases were raised by Aboriginal Territorians; in disability, 81% of cases (being a small number in total) were raised by Aboriginal Territorians; in mental health, 43% of cases were raised by Aboriginal Territorians.

The CVP would also like to acknowledge the efforts of staff to establish the AMT program in a short space of time and respond to the issues arising throughout the program. It was a significant undertaking over the past four years and this work is acknowledged.

A PROFESSIONAL CVP

The CVP has continued to develop the professional skill base of CV Panel members and Community Visitors. The CVP welcomes new members to the service, and provides orientation and support for the role.

The CVP policy and procedure manual is in the final stages of being completed, with amendments being made to account for the repealing of the *Alcohol Mandatory Treatment Act*. An orientation manual was completed by a social work student on placement with the CVP in Central Australia. The CVP will continue to support students on placement as part of its commitment to building the professional knowledge and skill base for official visiting throughout Australia.

Community Visitors who are employed on a permanent basis in the program receive external peer supervision. This is provided by a professional supervisor with experience in official visiting. The external supervision sessions are supported by the CVP to safeguard the skills, resilience and reflective practice of permanent staff performing the work on a daily basis.

Changes to the CVP Team

The Principal Community Visitor, Sally Sievers, was re-appointed in this role for a further three year period. New CV Panel members were appointed in all fields, in Central Australia and the Top End.

The CVP welcomed Dr Antonella Ventura, Samantha Bowden, Jared Sharp, Kim McRae, Greg Betts, Kenton Winsley, Michelle Alleman, Andrea Rennals, Andreea Lachsz, Linda Zargoskis, Katherine Whitfield, Kate Manley and Seranie Gamble. All were permanently appointed in 2016-2017.[4]

A long standing CV Panel member, and Community Visitor, Mr Mark O'Reilly resigned from the CVP after commencing as a member of the NT Civil and Administrative Tribunal. The CVP wishes Mr O'Reilly well in his role on the Tribunal.

With the repealing of the *Alcohol Mandatory Treatment Act* on 1 September 2017, the CVP also ceased to provide services to AMT facilities. Three positions in the CVP were funded by AMT. The CVP thanks Andrea Rennals, Jennifer Ryder and two administrative staff (Sarah Coe and then Kate James) for their hard work in the CVP team.

[4] Since being appointed, Jared Sharp, Kenton Winsley and Linda Zargoskis have resigned their appointments.

A New Focus for the CVP

This year, the CVP restructured its team to enable a more dedicated focus on the work in the disability field. This decision reflected the importance of the CVP's role in this dynamic area, including as the National Disability Insurance Scheme (NDIS) started to rollout across the Northern Territory.[5]

As service providers and the CVP become more familiar with areas of practice, new avenues of inquiry and systemic advocacy emerge. In that sense, the work of continuous improvement and supporting individual client rights never ceases.

The CVP is keen to continue to support the important work of visiting the most vulnerable people in our community, many of whom may not have independent people who know them or can advocate for their rights and needs.

With the reduction in the CVP staffing arising from the end of the AMT program, the CVP needs to carefully consider how the program can meet statutory obligations with its reduced resources. It is clear that funding from the expansion into the AMT field provided necessary capacity and supported the work of the CVP across all three areas of practice.

As the CVP moves into this next phase of its development, the practical limitations of the work with reduced funding has been raised with the Department of Health.

Quality assurance frameworks are a central aspect of professional service delivery. Official visitor programs, such as the CVP have an important role in the broader quality assurance framework for services. Further to this, the CVP enables rights and protections of legislation, including the right to individual care and treatment, to be given a voice.

The CVP will continue to speak up for people in facilities, supporting them to raise their matters of concern and working respectfully with services to resolve these matters.

Notes on Reading the Annual Report

'Quotes' used in the Annual Report faithfully represent the issues and matters raised by people in facilities. They are not intended to be read as direct, word for word statements. By including the 'quotes', the CVP does not imply that there were errors or failings in the service in response to any matters raised or represented.

The CVP notes that the Annual Report does not raise all issues that arise over the course of the year. Some serious matters are not reported on for confidentiality reasons or in the interests of fairness to the services overall.

[5] Chapter 3 provides more context for the changes that the CVP have observed in visiting to disability residential facilities.

CHAPTER 2: MENTAL HEALTH

Priority Needs

1. Increase the use of interpreters for consumers with English as an additional language
2. Maintain progress to reduce the use of restrictive practices
3. Sustained commitment to improve the Top End facility for acutely unwell consumers (the Joan Ridley Unit)

The work of the CVP in the mental health field continued strongly this year, with mental health visits and cases being the bulk of the CVP's workload. The CVP focuses on consumer and carer expectations for contemporary mental health care and treatment, including least restrictive practice.

150
visits

406
cases

POSITIVE CHANGE

The mental health services in the Northern Territory[6] provide a very important service for all Territorians. The staff of the services are dedicated to helping consumers to get well, stay well and live a meaningful life in the community. Recovery-oriented practice, and care and treatment in the community, are cornerstones of contemporary mental health care and treatment.

"[The youth ward] is not like a real ward in a hospital, it's more like a hotel or something. It's colourful and friendly, so it's quite good. The staff are really nice and they care and talk to you."

V/2017/145

This year, the CVP has seen some areas of positive change in mental health services. The main area is in youth mental health. In general, across the Northern Territory, there are now less children held in mental health in-patient units with adults.

[6] Top End Mental Health Services (TEMHS) and Central Australia Mental Health Services (CAMHS).

The new Youth In-Patient Program (YIPP) in Darwin is providing a very good service for children, and is sometimes used for youth (consumers over 18 years) if possible. [7]

The Youth In-Patient Program space is well-equipped. Staff in the program have shown a strong culture of working closely with children and carers. They are sensitive to the possible trauma histories of young people. Family members are encouraged to stay with their children as boarders. The program values the generally positive impact and emotional stability this provides to children. There has been only a very small number of re-admissions to the Youth In-Patient Program. This indicates that discharges are well prepared and care in the community is successful.

At a broader level, the CVP has observed that both the Top End Health Service and the Central Australia Health Service have been working actively to strengthen their quality and safety reporting. The services have identified a number of projects for quality improvement that, when fully implemented, aim to improve client care and treatment.

The reporting of involuntary admissions ('Form 10s') has also improved, indicating an appropriate attention to documentation of the basis for involuntary admission and the communication of people's rights on admission.

CULTURAL SAFETY

A high percentage of mental health consumers in the Northern Territory are Aboriginal. There are also consumers from culturally and linguistically diverse backgrounds. This demonstrates the need for mental health services to be culturally safe for all consumers.[8]

This year, about 40% of the mental health enquiries and complaints raised with Community Visitors were made by Aboriginal Territorians. When this data is combined with that raised by people with a culturally and linguistically diverse background, it increases to just over half of all CVP mental health enquiries and complaints.

"I like it here. I don't like the other ward. It's like a prison there. Here they are helping me."

V/2017/322

During visits, Community Visitors have observed a number of practices that demonstrate the services focus on cultural safety. There are 'talking posters' at the in-patient facilities to explain patient's rights in several local languages. Conversations are usually in plain English where needed.

[7] For clarity, in the report, the term child/children is used to mean any person under the age of 18 years and the term 'youth' is used to mean people aged 18-25 years. The 'Youth In-Patient Program' is the name of the facility for child consumers, however it sometimes accommodates youth at the discretion of the service.

[8] Standing Council of Health, *Mental Health Statement of Rights and Responsibilities 2012*, p 6 (Part 1, Inherent dignity and equal protection …(e) culturally and linguistically diverse communities receive culturally and linguistically appropriate services.)

Family members from remote areas are helped to board with their relative at in-patient facilities. Some doctors who treat consumers in the hospital also are able to visit that person's home community, providing continuity of care. In Central Australia in particular the attendance of traditional healers is actively supported.

> Carer: "She is very shy one and her English is not so good. She understands some but not when they are using big words. It's difficult for her to talk back to them."
>
> C/2017/103

However, consumers from culturally diverse backgrounds have raised concerns with the Community Visitors on many occasions. This has included on issues such as access to or use of interpreters and Aboriginal mental health workers, supporting cultural obligations or respecting cultural needs. The CVP's data on issues raised in the mental health field confirms the frequency of matters relating to cultural safety.[9]

Use of Interpreters

For several years the CVP has had particular concerns about the low use of qualified interpreters in mental health services across the Northern Territory. Qualified interpreters are bound by a code of conduct (including confidentiality) and receive specialist training to interpret. This includes interpreting in challenging contexts when a person is mentally unwell.

Consumers who speak an additional language to English have raised with Community Visitors about being uncertain about things such as their diagnosis, treatment, discharge, physical health needs or procedures. Some consumers talked about not being able to fully express their concerns or ask all the questions they had in mind.

Diagnosis and treatment decisions in mental health care rely largely on effective communication. The responsibility for effective communication rests with the service.

There are concerns whether the service had done everything possible to use an interpreter for key conversations, such as a person's rights on admission or in distressing situations, for example seclusions and restraints. Alternatively, if interpreters are not available on a regular basis, the services need to liaise proactively with relevant booking organisations[10] about the needs of consumers for interpreters.

To support this, the CVP has advocated for registers of interpreter bookings and outcomes to be established and kept current. The registers provide valuable information to demonstrate the service's commitment to using interpreters and the outcomes of efforts to meet consumer needs. At times, the CVP has observed that registers have not been current or not used to inform service liaison.

[9] See Appendix 1.

[10] The relevant booking organisations include the Northern Territory Aboriginal Interpreter Service (AIS), the national Translating and Interpreting Service (TIS), and the National Auslan Interpreting Booking Service (NABS).

Further to this, Community Visitors have observed that the use of interpreters is not consistent. There remain many misconceptions among staff about the use of interpreters and a person's capacity to fully participate in their treatment in English.

Even if consumers navigate everyday situations in English reasonably well, there still are many obstacles to communication. These include how stressful it can be to be unwell, away from home and family support, and in an unfamiliar hospital environment.

"I know I speak good English, but it's good to hear my own language. It makes me feel more relaxed and I can talk about things better."

C/2016/581

The words used in healthcare settings are different from everyday English words. Some staff may be difficult to understand for a range of reasons.

Many factors might affect how the consumer engages in the discussion. The 'power imbalance' between staff and consumers may be even harder to negotiate across language barriers.

The disadvantage consumers experience when no interpreters are being used is even greater for clients with hearing impairments. Many Deaf people from remote areas do not communicate in standard Auslan (the Australian sign language). Instead they have developed their own communication methods with families and their communities. [11] This can be isolating when the person needs to communicate with others.

A common misunderstanding is that family members might be able to help services to communicate by 'interpreting'. However, professional standards require that families are not used as interpreters.[12] Having to interpret is a demanding task with specific skills. It requires an independent, accredited person who has had training and professional support in the area.

Over recent years, the Aboriginal Interpreter Service has developed more options to increase the availability of interpreters (for example, phone and video link). The CVP knows that at times it can be difficult to get interpreters at the time they are needed.

A close collaboration between the mental health services with the Aboriginal Interpreter Service in particular is needed to resolve service problems together. The CVP is pleased to see that a quality improvement project to achieve this goal has commenced in the Central Australia mental health service.

[11] Sign language interpreters can be booked in the Northern Territory through the National Auslan Booking Service (NABS). The CVP's experience in using the local Auslan interpreter is that this service has developed a very good knowledge of local clients. The use of NABS to improve communication for clients with a hearing impairment is essential.

[12] Commonwealth Ombudsman, *Talking in language: Indigenous language interpreters and government communication*, 2011; Medical Board of Australia, *Code of Conduct for Doctors in Australia*; Northern Territory Government, *NT Language Services Policy*, 2012.

SECLUSION AND RESTRAINT

Seclusion and restraint[13] can traumatise consumers. There is no evidence that these practices have any therapeutic benefit for consumers.[14] Under the law, seclusion and restraint are only allowed to be used in very limited circumstances.[15]

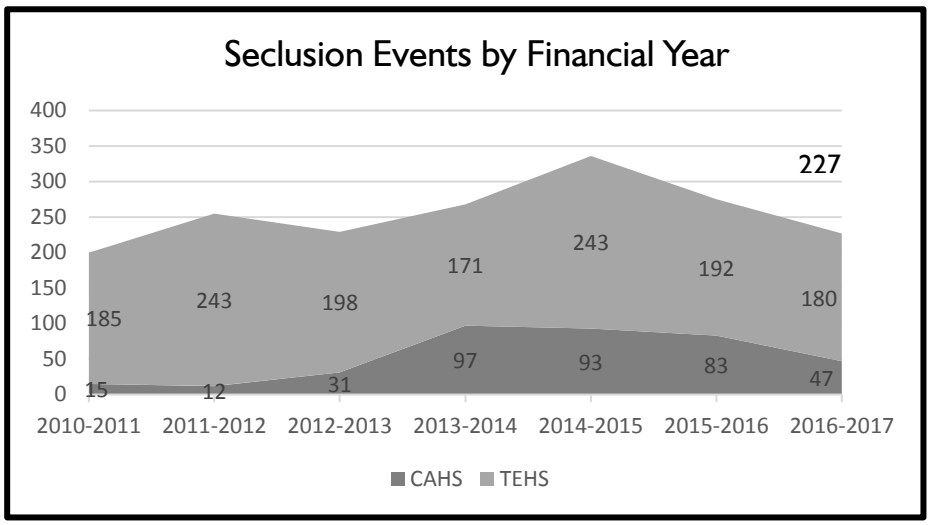
The services have policies and procedures in place on how the seclusion and restraint laws are implemented. The CVP is obligated to review the records the services keep on restrictive practices and comment on the findings.

Evidence shows that restrictive practices in mental health facilities can be significantly reduced.[16] In the last two years, both area health services have made considerable efforts to reduce the use of seclusion and restraint.

Seclusion Reduction

Projects based on the 'Safe Wards' model have been implemented in Darwin and Alice Springs, with the model adapted for the Northern Territory context.

The projects have focussed in particular on trying to reduce conflict and build stronger, more positive relationships with consumers.[17]



[13] Seclusion is defined as the "confinement of a patient at any time of the day or night alone in a room or area from which free exit is prevented", and restraint is the "application by health care staff of hands-on immobilisation or the physical restriction of a person to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment" (Australian Institute for Health and Welfare).

[14] Melbourne Social Equity Institute: Seclusion and Restraint Project-Overview, August 2014;
The National Centre of Mental Health Research, Information and Workforce Development Best Practice in the Reduction and Elimination of Seclusion and Restraint, Prepared for the National Mental Health Commission. Te Pou:: Seclusion: Time for Change, 2008

[15] *Mental Health and Related Services Act*, ss 61-62. The Act only allows seclusion and mechanical restraint to be used to prevent harm to the person or others, prevent the person from absconding or persistently destroying property.

[16] Melbourne Social Equity Institute: Seclusion and Restraint Project-Overview, August 2014;
Kevin Ann Hucksthorn: Reducing Seclusion & Restraint Use in Mental Health settings: Core Strategies for Prevention: Journal of Psychosocial Nursing and Mental Health Services, September 2004-Vol. 42-Iss9, pp.22-33

[17] Examples given: know each other, clear mutual expectations, calm down methods, bed news mitigation, soft/positive words, talk down, reassurance, discharge messages

227

Seclusion events in the Northern Territory in 2016/17

94 adults secluded

7 children secluded

Carer: "They told me to go away... [but] I think it would have helped him... and calmed him down, rather than being alone in this foreign environment by himself. Maybe they wouldn't have had to keep him in that horrible room."

C/2017/279

47

Aboriginal people secluded

Last year, the CVP reported on the success of the Top End project (called 'SafeCARE'). There were less seclusion events and, if events did occur, consumers were in seclusion for shorter periods of time.[18]

This year, the Central Australian 'Safe Wards' project has led to a reduction in seclusion events. There has also been a decrease in the number of seclusion events for children in Central Australia.[19]

Unfortunately, the initial positive trends in the Top End were not sustained this year. While there was a significant decrease in seclusion events in the first half of 2016, the number of seclusion events in the Top End has returned to similar levels as previous years.

The CVP has noted that some strategies in the Top End were not consistently maintained this year.[20] While nurses and other staff were involved in ongoing SafeCARE training, the CVP was told that medical practitioners were not.

As with previous years, there remain particular concerns about the use of restrictive practices with Aboriginal Territorians. Of those people secluded, Aboriginal men are more frequently secluded and for longer periods. The reasons for this are unclear.

The documentation the services keep shows that interpreters and Aboriginal Mental Health Workers are rarely used in the context of seclusions.

This might mean that a person who is already mentally unwell may spend many hours in seclusion without understanding what is happening or why.

Seclusion Events	CAHS	TEHS	Total
Over Four Hours	13	58	**71**

[18] Reduction from 159 seclusion events in July-December 2015 to 20 events in January to June 2016.

[19] In Alice Springs in particular, seclusions of children were reduced from 33 events in 2015-2016 to 2 events in 2016-2017.

[20] Strategies that were not as consistently implemented this year in the high security ward (Joan Ridley Unit) included the availability of structured activities, access to outdoor spaces, debriefing for consumers after seclusion, and reviews by consultant psychiatrists for all seclusions over 6 hours.

The CVP also has had concerns for the wellbeing of other vulnerable people, for example people with medical or physical problems, for example hearing loss, or a known history of trauma.

19
seclusion events of a child

Use of Restraint

With respect to restraints, the CVP has also made comments this year about the importance of using consistent, nationally agreed definitions for restraint. By using consistent definitions, the service is able to monitor restrictive practices with integrity. The CVP noted a record in which restraints were described as 'safe hold' and not recorded in the physical restraint register. This was raised as a concern with the service concerned.

With respect to mechanical restraint, this is defined in the *Mental Health and Related Services Act*. The CV Panel for the Central Australia Health Service made specific mention this year of restrictive practices as they apply to prisoners who are admitted for care and treatment under mental health legislation.

The services need to ensure that positive developments in seclusion reduction are sustained over time. Similarly, the service needs to maintain consistency in recording and monitoring the use of restraints. A culture of preventing restrictive practices need to be led and supported at all levels and in all professions of the service.

Overall, while there has been positive outcomes for the Alice Springs mental health services in reducing seclusion, the lessons learned in the Top End are timely. It is essential to maintain consistency and a strong focus in each successive year. Sustaining reductions in seclusion and restraint is a long term project for the services.

IMPROVING FACILITIES

Over many years, the CVP has raised concerns about the state of the 'high dependency' mental health unit in Royal Darwin Hospital.[21] This facility is called the Joan Ridley Unit (JRU). JRU has 8 beds and is the largest 'high dependency unit' for the Northern Territory.

"This place is so disgusting, I can't handle it. The nurses can leave, but we have to stay here the whole time."

C/2017/43

[21] 'Intensive' care and treatment for acutely unwell consumers is normally provided on a separate ward. These wards are usually called a 'high dependency unit' or 'low stimulus unit'. There are a number of wards in the Royal Darwin Hospital for mental health patients, therefore the CVP will refer to the specific unit of concern by its name, being the Joan Ridley Unit.

Towards the end of this reporting year, long anticipated renovations started. These are still underway at the time of writing.[22] This work has made a difference in the general appearance of the ward.

While these changes are positive, major structural problems and overcrowding continue to exist. It is not uncommon for there to be 3 to 5 patients on the ward, above the designated capacity. At times consumers sleep on mattresses, rather than beds, in an interview room.

Overcrowding leads to significant problems of safety, privacy, dignity and wellbeing. The CVP has concerns regarding the lack of private spaces, the overall cleanliness of the ward, and bathroom amenity. Of particular concern, female consumers report feeling unsafe.

The frequent presence of correctional officers to guard patients from prisons, and uniformed safety officers for other high risk patients, further contributes to an impression that JRU is a prison rather than a hospital ward.

The conditions of JRU impact negatively on consumers every day, and this is what Community Visitors hear when they visit the unit. As evidence of this, in Central Australia, safety concerns were only raised once this year. In the Top End, safety concerns were raised on 20 occasions.

> "I don't feel safe here. I am the only black girl. I'm scared of being raped and the boys are fighting all the time. I don't feel like that in [the other] ward."
>
> C/2017/44

Staff of the Top End mental health service share many of the CVP's concerns. Submissions have been made to try and improve the safety and facilities of the ward. To date no changes or improvements have been announced, beyond the current renovation work.

The CVP is of the view that it is not acceptable that the most unwell and vulnerable consumers (including those who require higher levels of security) are required to be held in an outdated, unclean and unsafe environment.

> "I know this has been a problem for over 20 years. It's not acceptable. Surely with all the advances in technology this problem should be resolved."
>
> C/2017/21

The CVP acknowledges the work staff undertake at JRU and their advocacy for consumers. They are supporting consumers with high levels of acute mental illness and agitation. They are doing so, however, while also dealing with a challenging environment

[22] The renovations include painting of walls and doors, concrete block beds replaced by modern beds, and carpets replaced by vinyl flooring. Nurses have also improved the garden area.

Consideration should be given to the urgent need for a contemporary facility for acutely unwell consumers in the Northern Territory. Such investment also needs to address endemic concerns with the infrastructure in adjoining wards (such as poor water pressure and temperature control in the bathrooms).

While JRU is the priority, an in-depth analysis of the issues (including community supports, discharge planning, and care in the community) needs to take place.

PARTNERSHIP APPROACHES

A partnership approach to care and treatment with consumers, carers and staff is required by national practice guidelines.[23] This is supported also by the legislation.[24]

In general, interactions with staff are positive. The CVP often receives feedback about the helpful, supportive and caring attitude of staff.

"The staff are really compassionate and have my best interests in mind."

V/2017/021

Nevertheless, there remain a number of cases raised with the Community Visitors where consumers and carers were not sufficiently involved in their treatment and care.

The CVP has noted that this can occur in particular when consumers are being treated against their wishes ('involuntary') and do not agree with the treatment decisions. The CVP acknowledges that the services have a duty of care, and often carry a high risk when making decisions about treatment and imposing restrictions.

However, people lose trust with services if they feel disrespected or control of their own lives is taken away from them. When people do not want to engage with the services because of lack of trust, it can result in the services making more restrictive decisions.

"They are treating me like a child. I try hard not to go off, but it's really hurting me the way they speak to me. I am not a child, I am a grown-up man."

C/2017/085

The service is responsible for making every effort to avoid this occurring and to act in a way that supports people to engage in their care as much as possible.

A culture of working in partnership with consumers and carers is required. Consumers' dignity and right

[23] National Standards for Mental Health Services 2010, Standard 3. National Mental Health Strategy: National Practice Standards for the Mental Health Workforce 2013: Part 3, Standard 2.
Northern Territory: Mental Health Service Strategic Plan 2015-2021, Priority Area 4

[24] *Mental Health and Related Services Act*, s12

to decide their own lives, as much as possible, needs to be protected. Staff need to listen carefully to consider how consumers and carers can contribute to treatment planning.

In recent years, both services have created peer worker positions.[25] These are valuable roles.

Although the rights of consumers and carers to be involved in treatment planning is part of the law,[26] the CVP would like to see a stronger focus on this in practice. There needs to be more evidence of the service's obligation to work in a genuine partnership with consumers and carers.

"My (loved one) has had bad experiences with services before. This has been very stressful... They don't remember these things; staff change and the corporate memory is short. That's why they need to talk to family."

C/2017/281

Planning and Review

Planning is an essential part of effective treatment and care. Plans need to be developed in a proactive and timely way together with consumers and carers, reviewed together for their effectiveness.

Although there has been some positive evidence of good planning, many cases raised with Community Visitors showed a lack of genuine involvement of consumers and carers, limited care planning, ad hoc responses and unclear responsibilities.

Sometimes there was very limited information about the person's goals and care needs and how these would be supported.

"There is no picture of a plan of what is going to happen now. Going home is really scary."

C/2017/254

Community Visitors observed that this delayed progress for the consumer for example, consumers remaining on the ward for longer periods of time, re-admissions soon after discharge, and repeated use of crisis services. This is also affecting the scarce resources of the services.

Trauma-Informed Care

The CVP has continued to pay close attention to the care of people who are vulnerable due to their experience of trauma. There is a strong link between mental health conditions and trauma, especially when experienced in childhood. Being admitted to a mental health in-patient

[25] In Central Australia two part-time positions for one carer and one consumer consultant, in the Top End one full-time position for a consumer and carer consultant.

[26] *Mental Health and Related Services Act* and *Carers Recognition Act*.

facility against your will, and possible experiencing other restrictions, can traumatise people further.

While there has been examples of good planning and practice to avoid re-traumatising people, at times consumers or carers have told Community Visitors about how services have caused further distress and added to their trauma.

The CVP considers that trauma-informed care remains a high priority for the NT mental health services, to ensure the best quality service for some of the most vulnerable people in the community.

YOUTH DETENTION

The need for specialist trauma-informed care for some people is particularly evident for young people in correctional facilities ('youth detention'). In previous years, the CVP has raised concerns about mental health care of children and young people. There has been some positive changes for children and youth in the community.

For children in youth detention, however, the CVP's concerns about the lack of mental health services remain. In the past year, there has been improved procedures for review of 'at risk' youth detainees. This is a limited improvement.

Children in youth detention still only receive a comprehensive mental health assessment if they need to be admitted to an emergency department. In the CVP's view there needs to be substantial improvements in meeting the mental health needs of youth detainees. This includes the need for routine mental health assessments and integrated care for children coming into and out of detention.[27]

This care needs to be supported by the involvement of child and youth psychiatrists wherever possible. This is particularly important considering the history of trauma that is known to be experienced by youth detainees.[28]

A PLACE TO LIVE WITH THE RIGHT SUPPORT

Affordable, secure and (for some people) supported accommodation is a cornerstone of wellbeing and recovery in mental health.[29] In the Northern Territory *Mental Health Services*

[27] This is particularly important considering the interim findings of the Royal Commission into the Protection and Detention of Children in the Northern Territory (31 March 2017). The interim report noted the complex needs of youth detainees, including cognitive disabilities, mental illness, addiction to nicotine, alcohol and other drugs as well as physical deficits such as poor hearing and sight, and, in some cases, also functional illiteracy (p 38).

[28] Royal Australian and New Zealand College of Psychiatrists: Maximising Opportunities for Recovery, Submission for the Royal Commission in to the Protection and Detention of Children in the Northern Territory, 2016
Strathis, S.L.; Harden, S.; Martin, G. and Chalk, J: Challenges in establishing forensic mental health services within Australian youth detention centres, *Psychiatry, Psychology and Law*, 20(6), 2013

[29] Standing Council of Health, *Mental Health Statement of Rights and Responsibilities 2012,* p 7 (Part II, Non-discrimination and social inclusion…(g) equal opportunities to access and maintain housing.)

Strategic Plan 2015-2021, a key priority area is increasing access to appropriate and supported housing.

The CVP has continued to raise the ongoing urgent need to increase the availability of secure and supported housing. Over the past few years, the Northern Territory mental health services have sought to expand supported accommodation options for acute or complex clients of the service.[30]

While positive, these successes have only provided a small number of additional beds. Concerns have also been raised about a lack of clear procedures and guidelines for protection of consumer rights.

The CVP has made comment in every annual report since 2003-2004 about the need for appropriate accommodation options for people living with mental illness. In 2011-2012, the CVP advocated for a comprehensive needs analysis on accommodation and support options to support service planning.[31]

Following this, a housing project was supported by the Department of Health. The scope and focus of the project moved away from needs analysis. The project resulted in housing officer positions being funded within the area mental health services. These staff work to help close accommodation gaps for consumers and support inter-agency collaboration.

The CVP remains concerned that at present the needs of certain vulnerable consumers remain inadequately met. Cases raised with the CVP this year have shown that some individuals remain in restrictive environments or receive insufficient support in the community.

In the past year, several people with high care needs have remained on the mental health in-patient wards for extended periods (sometimes 6 months and longer) due to lack of appropriate supported community-based accommodation.

The pressures of an acute care setting may also mean that these consumers' needs are not as high priority on a daily basis. The consumer is at risk of becoming institutionalised and lose life skills.

The planning processes for these complex consumer needs are often very slow, especially when multiple stakeholders are involved and responsibilities are unclear. The CVP is particularly concerned about the impact on individuals when they remain in an acute care setting that is not appropriate to their needs.

The need for appropriate supported accommodation for people living with mental illness is evident throughout the Northern Territory. There have been some additional initiatives put in place for the Top End. The Northern Territory Government's strategic policy for mental

[30] In Alice Springs the sub-acute facility was opened in 2013-2014. In Darwin, the Top End mental health service took over operation of an established facility in May 2017.
[31] CVP Annual Report, 2011-2012, p8.

health[32] includes a funded trial project to provide support and tenancy stability for people with mental illness living in public housing in Darwin and Palmerston.[33]

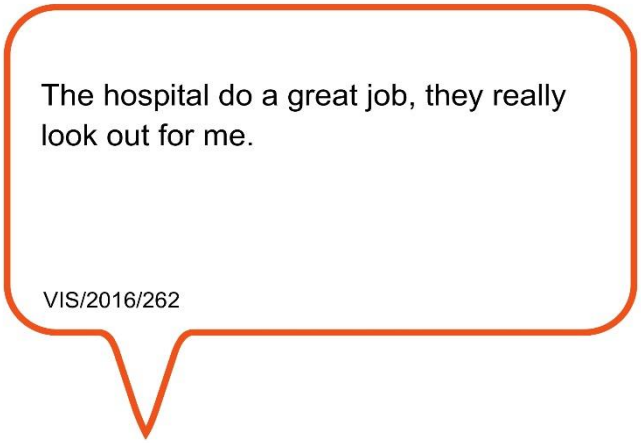
The trial project includes partner agencies such as Territory Housing, NT Mental Health Coalition, NT Shelter and the Top End mental health services. Partner agencies are working together to determine tenancy support needs of current public housing tenants with mental illness. The project is seeking to develop a viable model, with psychosocial support to be provided by community-managed mental health services.

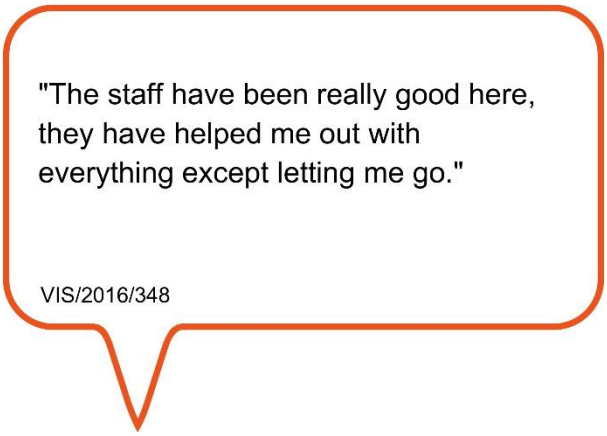
The various housing projects supported by the Department of Health provide some limited benefits, primarily in inter-agency coordination and collaboration. The tangible benefits for consumers across the Northern Territory, including those not currently in public housing, are less obvious.

It also remains unclear how the various projects inform strategic planning on the overall housing and support needs for people with mental illness in the Northern Territory. The CVP has observed that this lack of an evidence-based approach has affected the planning.

While various housing projects have been undertaken, there remains a lack of proactive, strategic approaches for the Northern Territory. There remains insufficient information to clearly determine the needs, and then put in place strategies to meet the needs for short and long term housing and support for consumers.

The CVP continues to strongly advocate for a more strategic approach to mental health housing and support needs. There needs to be active work to develop and fund a range of different accommodation options. This requires a 'whole of government' approach.





[32] Northern Territory Government, Strengthening Mental Health Policy, 2012.

[33] Northern Territory Government, Strengthening Mental Health Policy, 2012, 'The housing accommodation support initiative'. This trial project proposes to invest $3 million over four years to provide 'wrap-around' support system including clinical services, tenancy and psychosocial support. It is proposed that the wrap around services will support 50 consumers in the first year

FACILITY PRIORITIES & OPEN RECOMMENDATIONS

Top End Mental Health Service

Achievements

- 9 CVP recommendations closed.
- Improvement of record keeping of restrictive practices.
- Consistent very good provision of meaningful and diverse activities in Cowdy ward, with the facility also used by consumers in nearby wards.
- Some pro-active planning processes to support complex clients and some evidence of collaborative care planning with consumers and carers.
- For the youth in-patient program, a strong culture of client-centred, trauma-informed care with transparent work with families and carers
- Flexible use of the youth in-patient space for other vulnerable consumers and carers, and expanded admission criteria to improve services to children in acute crisis situations.
- Renovation work in Cowdy ward common areas, and the Joan Ridley Unit (beds replaced, bedrooms painted, garden improved, with work still underway).
- Improved outdoor area for clients in Cowdy ward who smoke.
- Taken responsibility for management of a pre-existing accommodation facility for consumers with specific needs.

Areas for Improvement

- A stronger focus on consumer rights, in particular relating to protections for consumers to communicate (section 98), accessing information before a tribunal hearing (section 132), and rights on involuntary admission and voluntary admission.
- Improved access to reliable complaints mechanisms.
- Strengthen planning processes and decision-making when consumers remain in the in-patient ward due to lack of accommodation (and providing additional resources to address the needs of these long term consumers).
- Consistently applying principles of trauma-informed and recovery-oriented care.
- Developing policies, including on the rights and responsibilities of consumers and carers, for people living in the newly acquired accommodation facility.
- Addressing the problems with water pressure and temperature in bathrooms in Cowdy ward.

Priority Issues

- Need for consistent use, and recording of the requests for and use of qualified interpreters for consumers who require interpreters.
- Substantially improving standards of facility and safety in the ‘high dependency ward’ known as the Joan Ridley Unit.
- Refocusing on pro-active strategies to reduce seclusion and restraint, including implementing policies that promote shorter and less frequent seclusions and reducing the use of restrictive practices on children.
- Engaging in genuine partnership with consumers and carers.

Top End Mental Health Service				
CVP Recommendations		**Made By**	**Date**	**Status**
1.	That a comprehensive accommodation and support model is developed, adequately resourced and provided in the Top End of Northern Territory. (Reworded, 2016)	CV Panel[34]	Nov 2006	Open
2.	That the Mental Health Service ensure that interpreters are present at assessment for all consumers whose first language is not English. It is further recommended that interpreter assistance is then arranged for all further assessments and to assist the consumer at any hearing before the Mental Health Review Tribunal.	CV Panel	May 2007	Open
3.	That the service provide evidence that in the process of involuntary admissions that there is adequate explanation of rights to consumers, including legal status on admission, offering of interpreters and early access to the Mental Health Review Tribunal. (Reworded, 2016)	CV Panel	Nov 2011	Open
4.	That the Top End Mental Health Service (TEMHS) implement strategies to ensure the cultural safety of clients with a particular focus on the needs of Indigenous clients in line with TEMHS values and objectives.	Community Visitor	May 2013	Open
5.	That management request a report from the Director of ECT on evidence of quality activities, demographics of clients receiving ECT, the nature of consent and key clinical indicators for ECT across the patient population.	CV Panel	Apr 2013	Open
6.	It is recommended that clear, culturally and therapeutically safe arrangements be made for the management of women consumers on the Joan Ridley Unit (JRU).	CV Panel	Mar 2016	Open
7.	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 section 132 of the *Mental Health and Related Services Act* (MHRSA).	Community Visitor	Nov 2016	Open

[34] The CV Panel for Top End mental health in-patient facility was not convened for the period January-June 2017. The CV Panel visit occurred on 7 November 2016 and open recommendations date from this visit report.

Top End Mental Health Service				
8.	That TEMHS address the need for improved JRU infrastructure to meet the requirements for all clients, but particularly women with high care needs to have a safe and therapeutic hospital environment.	Community Visitor	Nov 2016	Open
9.	That the interior and exterior environment of the High Dependency Unit (HDU) of Cowdy be refurbished and activities be made available on HDU to ensure an appropriate therapeutic environment for consumers.	CV Panel	Dec 2016	Open
10.	a) That TEMHS urgently develops and implements appropriate recovery-oriented care plans for long term clients in the In-Patient Unit (IPU). b) That the service develop a policy that triggers recovery-orientated nursing plans and interventions for clients who are likely to remain on the ward for longer periods and provides appropriate resources for this.	Community Visitor	Mar 2017	Open
11.	That TEMHS develop policies and procedures clarifying the use of section 98 restrictions to ensure that clients only have their rights restricted in line with legislation.	Community Visitor	May 2017	Open
12.	That TEMHS establish and advise the service's targets to improve trauma-informed care. (reworded)	Community Visitor	Jul 2017	Open
13.	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.	Community Visitor	Aug 2017	Open

Central Australia Mental Health Service

Achievements

- 12 CVP recommendations closed.
- Increased focus on SafeWards seclusion reduction initiative, including training for staff and strategies to de-escalate behaviours of concern.
- Significant decrease in the use of seclusion on children.
- Transition of a long-term consumer on the ward to more appropriate accommodation.

Areas for Improvement

- Greater focus on the use of trauma-informed care.
- More detailed discharge planning, including collaboration with all stakeholders.
- Increased focus on the needs of Aboriginal consumers, in particular those experiencing or at risk of restrictive practices.
- Increased consumer and carer involvement in care planning and decision-making.
- More robust internal complaints procedures and follow-up, including for matters seen as minor, to avoid escalation of concerns.
- Greater clarity in governance of forensic mental health services, including the role and responsibilities of the Top End Health Service.
- Clarify responsibilities, leadership and decision making pathways for consumers who are also cared for by other departments, in particular Office of Disability.

Priority Issues

- Building strong relationship with Aboriginal Interpreter Service to ensure greater availability of qualified interpreters for Aboriginal Territorians.
- Focus on staff training in the professional use of accredited interpreters to improve assessments, reviews and consumer information about rights.
- Develop policies and rights and responsibilities of consumers and carers for the sub-acute facility.
- Consistent recording of restraints according to national guidelines and to promote continuous improvement.

CVP Recommendations		Made By	Date	Status
1.	That the Mental Health Unit review its seclusion practices and introduce strategies aimed at reducing the rates of seclusion, with a special focus on de-escalation techniques. (Reworded)	CV Panel	Dec 2013	Open
2.	That significant efforts are made to recruit to the Aboriginal Mental Health Worker position within the Forensic Mental Health Team, including any development required to upskill a suitable applicant. (Reworded)	Community Visitor	Aug 2014	Open

Central Australia Mental Health Service				
3.	That the CAHS and TEHS Boards formalise arrangements for responsibility for forensic mental health services in the Central Australian region, including the provision of appropriate and accessible mental health support to Central Australian youth and adult detainees.	Community Visitor	Dec 2016	Open
4.	That CAHS and TEHS urgently provide integrated mental health services to youth detainees in the Northern Territory, supported by child and adolescent psychiatrists or forensic psychiatrists with adolescent experience.	Community Visitor	Dec 2016	Open
5.	That CAHS Mental Health review processes to improve effectiveness of processing both internal and external complaints and provides CVP with the service complaints register.	Community Visitor	Jun 2017	Open
6.	That a new policy be developed in accordance with professionally accepted standards and the least restrictive principles as required by the *Mental Health and Related Services Act* to ensure that adopted practices in the Mental Health Unit (MHU) comply with the fundamental principles of the Act when a prisoner becomes a mental health patient, to revert to prisoner status when out of the facility	CV Panel	Jun 2017	Open
7.	That CAHS Mental Health actively pursue negotiations with Aboriginal Interpreter Service (AIS) management in Alice Springs with a view to improve interpreter attendance in matters related to mental health and insist on the human right of mental health consumers to be heard and understood in their primary language to ensure the best possible outcome in their care and treatment.	CV Panel	Jun 2017	Open
8.	That existing seclusion policies and procedures include detailed strategies to reduce the use and impact of seclusion on minors. (Reworded)	Community Visitor	Jul 2017	Open
9.	That CAHS Mental Health demonstrate in the review of its policy and procedures how National Best Practice is embedded in the definition, use and recording of episodes of restraint when used across the Mental Health Unit (MHU).	Community Visitor	Jul 2017	Open

CHAPTER 3: DISABILITY

Priority Needs

1. Better quality clinical treatment and oversight, especially in Positive Behaviour Support Plans and client reviews.
2. Formal agreements with other agencies involved with resident care and treatment.
3. Use of independent accredited interpreters for significant clinical and management discussions with residents.

The CVP has seen an increase in the places visited and the number of cases raised by people in specialist disability places. This is a positive sign of the increased role of the CVP with some of the most vulnerable people in our community.

33 visits

32 cases

POSITIVE CHANGE

The CVP is pleased to report a number of positive events this year in the work of the CVP and the Office of Disability in specialist disability places. While concerns remain in key areas, the CVP has seen some good progress and outcomes. The positive changes that particularly stand out are long term residents moving to community accommodation and a stronger focus on building staff capacity.

This year, there has been a significant increase in the number of matters raised with a Community Visitor for assistance. The total number of residents in disability places covered by the work of the CVP has remained about the same. However, the number of cases raised by residents and others in the specialist disability area has increased by 88% over twelve months.

This increase in cases is positive. Many residents are long-term clients. Over time, the residents and others in the specialist disability area have come to see Community Visitors as familiar faces. Residents better understand the role of the CVP.

The majority of residents in specialist disability places speak English as an additional language. This past year Community Visitors have worked hard to make sure, as much as possible, that interpreters are available on visits. The Community Visitors have reported that some residents who previously were quieter are now raising issues.

From the service perspective, the CVP has seen the service improve in a number of ways. For the past two annual reports, the CVP asked how residents were being supported to move to community-based accommodation. This year, four long-term residents moved into the community while still receiving direct support from the Office of Disability.

Moving to a house in the community was a significant and much anticipated move for the residents. The pleasure on the faces of residents when showing Community Visitors their new house was obvious.

The Office of Disability has had some staffing challenges this year, with turnover in senior staff positions in facilities and the organisation more broadly. Despite this, in general terms the organisation managed to maintain quality care for residents during these periods.

The Community Visitors have noticed that there was increased clinical input from professional staff and consultants working on-site. Professional staff have focussed in particular on supporting disability workers to build their skills and knowledge.

[Staff to CV]: "It's gentle support. But different for each client."

C/2017/109

Over the year, Community Visitors were also told about a move towards a 'key worker' model of staffing support. This model assigns workers to the same resident, which in turn increases staff knowledge, rapport and understanding of how best to support residents. The CVP supports this direction.

Importantly, there was an overall reduction in restrictive interventions used on residents. Alongside this were more robust processes, especially in Central Australia, for debriefing and learning from incidents of concern with all staff involved. This is further evidence of the service's increasing focus on staff skills and a 'least restrictive' approach to care and treatment.

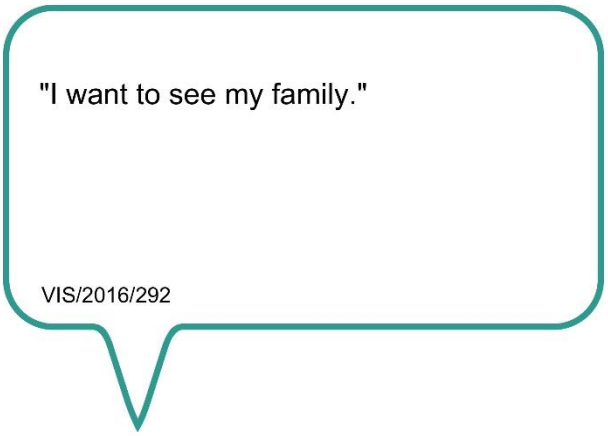
The quality of staff interactions with residents continues to be observed as generally very good. When difficulties with staff were raised directly by residents or other staff, the Community Visitors saw evidence that these concerns were taken seriously.

In this year, especially in Central Australia, the service recruited a number of Aboriginal staff. A cultural advisor with language skills was appointed in the Secure Care Facility. When a female resident moved into one facility, there were more female staff recruited and issues related to her care were well managed.

These achievements are positive steps towards client care and a quality service. The CVP commends the Office of Disability for the above improvements.

RESIDENT NEEDS

The most common issue raised with the Community Visitors by residents is their strong desire and interest to have more contact with their families and communities. All residents visited by the Community Visitors are Aboriginal Territorians.



The desire to see family and go home to their communities is a human need, but for Aboriginal residents it is also one of cultural safety in the provision of services by the Office of Disability. The Community Visitors observed that, in general, there was a strong commitment to support more family contact.

Where family members are well known to the service, this contact usually occurs for residents in a timely way. The Community Visitors have noted the service taking residents overnight to communities, or supporting them if staying overnight on their own at a family member's residence.

Unfortunately, some residents may be disconnected from their families, or their families live remote from the residential facilities. This can present challenges for the service to get to know families and consistently encourage positive contact.

The CVP encourages the service to keep working towards greater contact with families and communities. This is a right for all people with disabilities, and part of Australia's national disability standards.

"Can you really help me with [visiting home]? I could give the little ones a hug." C/2017/179

"There's ceremony there, I want to go." C/2016/735

POSITIVE BEHAVIOUR CLINICAL SUPPORT

For the past few years the CVP has commented on the need for greater clinical depth in developing, implementing and reviewing residents' positive behaviour support plans (PBSPs). The CVP's concerns in this area remain constant.

These concerns are based on the need to move beyond care and compassion in resident treatment. The service needs to provide clinical support that enables a 'least restrictive' approach to care and treatment. This approach helps residents progress to accommodation in the community with the right supports, without the need for supervision.

Currency and Depth of Plans

The CVP remains concerned about the currency of residents' PBSPs. The plans have information on the person's social history, their likes and dislikes, how to recognise early warning signs of behaviours, and what responses to behaviours are authorised under the plan.

There is very little detail however about the therapeutic goals for working with the person, the clinical hypothesis for the person's behaviours of concern, the ways in which staff will specifically support the development of alternative behaviours, and how these interventions will be measured.[35] Even though PBSPs have to be reviewed on a yearly basis, there was little evidence that this occurred in a robust manner.

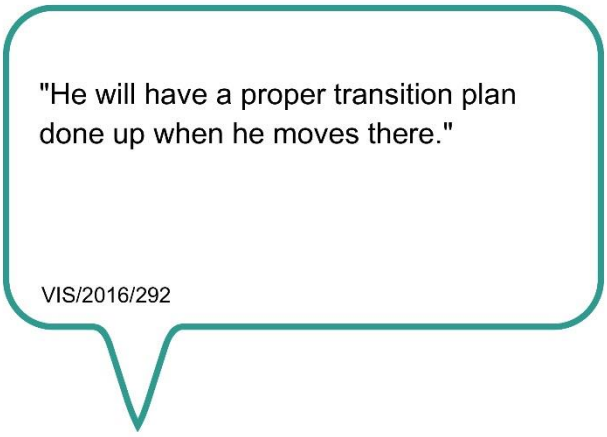
One of the observations made by the Community Visitors is that staff are often not aware of the detail of an individual's plan. Sometimes there is little evidence that general strategies described in the plan are used. A plan that is not well understood cannot be faithfully implemented.

It is clear that clinical staff know longer term residents well, having worked with them for years. This depth of knowledge is not always reflected in updated PBSPs nor updated therapeutic strategies to address new or emerging needs of residents.

The CVP continues to assert that the PBSPs need to be current, dynamic, more specific and detailed for the person and their individual circumstances. The PBSPs also need to be supported by detailed and current functional assessments.

Clinical Support for Transition

Even though a number of long term residents transitioned into community houses this year, the PBSPs were not updated to reflect this significant change. Many of the plans stress the importance of routine for residents, and yet with such significant change to a resident's living situation, the plans remained silent.



[35] In making this statement, the CVP has noted the range of information that is included in policy and procedure documents for other similar services in Australia (for example, in NSW: http://www.adhc.nsw.gov.au/sp/delivering_disability_services/behaviour_support_services/behaviour_support_policy_and_practice_manual; in Victoria: http://www.dhs.vic.gov.au/__data/assets/pdf_file/0003/845346/New-Toolkit-Section-2-How-to-complete-a-BSP-Planning-Guide-2017.pdf; and in Queensland: https://www.communities.qld.gov.au/resources/disability/key-projects/positive-behaviour-support/positive-behaviour-support-plan.pdf). The CVP recognises that the NT service is a smaller service than other Australian States, nevertheless the scope of a quality positive behaviour support plan would be constant regardless of the size of the service.

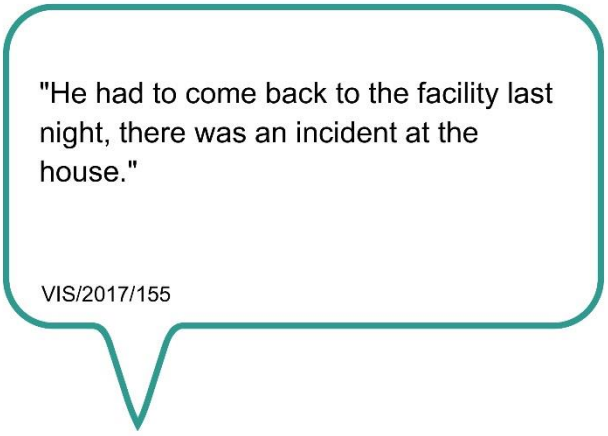
Neither the PBSPs nor transition plans reviewed by Community Visitors clearly stated the risks, behaviours and intervention strategies for residents on transition.

Unfortunately, for some residents who moved into the community, there was a temporary escalation in the use of restrictive interventions. In the CVP's view, the lack of planning increases the risk of behaviours occurring during transition.

For one resident with complex medical needs, there was an exponential increase in the use of chemical restraint over a period of three months. Following a comprehensive clinical review, and changes to this person's management in the community, there was a reduction in restraints. The resident's behaviour settled. The success of this intensive clinical work reinforces the need for detailed clinical planning and support on-site.

For newer residents, there appears to be very limited clinical assessment in preparation for new clients moving into facilities. Some residents who have been in the disability places now for some months do not have PBSPs.

The lack of detailed preparation for new residents, and the lack of planning to enable staff to manage behaviours that arise, is concerning. Some residents with limited planning and support documentation have returned to prison during transition periods. This has happened after serious incidents, usually involving assault of a support worker.



Individual Review Processes

The CVP understands work in this field is dynamic and unpredictable. Nevertheless, the CVP has commented for the past three years on the importance of robust individual client review processes.

Although the *Disability Services Act* requires a formal review with the person themselves and their guardian on an annual basis, there was no evidence to show this is a standard practice. The formal review is an annual requirement. There was also limited evidence of regular, individual reviews throughout the year.

Such reviews need to be informed by detailed knowledge of client behaviours. Reviews need to be informed by evidence from planned therapeutic interventions, measured over time. Reviews need to link to updated or new plans.

For evidence of review processes, the CVP was directed towards minutes of staff meetings, and emails exchanged between senior staff. These sources were not detailed. The information was more informal and not stored on individual client records. There was no evidence of objective measures of client review.

There was no clear evidence of structured, individual review processes involving all relevant people. The CVP has formed the view that there is not enough evidence of robust individual client review processes. The limited changes to the PBSPs on an annual basis reflect the low quality of clinical review throughout the year.

Quality Assurance in Clinical Planning

Each year the CVP has noted the importance of the positive behaviour support 'Review Panel' as a way to oversight the quality of plans. Section 40 of the *Disability Services Act* provides this mechanism as a way to review restrictive interventions in a PBSP.

Until recently, the Office of Disability has taken a narrow view on the legislative scope of this Review Panel. The CVP maintains that the Panel provides an important way to independently review PBSPs. If the Review Panel were established, it would be a very useful addition to the quality assurance framework for residents more generally.

Overall, the CVP notes that the nature of clients transitioning into and living in specialist disability places are those who present the greatest risk to themselves or others. The greatest burden of risk is held by the client. The person with a disability is at risk of returning to a more restrictive environment (for example, prison).

The obligation to support the person to avoid such restriction is with the service. The best way to meet this obligation is by careful, detailed planning and high quality clinical support and review. This is an area in which the Office of Disability needs to invest more to ensure quality care for their clients.

The CVP notes that with the introduction of the National Disability Insurance Scheme (NDIS), agreement has been reached for a national quality and safeguards framework. The Northern Territory has agreed to an approach for implementing this framework with local disability providers.[36]

In the CVP's view, the same expectations for a quality service need to apply to the Office of Disability's own direct service provision. The CVP notes in particular the requirements for all disability providers to have person-centred planning, safeguarding of rights, and culturally safe services.

PERSON AT THE CENTRE

The CVP has seen a small increase in new residents in the specialist disability residences in the past year. The number of residents seen by the CVP is around fourteen, however some people may transition in or out at any point in time.

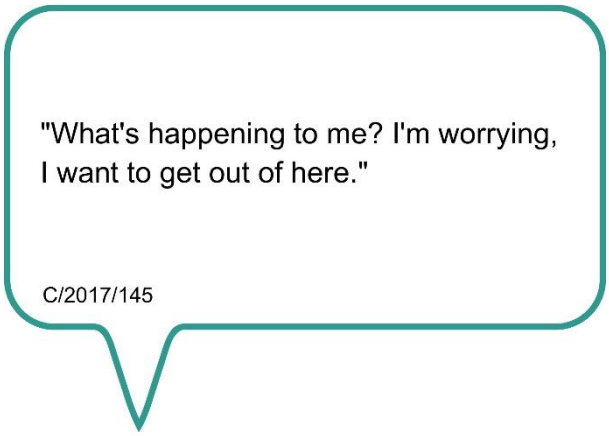
[36] Northern Territory Government, *NT Quality and Safeguarding Framework 2016*.

One of the trends among the new residents is the increasing complexity of residents who are mutual clients of other agencies. The agencies most relevant are corrections, mental health, public health, aged care and public guardians.

Some departments have frequent interactions with the Office of Disability (such as the Department for Corrections). Some residents may be mutual clients of both agencies for many years.

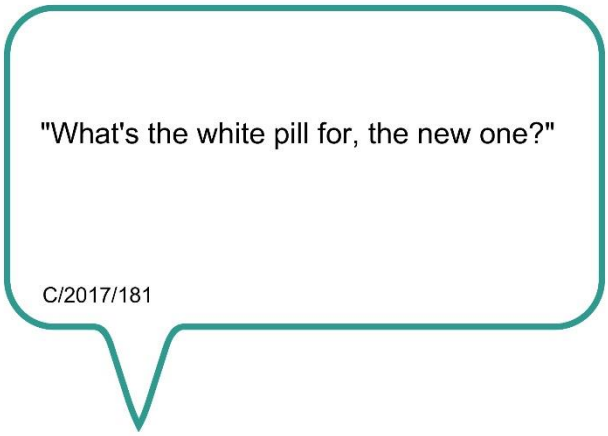
Age-Related and Mental Health Needs

This year, a small number of residents had questions raised about the appropriateness of their placement in residential facilities operated by the Office of Disability. The use of residential facilities for people with other needs presents a significant challenge to the service.



For some residents, the Office of Disability provides the day to day support, however other health services are responsible for treatment and transition out of the facility.

Some clients transitioning into residences have been identified to the Community Visitors as needing accommodation and support from an aged care framework, more than disability services. There have been delays in organising appropriate transition arrangements as staff need to plan for and negotiate more appropriate aged care support.



Some residents have been in disability residential facilities for extended periods of time, even if it was anticipated that they have a short stay. In some cases, the legal and administration arrangements for such residents have been complicated and confusing. The CVP has raised these concerns with the service.

Changing Practice Framework

These complex clients moving into specialist residential facilities are on custodial supervision orders made by the Supreme Court. They are stepping down from prison to the less restrictive environment of a supervised residence. Corrections staff are often closely involved in monitoring and the transition and responding to incidents of concern.

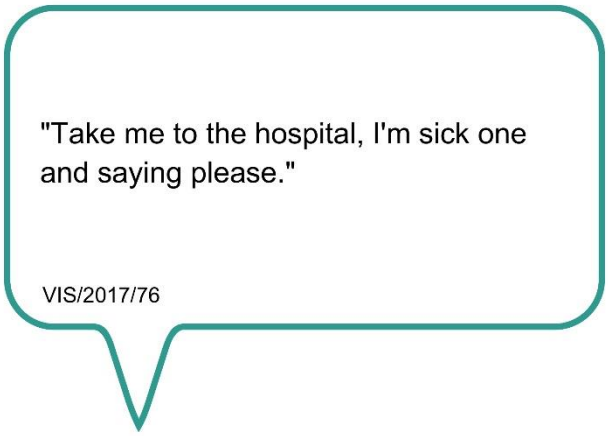
While the CVP strongly supports 'least restrictive' principles and approaches to care, the original intent of the Secure Care Facility (and other appropriate places managed by the Office of Disability) is changing in practice.

The Secure Care Facility and other appropriate places run by the Office of Disability are for clients with a complex cognitive impairment, a disability, and who could benefit from 'goal-oriented' therapeutic services. This is the main expertise and skill set of staff, and the basis on which policies and programs are delivered.

For clients presenting with complex needs, the primary 'service' being offered by the Office of Disability is supervised accommodation. These clients need for supervision may come from a mental health and/or age-related impairment, rather than an intellectual disability. This changes the nature of support being provided and required on transition.

This change needs to be acknowledged and new agreements put in place with other relevant agencies to better manage the needs of these residents in disability facilities. These agreements would also assist in avoiding unintended outcomes, such as lengthy transition planning out of the residences.

Formalising Agreements with Agencies



The CVP is of the view that formal agreements with agencies who commonly have mutual clients with the Office of Disability is beneficial. Streamlined agreements that respond to the unique needs of both agencies are beneficial for all concerned, providing safety and support for all involved.

Agreements with the area health services, in particular mental health and aged care services, are needed. It would be useful to formalise agreements with emergency departments, as this can also be a place where residents' behaviour can escalate and present risks to all.

Some agencies have a high level of interest in the work of the Office of the Disability, and would benefit from having agreements in place for communication and information sharing. The Office of the Public Guardian and the CVP are two such agencies.

The CVP has an existing protocol with the Office of Disability. This was a useful starting point for clarifying mutual roles and responsibilities. Towards the end of this reporting period, there has been good progress towards revising and updating this protocol.

The work of the Office of Disability in specialist disability residences has evolved over the past few years. The complexity of clients has increased. The need for clarity in roles and responsibilities of other agencies has become more evident.

The CVP is of the view that formal agreements will help address the range of needs for clients, provide improved clarity about each service's roles and responsibilities, and ensure high quality and timely care for residents residing in these facilities.

BEING HEARD AND UNDERSTOOD

As noted above, in this year, the Community Visitors have seen an increase in the number of issues raised during their discussions with residents. There are challenges in communication that come from the nature of people's disabilities.

For most residents who the CVP visits in specialist disability places, however, these challenges can be reduced. One of the most useful ways of doing so is to communicate in the person's preferred language.

"I like hearing language, more language..."

C/2017/234

Unfortunately, the CVP has observed that there has been very little engagement by the Office of Disability with the need for independent, accredited interpreters for residents in their care. When asked directly, the service responded that interpreters were not regularly used.

The service has directed the CVP towards its recruitment of multilingual staff as evidence of its commitment to good communication. While multilingual staff are very important part of culturally safe client care, these staff are not independent and trained as interpreters.

"If the client does not understand something, it is more related to cognition than language, therefore the language it is delivered in is not relevant" (L231116)

The obligation to use interpreters rests with the service, to communicate fully with residents, understand their needs and to respond to those needs in a professional manner.[37] When these matters of quality, professional responsibility for communication were raised with the service, the CVP found the responses to be disappointing.

Communicating everyday matters in English may work when a resident is very familiar with routine. Communicating about significant matters with people with a disability, such as obtaining information to do an assessment, review or debriefing, is another story. The CVP considers the use of interpreters for such significant conversations as essential and best practice.[38]

Within that broader context of hearing and understanding resident needs, the CVP has raised with the service the importance of having a robust internal complaints system. The *Disability*

[37] Northern Territory Government, *NT Health Aboriginal Cultural Security Framework 2016-2026*, domain 2 (communication).

[38] Australian Government, *National Standards for Disability Services*, standard 3.

Services Act requires this to be in place.[39] These systems are not working in the residential facilities.

> [About one staff member]: "He's always looking at me, talks down to me... I don't want him around."
>
> C/2017/326

An internal complaints system, which has a broad definition of a 'complaint' (recognising that the person has a disability), is a central part of any service. It is important as part of its commitment to resident participation and responsiveness, quality assurance and continuous improvement.[40]

The Office of Disability requires government funded disability providers to have such systems in place. It is critical that the Office of Disability's own direct services have the same system in place to hear, understand and respond with integrity to resident concerns. To give residents a voice in their own care and treatment.

FACILITY PRIORITIES & OPEN RECOMMENDATIONS

Secure Care Facility

Achievements

- Three recommendations closed
- Recruitment of a more diverse workforce, including Aboriginal and female staff
- Employed an Aboriginal cultural advisor
- Improved incident debriefing and documentation

Areas for Improvement

- Building staff knowledge and skills in the use of accredited interpreters
- Improving processes for individual client review
- Formalising agreements with agencies involved in resident care and treatment

Priority Issues

- Need for on-site clinicians to support management and disability support workers in their roles
- Finalising procedures related to site safety, risk management (including in houses managed by SCF group home manager), and robust internal complaints procedures
- Working with mental health services collaboratively to resolve transition of a long term mental health client out of the facility into more appropriate accommodation
- Ensuring senior level clinical staff attend the next CV Panel visit to enable the Panel to consider closing or amending recommendations

[39] *Disability Services Act* (NT), Part 5.
[40] Australian Government, *National Standards for Disability Services*, standard 6.

Secure Care Facility				
CVP Recommendations		**Made By**	**Date**	**Status**
1.	That adequate duress alarms for staff and visitors are installed. (Reworded)	Community Visitor	May 2013	Open
2.	That the service provides the quality assurance framework documentation and process that underpin quality assurance for the Secure Care Facility and appropriate places.	Community Visitor	Aug 2014	Open
3.	That the Positive Behaviour Support Panel be established in accordance with sections 36 and 40 of the *Disability Services Act*.	Community Visitor	Aug 2014	Open
4.	That Secure Care Facility management and the Aboriginal Interpreter Service meet to organise an orientation session for interpreters called to have language and cultural assistance with the Secure Care Facility residents.	CV Panel	Oct 2014	Open
5.	That Secure Care Facility management explore options for accommodating women within the facility separate from men.	CV Panel	Oct 2014	Open
6.	That information available about early childhood of residents is taken into consideration when Positive Behaviour Support Plans (PBSP) are established.	CV Panel	May 2015	Open
7.	That a clear individualised transition plan be established for each resident at the facility upon admission, showing steps achieved towards exit.	CV Panel	May 2015	Open
8.	It is recommended that an on-site clinical role be filled at the Secure Care Facility. (Reworded)	Community Visitor	Jul 2015	Open
9.	That to ensure proper consideration of biological and/or psychiatric causes of significant difficult behaviour incidents, a clear procedure should be developed for notifying the General Practitioner and psychiatrists of such incidents and of subsequent actions taken by both.	CV Panel	Jun 2016	Open
10.	That the Secure Care Facility update each resident's Positive Behaviour Support Plan with a more detailed therapeutic program of specific and measurable interventions, including related to transition. (Reworded)	Community Visitor	Jul 2016	Open
11.	That the Secure Care Facility implement a quality data analysis and measurement process related to each client's therapeutic program, including improved processes for individual client review.	Community Visitor	Jul 2016	Open

Secure Care Facility				
12.	That the CVP is notified in a timely way of all new and transitioning residents in residential facilities covered by the *Disability Services Act*, including being provided with all relevant documentation on new and transitioning residents.	Community Visitor	Feb 2017	Open
13.	That the Secure Care Facility establish an effective internal complaints register and report on complaint handling according to section 49 of the *Disability Services Act*.	Community Visitor	May 2017	Open
14.	That the Secure Care Facility establish a register to record the booking and use of interpreters for clients.	Community Visitor	May 2017	Open

"This is my house, have a look."

VIS/2017/69

"I look after this, water the plants, collect the eggs."

VIS/2016/349

Other Premises

Note: Information is very general to protect people's privacy. There is one house in the community that is visited by the CVP.

Priority Concerns

- That planning for transition to the National Disability Insurance Scheme is prioritised to ensure a smooth transition for the resident.

Nil Recommendations

Appropriate Places (Criminal Code)

Note: Information is very general to protect people's privacy. In the Top End, there is a facility near the Darwin Correctional Centre and a house in the community. In Central Australia, there are three houses in the community.

Achievements

- In the Top End, additional clinician position recruited on-site
- Increase in mentoring and support for disability workers
- Signification reduction in restrictive interventions for some residents
- Some long-term residents have moved to community-based accommodation

Areas for Improvement

- Building staff knowledge and skills in the use of accredited interpreters
- Formalising agreements with agencies involved in resident care and treatment, in particular the Department of Corrections (especially for transitioning clients)

Priority Concerns

- For the Top End, a better understanding of the legislation in relation to the use of restrictive interventions is required. The use and recording of restrictive interventions must relate to a person's individual PBSP and the actions of staff employed the Office of Disability.

CVP Recommendations		Made By	Date	Status
1.	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.	Community Visitor	Dec 2016	Open
2.	That the Office of Disability improve the review processes of Positive Behaviour Support Plans (PBSP) in line with section 39 of the *Disability Services Act* and best practice guidelines.	Community Visitor	Dec 2016	Open
3.	That the Office of Disability provide evidence of the systematic implementation of strategies described in the Positive Behaviour Support Plans (PBSP) and evidence-based changes to the PBSPs.	Community Visitor	Dec 2016	Open

CHAPTER 4: ALCOHOL MANDATORY TREATMENT

Priority Needs

1. Greater use of interpreters, in particular as the majority of people in AMT facilities have English as an additional language.
2. Consistent attention and focus on the 'least restrictive' principle in all aspects of decision-making.
3. A consistent service for all people in AMT facilities across the Northern Territory, regardless of the place of admission, with a strong focus on safety and therapeutic objectives.

The AMT Act was repealed on 01 September 2017. The CVP supported people in AMT facilities throughout this reporting period and as the program ceased.

171 visits

228 cases

POSITIVE NOTES

In the past year, the AMT evaluation was completed.[41] This was a milestone in the program. The CVP has raised the need for a robust evaluation throughout the course of the program.

As noted in previous reports, the CVP remains of the view that the most effective evaluation frameworks are those that are designed and implemented at the start of a program.

"They are good people [staff] in here, this place is alright... it is good to be by myself."

VIS/2017/09

The Community Visitors continued to observe that many people in AMT facilities felt safe and were treated well. These positive comments were made despite many people not supporting the involuntary nature of the program.

The CVP maintained a regular schedule of visits as the AMT program moved towards closure. There

[41] PwC Indigenous Consulting and Menzies School of Health Research (January 2017), *Evaluation of the Alcohol Mandatory Treatment Program*.

are inherent risks to client safety that can arise in such situations, especially as staff turnover increases and it is difficult to recruit new staff. It was pleasing to see that despite the many challenges of the transition towards closure, safety of people in facilities was maintained.

"I'm happy to be here. I can get healthy again."

VIS/2016/358

THE RESIDENT'S VOICE

Overwhelmingly, people in AMT facilities who spoke to Community Visitors stated that they did not wish to be there. The concerns about the involuntary nature of the AMT program were a frequent theme in issues raised over the past three years.

"I don't like it... everyone is always talking so much. I don't know why."

C/2016/649

The loss of people's freedom to choose where they lived and how they engaged with services was deeply felt. Matters related to the 'least restrictive alternative' were about a quarter of the total AMT issues raised this year.

"I need to go home. I'm taking care of my aunty. She is on dialysis. I'm looking after her." C/2017/154

"I was just [in town] doing some things for one week, going to the bank. I was trying to get back home and they brought me here. I want to go home." C/2017/09

"I didn't do anything wrong. They just picked me up, I only had two ciders that day. I didn't get to blow into that thing and they took me here. I had been at the bus stop waiting with my wife and my daughters for the bus to Katherine." C/2016/494

Often issues were raised on practical matters, such as access to mobile phones, shopping and a desire to smoke.

Although sometimes seen as minor, these concerns are part of daily life and freedoms. They are about spending time with family and friends, and making personal choices that are available to others in the community.

For people who are smokers, some raised that it did not make sense for them to be detained for alcohol misuse and also be required to give up smoking. This issue caused a lot of stress and potential behaviour issues at most of the AMT facilities.

Sometimes issues were related to cultural safety or needing more information. These are discussed later in this chapter in more detail.

Less Cases Raised

The CVP noted that this year there has been a decrease in complaints and enquiries raised with Community Visitors.[42]

As the program moved towards closure, the numbers in AMT treatment centres decreased. There was a decline in residents numbers at some AMT facilities, in particular Katherine and (for some of the year) Darwin.

Since December 2016 the Katherine Mandatory Assessment Rehabilitation Services had not admitted any people to their service. Numbers in Darwin also fluctuated throughout the reporting period.

The CVP also made the decision to reduce the number of visits to AMT treatment centres to fortnightly (instead of weekly). As residents are in AMT treatment centres for three months, and in response to capacity and other issues at various points throughout the year, the CVP extended the visiting timeframe.

The CVP considers that some of the reduction in AMT cases this year may be due to less frequent visits. A regular visiting service helps the CVP be more accessible. Many people feel more comfortable raising issues in person, rather than contacting someone for support by telephone or asking staff of the service. This may be particularly relevant when people have English as an additional language, such as in AMT facilities.

CULTURAL SAFETY

The vast majority of people affected by the provisions of the *Alcohol Mandatory Treatment Act* were Aboriginal Territorians. It is not surprising therefore that issues related to cultural safety continued to be a big feature of the cases raised with the Community Visitors.

The two most frequently raised issues of this nature were related to communication (in particular, the use of interpreters) and people's need to meet their cultural obligations.

> "I ran away last week because I wanted to be with family. I got a bit drunk and came back here. But it's hard when you can't be with family. That's why I ran away."
>
> VIS/2016/393

Access to Interpreters

The *Alcohol Mandatory Treatment Act* required that a person must receive certain information in a language that they can adequately communicate in.[43] Many people in AMT facilities do not

[42] There has been a 30% decrease in cases raised (326 cases were raised in 2015-2016 compared to 228 cases in this reporting period).
[43] *Alcohol Mandatory Treatment Act*, ss 15(3), 55(3), 116

have English as their first language. Access to interpreters is therefore an important part of the program.

In cases raised with Community Visitors and on visits, the CVP noted times when people did not understand why they were in the facility. This included what would be happening next (such as attending AMT Tribunal) and possible outcomes from the assessment.

"I don't know, people don't tell you anything around here."

C/2016/716

At times, the Community Visitors observed that the services may have over-estimated a person's level of English required for the discussion. This is not an uncommon issue for the provision of health services to someone with English as an additional language.[44]

In the CVP's view, it is essential that the service discharge its professional and legal obligation to ensure clear communication. This may mean booking an interpreter when there is any doubt about the person's language skills.

The CVP has noted throughout the year that accessing interpreters was sometimes difficult. Interpreters are required to assist with explaining Right Statements, conducting assessments, at the AMT Tribunal and in treatment centres.

At times, interpreters were not available and the assessment could not be completed within the required 96 hour timeframe. This resulted in the person being released from an AMT assessment facility.

To support communication, Rights Statements were produced in an audio book format. These were available in several commonly spoken languages for the region. The CVP commented on a number of occasions that certain languages (such as Kriol, Pitjantjatjara and Anmatyerr) were not available to people in AMT facilities.

The use of audio books to ensure client rights are understood is a positive communication tool. It was disappointing that these common languages remained absent from the program's resources.

[44] The Aboriginal Interpreter Service information sheet 'How to decide if you should work with an interpreter – Health' notes that untrained people 'tend to significantly underestimate the amount of miscommunication that occurs when communicating with someone for whom English is a second language'. The information sheet further notes that when an interaction uses 'specialised language and unfamiliar situation', there is a greater need for consideration of an interpreter.

The Community Visitors observed that there was greater use of interpreters in AMT assessment facilities compared to AMT treatment centres.[45] Although the context and length of stay in both facilities is different, there is unlikely to be a significant difference in the communication capacities of people between the two phases of the program. This suggests that there was insufficient use of interpreter in AMT treatment centres.

The work of the CVP in the AMT field this year highlights the importance of engaging with the Aboriginal Interpreter Service to resolve service availability issues, and ensuring resources are available in all relevant languages.

Cultural Obligations

A consistent issue raised with the Community Visitors was the need for people in AMT facilities to meet their cultural obligations. This included obligations such as participating in or attending funerals and 'sorry' business.

It was clear that staff in AMT assessment facilities and treatment centres recognised the importance of cultural obligations. In the main, efforts were made to work with communities and the person concerned to identify the details required to consider leave.

It is very concerning, however, that some requests to meet cultural obligations were not resolved in a timely way. Some people reported that they missed out on funerals.

The CVP raised these concerns with the services involved. Over the course of the year, some positive change to address the issues raised was noted. Nevertheless the Community Visitors regularly received enquiries or complaints related to this issue throughout the year.

With such a large number of Aboriginal people in AMT facilities, the services have an obligation to ensure that cultural obligations can be met and the 'least restrictive' decisions are made in the interests of the person.

"I can't stay there. My poison cousin is there."

C/2017/314

"They made wrong for me. I called my sister. She is really sick and I can't be there. They made me cry for my kids. I just want to go home."

C/2016/669

"White man won't be getting locked up when he's drunk... everything here is racist. It's better in community. I want to go back on the bush bush and take my wife. It's a dry place."

VIS/2017/084

[45] As registers of interpreter use were not consistently kept in all AMT facilities, it is not possible to comment more definitively than this observation.

'LEAST RESTRICTIVE' DECISIONS

The *Alcohol Mandatory Treatment Act* was based on a principle that 'least restrictive' decisions are made in relation to each person affected by the law.[46] What is 'least restrictive' for one person will not be the same for another person. The decision must be made on an individual basis.

As with previous years, the CVP has continued to express concern that the 'least restrictive' principle was not fully understood or being applied consistently.

The AMT evaluation report also noted similar points.[47] Building understanding of the 'least restrictive' principle was the responsibility of the Department of Health.

The CVP offered to participate in a training workshop to build AMT staff knowledge and understanding about the 'least restrictive' principle. This workshop did not proceed as it was not seen by the Department of Health as an 'action item' within their area of interest or expertise to progress.

"I don't have a parole or a bond. I'm a free man. So why am I here?" C/2017/026

"We're lonely and want to go home. [Staff] are free to leave whenever they like... I haven't done anything wrong. How can they keep me here? I want to talk to a lawyer." C/2016/516

"Yes, I would stay [if it was voluntary], but I don't think many other people would. ... But everyone has to work out for themselves. When you're ready, you think about your life." VIS/2017/116

"I was skin and bones when I came here. ... I am feeling strong now. No more grog. My brain is clear." VIS/2017/156

This year a quarter of the issues that were raised by people in facilities with Community Visitors were related to the 'least restrictive' principle. About half of these cases were resolved, while a quarter were withdrawn.[48]

Some people in AMT facilities expressed a very limited understanding of the concept of mandatory treatment. Some raised the issue of discrimination.

[46] *Alcohol Mandatory Treatment Act*, section 6, principles: "The following general principles must be applied by a person when exercising power or performing a function under this Act: (a) involuntary detention and involuntary treatment of a person are to be used only as a last resort when less restrictive interventions are not likely to be effective or sufficient to remediate the risks presented by the person; (b)'the least restrictive interventions are to be used when a person is being treated or dealt with under this Act; (c) any interference with the rights and dignity of a person are to be kept to the minimum necessary".

[47] PwC Indigenous Consulting and Menzies School of Health Research (January 2017), *Evaluation of the Alcohol Mandatory Treatment Program*, 24.

[48] The analysis of the cases that were withdrawn shows that most of the cases came from the AMT assessment facilities, and were related to the person not wanting an involuntary treatment order. Those that did come from AMT treatment centres mostly related to concerns about the decision to make an involuntary *residential* treatment order.

Some people raised their need to care for others, including children. Or that they had only come into urban areas recently and were not usually drinking to excess.

Being free in the community is a fundamental human right. When a person's liberty is removed for therapeutic purposes, the 'least restrictive' decisions for that individual are the guiding principle.

The CVP recognises that the services and AMT Tribunal have the responsibility to make the final decision on least restrictive decisions. The CVP respects these decisions.

However, throughout this year, the number of cases relating to the 'least restrictive' principle suggests that people subject to involuntary detention in AMT facilities may not feel fully heard. In light of the cultural and linguistic diversity of people detained in AMT facilities, this points to the need for greater attention to ways of listening, hearing and understanding people in facilities. This is needed so that staff can consider their preferences and work towards decisions that are the least restrictive and likely to have a therapeutic benefit.

PROGRAM MODEL (TREATMENT)

One of the concerning aspects of the AMT program has been the frequency of people returning through AMT facilities. Some were admitted more than once in a quarter or had multiple admissions over the course of the program. The AMT evaluation affirmed the high percentage of people who 'cycle in and out of the AMT system'.[49]

The CVP acknowledges that repeated attempts at change are not uncommon when addressing addictions. The involuntary nature of the AMT program, however, raises ethical issues related to the restriction of people's liberty to achieve a therapeutic purpose.

For this reason, the CVP has maintained a close interest in the program model and therapeutic benefits and has raised this throughout the course of the AMT program.[50] The AMT evaluation acknowledged that the program was attempting to address a complex issue 'without the benefit of a comparison model and with insufficient time to develop a sound program logic.'[51] The AMT evaluation also found that as a result of some of the flaws in the initial design of the program, it 'evolved over time and worked differently in different regions'.[52]

[49] PwC Indigenous Consulting and Menzies School of Health Research (January 2017), *Evaluation of the Alcohol Mandatory Treatment Program*, iii.
[50] CVP Annual Report, 2014-2015, p 70 and CVP Annual Report, 2015-2016, p46.
[51] PwC Indigenous Consulting and Menzies School of Health Research (January 2017), *Evaluation of the Alcohol Mandatory Treatment Program*, ii.
[52] PwC Indigenous Consulting and Menzies School of Health Research (January 2017), *Evaluation of the Alcohol Mandatory Treatment Program*, ii-iii.

Inconsistencies across the NT

Over the course of the program, the CVP repeatedly raised issues with the Department of Health related to the program model of care and treatment. This included regional variations in the program unrelated to individual or local service needs.

While the AMT program is underpinned by legislation and common policies and procedures, there remained significant inconsistencies across regions. This lead to inequitable outcomes for people in AMT treatment facilities based on where they were admitted to the AMT program.

One of the main variations noted in this year's visit to AMT facilities was the charging of fees for people in AMT treatment centres. Although the *Alcohol Mandatory Treatment Act*[53] allows treatment providers to charge clients for 'consumables', there was inconsistent application of this provision across the Northern Territory.

> "I want to get my money, I had to come back because I got no money. Why is that money being taken from my bank? That's too much for being here."
>
> C/2017/207

In Darwin, the AMT treatment provider stopped charging fees in August 2016. People subject to a mandatory residential treatment order in Alice Springs, however, were required to pay fees for their mandatory order to stay at the AMT treatment centre.[54]

In response to concerns raised about fees, the CVP reviewed processes related to informed consent. In Alice Springs, while people could decline to pay the fees, very few did so. This was surprising considering that fees were paid out of the person's Centrelink benefits. The issue of informed consent was not definitely resolved even after liaising with staff and reviewing documentation.

The capacity of the AMT treatment providers to make decisions about the charging of fees appeared to be different. The Alice Springs AMT treatment provider advised the CVP that fees paid by involuntary clients contributed to the financial sustainability of the program. It is very concerning that inequitable impacts occurred based on the person's place of admission.

MANAGING SAFETY

Robust structures and procedures are necessary to ensure quality care, in particular the safety of people in facilities. The CVP maintained close attention to safety and risk management, and

[53] *Alcohol Mandatory Treatment Act*, s70. Consumables is defined in this section of the Act to include 'food, medication and other consumables'.

[54] Most people subject to a mandatory residential treatment order at the Central Australian Aboriginal Alcohol Programmes Unit (CAAAPU) were charged $175 per week towards their living expenses for the period of the three month order.

raised concerns as needed with the service either through regular reporting or direct liaison for more urgent matters.

Domestic Violence

Concerns related to domestic violence were raised in both AMT assessment and treatment facilities (mostly in the Top End, where there were greater numbers of people in facilities).

> "I think the DVO finished a few months ago... I think I'll be alright with him here... But I don't know if he will get jealous if he sees me talking to another man."
>
> C/2017/92

Some people in AMT facilities were either in relationships or had previous relationships with a known history of violence.

For the most part the services did recognise these potential volatile situations and implemented measures to reduce risks and provide a safe place for all people in AMT facilities. However, there were some cases raised by the CVP where people with a known history of domestic violence were in the same facility or recommended to be in the same facility.

The Northern Territory's *Domestic and Family Violence Act*[55] states that a person must report domestic violence to the police if a person has caused or is likely to cause harm to another person. The services have a duty of care to all people in AMT facilities, to comply with both the 'least restrictive' principle and ensure a safe environment. Specific protocols and policies to manage these situations were required. As such the CVP raised the need for these with the relevant services.

Managing Transition to Closure

On 1 September 2017 the *Alcohol Mandatory Treatment Act* was repealed. Until the Act was repealed, all AMT services needed to be provided consistent with the legislation.

In May 2017, the CVP was provided with information about how the transition plan would be implemented. The main focus of the Department of Health's transition plan was to reduce bed capacity and to provide for mandatory orders to be varied.

Throughout the transition period, the CVP maintained a strong focus on ensuring that safety and quality of care was maintained. In general, AMT facilities responded well to the challenges of transition.

Although this was a stressful time period, with staff numbers changing, the wellbeing and safety of people in AMT facilities remained a priority. AMT treatment providers continued to conduct

[55] *Domestic and Family Violence Act*, s124A.

therapeutic programs, provide medical care where required, and maintained social outings as much as possible.

Despite this, the CVP noted a lack of communication and unclear planning in the transition period. The initial plans were changed and sometimes services providers were unaware what was happening and what was expected. The initial plan focused on the administrative elements of reducing beds and varying orders.

There was an observed lack of involvement of AMT clinicians. At times, there appeared to be a lack of client-centred focus. The CVP expressed concerns that the therapeutic needs of the clients did not seem to be at the forefront of planning.

Questions were raised about ethical and clinical issues related to admitting clients when those clients would be release shortly afterwards. There were inconsistencies between regions. The Top End Health Service, based on advice from their clinicians, chose to close their admission service earlier than the original transition plan. The changing decisions to close one assessment service and have the other one remain open illustrates a lack of attention to exploring and resolving such issues in the transition planning process.

The AMT program started in haste. In the CVP's view, the way in which the program moved towards closure demonstrated a similar lack of attention to planning.

FACILITY PRIORITIES & OPEN RECOMMENDATIONS

Statement on Program Closure

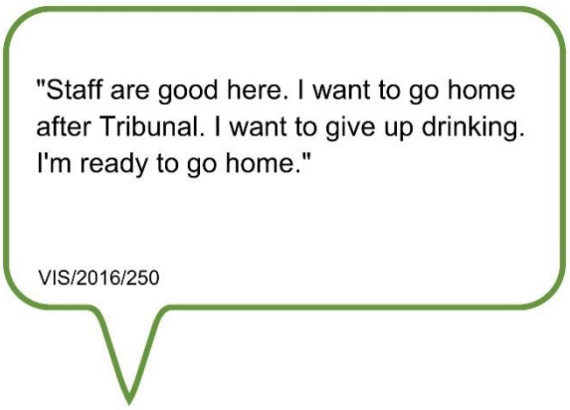
The CVP acknowledges that the AMT program has ceased at the time of submitting this report.

The services worked hard to ensure client safety in the transition phase to close the facilities. Numerous open recommendations were reviewed and closed. In some cases, the service responded that as the program was known to be ceasing in 2017, there would be no action taken towards closing the recommendation or item of concern.

Some outstanding open recommendations made by the CVP could not be closed due to the significance of the matters. These areas remain as unresolved and open recommendations. These open recommendations may inform any relevant policy development and planning for services in this field in the future.

> [Nurse]: "I hope they are not closing this. It would be a shame to lose it. Maybe it should be voluntary. But they should not close it and take it away."
>
> VIS/2016/279

AMT Assessment Services



Darwin Alcohol Assessment Service

Achievements

- Eight CVP recommendations closed.
- Aboriginal Liaison Officers were supportive and attentive to people's needs, in particular supporting decisions on cultural obligations such as funerals.
- An increase in Community Treatment Orders (CTO) recommendations by the end of the year, applying the 'least restrictive' principle.
- Audio Rights Statements in multiple languages were accessible.
- People often commented that they felt respected by staff and the food was good.

Priority Issues

- There remained issues with people in the facility not being able to challenge the basis of their detention (that is, the basis of the protective custody event made by the police).
- There remained inconsistent outcomes in relation to being taken to the facility by police (some people were detained after three protective custody events as per the Act, while others received many more before being detained).
- Some people were released hours before the 96 hour assessment timeframe when it was evident from much earlier that their assessment would not be completed within the prescribed time.

CVP Recommendations		Made By	Date	Status
Top End Health Service				
1.	That Assessable Persons with cognitive impairments of other needs beyond the Darwin Alcohol Assessment Service's scope of practice are referred in a timely and appropriate way. (Reworded)	Community Visitor	Mar 2014	Open
2.	That protocols be developed in relation to urgent guardianship applications and referral of Assessable Persons to NT Aged and Disability Services.	Community Visitor	Mar 2015	Open

Katherine Mandatory Assessment and Rehabilitation Service

Achievements

- Two CVP recommendations closed.
- The service made positive steps to improve the outdoor area.
- People spoke positively about staff members and their experience at the facility.
- Assessments were completed in a timely manner and peoples were seen by the AMT Tribunal at the earliest time available.

Priority Issues

- Difficulty recruiting Senior Assessment Clinicians, which led to people not being admitted to the facility from November 2016.
- Need for an audio Rights Statement in Kriol.
- Need for more clarification of policies when a person is on leave and is apprehended by the police.

CVP Recommendations		Made By	Date	Status
Department of Health				
1.	That policies be clarified by Department of Health regarding the processes to be followed in situations where Assessable Persons who are subject to Community Treatment Orders (CTOs) or Mandatory Residential Treatment Order (MRTO) leave conditions are apprehended by police at a significant distance from the relevant treatment centre.	Community Visitor	Jul 2015	Open
Top End Health Service				
2.	That steps be taken to provide an accessible and appropriate outdoor areas for sole use by MARS clients.	Community Visitor	Jul 2015	Open

Alice Springs Alcohol Assessment Service

Achievements

- Three CVP recommendations closed.
- Generally there was a good level of attention to booking interpreters for people requiring one, and the interpreter register was well maintained.
- Positive comments from people in the facility regarding staff
- Staff focused on applying the 'least restrictive' principle.
- Calm and effective transition towards closure of the program.

Priority Issues

- Need for audio Rights Statements in Pitjantjatjara and Anmatyerr.
- Shortage of senior clinical staff, with one person acting as both the Senior Assessment Clinician and the Nurse Manager.
- Issues related to the lack of activities in the facility, with feeling 'bored'

CVP Recommendations		Made By	Date	Status
Department of Health				
1.	That the Department of Health develops clear policies and procedures for management of Assessable Persons with diagnosed or suspected cognitive impairment within the Alcohol Mandatory Treatment Program.	Community Visitor	Jun 2014	Open

AMT Treatment Centres

Darwin AMT Treatment Provider ('Saltbush Mob')

Achievements

- Four CVP recommendations closed.
- Participant Advisory Board is available for people in the facility to raise issues of concern and provide suggestions for Saltbush Mob.
- Saltbush Mob staff have all been trained in P3 (use of force training).
- People who had engaged in the program came back voluntarily to Saltbush Mob to engage in vocational skills for employment.
- Saltbush Mob recruited a female Therapeutic Counsellor to teach the 'Footprints' program to women in the facility.
- High number of Aboriginal staff employed who assisted with cultural liaison.
- Top End Health Services and Saltbush Mob worked together well to address medical needs. There was a doctor available at least once a week.
- Saltbush improved their process to meet cultural obligations (funerals), and increased the priority placed on responding to these needs.
- Saltbush Mob adhered to the Department of Health transition plan and continued to provide therapeutic interventions and supports throughout the transition.

Priority Issues

- Ongoing concerns about the 'rewards' program set up by Saltbush Mob, which did not appear to have the intended motivational impact. This led to some people not being able to go on outings for a period of weeks.
- Concerns were raised by people in the AMT treatment centre about the shop, including the cost of items compared to shopping in the community and the loss of their right to choose where they spent their money.
- Processes for media access to the centre, to ensure people's rights and privacy are protected.
- The use of interpreters appeared to be minimal, despite many people speaking English as an additional language. The CVP raised issues related to the use of interpreters and its impact on the therapeutic objectives of the program.
- The need for policies to address safety issues specifically relating to issues of domestic violence.
- Greater attention to the need for 'least restrictive' decisions on an individual case-by-case basis.

CVP Recommendations		Made By	Date	Status
Department of Health				
1.	The Department of Health reviews the suitability of the facility for mandatory alcohol treatment, considering Affected Persons' potential risk of suicide/ self-harm.	CV Panel	Sep 2015	Open

Darwin AMT Treatment Provider ('Saltbush Mob')				
2.	Policies and procedures regarding tobacco are reconsidered by Department of Health with a particular emphasis on their impact on alcohol rehabilitation.	CV Panel	Sep 2015	Open
3.	The Department of Health provide furniture at the Centre to enable Affected Persons to store personal items securely as a matter of priority and at least one lockable drawer being available for all Affected Persons.	CV Panel	Mar 2016	Open
4.	That Department of Health review the health care services provided by other similar types of centres, such as prisons, detention centres, and residential mental health facilities to ensure the proper health care of the affecter person, notwithstanding the contract arrangements between Department of Health and Saltbush Mob. That the record being kept by Department of Health and Saltbush Mob are adequately maintained and accessible to on-call doctor or hospital (as the case may be), as well as the senior Saltbush Mob staff.	CV Panel	Jun 2016	Open
5.	That the Department of Health ensure there are detailed policies and procedural guidelines for mandatory alcohol treatment facilities. Such guidelines must take account of the complexity of the governance environment, any associated risks to client safety and risk management, and the principle of the 'least restrictive' treatment and care in decision-making. (Reworded)	Community Visitor	Jun 2017	Open
6.	If the Northern Territory Government decides to embark on another alcohol treatment program it should consider closely the findings and recommendations to the report[56], and put a proper structure in place to facilitate the best outcomes for the intended clients. Corporate knowledge is easily lost when a facility closes, so efforts should be made to minimise this occurring.	CV Panel	Jun 2017	Open
Top End Health Service and AMT Treatment Provider				
7.	Less restrictive interventions are thoroughly and systematically considered for all affected persons.	CV Panel	Sep 2015	Open

[56] Evaluation of the Alcohol Mandatory Treatment Program, PWC's Indigenous Consulting with Menzies School of Health Research January 2017

Darwin AMT Treatment Provider ('Saltbush Mob')

AMT Treatment Provider				
8.	That the therapeutic programs are reviewed by an appropriately qualified addiction specialist to consider and enhance their effectiveness.	CV Panel	Mar 2016	Open
9.	That a safe way of placing coverings on the windows be explored and implemented as a matter of priority.	CV Panel	Mar 2016	Open
10.	Saltbush Mob review the arrangement with the medical practitioner and consider whether it meets the need of mandatory alcohol treatment for clients with complex and chronic conditions.	CV Panel	Jun 2016	Open
11.	That consent forms be amended immediately to remove any references to photographs, and Saltbush Mob review its policy and consider whether it is necessary in relation to the services they had been contracted to provide.	CV Panel	Apr 2017	Open
12.	Equity issues be reviewed in accordance with the 'least restrictive' requirement under the legislation	CV Panel	Apr 2017	Open

"I want to go to Saltbush Mob. It's helping me stay off the grog for a while. I am getting my health back."

VIS/2017/16

Alice Springs AMT Treatment Provider ('CAAAPU')

Achievements

- Six CVP recommendations closed.
- Improvements to the use and currency of the interpreter register.
- A continued focus on cultural safety as a top priority.
- Regular liaison and interaction with the funded organisation providing aftercare.
- A broad range of activities that people in the facility enjoying participating in.
- Training staff members in contemporary Alcohol and Other Drug resources.

Alice Springs AMT Treatment Provider ('CAAAPU')

Priority Issues

- Lack of theoretical and practical knowledge for staff in key clinical positions, including skills and knowledge required under section 133 of the *Alcohol Mandatory Treatment Act*.
- Need for greater focus on implementing clear treatment plans, with plans accurate and appropriate for the person's individual therapeutic needs.
- The Primary Health Care Nurse position was vacant for an extended period.
- Questions regarding the informed consent process for people electing to pay fees while on a mandatory residential treatment order.
- Ongoing high level of people who abscond, which raises concerns about risks and how these critical incidents are reported and strategies put in place to reduce the risks.

CVP Recommendations		Made By	Date	Status
Department of Health				
1.	That the Senior Treatment Clinician (STC) be given clear direction by the Department of Health and Department of Health provide training to the STC to ensure they are appropriately qualified and understand their role according to the AMT Act.	CV Panel	Oct 2016	Open
Central Australian Health Service				
2.	That the Department of Health urgently improve the responsiveness of the referrals of Affected Persons to Aged Care, Disability Services and for cognitive assessment so that relevant assessments can be undertaken whilst an Affected Person is in treatment at the Treatment Centre.	Community Visitor	Jul 2014	Open
3.	That urgent attention be given to the availability of appropriately qualified medical staff at all times, so that non-medically trained staff are not being required to make medical decisions.	CV Panel	Dec 2014	Open
AMT Treatment Provider				
4.	That the use of interpreters in communicating client rights, and during treatment, is significantly increased, and records kept of request for, and use of, interpreters.	CV Panel	Sep 2015	Open
5.	That the complaints policy is reviewed, and staff receive training in same	CV Panel	Apr 2016	Open

Alice Springs AMT Treatment Provider ('CAAAPU')				
6.	That the record keeping systems are reviewed and if possible amalgamated into one system.	CV Panel	Apr 2016	Open
7.	That CAAAPU incorporate Department of Health AMT procedures into the CAAAPU Treatment Manual and that the Department of Health and CAAAPU develop clear guidelines for the reporting and follow up of incidents.	Community Visitor	Jun 2016	Open
8.	That the process and explanation of charging fees, choice to pay fees and authority of deductions is clear to clients to ensure that informed consent is provided.	CV Panel	Oct 2016	Open
9.	That the incident policy is reviewed, and staff receive training in same.	CV Panel	May 2017	Open

APPENDIX 1: DATA TABLE

Visit Data

	Mental Health			Disability				Alcohol Mandatory Treatment					Other	
	CAHS	TEHS	Total	Secure Care	Appro priate Place	Other (DSA)	Total	Assessment (CAHS)	Assessment (TEHS)	Treatment (CAAAPU)	Treatment (Saltbush Mob)	Total		TOTAL
VISITS	64	86	150	16	13	4	33	51	50	39	31	171		354
Community Visitor	59	81	140	15	13	4	32	51	50	37	29	167		339
Inspection	3	4	7											7
CV Panel	2	1	3	1			1			2	2	4		8

Case (Complaints & Enquiries) Data

	CAHS	TEHS	Total	Secure Care	Appro priate Place	Other (DSA)	Total	Assessment (CAHS)	Assessment (TEHS)	Treatment (CAAAPU)	Treatment (Saltbush Mob)	Total	Total	TOTAL
CASES	106	300	406	21	11	0	32	54	91	26	57	228	8	674
Complaints	7	53	60	2	0	0	2	2	3	2	8	15	0	77
Enquiries	99	247	346	19	11	0	30	52	88	24	49	213	8	597
Cases 'Raised By'														
People/Consumer	84	222	306	16	9	0	25	51	91	20	50	212	2	545
Carer/Relative	8	32	40	0	0	0	0	0	0	0	0	0	2	42
Service Provider/Case Manager	4	25	29	3	2	0	5	3	0	5	7	15	3	52
Nurse/Doctor	9	16	25	0	0	0	0	0	0	1	0	1	1	27
Guardian	1	0	1	2	0	0	2	0	0	0	0	0	0	3
Friend	0	5	5	0	0	0	0	0	0	0	0	0	0	5

Case Issues	CAHS	TEHS	Total	Secure Care	Appro priate Place	Other (DSA)	Total	Assessment (CAHS)	Assessment (TEHS)	Treatment (CAAAPU)	Treatment (Saltbush Mob)	Total	Total	TOTAL
ISSUES RAISED	**202**	**566**	**768**	**41**	**20**	**0**	**61**	**119**	**121**	**56**	**103**	**399**	**9**	**1237**
Quality of Service Provider	78	218	296	21	10	0	31	45	41	21	53	160	0	487
Assessment & Treatment	10	32	42	1	1	0	2	2	1	4	2	9	0	53
Cultural Safety	12	39	51	5	6	0	11	16	25	5	18	64	0	126
Management Plan	3	18	21	2	1	0	3	3	3	1	5	12	0	36
Activities	5	3	8	1	0	0	1	6	1	0	5	12	0	21
Discharge Planning	14	24	38	3	0	0	3	0	0	2	0	2	0	43
Facilities	1	13	14	0	0	0	0	1	0	1	1	3	0	17
Relationship with Staff	8	26	34	4	0	0	4	1	4	0	5	10	0	48
Aftercare	2	3	5	0	0	0	0	1	0	0	0	1	0	6
Health – Physical / Mental	5	28	33	3	1	0	4	8	1	3	2	14	0	51
Procedures	7	14	21	2	1	0	3	3	2	4	7	16	0	40
Consultation Carers/Consumers	10	15	25	0	0	0	0	1	4	0	1	6	0	31
Other	1	3	4	0	0	0	0	3	0	1	7	11	0	15
Rights	48	114	162	9	0	0	9	25	69	12	23	129	0	300
Least Restrictive Alternative	17	28	45	1	0	0	1	11	64	6	15	96	0	142
Legal	8	18	26	1	0	0	1	3	2	0	3	8	0	35
CV Information on Rights	5	2	7	0	0	0	0	3	0	0	1	4	0	11
Detention/Early Review of Detention	0	6	6	0	0	0	0	2	0	1	0	3	0	9
Community Accommodation	9	2	11	4	0	0	4	0	0	1	1	2	0	17
Respect for Dignity	6	9	15	0	0	0	0	0	0	1	2	3	0	18
Safety	1	20	21	0	0	0	0	2	1	1	1	5	0	26
Voluntary/ Involuntary	2	13	15	0	0	0	0	0	0	1	0	1	0	16
Transport by Police	0	2	2	0	0	0	0	4	0	0	0	4	0	6
Location of Admission	0	10	10	0	0	0	0	0	2	0	0	2	0	12
Other	0	4	4	3	0	0	3	0	0	1	0	1	0	8

Information	14	64	78	3	0	0	3	14	4	7	4	29	7	117
Request for information from CVP	5	23	28	3	0	0	3	4	1	3	0	8	0	39
Information Provided	7	27	34	0	0	0	0	9	3	3	1	16	0	50
Other	2	14	16	0	0	0	0	1	0	1	3	5	7	28
Advocacy	40	59	99	5	1	0	6	26	3	10	16	55	2	162
Smoking	7	20	27	0	0	0	0	1	1	0	1	3	0	30
Visit/Support	7	34	41	2	6	0	8	3	2	4	4	13	0	62
Other	2	27	29	0	0	0	0	2	1	2	2	7	0	36
Medication	6	30	36	1	3	0	4	3	0	0	0	3	0	43

Case Issues - Outcomes	**CAHS**	**TEHS**	**Total**	**Secure Care**	**Appro priate Place**	**Other (DSA)**	**Total**	**Assessment (CAHS)**	**Assessment (TEHS)**	**Treatment (CAAAPU)**	**Treatment (Saltbush Mob)**	**Total**	**Total**	**TOTAL**
Resolved	109	248	357	16	13	0	29	56	76	27	44	203	4	593
Ongoing Monitoring	58	30	88	18	7	0	25	27	1	13	6	47	0	160
Not Resolved	7	54	61	2	0	0	2	10	7	1	16	34	0	97
Referred	18	59	77	2	0	0	2	21	9	9	0	39	5	123
Lapsed	2	46	48	0	0	0	0	3	10	3	22	38	0	86
Withdrawn	2	38	40	0	0	0	0	1	18	0	11	30	0	70
Other	2	73	75	3	0	0	3	1	0	3	4	8	0	86
(Open)	4	18	22	0	0	0	0	0	0	0	0	0	0	22

APPENDIX 2: CVP VALUES

Respect
Empowerment Courage
Independence
& Integrity

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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