



The South Australian Community Visitor Scheme

Principal Community Visitor

ANNUAL REPORT

Mental Health Services 2017-18



FOR FURTHER INFORMATION:

PRINCIPAL COMMUNITY VISITOR

South Australian

Community Visitor Scheme

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Hon. Stephen Wade, MLC
Minister for Health and Wellbeing
Level 9, Citi Centre Building
11 Hindmarsh Square
ADELAIDE SA 5000

Dear Minister

In accordance with Division 2, section 54 (1) of the *Mental Health Act, 2009* (the Act), it gives me great pleasure to submit to you this Mental Health Services Annual Report of the Principal Community Visitor 2017-18 for presentation to Parliament.

Appendix 5 provides a summary of the Community Visitors Scheme compliance with the Department of Premier and Cabinet Circular (PCO13) on Annual Report Requirements.

This report provides an account of the work of the South Australian Community Visitor Scheme during the financial year ending 30 June 2018. I would like to draw to your attention our individual and systemic advocacy as they are core to the role and function of Community Visitors, as is the issues and outcomes arising from visits and the associated reports. You will see that we have again collated a range of comments out of these reports which gives specific insights into the effect of mental health service provision on the individuals and families we are there to serve and safeguard.

Yours sincerely

A handwritten signature in black ink, appearing to read "Maurice Corcoran".

Maurice Corcoran AM

28 September 2018

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1. Introduction

1.1 Message from the Principal Community Visitor

This report represents the work of the South Australian Community Visitor Scheme (CVS) for 2017-18 and is prepared on behalf of the great team of Community Visitors that I have the pleasure to work with, and alongside of, as well as our very committed team in the office who coordinate and manage the Scheme as a whole. Although this is the Annual Report of the Principal Community Visitor (PCV), it is without doubt, the culmination of combined efforts of all our Community Visitors and staff.

The past year saw a number of enquiries into the Oakden Older Person's Mental Health Service and the ICAC investigation and report, *Oakden: A Shameful Chapter in South Australia's History*, specifically outlined recommendations regarding the CVS. These recommendations related to the use of the Community Visitors power to conduct unannounced visits (recommendation 6) and a review of Community Visitors training and qualifications (recommendation 7).

In response to these recommendations, I have been working closely with the Office of the Chief Psychiatrist to address these and ensure that we maximise the opportunity that this review will provide in terms of refining and continuously improving what we do. The CVS has been undertaking a greater number of unannounced visits to mental health treatment centres and will conduct an evaluation and comparison between these and announced visits to ascertain whether there are benefits and detriments either way.

I welcome the forthcoming review, which I am confident will showcase the robust skills, qualifications and experience of our Community Visitors and the significant training that we implement with all new applicants.

I am confident that we will learn and improve from all of this work, we already have in terms of our record management, follow up on issues and tracking them to hold services and us to account.

As you can see from the various sections of this report, the Community Visitor Scheme, through its very committed visitors has had thousands of interactions with individuals who have been using the mental health services in South Australia over this past year. They have also spoken to many families and staff and from these conversations, observations and scrutiny of services, extracted valuable commentary on what's working well and what needs to be improved. The services we visit are increasing to use this feedback in a range of ways to improve quality and continuous improvement strategies.

I also believe that this report demonstrates that the CVS has made genuine improvements to its responsiveness to issues raised and escalated serious matters much sooner to both the Minister and/or the Chief Psychiatrist. I would hasten to add, that the acknowledgements and responses back to the CVS has also been very re-assuring from both the Minister's office and the OCP. In many instances, the Chief Psychiatrist has acted promptly and initiated an immediate unannounced visit to the facility where the issue or incident occurred and provided in-depth reports and recommendations to address issues.

This is greatly appreciated by all involved and we look forward to building upon this collaborative approach.

1.2 Highlights and achievements

The 2017-18 year saw the expansion of the CVS in to community mental health settings which has provided great opportunities for the CVS to see the continuum of a person's journey through the mental health system and to provide greater advocacy to clients receiving care through a community mental health facility.

Our improved more robust process of tracking and following up issues raised in reports has delivered many positive outcomes for individuals and their families and continues as a positive highlight for our team both in the office and our CVs. Ninety-five (95) issues were raised in reports that required follow up with mental health services management with seventy-one (71) (75%) being resolved during the reporting period.

The level of contact to the office from patients, their families and from staff seeking support with both individual and systemic advocacy has been significant. The office has responded to 93 calls of concern covering a vast range of issues. While not always able to deliver on the expectations of those seeking support with orders or discharge, they have in most cases, expressed appreciation that an external agency outside the treatment system is aware of their situation. Further, they have been appreciative that we have listened to them, presented their concerns to the treatment team and ensured they are aware of their rights and options available.

There have been significant learnings gained by the CVS from the Oakden enquiry and especially the ICAC investigation that examined how and when the CVS escalated issues of concern to Ministers or senior officers within the Northern Adelaide Local Health Network (NALHN). This has also highlighted the importance of our monitoring of issues raised through visits and it has been an area that I am very proud to say, has been significantly improved over the past 2 years through our internal and external processes that communicates issues to service providers and seeks responses.

We continue to increase the number of unannounced visits to facilities where concerns were raised, either through scheduled visits or by the Department, family, friends or others. For these unannounced visits, we draw on the skills of CVS who have specialist backgrounds and professional qualifications in investigative processes and interviewing techniques.

Through regular meetings, the CVS has given a renewed priority to maintaining strong relationships with mental health directors across the Local Health Networks. These meetings provide an opportunity to review the CVS visits undertaken, review issues raised during the visits and give consideration to addressing any systemic issues. The CVS can report that the responses to issues raised have vastly improved over the past 12 months. We have also received an increased number of communications including complaints from staff working across the sector who have genuine concerns about the clients in care.

1.3 Recognition of Community Visitors

The recruitment and retention of CVS remains a challenge and a regular highlight. I remain impressed by the range of high quality people from a vast array of backgrounds and ethnic diversity who apply to undertake this important role. It is pleasing that in addition to the important visitation and reporting aspect of the role, they have opportunity themselves to gain valuable insights into the responses that services provide to visit reports and issues identified.

"The follow up and outcomes post the report reaffirms the importance of whatever little we can do to add value to the lives of the clients."

"Very pleased to see such a quick response to what is a significant issue, and even more that it was driven by our CVS team". "It's great to know we are making a real, practical difference and a safer environment for the residents".

More details on our community visitors is provided later in section 4 - Workforce.

2. Functions of the Community Visitor Scheme

2.1 The purpose & objectives

The Community Visitor Scheme (CVS) is an independent statutory body, reporting to the Minister for Health and Wellbeing on matters related to the Scheme's functions under the *Mental Health Act 2009* and to the Minister for Human Services on matters related to the Scheme's functions under the *Disability Services (Community Visitor Scheme) Regulations, 2013*.

The purpose of the CVS is to further protect the rights of people with a mental illness who are admitted to mental health care units and limited treatment centres and people with a disability who live in a disability accommodation or a Supported Residential Facility (SRF).

The independence of the CVS is integral to the Scheme, enabling patients/residents, workers and family members to speak with individuals who are not associated with the provision of support and services.

Section 51 of the *Mental Health Act, 2009* describes Community Visitors as having the following functions:

- » to conduct visits and inspections of treatment centres as required or authorised by the Act
- » to conduct visits to and inspections of authorised community mental health facilities as required or authorised under this Division
- » to refer matters of concern relating to the organisation or delivery of mental health services in South Australia or the care, treatment or control of patients to the Minister, the Chief Psychiatrist or any other appropriate person or body
- » to act as advocates for patients to promote the proper resolution of issues relating to the care, treatment or control

of patients, including issues raised by a guardian, medical agent, relative, carer or friend of the patient or any other person who is providing support to a patient under the Act, and

- » any other functions that may be assigned to them by the *Mental Health Act, 2009* or any other Act.

The PCV through the support of the CVS office team also undertake the following additional functions:

- » recruit, train and coordinate the performance of the Community Visitors and provide advice and assistance in the performance of their functions
- » through reports, representation on committees and input into consultations, influence plans, policy and practice development across the sector, and
- » report to the Minister about the performance of the Community Visitors functions.

2.2 Conducting Monthly Visits and Inspections

The *Mental Health Act 2009* previously mandated that each approved treatment centre will have a visit and inspection by two or more Community Visitors once a month.

In June 2017, the *Mental Health (Review) Amendment Act 2016* came into effect and this expanded the scope of the Community Visitor Scheme to undertake visits and inspections of authorised community mental health facilities. In order to achieve this, it is now mandated that treatment centres and community mental health facilities must be visited and inspected at least once in every 2- month period.

The 2017-2018 financial year saw the closure of a number of mental health units and treatment centres such as Oakden Older Person's Mental Health Services and wards 17 and 18 at the Repatriation Hospital. However, there has also been the opening of new facilities in their place, including Northgate House, the Jamie Larcombe Centre, Ward 18V at Flinders Medical Centre and the new Royal Adelaide Hospital.

In the 2017-2018 financial year, there were 13 facilities within South Australia that were gazetted as approved treatment centres for the purposes of administering the Act. They were:

- | | |
|-------------------------------|------------------------------------|
| » Adelaide Clinic | » Northgate House |
| » Flinders Medical Centre | » Oakden Services for Older People |
| » Glenside Campus | » Repatriation General Hospital |
| » James Nash House | » Royal Adelaide Hospital |
| » Lyell McEwin Health Service | » The Queen Elizabeth Hospital |
| » Modbury Public Hospital | » Women's and Children's Hospital |
| » Noarlunga Health Services | |

Treatment centres may have a number of units within them, these are listed in Appendix 2.

In addition, three gazetted Integrated Mental Health Units located in regional areas received monthly visits:

- » Whyalla Hospital and Health Service;
- » Riverland Regional Health
- » Mount Gambier and Districts Health Service

With the expansion of the Act into community mental health, the CVS first commenced visiting the inpatient facilities; community rehabilitation centres and intermediate care centres. The gazetted Authorised Community Mental Health Facilities visited by the CVS in 2017-2018 financial year were:

- | | |
|--|--|
| » Ashton House | » Trevor Parry Centre |
| » Elpida House | » Western Intermediate Care Centre |
| » Salisbury Community Mental Health Centre | » Wondakka Community Rehabilitation Centre |
| » Southern Intermediate Care Centre | |

Community Visitors inspect all areas of the treatment centres used to provide treatment, care and rehabilitation to people

experiencing mental illness.

Further to the monthly 'scheduled' visits as described above, the Scheme also conducts 'requested' visits. As the name suggests, these visits occur when a client, carer, guardian, relative, friend, or any person or organisation who is providing support to a client, makes a request for a visit by a Community Visitor. If a request is made to a manager of, or a person in a position of authority at a treatment centre or community mental health facility, that person must advise the CVS office of the request within 2 working days. The CVS may on occasion also undertake unannounced visits as deemed necessary and as referred to earlier, since the release of the ICAC report, the CVS has made a concerted effort to undertake more unannounced visits.

2.3 Recruitment and training of CVs

The recruitment and retention of CVs remains a challenge and a regular highlight. I remain impressed by the range of high quality people from a vast array of backgrounds and ethnic diversity who volunteer to undertake this important role. While it is easy for the word 'volunteers' to cloud judgement of who CVs are, section 4.4 highlights the diversity of and quality of knowledge, education and experience they bring to the role.

It is pleasing that in addition to the important visitation and reporting aspect of the role they have opportunity themselves to gain value from the role.

"The follow up and outcomes post the report reaffirms the importance of whatever little we can do to add value to the lives of the clients."

"Very pleased to see such a quick response to what is a significant issue, and even more that it was driven by our CVS team". "It's great to know we are making a real, practical difference and a safer environment for the residents".

2.4 Advocacy

2.4.1 Individual advocacy

A key element of the Community Visitors' role is to provide support and advocacy in referring matters of concern emanating from visits to the Principal Community Visitor (PCV). On a daily basis, the CVS also provides information regarding patient rights and supports individuals via phone and in-person. In addition, the PCV responds to individual advocacy requests as per examples provided below. While the CVS is not a complaints resolution body or an investigation unit, it will refer individuals to other agencies and support them through formal complaints processes as needed.

During 2017-18 the CVS received approximately 93 requests for advocacy from clients, family members, carers and staff members. Some examples of the advocacy undertaken by the CVS office include:

Patient handcuffed and shackled in Flinders Emergency Department

In 2015, I was contacted by a senior mental nurse in Flinders ED who raised significant concerns for a forensic patient in his care, who he believed was unnecessarily restrained and shackled in the ED for 4 days, due to the lack of availability of a secure bed at James Nash House. After speaking to the client, who relayed the humiliation and embarrassment she felt by having the restraints, as well as swelling and skin damage caused by prolonged use of metal wrist cuffs and ankle shackles, I referred this matter on to the Ombudsman, and lodged a complaint against the Department of Correctional Services (DCS) on behalf of the client.

The Ombudsman subsequently undertook an investigation and in February 2017, the Ombudsman released his final report, which found that the client was unreasonably restrained and DCS should provide the client with an apology regarding the actions they took against her. The Ombudsman found that Warrant of Remand in Detention (the warrant) to which the patient was subject, was wrongly read or interpreted and that she should not have been taken into custody as a DCS client but as a forensic client who should receive Forensic Mental Health Services. **Therefore, the department ought not to have taken custody of the patient from 1 to 5 October 2015.**

The report also provided the following recommendations to DCS:

I recommend under section 25(2) of the Ombudsman Act that the department:

1. *conclude its review of bedside admission processes to ensure correct interpretation of warrants*

2. *provide clarification in the Standard Operational Procedures (SOPs) about when a patient ought to be considered a prisoner for the purposes of the SOPs*
3. ***apologise to the patient for taking the patient into custody by mistake***
4. *consider the application of the eight-hour rule to include compliant prisoners and require that paragraph 3.5.4 of SOP 032 (Use of Restraint Equipment) apply to compliant and non-compliant prisoners/patients*
5. *provide clarity around when to apply SOP 031 Supervised Prisoner Escorts where the department is not escorting a prisoner/patient and include the definition of escort in SOP 031 and whether it includes supervision of a patient or prisoner*
6. *provide for circumstances where prisoners/patients' restraint regimes are always to be individually reviewed by telephoning a GM when the department assumes custody of the prisoner or patient and not default to a High 2 security rating*
7. *revise paragraph 3.10.3 of SOP 013 to include the words 'unless situation meets paragraph 3.10.5'*
8. *revise paragraph 3.10.5 of SOP 013 to include clarification as to what circumstances are considered urgent and include specific insertion that public holidays are considered to fit the urgent criteria*
9. *SOP 013 be amended to include the requirement that any proposed change to the level of restraint must result in a phone call to the prison's GM and that restraint can be changed based on verbal approval from the GM, with the compliance officer required to note the approval in the hospital watch log book*
10. *the relevant SOPs be amended to require that an individual review of the restraint regime of any prisoner/patient be conducted by departmental officers upon taking custody of a prisoner or patient.*

In July this year, I was formally advised by the Ombudsman that DCS has finalised the implementation of all 10 recommendations above and the client has received a letter of apology from DCS.

I was recently contacted by this client who was the subject of this investigation and who the CVS has supported at various times over the last few years who wanted to give me an update on her life and recovery journey and how she is going at the moment. This client also passed on her appreciation for the support and advocacy they received by the CVS at times when they were vulnerable and very kindly provided the following letter to myself to support this.

Hi Maurice,

Thank you very much for understanding my situation and what I have been through and coping with.

I have attached a copy of my medical certificate with correct diagnosis of PTSD.

I would like to say that you Maurice, all of your team and people you have referred me to have been amazing support. As I have a disability of PTSD, I have to be careful with how much stress I subject myself too. Without this wonderful service of an organization to help people who have a disability, I could possibly still be stuck in the system being tortured with medication my brain doesn't need. Being misdiagnosed and wrong medication has had a huge negative effect on my life in so many ways and on so many levels.

I want to thank everyone at the community visitor scheme for standing up for my rights when I was unable to, so I could be treated correctly to human rights standards not taken advantage of because I have a disability and became unwell.

Thank you again.

Please don't hesitate to contact me if anyone would like more details on how this scheme has and is helping me.

(name withheld for privacy reasons)

This letter provides a heart-warming example of the important service that both the CVS and Ombudsman's Office provides on a daily basis and I am so grateful to this client for sharing her story and thanks with the CVS. She did this in the hope that it would encourage other nurses in emergency departments or other wards to contact the CVS if they witness a similar situation. She also wanted other patients to be aware that this is wrong and that they may also be encouraged by what she has done, to eventually get recognition that her restraint was inconsistent with basic human rights and should be challenged.

Pressure on discharge

I highlighted the pressure on discharge of mental health patients in my 'Special Report' that was tabled in Parliament in May 2018 and reported on via various media outlets soon after. Within days of these reports, I was also contacted by a psychiatrist working in a mental health service in the South who voiced strong concerns about the pressure on clinicians to discharge clients early, in the name of creating bed flow.

This psychiatrist highlighted a range of examples where he and colleagues he named, believed it placed clients at high risk and forwarded a range of documents where these views had been raised with the then CEO, SA Health, Vickie Kaminski. Further, the correspondence highlighted there has been ongoing shortfalls in Consultant Psychiatrist and Senior Medical Officers (SMOs) positions since January 2017 in the outer South and the fragmentation of medical care provided in response to these shortages together with an inference from management, that Noarlunga psychiatrists should simply work harder with fewer resources, has caused enduring damage to the morale and goodwill of the consultant group.

The CVS avoids getting involved in disputes between staff and management and decisions related to clinical care, however, if there is clear detriment to service provision and impacts on patient care, then we have a duty to raise these concerns with appropriate bodies to investigate further. In this instance, the PCV relayed concerns to the Minister and the Chief Psychiatrist.

I previously reported that the CVS was receiving anecdotal evidence from staff regarding the impact of the 24 hour ED target for mental health patients and the pressure this is creating on the mental health units, including a perceived pressure to discharge clients earlier than needed. This was described as becoming a 'revolving door' or increase in readmissions relayed to CVs by staff at visits.

It seems that this trend has continued in this reporting period and the following comment provides an example of the anecdotal pressure on the mental health units and subsequent pressure to discharge early to meet bed flow targets:

At the time of the visit, 6 MH patients were being held in ED and in ward XX's 20 beds were full, with 12 of these clients under an ITO. There continues to be breaches to the standard of 24-hour target stays in ED for MH patients. There were 4 breaches last week alone. These breaches are caused by a lack of vacant beds in FMC or Morier etc., where these patients can be referred or a lack of ambulances to affect transfers

My Special report on this issue and follow up media reports also prompted the parent of a young man to contact the PCV stating that his son was discharged too early from a treatment centre in the South and the consequences of this were devastating. For privacy reasons, I will refer to this young patient as J. This Father relayed his families' experience where his son had been admitted into an acute mental health unit after a serious suicide attempt by J through an overdose of prescription drugs just prior to Christmas 2017.

Three months later, he was referred back into acute care for his second admission for extreme anxiety as recommended by his Community Psychiatrist. He only stayed in the unit for a short time but was then discharged back into the care of his Mother and she recalls going to pick J up to take him home and a staff member said to her, "make sure you keep a close eye on him", inferring he was still very unwell and at risk of self-harm. Two days later, J's mother returned from the nearby shops and he was nowhere to be seen, so she rang the unit and their immediate response was for her to call the police. Tragically, J's body was found the following day, he had taken his own life.

The CVS spoke with both parents and then formally wrote to the Chief Executive of SALHN seeking a response from them on a number of issues raised and then organised to meet with the mental health executive and treating team in an effort to get answers for the parents. This is discussed further under section 3.3.3 and includes a recommendation for the Coroner to investigate.

Alleged assault of patient by staff member and referral to SAPOL

During a scheduled visit to a mental health treatment centre, two Community Visitors spoke with a client who disclosed to them that between the hours of 12–2am the previous day he was punched in the stomach by a staff member. The client reported to the Community Visitors that it occurred in the common area in front of the nurse's station and that the incident should have been caught on the CCTV. The CVs enquired as to what action the client wanted to take and he advised he wanted the matter reported to the police.

Immediately after the conversation with the client, the Community Visitors reported the allegation to the staff who were already aware of the allegation. The staff advised the CVs that an incident report had been completed and the CCTV footage had been requested. The CVs relayed to the staff at the unit, that the client has requested the matter be reported to the Police. The Community Visitors then contacted the CVS office and relayed the allegation and clients request to the CVS Mental Health Coordinator.

In the first instance the CVS office followed up with the Nurse Unit Manager of the service to request a copy of the incident report and ascertain whether the client's request of the incident being reported to SAPOL has been undertaken. The CVS was advised that an internal investigation was being undertaken and the CCTV had been requested from security to ascertain whether there was anything of substance to report. It was unclear whether SAPOL had been informed of the allegation on behalf of the client by the unit manager.

The mental health coordinator then spoke again with the client who confirmed that SAPOL had not spoken to him and that he could like the CVS to make the report on his behalf. Immediately following this, the CVS Office Manager contacted SAPOL and made a report of the allegation on behalf of the client. We were informed that a Police patrol visited the mental health unit shortly after to commence an investigation. The CVS followed up with the unit and 25 days later, were advised by the Nurse Unit Manager and Senior Clinical Risk Manager that the CCTV footage had been reviewed and no assault incident could be seen.

Following the incident, I consulted with the Department for Human Services Incident Management Unit Director, who confirmed that *'if you or your staff have disclosed to them by clients and or carers allegations that may amount to criminal offences and are requested by them to report to police that you report asap. If agencies/service providers are not reporting criminal offences in a timely manner, then you should proceed with a SAPOL notification'*.

I subsequently met with the Co-Director and Clinical Director of CALHN regarding the incident and relayed my concern that the alleged incident had not been investigated by an external body and that SAPOL had not been contacted by the staff in the mental health unit initially following the patient's allegation and request to report to the police. I was advised that an external investigator had now been appointed to review the investigation and complaint.

At a meeting on 13 November 2017 with the Hon Peter Malinauskas, the then Minister for Mental Health and Substance Abuse, I also raised the alleged assault and information regarding my follow up with the unit and SAPOL. On 14 February 2018, Minister Malinauskas advised that CALHN had engaged an external investigator to complete an investigation in to the alleged incident and the investigation found that the staff member did not engage in misconduct and is not liable for disciplinary action. Whilst the alleged incident was eventually externally investigated and an outcome delivered, it highlighted to me the need for a clear policy around reporting allegations of a serious nature and particularly the need for an external body, namely SAPOL, to undertake the investigation, for the sake of all involved.

2.4.2 Systematic advocacy

During this period, the CVS has continued to lobby for systemic change that would deliver improved outcomes for service consumers. Some of the CVS's key focuses are:

Forensic Mental Health Services - The release of the Review of South Australian Forensic Mental Health Services and the SA Health Response is a welcome step in addressing the ongoing issues for forensic and corrections clients across the system. However, in the last year it seems the impacts are becoming greater, including issues with bed block in the secure Psychiatric Intensive Care Units (PICUs) and clients waiting in EDs for a number of days waiting for a secure bed to become available.

During this waiting time, these clients are being chemically and physically restrained which is distressing for them and for all those involved in their care. In one case, a client had been restrained for 10 days, (four days in the RAH ED and six days in a surgical ward) awaiting a transfer to a secure mental health unit. Staff were concerned for these clients and the implications of not only the physical restraint for a significant period of time, but the delay in receiving the appropriate psychiatric treatment required.

At CVS visits and meetings with the Local Health Networks, I have been increasingly hearing of the concerns about the lack of available and appropriate forensic or secure mental health beds. With the PICU at the RAH not open due to the faulty duress alarm system, I understand that at this point of time, Ward 5J at Margaret Tobin Centre is the only other gazetted mental health treatment centre that can admit the Department of Correctional Services (DCS) clients transferred from correctional facilities.

The limited availability of beds at James Nash House and the non-functioning PICU at the RAH has placed significant demand on Ward 5J to admit DCS clients. With the demand for closed PICU beds high across the system, this is having an impact on access to closed beds for mental health consumers in the South, as well as placing pressure on the unit to move patients to the open ward earlier.

I raised this issue with the Minister for Health and Wellbeing in late May at our first meeting within the context of discussing key issues within my Special Report and then wrote to the Minister early in July specifically about this matter. The CEO of Central Adelaide Local Health Network (CALHN) and the Chief Psychiatrist were both provided with a copy to this correspondence and the key points raised included the following:

In South Australia, the Courts also direct clients requiring a mental health assessment to be taken to an emergency department. However, when the only option available is in RAH Emergency Department and where they are required to be hand-cuffed and shackled for long periods of time (which we know is detrimental to recovery), then this should be

deemed an unsatisfactory option.

Other alternative options need to be looked at, such as use of the Yatala Prison infirmary or as I have identified in section 3.3.1, a specific assessment unit should be established within our Remand centre similar to what is available in Victoria and provision be also made for a mental health unit within the women's prison such as what is available in Victoria.

The 2015 Review of the South Australian Forensic Mental Health Service, specifically recommended the following: which if implemented, would all support the appropriate and timely assessment and treatment of clients requiring mental health care in a custodial setting:

"2.2 Establish clear models of service and a multidisciplinary admission, transfer and discharges process to ensure clear clinical governance and coordinated and informed decision making about flow through the high security inpatient services.

2.3 Develop a model of service for the Community Forensic Mental Health Service, which includes clear mechanisms for collaboration with key stakeholders, and as part of future planning for the forensic mental health system, consideration of the resources required to manage forensic patients in the community.

2.4 Establish a dedicated multi-disciplinary Prison Mental Health Service to provide assessment, treatment and care services in custodial settings.

2.5 Establish a multi-agency prison mental health steering committee and develop information sharing guidelines to support responses to individuals with mental illness in custodial settings."

The CVS will continue to advocate for the implementation of the recommendations of this important Review and my July letter to the Minister for Health and Wellbeing, requested action on these key recommendations. The Minister responded to this matter and has organised a meeting with the PCV, the Chief Psychiatrist and himself to progress discussions and actions on this ongoing issue. Whilst addressing the issues will require cross agency support, the CVS welcomes any opportunity to be involved in the process.

This issue is explored further in section 3.3.1.

Older Person's Mental Health

Through involvement on the Oakden Oversight Steering Committee, the CVS has continued to advocate for better standards of care, which has been seen at the new Northgate facility.

There have been significant lessons learnt from Oakden Older Persons Mental Health Services (OOPMHS) investigation by the Chief Psychiatrist, Aaron Groves and then the ICAC Enquiry. This includes better documentation of all our work and significant meetings and that we ensure there is agendas and notes of all meetings with Ministers, Senior Departmental staff and other Statutory officers. As part of the ICAC enquiry, the CVS was required to submit all visit reports, and any other documents and correspondence including records of meetings, phone conversations and emails related to Oakden.

These went back to when we first visited Oakden in July 2011, so there were thousands of pages and it really tested our record keeping and follow-up on issues arising. As an Independent Statutory office, we have had to continuously improve our information management system and I am extremely proud of what we have achieved, especially given the resources available to us.

Right from 2012 and 2013 our visit reports highlighted concerns about staffing levels and that as a result of the then Government indicating they were intending to tender out the service to the Non-Government sector, many of the permanent staff left positions due to uncertainty. This resulted in higher rates of agency staff being used in Oakden but this also had implications for those permanent staff who remained, as there were less staff who were competent in documenting and reporting on patient care and medication management.

Another warning indicator was that a number of Allied Health workers (such as social workers, OTs or activity coordinators) were transferred and/or positions became vacant, which again, placed enormous pressure on existing permanent staff, some of which worked tirelessly to try and make up for these gaps. The CVS regularly highlighted these issues to senior management at NALHN via visit reports and wrote specific letters and emails to senior management highlighting these gaps and the pressure it caused to existing staff and the overall service.

The people in these senior management positions reported directly to the Chief Executive of NALHN and were in decision-making roles that could have ensured these positions were filled. They were part of the governance structure for NALHN and would have been directly involved in discussions on budget, savings and resource and staff allocation.

This lack of action in making staff allocations to these positions at Oakden, also affected staff morale and workplace culture and ultimately, the care and treatment of patients. Our reports and correspondence on all the above, was submitted to the ICAC however, I can only assume that they did not fully understand this governance structure as they did not find fault in the governance of NALHN and made no maladministration findings against them.

Our initial advocacy for families regarding over-medication, unexplained bruising, restraints, neglect and abuse was detailed in a written complaint forwarded to the Interim Nursing Director at Oakden on 7 June 2016. When our complaints were received by the Nursing Director, we spoke directly with him and received a written email reply that evening stating that he “would forward the complaint to our Consumer Liaison Officer who I will work with to coordinate an investigation “.

Over the next three months, the CVS made numerous phone calls and emails to the Nursing Director and Consumer Liaison Officer and were then informed on 10 August 2016 that the investigation report and response was with the NALHN Office of Chief Executive. We then communicated with the Executive Director of Mental Health at NALHN seeking to obtain a response and again were not responded to in a timely manner, so I documented all of this in my Annual Report to Parliament with a recommendation to review the Oakden service.

Once our Annual Report was tabled in Parliament, respected ABC journalist, Nicola Gage picked up on these matters and contacted me for comment and requested that I ask the families affected, whether they would be willing to talk.

Our support to families continued throughout the public reporting and during and after the Oakden investigation and report by the Chief Psychiatrist, Aaron Groves and later the ICAC enquiry. Following the ICAC report, the CVS also referred the families to the Commissioner for Victims' Rights, Michael O'Connell, and met with them to obtain a referral to a suitable legal team for legal advice and assistance.

Comorbidity - Comorbidity has been a long-standing issue advocated on by the CVS. A significant time has elapsed since the Social Development committee's "Inquiry into Comorbidity"¹ was released. At the time both the Minister for Disabilities and the Minister for Mental Health and Substance Abuse² presented the NDIS as the potential solution to many of the recommendations.

A key recommendation of the report was that “It is imperative that they experience an integrated treatment and service system that has a ‘no wrong door’ approach. A system where they receive timely and appropriate screening, and assessment, and are assisted with all of their treatment and service requirements”. Given that the NDIS is focussed on empowering individuals with choice and control rather than establishing system solutions (focus on market driven solutions) it is unlikely that the key health and human services departments will be developing integrated pathway solutions it will therefore be important that this client group have the required support to navigate the pre-existing systems.

It is difficult to assess at this time as to the quantity and quality of complex care coordination that will be available to individuals under the NDIS. The Mental Health Coalition is flagging concerns that the funding model does not give consideration to the ongoing mentoring and support with skills development required for such clients under the NDIS funding model. They are also concerned that funding will not be sufficient to attract, retain or train people with specialist skills in this area.

The Productivity Commission Study report highlights Mental health services as a particular concern especially where States and Territories are withdrawing their funding for a number of mental health support programs and using this funding to offset part of their contribution to the NDIS. It further highlights that there needs to be support for people with mental health illnesses outside of the scheme — a responsibility that remains (largely) with State and Territory Governments. It identifies that at this stage, it is unclear what supports will be available for people with a mental illness who do not meet the NDIS eligibility criteria and that this should be clarified as a matter of urgency.

Early indications are that some solo private practitioners will not find it financially viable to operate under the funding model as well as meet the reporting requirements. The PCV is however pleased to note that funding for the Exceptional Needs Unit (ENU), Centre for Disability Health and the Chemical Restraints project has been committed to by the State government for the next 12 months. There is risk in the expectation that this business will be picked up by the private sector. Large organisations with new graduate employees may present as the only viable business solution.

¹ Inquiry Into Comorbidity, thirty eight report of the Social Development Committee
<https://www.parliament.sa.gov.au/Committees/Pages/Committees.aspx?CTId=5&CId=302>

² Social development Committee – Inquiry into Comorbidity Submission from the south Australian Government 8 February 2016
<https://www.parliament.sa.gov.au/Committees/Pages/Committees.aspx?CTId=5&CId=302>

2.5 Referring matters of concern

A key component of the role of the CVS is to refer matters of concern raised in visits reports to the appropriate people for resolution. Dependent on the nature and scope of the issue, these referrals can be to management of the service provider, the Minister's delegate or to the Minister. Matters of concern can also be referred to other external bodies for investigation such as the Office of the Chief Psychiatrist, Health & Community Services Complaints Commissioner, Public Advocate, Ombudsman etc.

Any significant issues of concern or re-occurring themes indicating a possible systemic issue that are raised within visit reports, are transferred onto the Issues Register and referred to the CVS Advisory Committee meetings for discussion. The Advisory Committee provides advice to the PCV about potential actions and develops shared, cross agency strategies and responses where there are common issues.

As example:

- » ninety-five (95) issues were raised in reports that required follow up with mental health services management with seventy-one (71) (75%) being resolved during the reporting period.
- » concerns regarding the restraint of shackling of numerous forensic clients for a number of days in the RAH ED were referred to the Chief Psychiatrist, who conducted visits and inspections to the RAH and provided guidance on how a least restrictive environment should be applied.
- » the alleged assault of a patient in a mental health unit was referred to SA Police (SAPOL). The CVS was very concerned that where the patient had requested that he would like to the police notified, the unit staff had not contacted the police, and were instead awaiting the outcome of their own internal investigation. After re-confirming with the patient his wishes to have SAPOL notified, the CVS contacted SAPOL who attended the unit and conducted an investigation.
- » the CVS continues to refer incidents of restraints of Correctional Clients when they are taken to the emergency departments for mental health assessments, to the Ombudsman's Office for investigation. We are extremely grateful for the work that the Ombudsman's Office had been able to do, there forensic investigations have found in a number of instances that DCS have acted outside of the law and not met National Standards.

2.6 Influence plans, policy and practice development

A significant and important role the CVS plays is its contribution to planning, policy, strategy, reviews and investigations at both a commonwealth and state level. The PCV has been invited to attend committees and discussion panels and been asked to contribute to an array of reviews, investigations, reports and discussion papers. Examples include:

- » Australian Human Rights Commission - A Future Without Violence: Quality, safeguarding and oversight to prevent and address violence against people with disability in institutional settings report
- » Senate Community Affairs References Committee - Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised

In addition, the CVS has an important role to play to ensure policy and clinical practise development is influenced by the experience of people with disability and their relative, guardian, carer, friend or supporter. The CVS therefore takes every opportunity to through representation on committees, through its own advisory committee and through input/comment on planning, policy and clinical practice documentation as listed below:

- » SA representative on the Independent Advisory Committee of the National Disability Insurance Agency
- » NDIS Stakeholder Forum - Key Influencers and Industry Group
- » Meeting with the Ombudsman and Chief Psychiatrist regarding the shackling of prisoners
- » ICAC investigation into Oakden
- » Commonwealth Ombudsman – Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)
- » SA Health - Oakden Oversight committee
- » SA Mental Health Act Review Implementation

- » Statutory Authorities Group and Rights Protection Agencies meeting
- » SA Ambulance Services – Community Advisory Committee
- » Stakeholder Focus Group on Supported Decision-Making
- » National teleconference meetings with Community Visitor Scheme managers across Australia.
- » Rooming Housing Roundtable - Minister Zoe Bettison
- » SA Intellectual disability and Mental Health network meeting
- » Reducing the use of chemical restraint within Disability Services
- » NDIS Quality and Safeguard Commission Transfer and Establishment meeting

3. Mental Health outcomes and themes

3.1 Visit statistics

At commencement of the 2017-18 reporting year, the CVS introduced a new report format (appendix 4) to be completed by Community Visitors (CVs) after every visit.

The new report gives focus to five (5) main domains:

Communication – client and staff interaction/respectful communication

Environment – suitability of facilities and their maintenance

Quality of client services and access

Safety and Rights – least restrictive practices, and

Treatment and Care planning

The report also provides opportunity for any issue of concern or request for advocacy to be presented to the Principal Community Visitor for follow up.

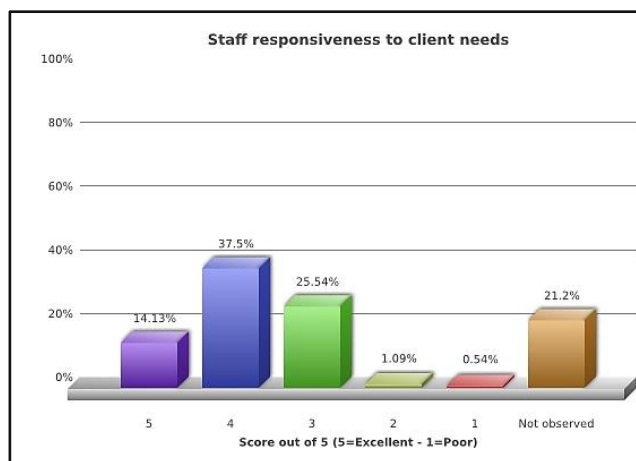
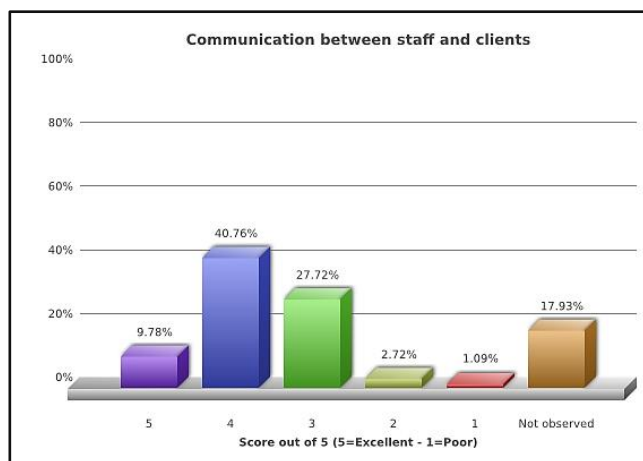
In the first three areas of the report, the CVs are requested to provide a rating out of five for the service against a range of questions related to that section.

Following is a presentation of the rating and a snap shot of comments made.

3.3 Key Report findings

3.2.1 Communication – client and staff interaction/respectful communication

The following two (2) charts present data on CV ratings of services in respect to communication between staff and clients and staff responsiveness to client needs.



In addition to ratings CVs also provided comments where relevant.

Positive comments – 127 positive comments were made; examples as follows:

Communication was open and respectful. Patients reported they felt listened to. It was evident that clients had a great deal of respect for staff especially the activities co-ordinator.

At every point, communication was exercised by staff at a high and inclusive level.

Daily meetings at XX ensure excellent communication between staff and clients. All housekeeping and procedures are explained and the clients are given an opportunity to have their say in a relaxed environment. It is a calming atmosphere and the staff are engaged and friendly.

Issues – 25 issues of concerns were identified; examples as follows:

A client commented that it was hard to gain attention from staff at the nurse's station due that they always appeared very busy or inside the office.

We did not observe a lot of communication between staff/clients, it appears staff are mainly occupied with filling out paperwork i.e. documentation and not much actual time with consumers.

A new development on the closed ward has been the implementation of a glass screen at the nurse's station that covers the entire front desk, surface to ceiling. This has been put in place to protect staff from potential dangers, ie, clients attempting to jump over the counter. However, this now means that if clients need to speak to staff in the nurse's station, if staff do not see them, they have to knock on the glass.

Across the ratings given, approximately 20% of visits noted communication between staff and clients was not observed, often due to clients being in their bedrooms, off-site, outside or otherwise occupied in other activities.

The observations of communication and responsiveness between staff and clients highlighted the positive interactions in a large number of units and the morning client meetings held in some units were observed to be a good forum for communication and enhance the responsiveness of any issues raised by clients.

Whilst the majority of the observations of communication and interactions between staff and clients was rated above satisfactory, in the instances where it was not, common themes were highlighted, including the time spent by staff in the nurse's station completing administration tasks and paperwork. This has also been commented on by staff themselves, who have been raising this same issue that they have less time to interact with clients due to the time required completing administrative duties. Another contributing factor to effective communication and responsiveness are the glass security screens that some units have around their nurses' station. Whilst the CVS understands this is a security measure, clients have reported that it is hard to gain the attention of staff through the glass screen and that client's feel they are ignored by staff behind the screen.

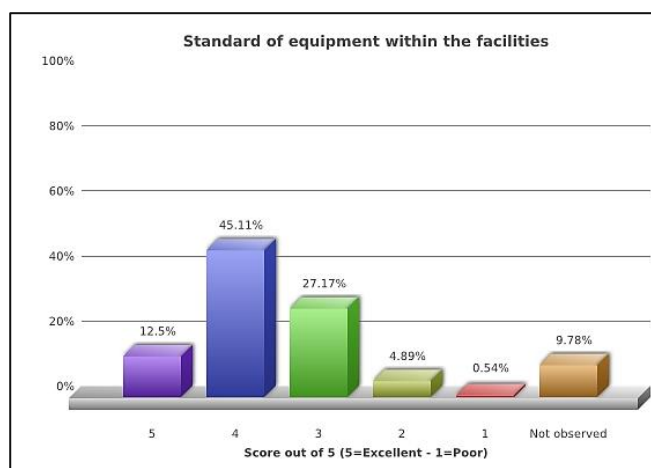
One of the most disturbing comments CVS received was where a woman who was experiencing her first stay in an acute unit and was feeling very anxious but built up enough courage to approach her nurse at the nurses' station. She stood for quite some time and the nurse glanced up and then returned to writing notes and after a significant amount of time, the nurse looked up and made a frustrating face towards the client and stated "can't you see I'm busy"! The patient returned to her room and said she just laid on her bed and cried feeling like the 'burden' once again and her self-harming thoughts returned.

Recommendations

1. The CVS continue to monitor interactions and responsiveness between staff and clients and report on any instances of unsatisfactory communication.

3.2.2 Environment – suitability of facilities and their maintenance

The following charts present data on CV ratings of services in respect to standard and appropriateness of the physical environment of the mental health facilities, including observations of the standard of the building, grounds, equipment and privacy for clients.



Building facilities, equipment and grounds

The 2017-18 year saw the opening of four new facilities or units that provided a welcome update to the standard of building facilities, equipment and grounds. In particular, two new facilities, the Jamie Larcombe Centre (previously Ward 17 at the Repatriation General Hospital (RGH)) and the Ward 18V at Flinders Medical Centre (previously Ward 18 at the RGH) must be commended for the impressive design and layout of the new units, undoubtedly a result of the consultation and input of the staff and clients from Wards 17 and 18.

The move to new facilities has also come with some challenges, and the mental health unit in the new Royal Adelaide Hospital has had some 'teething problems', including the major issue of the malfunctioning duress alarm system, which has resulted in the Psychiatric Intensive Care Unit (PICU) unable to open and security guards needing to be stationed throughout the wards.

Common issues raised in regards to building facilities and grounds, included lack of outdoor or courtyard spaces, shared bathrooms, generally tired and run down wards and informal smoking areas littered with cigarette butts, often at the entrance to the building.

The following comments are from visit reports regarding standards of building facilities, grounds and equipment.

Positive comments – 140 positive comments were made; examples as follows:

A well maintained building, which provides a great environment where clients can relax and have visitors, all contributing to the recovery process. The waiting areas and dining areas were well lit by natural light coming through the atrium. Corridors were wide, pleasantly scented and decorated.

Purpose built with close attention to the outcomes of detailed early consultation with veterans and staff, counters with cut-outs to accommodate veterans in wheelchairs and completely level paths through all doorways, nursing stations with close-by 'time-out' facilities and no 'blind spots' to rooms, views of outdoors (greenery) from all rooms, air-con controlled within each room/office, Meditation and Mindfulness Room, excellent Staff Room and Courtyard, a Student Room for 4 nurses on placement and one for Researchers, a wing for more vulnerable veterans, those needing some segregation or females, several lounge areas to accommodate different interests and levels of noise (one with Foxtel for sports enthusiasts).

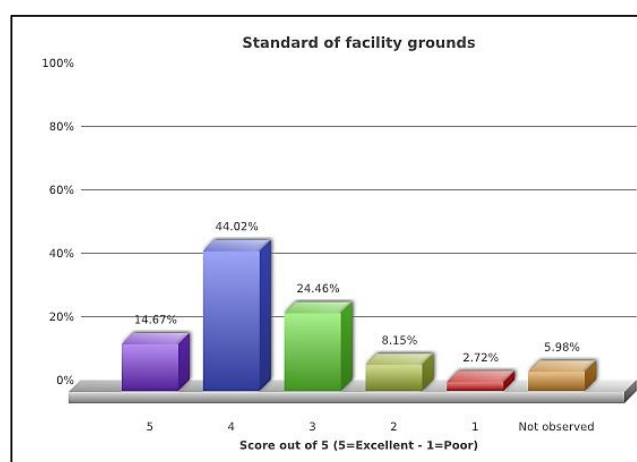
A new (used) BBQ has proven to be a hit, and a table tennis table (used) has been delivered recently.

It is well equipped for consumers to live independently.

A feature of the facility is the number and quality of the courtyards/grounds, most with gardens, maintained by the Garden Group and almost every area in the Centre has views of greenery.

In XX, well established fruit, vegetable and herb garden and clients have also made a Sensory Garden. Client X feels strongly about the visual appearance of the entrance and wants to improve the visitor experience by replanting with more attractive plants and a water feature. He hopes to do with a grant.

Beautifully landscaped grounds that, themselves, must be therapeutic



Issues – 126 issues of concerns were identified; examples as follows:

The ward is dated and as of around 4 months ago, is now shared with a surgical ward. The area is very busy and generally noisy, with pressure on lounge and dining areas as multi-use spaces. The lounge is cramped and used by all, including for those in recovery after ECT on Monday, Wednesday and Friday mornings. There are two dining rooms, one of which is dedicated for use by clients in the eating disorder program and is also used for handovers. There are three shared rooms and three single rooms. The two single rooms on the surgical side used by Ward 4G, are subject to a lot of noise from the nurses' station. Three bathrooms are shared among the ten patients.

XX was purpose-built 40 years ago but staff commented that client needs have changed and it is now seen as dated. All await upgrades, which have been promised for many years without being achieved, though some minor repairs

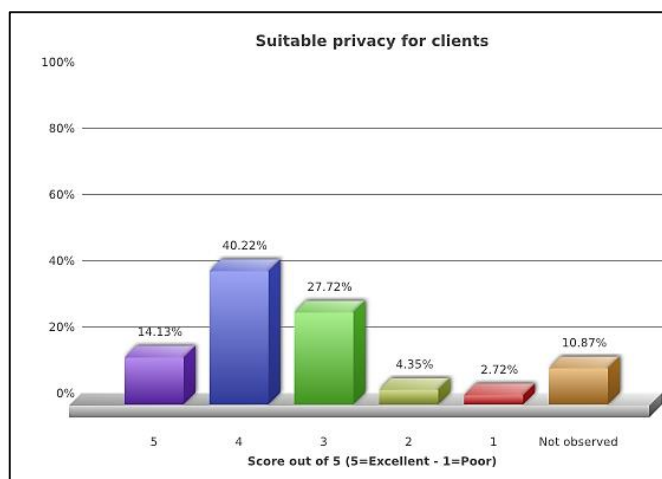
have been carried out recently. Clients reported that not all of the bedrooms have power points, making recharge of phones and laptops difficult.

Well maintained with the exception of the entrance that had a heavy build-up of cigarette butts.

Privacy

Whilst the majority of visits recorded satisfactory privacy arrangements for clients, there were still examples noted where units do not provide adequate privacy. For example, when clients are making a personal phone call or meeting with family members, carers and even their treating team, they are unable to do this in private. Privacy for clients in ED is still an issue with limited access to private space or interview rooms however, the redevelopment of two Short Stay Units at Flinders Medical Centre and The Queen Elizabeth Hospital provide clients with greater privacy than they would otherwise have in an ED cubicle.

The CVS was also notified of a policy in a PICU where bathroom doors were to be locked in the open position, as the result of a ligature point audit, however by locking these doors open, client's privacy was compromised as staff or other clients could view through the viewing window of the bedroom door, directly in to the bathroom.



The following comments are from visit reports regarding suitable privacy for clients.

Positive comments – 45 positive comments were made; examples as follows:

Each client has a single private room with a television and lounge suite to relax and also enjoy such things as reading novels. There is also a private ensuite in each room. There are also many lounge areas where a client can enjoy their privacy if they wish and watch Foxtel television. There is also a carers' room as well as private interview rooms for the psychiatrists to consult with their clients.

Each client has their own bedroom, which is personalised with their belongings, and the building has many naturally lit nooks near windows with chairs to allow for a private space with visitors.

All clients have their own bedrooms and ensuites.

Issues – 40 issues of concerns were identified; examples as follows:

A client reported issues with the batteries in the portable phones as they do not last long enough for the clients to complete their calls (e.g. on hold to Centrelink for over an hour), and the wall phone offers no privacy. A land line phone in a private space is needed and this matter has been raised many times over the years as the clients in XX have a right to conversations with CVS and their lawyers in private.

Clients have little if any privacy, particularly those in shared rooms. There is little space for one on one counselling or an area for clients to retreat to for dignity when distressed. Should family members visit, there is no private space. The communal lounge area is used by the entire floor. Even meetings for staff/families tend to be held in dining areas due to the lack of a dedicated space. The current floor layout is not conducive to providing an area of private conversation or interaction.

This was a matter of some concern for patient, A. but not for himself. When another patient was being admitted he was searched for cigarettes/drugs in front of clients already there and in the common area, the day before. A found it offensive on behalf of the new client.

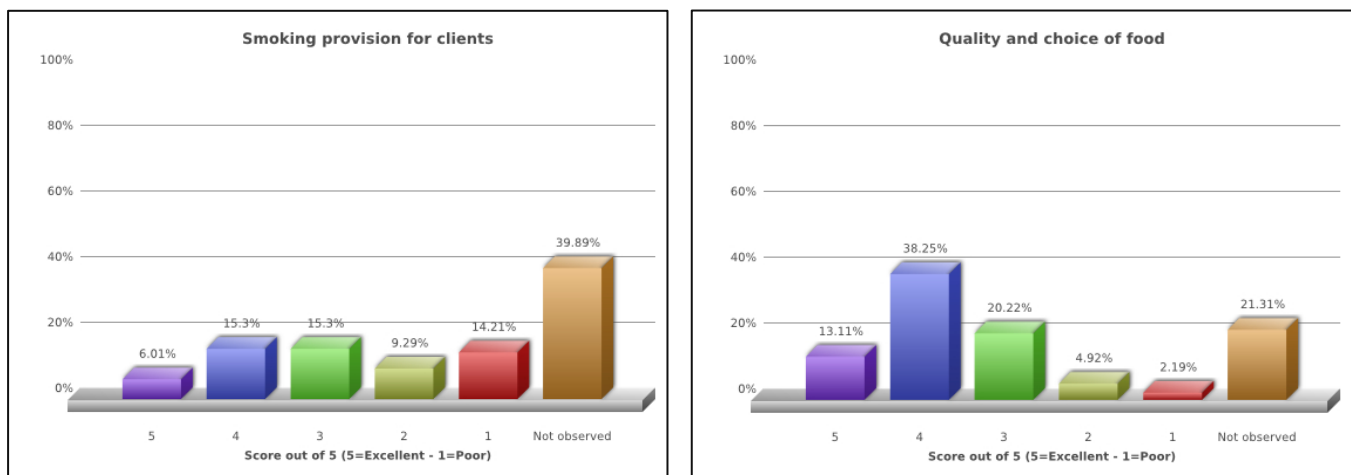
Staff had also noted that the medication is kept in the treatment room and as a result when clients are receiving treatment, other staff are having to go in to get medication and equipment needed for other clients. This is disruptive and is not ideal for safe medication, privacy and dignity.

Recommendations

2. The CVS continues to monitor the standard and suitability of the mental health facilities and grounds.

3.2.3 Quality of client services and access

The following charts present data on CV ratings of services in respect to smoking provisions for clients and quality and choice of food.



Smoking provisions

As was reported in the 2016/17 report, smoking provisions and the SA Health Smoke-Free Policy is continuing to be an issue of contention with both clients and staff. Whilst the CVS has been promoting the exemption clause for crisis situations within the Smoke-Free Policy, it was brought to CVs attention during a visit that the Policy was updated in late 2017 and the exemption clause for crisis situations now specifies that this is a 'once off' only. Whilst I am yet to hear if this change has had further impacts for clients and staff in the treatment centres, CVs are still consistently hearing of the 'unfair' nature of the Smoke-Free Policy for those in closed units and will continue to advocate for these clients under anti-discrimination legislation.

CVs also reported that some clients were being fined by hospital security for smoking on a hospital site, in some cases fines of \$200. For those clients who are unwell, these fines can add to the pressures and hamper recovery.

The following comments from visit reports highlight the complaints and issues raised to CVs regarding the smoking provisions, from the perspective of clients and staff.

Issues – 59 issues of concerns were identified; examples as follows:

XX advised that the Smoking Policy had very recently been amended to remove the paragraph at the end which provided for smoking in 'crisis situations' in facilities such as this, requiring a gradual and carefully managed implementation, now underway, to disallow smoking anywhere on the premises. This is presenting a major challenge for management, staff and particularly consumers.

Smoking is an issue, consumers have to go to the streets to smoke only if they are as voluntary admission, many has been fine by security \$200, nothing can be done to wave the fines due that is under Spotless control. When Consumers are under ITO, becomes an issue for escalation and many times to aggression.

Smoking only permitted off the premises, which is some distance away. A lenient approach seems to be taken with consumers observed smoking in an area close to the facility without apparent impact on non-smokers. PCV explained the WA legislation, which permitted exceptions to the no-smoking rules by declaring appropriate areas (such as closed unit courtyards) as 'designated exceptions'. WA had prepared guidelines to ensure protocols and procedures for exceptions did not impact on those non-smokers amongst staff and consumers. Management agreed to further pursue a solution given the significant impact on consumers of full adherence to the no-smoking policy.

The 'no smoking' policy continues to be an issue (1) clients are being asked to withdraw from smoking at a time when

they are attempting to address other pressing medical and mental health issues. The no-smoking policy does lead to code blacks. (2) the effectiveness of antipsychotics is compromised (diluted) when clients resume smoking upon discharge.

This is a contentious issue for patients in the closed ward. Some patients have "Smoking Leave", whereby they are allowed to leave the closed ward to smoke outside. However, that policy of smoking leave has been discontinued for all new patients, with the result that some patients have smoking rights and others don't. Given that patients can typically spend months in the closed ward, this inequality is not going to dissipate soon. Further, as part of their recovery process, patients have activities and visits outside the hospital, often with patients from open wards who have ready access to cigarettes and lighters. Unless a smoking area is permitted for closed ward patients, the enforced nicotine withdrawal (notwithstanding patches and inhalers) will continue to hamper patients' recovery and can be a source of frustration and aggression to staff and other patients.

Those who choose to smoke are allowed to use open areas adjacent to front entrance. This is an ongoing problem/issue with non-smokers having to traverse the area and cigarette butts and other rubbish littering that area.

Clients smoking near the front door is an issue for those who require access to the building without being subjected to cigarette smoke. It was mentioned that there are very real risks with asking volatile clients to not smoke near the door. It was also mentioned that there could be involvement by security if they are asked to intervene, however they have not been asked.

Quality and choice of food

As has been reported on in previous years, quality and choice of food is an important contributor to wellbeing for those in mental health facilities and evidence shows that good nutrition has positive impacts on good mental health. While visiting the Intermediate Care Centres and Rehabilitation Centres, CVS saw evidence of good practice in regards to meal planning and preparation, where dinner menus are often collectively decided on by clients at a morning meeting and clients participate in the cooking, which provides good opportunities for clients to practice their skills and gain confidence in preparing meals for themselves. The CVS has been impressed with the project in Ken O'Brien Centre East, where clients are involved in growing vegetables and fruit for consumption.

Whilst there has been positive examples and comments on quality and choice of meals, negative comments still continue to be reported, particularly for those in long stay facilities, where a one-week rotating menu is not only repetitive, but are often sourced from a neighbouring hospital and are reheated at the site, lacking any genuine nutrition. The CVS is advocating for the services of a dietician to be employed to review the menus and develop a wider nutritional menu.

The CVS has also been contacted in recent times by concerned staff in the RAH ED, who are experiencing difficulties with sourcing hot meals for mental health patients in the ED. With the current pressure on the system and bed block occurring, particularly for those needing a forensic bed, clients are unfortunately spending greater than the 24-hour target in the ED, with some examples of up to 5 days. Due to the kitchen and meal arrangements at the RAH, only a limited number of meals are provided to the ED and often mental health patients are left with only sandwiches for lunch and dinner. The CVS has been advised that a more flexible policy will now be put in place to allow hot meals for mental health patients in ED who are waiting greater than 24 hours and we will continue to monitor this to ensure that patients who are having to wait longer in ED are at least able to access more substantial meals whilst in ED.

The following comments from visit reports highlight the positive comments and issues of concern regarding the choice and quality of food for clients.

Positive comments – 91 positive comments were made; examples as follows:

3 patients were all complimentary of the standard of food and the size of the portions. On Sundays and Tuesdays, a roast is cooked in the local kitchen.

All clients expressed they were happy with the food choices and are also provided with a kitchen to make snacks at any time. XX ran a cooking session with the clients the day before. The clients did like this.

Clients assist with dinner meal preparations, which is planned at the Morning Meeting. It was decided that morning that dinner would be spaghetti bolognaise. Clients also have input into the daily menu. Clients prepare their own breakfast and lunch meals.

Issues – 26 issues of concerns were identified; examples as follows:

Food is a concern. It is presumed that acute Mental Health Unit clients are in a need of a special low calories diet/ that is healthier than the other Hospital clients. That involves only 3 meals a day (breakfast, lunch, dinner) in small portions and sugar free, between meals there is available only fruit and plain water. Clients are hungry due to the scarce portions of meals, they are not allowed to have yogurt (except at breakfast) or sandwiches, during the day. Staff mentioned an incident where a client was only given a banana and gravy for dinner.

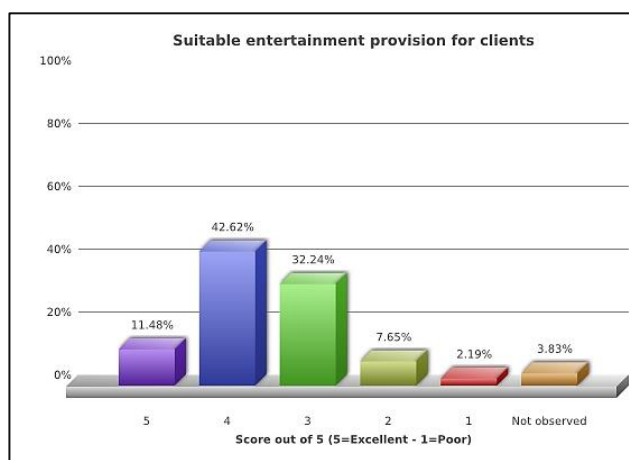
A number of clients raised concerns with the menu and quality of food, one client reported it is 'inedible'. In XX ward, clients used to cook their own meal every night, but that has been reduced to 3 nights a week. The menu is not designed for long-term clients.

In XX clients reported how "disgusting" the food is. They are allowed bread a few days a week to make their own sandwiches if they don't like what's on the menu but staff informed CVs, clients are opting for this option whenever it's available. CVs were provided with a copy of the menu and were informed the Dietician has come on board to look into it. ...appears to be getting worse and menu not designed for long-stays.

The overall reported lack of quality, quantity and choice of food is a constant complaint from both staff and clients. Information received from those spoken to during this visit, suggest that the menu provided is generic and seemingly based on the dietician's recommendations to help control potential obesity problems. The clients that we spoke to about food choices in both XX and XX complained that they were often hungry because of insufficient quantity in particular. They also complained that the quality of hot meals was still problematic due to the need to thaw and reheat pre-prepared meals.

Activities and entertainment

The following charts present data on CV ratings of services in respect to suitable activities and entertainment provisions for clients.



As is widely known, meaningful activities and stimulation for clients in mental health units is important to break the boredom and provide opportunities for clients to participate in activities that promote good mental wellbeing or encourage skills for post discharge. Many good examples of structured activity programs have been highlighted during CVS visits, including involving artists in residence, spa days, cooking classes and mindfulness sessions. However, all too often CVs report on the television being the only source of entertainment available to clients, particularly in the PICUs.

As I reported last year, reduced staffing and vacant positions such as activity coordinators and occupational therapists continues to impact on the provision of meaningful and diverse activity programs, with clients reporting to CVs, that activities are lacking when either these staff are on leave or not on duty over the weekends.

In addition to ratings, CVs also provided comments where relevant.

Positive comments – 160 positive comments were made; examples as follows:

Activities are plentiful and of good variety. Clients would like cooking lessons every day so they can eat the delicious

food!

Client X in XX has masterminded the outdoor projects and has put in an application to have chickens, composting bins and a recycling system and 11 of the 20 in XX are currently participating in the gardening work. Other clients have just started producing a Newsletter.

Residents have their own individual support plans in which preferred activities are listed (as reported by staff). As there is a large degree of independence, residents can choose to do their activities when and where they like. There is opportunity to join a gardening, walking and cooking group. Residents have access to the residential fitness facility (5 work stations) or can choose to join a gym outside. A large weekly general activity plan is displayed near the lobby area informing residents 'what's on'. There are excursions to outside recreational facilities. A new activity, walking greyhound dogs from the SA adoption program at Semaphore, will be introduced this week.

Bright posters are displayed containing a list of things available to do, which include: jigsaws, word games, books and magazines, games, cards, bocce, 10 pin bowling, indoor bowls, knitting, movies, gardening, quoits, drawing, colouring mandalas, listening to music in the dining room, and a CD player is available for patients to use in their room as a relaxation tool. Many patients were observed engaging with visitors and in groups with each other. Patients spoke of the value in being able to share aspects of familiar life experiences with each other.

Issues – 61 issues of concerns were identified; examples as follows:

Staff raised the issue of access to the OT room and materials over the weekend advising that lack of access, limits their ability to provide meaningful and therapeutic activities for patients over the weekend.

Clients' main complaint was the lack of activities, especially on weekends and when the social worker and activity coordinator were not available. Staff told CVs that home visits over weekends are therefore encouraged for suitable clients.

Staff advised that the art therapist was on leave and the position was not backfilled. Nursing staff were doing their best to facilitate alternative activities when time allowed. Staff advised that some patients were disappointed that the full range of activities was not available. CV's note that particularly for Eating Disorder patients who are confined to the ward, the value of activity program should be recognised.

Clients often feel sleepy because of their medications, on the other hand there is little stimulation available in the unit. Some clients complained this leaves them with too much time to think about their problems.

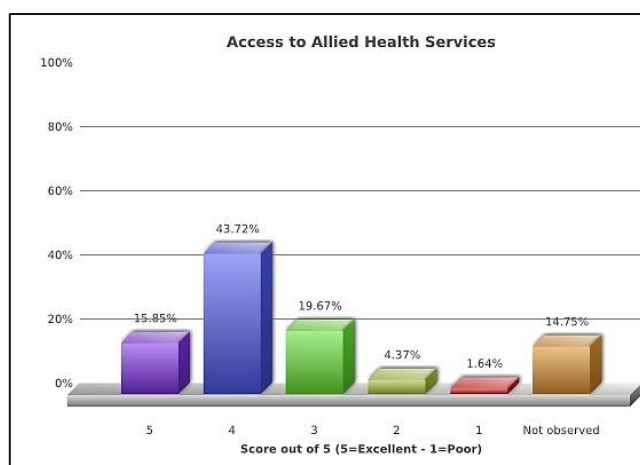
Whilst an activities room is provided, complete with snooker table etc., it was locked and not accessible. Interestingly, staff advised that they had never at any stage seen it open during the week. Staff said they understood the room was accessible on weekends, although they had not been in attendance at the time.

Access to Allied Health Services

The following chart highlights data on CV ratings of access to allied health services for clients.

As highlighted above regarding activity offerings, similar comments have been made in regards to the lack of allied health services provided when allied health staff are on leave or not available on weekends. CVs often hear about this issue.

Access to Social Workers is becoming increasingly relied upon as clients need greater assistance finding housing and accommodation post discharge and it is important that mental health units are properly resourced to meet these needs.



Another aspect raised in the long term mental health units, particularly James Nash House, is access to less common allied health services for services such as dental work and physiotherapy, which often have to be undertaken off-site. One CVS report commented as such - *We have every reason to believe that allied health services would be used on an as needs basis. However, "need" is dependent on definition, for example, a client would not see a dentist, even during a stay of many years, unless a crisis of pain was experienced.*

Positive comments – 57 positive comments were made in this reporting period, examples as follows:

A second peer support worker is about to start, along with a newly appointed OT. Increased staffing now can increase the community engagement and offer those activities, with two staff members at every community activity, for safe management of staff and clients, taking clients to the shops, to the Blue Lake or to the beach.

CV's witnessed a notice-board where patients could lodge a request to see allied health personnel, and during previous visits, an invitation to see doctors and allied health people was offered during the morning meeting. An exercise physiologist is currently working on a part-time basis as a work placement, and is designing exercises specifically for clients.

CVs spoke to several clients in the lounge during the visit. The positive feedback from the client who pointed out the level of the service support makes him feel comfortable as Allied Health Services are available to fit their needs.

Issues – 30 issues of concerns were identified; examples as follows:

Currently experiencing a reduction in the level of services and higher than normal level of relieving consultants relating to establishment of nRAH, illness and personal leave.

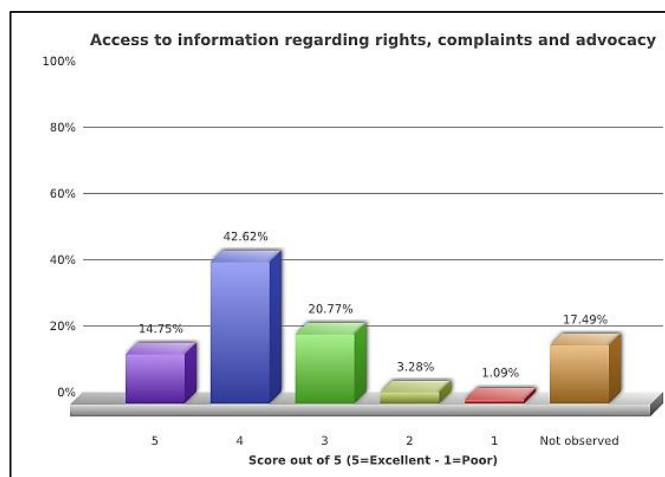
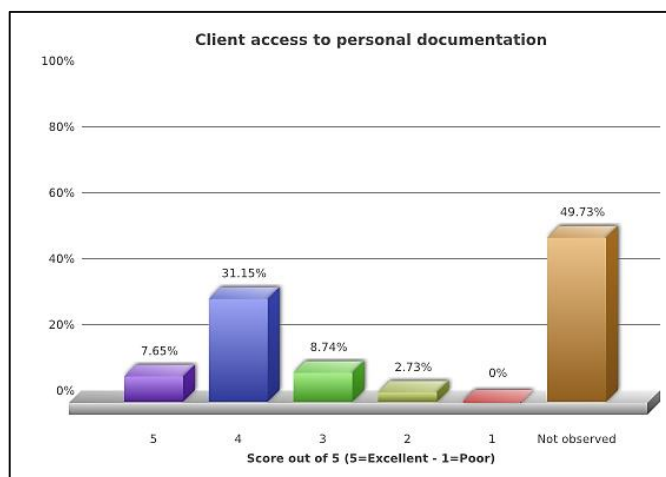
There has been a reduction in these services lately, with a move to part-time. 1-4 social workers, an OT and only one psychologist (there were two) recently.

This is a constant issue, especially for dental or others that require transport.

We have every reason to believe that allied health services would be used on an as needs basis. However, "need" is dependent on definition, for example, a client would not see a dentist, even during a stay of many years, unless a crisis of pain was experienced. Costs are a factor in determining availability and extent of services offered directly to clients.

Client access to personal documentation and access to information regarding rights, complaints and advocacy

The following charts display data on CV ratings of access to their personal documentation and information regarding rights, complaints and advocacy.



Overall, mental health services rated well in regards to access to information including client rights and advocacy, and CVs were generally pleased to see the CVS was well promoted in the treatment centres, including the CVS visit notification posters on display around the common areas. Access to interpreters and roles such as the Aboriginal Liaison Officer are also important in assisting clients with advocacy and understanding their rights where they may be language or cultural barriers.

Whilst CVs were assured to know that clients are receiving their Statement of Rights information when admitted to a treatment centre, it was commented to CVs that the degree to which unwell patients may understand and retain this information may be limited, and it is important that clients are reformed of their rights as they gain greater awareness. This is where the role of the CVS plays an important part in reiterating clients rights, particularly for those involuntary

clients under an Inpatient Treatment Order.

Positive comments – 89 positive comments were made; examples as follows:

Access to interpreter made available.

CV's were advised that all consumers upon admission to XX are given an information pack which includes a brochure about the CVS. In the ED waiting room, CV's observed a CVS A3 poster and brochures on display. Again a A3 poster and brochures were on display and easily available in ED itself.

XX said that ED mental health consumers are welcome to speak to the hospital's Patient Complaint Officer and sometimes (where appropriate) they are encouraged to write to the Minister for Mental Health about their complaint. In XX, CV's observed a suggestions/feedback box and an inpatient consumer feedback form was available for consumers to fill out.

Information posters and brochures (including CVS brochures and a flyer advising of the scheduled visit) were on display. CVs were invited to speak about the role of the CVS in the client meeting and speak with clients afterwards.

Issues –19 issues of concerns were identified; examples as follows:

There are no information brochures that are easily accessible for clients. The admission package containing information that clients used to receive has not provided since the move. This is a good practice that should be implemented again.

A comment was made to a client in ED who was under an ITO, while receiving some documentation was not fully informed of his rights. As it transpired, the ITO was revoked and the client left, staff acknowledged this had not been handled well and made the comment "that it was a shame we didn't get the opportunity to talk to him".

There are real challenges with a proposed paperless approach especially when clients are used of brochures and information about their Rights, advocacy services and Appeals have been previously provided. This would be the same for individual plans.

Appropriate family/carer/representative involvement

The following chart provides data on CVs ratings of appropriate family/carer/representative involvement. Whilst a large proportion (40%) rated as not observed, some positive examples of family and carer involvement were highlighted by CVs as identified below.

Positive comments – 49 positive comments were made; examples as follows:

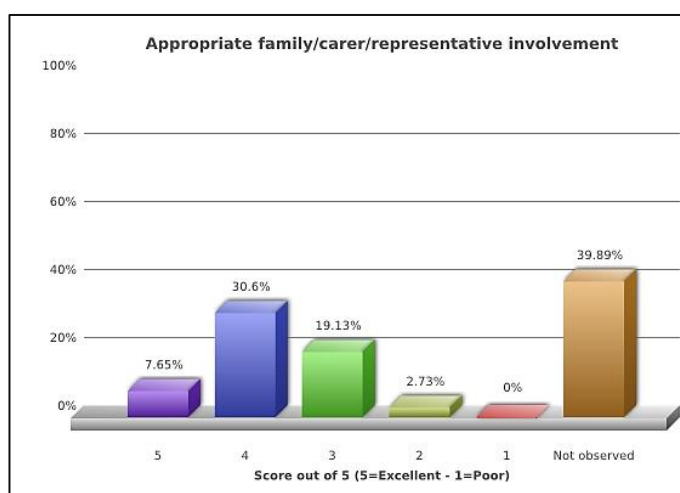
There is a high degree of family/carer involvement in care of clients at XX and in choice of nursing home placement. Groundwork is done with family to ensure as smooth a transition as possible and a wraparound service is provided from the team of staff when a client is moved, providing ongoing support to both the family and staff at the new place of residence for as long as is felt needed.

A client's family members were observed to be visiting. In the client meeting, specific mention was made of the availability of the Carer Consultant and their role in providing support and information to family members.

Female client reported that her partner and her work colleagues had been made welcome, that the staff have been proactive in engaging with her social supports, in forming her treatment plan to return to the community.

For the client progress reviews, family members are invited to attend unless a client specifies otherwise. Where families are invited, most do attend. They are asked about their opinion/perspective on a client's progress. There are also monthly meetings for carers, conducted by Carer Consultants.

The role of the carer consultant found in a number of units provides a welcome avenue for not only the engagement and



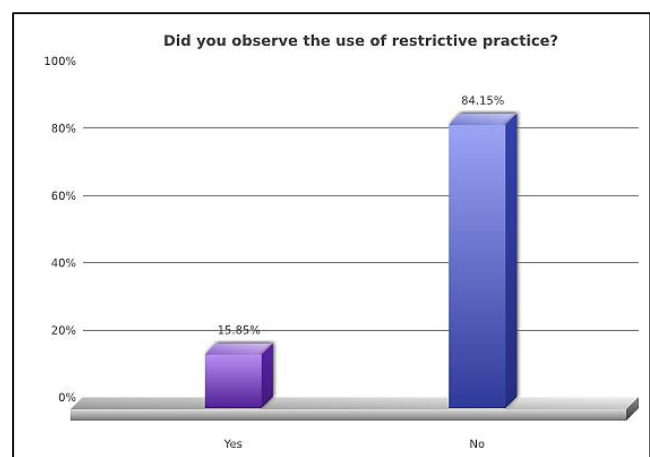
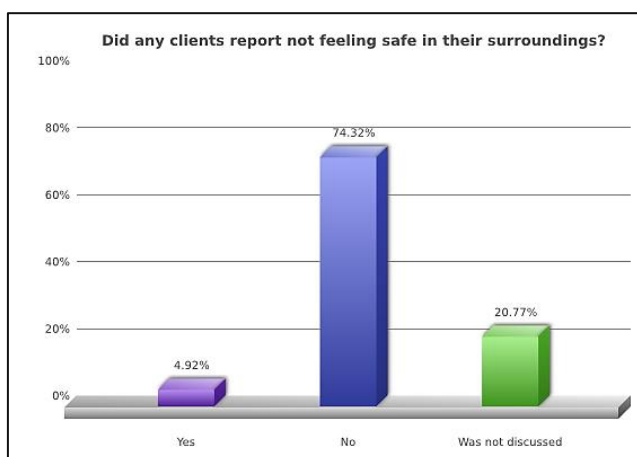
involvement of carers in their family members/friends treatment and recovery journey, but also provides important information and support to carers.

Recommendations

3. The long stay mental health facilities obtain the services of a dietician to review the menus, ensuring a nutritional meal plan.
4. That the SA Department for Health and Ageing undertake a detailed risk-assessment into the impact to patients who have smoking addictions and who have been placed into closed units.
5. That the Community Visitor Scheme continues to explore individual patient rights under anti-discrimination legislation and specifically those who have smoking addictions and who have been placed in closed units.
6. The Community Visitor Scheme continues to monitor levels of activities offered to patients and participation rates.
7. That an objective assessment of Treatment Centre activities and programs be undertaken as a means to highlight and promote good practice and explore the impact of the above on patients and their recovery.
8. The Community Visitor Scheme continues to monitor access to allied health services and the availability of these roles within mental health units.

3.2.4 Safety and Rights – least restrictive practices

The following charts present CV observations of client's safety and rights, including whether any clients reported not feeling safe in their surroundings and whether any restrictive practice was observed.



The CVS continues to monitor personal safety at all visits drawing attention to situations and environments, which could potentially expose individuals to risk. This year the CVS undertook a two-month focus on consumer safety which is highlighted further below.

In my report last year, I noted the 'Safe Wards' program that has been implemented in Victoria, based on a model used in the United Kingdom. It was pleasing to hear that a particular unit was planning to implement the program, as was noted below:

Staff commented that their professional development has been improved recently with weekly in-service training sessions by workers from a variety of backgrounds. XX is planning to introduce a "Safe Wards" program which has proved successful elsewhere; it has 10 modules focussed on improving staff safety and reducing stress, by improving responsiveness to and communication with consumers.

Another positive to come out of the closure of Oakden and move to Northgate House, is the significant reduction and removal of restrictive practices such as restraints. The positive impact of this on the clients was described by CVs at a visit below:

There are no restrictive practises in place. This includes pelvic restraints in chairs etc., and represents a significant

change from the old Oakden site. One patient who used to spend much of her time in an Angel Chair was in a normal chair and has now started to walk again.

Of concern is the ongoing use of handcuffs and shackles for forensic and corrections clients in ED who are awaiting transfer to a secure mental health unit. I have been contacted by numerous concerned staff in ED, where they have had forensic clients in their care for up to five or six days, during which they have been restrained to the bed and guarded by two DCS guards.

The overuse of security guards in the mental health units, has also been raised at various visits, as a high presence of security guards can be intimidating to clients and certainly does not assist in creating a therapeutic environment, nor does it help with alleviating stigma. A DCS client in a mental health unit requires two security guards per client, and I have heard of a recent experience where a PICU had five corrections clients admitted to the unit at one time, resulting in 10 guards stationed in the unit.

Similarly, with the duress alarm system at the RAH still not functioning, the mental health unit has security personnel stationed at various points around the unit. Whilst these security personnel are in plain clothes, their presence is still not subtle for clients.

With the current demand for mental health beds exceeding capacity, the CVs have witnessed times where there are clients ready to be transferred from a closed to an open ward, however, there are no available beds or clients in the EDs get priority which results in clients spending unnecessary days in the restrictive closed ward. This fails to meet the principle of 'least restrictive' interventions under the *Mental Health Act 2009* and should be reported on the SLS.

The above issues and others relating to restrictive practices and personal safety were commented on below:

At the time of the visit, there were 6 patients in XX who had been listed for open beds but had not been transferred due to bed unavailability. Two of these patients had been waiting since 14/11. There is a sign in XX advising patients that only 2 outgoing calls can be made per patient per day.

Doors to both XX and XX were unlocked at the time of visit. Staff advised patient in XX had been waiting up to 5 days after being deemed clinically suitable for an open bed for the transfer to occur due to no beds being available in the open ward.

Staffing levels of RNs etc. mean the units are largely handled by level 1 staff at present. Also due to bed flow and the availability of clinicians to assess, clients are exceeding assessment times in ED. One client would be in ED for a day waiting for assessment, and another was expected to be in breach by 7.30 that day due to non-availability of ward beds.

On the day of the visit, a female prisoner was an inpatient and required two security guards to monitor her every movement. This is disconcerting for many in an open ward but is a DCS stipulation.

CVs spoke with one client who was not happy about having to take medication. Staff were aware. The use of restrictive practices is minimised wherever possible and used as a last resort. Measures implemented to manage distress include the use of a sensory trolley, talking therapies and groups. There had been occasions over the last week where enforced chemical restraint and seclusion had been used, with security presence utilised for a client to comply with taking medication. Restrictive practice use is reduced wherever possible, while ensuring the safety of other clients and staff.

Focus on Personal Safety of Clients in Care

In May and June 2018 we undertook a Focus on Personal Safety of Clients in Care at all visits conducted during this period. In preparation for the focus the CVS held a half-day training session for Community Visitors regarding the process of the focus and included two guest speakers who discussed various aspects of client personal safety in the mental health and disability environments.

The focus included questions to both staff and clients and knowledge of their rights and personal safety, training that is available to staff and clients and the reporting process of any incidents of abuse. CVs also asked staff to provide examples of documents such as policies/guidelines for incident reporting and the monitoring of allegations and/or investigations.

Preliminary analysis of the responses and data captured at visits during the focus highlighted the following:

- » As expected, the large majority of staff indicated there were organisational policies and procedures in place regarding personal safety of clients and most highlighted these were available in hard copies and online for staff to

access. It was noted that a small number of staff were not aware of any specific policies regarding personal safety of clients, however they reported that the principles of personal safety overlay all organisational policies.

- » Staff overwhelmingly reported that training is provided in personal safety and protective behaviours, most commonly Managing Actual and Potential Aggression (MAPA) training.
- » Mental health units can generally respond well to clients requests well regarding gender specific staff, however the provision of separate areas such as gender specific or relaxation areas can be limited due to the physical environment, particularly in Emergency Departments.
- » A small number of clients had requested a particular gender support staff and all felt that their request had been carried out in a positive manner.
- » Approximately 45% of staff felt that implementing restrictive practices had impacted on their safety, including examples of when conducting searches of personal property and enforcing the smoke free policy in PICUs. It was reported this is often mitigated by experienced staff implementing the restrictive practices.
- » In regards to client's experiences, only one client reported not being aware of their rights to feel safe and all clients reported feeling safe in their surroundings. Clients relayed being informed of their rights regarding personal safety through avenues such as client community meetings, admission and welcome booklets and posters in notice boards.
- » Overwhelmingly clients reported that they knew who they could speak with if they were concerned about their personal safety and felt that they would be comfortable talking to staff, particularly a peer worker.

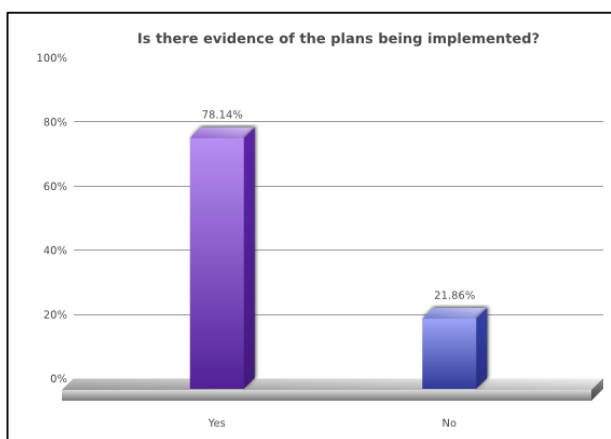
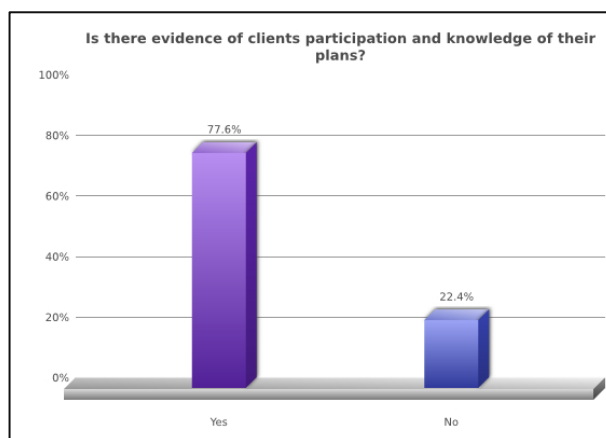
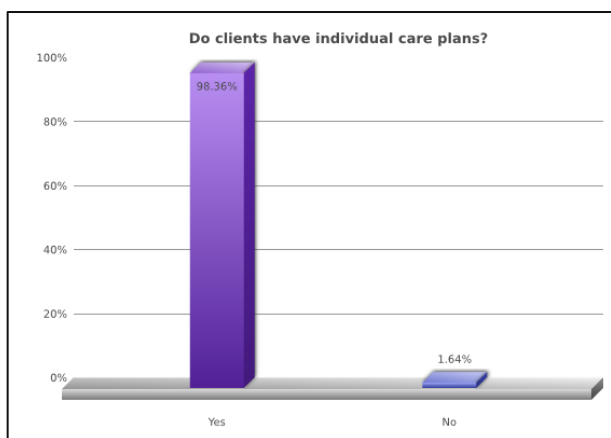
The CVS will be completing a detailed report of the focus and outcomes and this will be provided to the CVS Advisory Committee for review in due course.

Recommendation

9. The Community Visitor Scheme continues to monitor the incidence of seclusion and restraint and least restrictive practice.
10. The Community Visitor Scheme continues to refer incidences of concern regarding the inappropriate or prolonged restraint of forensic and mental health patients to the relevant agencies.

3.2.5 Treatment and care planning

The following charts present CV observations of the development, use and review of treatment and care plans, including client expectations and participation in their care plans.



In the above graphs, it is interesting to note that while CVs reported that 98% of visits indicated that clients have individual treatment and care plans, only 78% reported there is evidence of the plans being implemented and 77% reported evidence of client participation and matching the expectations of clients.

Whilst evidence of client knowledge and participation of their treatment and care plans may be harder in a PICU environment for example, the CVS is interested to see the continuation and use of treatment and care plans in the community mental health setting, and how well these transition between the acute and community services.

Rated even lower was the evidence of family, carer or guardian involvement in the development of the treatment and care plans, with only a third (66%) of visits highlighting this. This aspect of a lack of carer involvement in treatment and care plans, has been reported to the CVS and includes examples in both the development and ongoing use of the care plans, including how much information carers listed on a client's treatment and care plan are provided when their loved one is admitted to a facility.

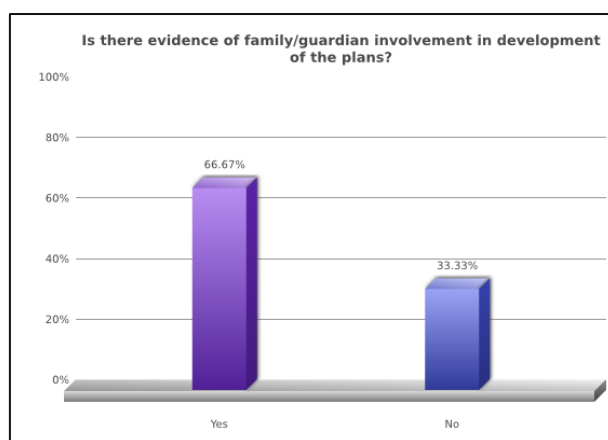
Treatment and care plans are an important document in giving the client some control over their life when they become unwell and provide an avenue to adhere to their wishes, documented at earlier times in their recovery journey. They also assist clients in not having to 're-tell' their story each time they are admitted to a new unit or reviewed by a new consultant.

Some positive examples of the use of client's treatment and care plans were recorded by CVs as follows:

Positive comments were made; examples as follows:

Care plans are a big focus at Whyalla. They are actively promoted particularly by the community teams and they are careful to have in place contingency plans should someone become ill. They contain the resources the client can access, how best to do that and remind the client what has worked well in the past. Communication among service providers is good and response times are good. This is particularly helpful in saving people from being admitted.

Staff seemed very aware of patient needs and preferences and do their best to encourage skills such as budgeting and food preparation in preparation for life after discharge.



Whilst there have been good practices as outlined above, there have also been issues raised in relation to the use and involvement of clients in their treatment and care plans.

Issues – issues of concerns were identified by CVs; examples as follows:

CV's asked clients of awareness of their care plans, none of them were aware of them. Staff told CV's that this was done with clients on admission. A female client told CV's that she had been extremely frustrated at not being able to find out what the plan for her discharge was. She said she saw psychiatrist 3 times a week and that nursing staff were unable to communicate with doctors and didn't know anything about it.

While care plans are viewed as a valuable multi-disciplinary tool, it was mentioned there are challenges with the use of them being embedded in practice, from both the client and staff perspective. Clients are given a 'My Recovery Folder' to assist them post discharge and the consumer care plan is in the back section of this folder. In general, there is a reluctance by clients to complete the folder, compounded by lack of encouragement from staff to complete it. Although it is intended that a client take the folder with them once discharged, often the folder is left behind or taken away incomplete. Staff are exploring strategies on how to better engage people, including recommencement of morning consumer community meetings. It was mentioned that the care plan process is currently under review in country areas and is being trialled in Murray Bridge.

Recommendation

11. The Community Visitor Scheme monitors the practice of developing and maintaining treatment and care plans, as part of the LHN's reported Key Performance Indicators.
12. The Community Visitor Scheme continues to monitor the level of involvement by clients, their family members and carers in the development and implementation of treatment and care plans.

3.3 Issues and Challenges impacting on Mental Health Services

3.3.1 Forensic Mental Health Services

In my Special Report last year, I highlighted a number of issues relating to the forensic mental health care, including the lack of available beds and the flow on effects this was having on the wider mental health system. Sadly, since my last report the same issues are still being felt, if not worsened. Whilst the independent Review of the South Australian Forensic Mental Health Service and the SA Health response to the recommendations was finally released last year, the CVS cannot help but feel there has been a lack of action and progress with addressing the recommendations of the review.

At CVS visits and meetings with the Local Health Networks, I have been increasingly hearing of the concerns about the lack of available and appropriate forensic or secure mental health beds. With the PICU at the RAH not open due to the faulty duress alarm system, I understand that at this point of time, Ward 5J at Margaret Tobin Centre is the only other gazetted mental health treatment centre that can admit the Department of Correctional Services (DCS) clients transferred from correctional facilities.

The limited availability of beds at James Nash House and the non-functioning PICU at the RAH has placed significant demand on Ward 5J to admit DCS clients. With the demand for closed PICU beds high across the system, this is having an impact on access to closed beds for mental health consumers in the South, as well as placing pressure on the unit to move patients to the open ward earlier. This was commented on at a CVS visit to 5J:

The patient was a forensic patient and ward staff advised they had been receiving increasing numbers of requests to accept forensic patients for the last 3 weeks. One staff member commented this may be because they are unable to go to the unit at the new RAH. The swing beds in 5H were open making the ward a 17-bed unit. Staff advised this has been occurring quite often recently. When these beds are open, one additional staff is allocated on the day shift but there is no increase in staffing on the night shift. Staff in 5H also commented that having 3 or 4 admissions in a single day is a potential safety concern.

In the past year I have also been contacted on a number of occasions by concerned staff in the RAH Emergency Department who have been concerned about forensic and DCS clients in their care, who have been in the ED for a number of days, handcuffed and shackled, awaiting a transfer to an appropriate mental health facility. In one case, a client had been restrained for 10 days, (four days in the RAH ED and six days in a surgical ward) awaiting a transfer to a secure mental health unit. Staff are concerned for these clients and the implications of not only the physical restraint for a significant period of time, but the delay in receiving the appropriate psychiatric treatment required.

The CVS believes that DCS needs to provide greater services and dedicated mental health facilities for their clients within their own correctional system. In other jurisdictions, the Correctional Services facilities actually have a significant number of mental health units/beds. For instance, Victorian Correctional Service have dedicated mental health practitioners and qualified mental health nurses provide mental health care at all prisons, with specialist support from visiting psychiatrists at most locations.

At the Melbourne Assessment Prison which is the equivalent to our Remand centre, psychiatrists and qualified mental health nurses provide specialist mental health care to male prisoners. The Acute Assessment Unit at the Melbourne Assessment Prison is a special mental health unit that provides assessment and treatment for male prisoners with serious psychiatric conditions. A 16-bed short stay assessment unit is provided for prisoners thought to be mentally ill and/or at risk. The multi-disciplinary staff in the unit provide psychiatric assessments and a range of short-term interventions and support. The assessments are used to determine future treatment and detention needs.

Victoria also has the **Metro Remand Centre** that has a capacity of 883 but also has a special unit 204 beds in varied units allocated for special needs such as (but not limited to) vulnerable prisoners, young adult, prisoners at risk.

At the Dame Phyllis Frost Centre, psychiatrists and qualified mental health nurses provide mental health care to female prisoners. The Marmmak Unit at the Dame Phyllis Frost Centre provides assessment and treatment for female prisoners with serious psychiatric conditions and opened in August 2007. The 20-bed Marmmak Mental Health Unit delivers specialist treatment services for women prisoners who experience mental illness.

The Marmmak Integrated Mental Health Service includes the establishment of a specialist mental health in-patient unit, as well as out-patient, outreach, consultancy, and training services at DPFC.

Prisoners who require involuntary mental health care are transferred to Thomas Embling Hospital under the Mental Health Act 1986. Thomas Embling Hospital is a high-security forensic mental health hospital. The facility is operated by the Victorian Institute of Forensic Mental Health, known as Forensicare, who are responsible for providing adult forensic mental health services in Victoria.

The hospital provides acute and continuing care for patients from the criminal justice system who are in need of psychiatric assessment, treatment or care (security or forensic patients) as well as patients from the Victorian public mental health system who need specialised management (compulsory patients), and includes a dedicated women's unit. Purpose-built with 116 secure beds, the hospital opened in April 2000.

That adds up to 162 secure beds with their Corrections and forensic system, and another 204 beds in the Remand centre for special needs = **total 366 beds**.

In SA, we have JNH with 3 wards Aldgate = 8 acute beds; Birdwood = 14 acute beds; and Clare = 8 sub-acute beds. KOB has two rehab units each with 10 beds. There is also a step-down cluster of units, Ashton House that has an additional 10 beds. A total of **60 forensic beds**.

I believe the two significant differences are the 16 bed assessment unit within their Remand Centre and specific women's units – the 20 bed unit within the Women's prison and a dedicated women's unit in the forensic hospital, Thomas Embling.

And we wonder why all roads lead to our ED in SA??

This issue was raised with the Minister for Health and Wellbeing in late May at our first meeting and then wrote to the Minister early in July specifically about this matter. The CEO of Central Adelaide Local Health Network (CALHN) and the Chief Psychiatrist were provided with a copy to this correspondence and the key points raised included the following:

In South Australia, the Courts also direct clients requiring a mental health assessment to be taken to an emergency department. However, when the only option available is in RAH Emergency Department and where they are required to be hand-cuffed and shackled for long periods of time (which we know is detrimental to recovery), then this should be deemed an unsatisfactory option. Other alternative options need to be looked at, such as use of the Yatala Prison infirmary or as I have identified above, a specific assessment unit should be established within our Remand centre similar to what is available in Victoria.

The 2015 Review of the South Australian Forensic Mental Health Service, specifically recommended the following: which if implemented, would all support the appropriate and timely assessment and treatment of clients requiring mental health care in a custodial setting:

"2.2 Establish clear models of service and a multidisciplinary admission, transfer and discharges process to ensure clear clinical governance and coordinated and informed decision making about flow through the high security inpatient services.

2.3 Develop a model of service for the Community Forensic Mental Health Service, which includes clear mechanisms for collaboration with key stakeholders, and as part of future planning for the forensic mental health system, consideration of the resources required to manage forensic patients in the community.

2.4 Establish a dedicated multi-disciplinary Prison Mental Health Service to provide assessment, treatment and care services in custodial settings.

2.5 Establish a multi-agency prison mental health steering committee and develop information sharing guidelines to support responses to individuals with mental illness in custodial settings."

The CVS will continue to advocate for the implementation of the recommendations of this important Review and my July letter to the Minister for Health and Wellbeing, requested action on these key recommendations. The Minister responded to this matter and has organised a meeting with the PCV, the Chief Psychiatrist and himself to progress discussions and actions on this ongoing issue. Whilst addressing the issues will require cross agency support, the CVS welcomes any opportunity to be involved in the process.

Recommendation

13. The recommendations of the 2015 Review of the South Australian Forensic Mental Health Service are given appropriate consideration by a high-level cross –agency working group and implemented as a matter of priority.

3.3.2 Accommodation shortages and discharge

An increasingly common theme at CVS visits is the shortage of appropriate accommodation options and the impact this is having on discharge. The closure of two Supported Residential Facilities (SRF) in the last year, resulting in the loss of 72 licensed beds has had a significant impact on hospital discharges in this reporting period. This loss together with the initial uncertainty of the SRF sector within the National Disability Insurance Scheme (NDIS) environment, has had an impact on available accommodation and in the last year, CVs have heard many stories of clients being discharged to boarding houses, caravan parks and couch-surfing. Whilst policy states that clients should not be discharged to homelessness, some would consider the previous examples as homelessness, as they lack many of the vital services that vulnerable clients need post discharge, including medication support, meals and security.

As stated earlier in this report, CVs are being advised that Social Workers are spending a significant amount of their time sourcing appropriate and available accommodation options for clients ready to be discharged, and in one unit have even had to upskill other nursing staff to assist in finding accommodation options for their clients.

This lack of accommodation has also meant that clients ready for discharge are staying unnecessarily longer in acute and community mental health units until accommodation is available, causing a flow on bed block effect for other clients in need of an admission. The CVS is aware of a small number of complex clients in community rehabilitation centres who have been a resident for long periods of time and in one instance, a client has been in a CRS for over three years, with staff unable to find the appropriate accommodation and support.

With the full roll out of the NDIS in psychosocial disability happening in the coming year, this is an opportune time for these clients with complex needs to seek the funding and services to enable them to transition out of the community rehabilitation centres. However, when this matter has been discussed with CRS clients and staff, it has been evident that there is little knowledge and connection with the NDIS, Local Area Coordinators and the Non-Government Organisations or agencies that are capable and have years of experience supporting clients with complex needs and associated behavioural challenges.

This same scenario was within the SRF sector previously and the Department of Human Services worked closely with the sector, identified a key worker to work across this sector in preparing pre-plans and liaising with NDIA planners and this had outstanding results for individual residents of SRFs and the sector in general. These clients have for the first time individual plans with sufficient resources allocated to enable them to make life-choices and pursue goals that will lead to greater community participation and better quality of life outcomes. The CVS believes that it would make sense for SA Health to follow this model in CRCs and Community Mental Health to enable as many clients as possible to obtain psycho-social support services through NDIS funding.

The following comments from CVS visit reports highlight the concerns around accommodation shortages and the impact this is having on discharge of clients:

A difficulty raised by the staff is the increasing number of homeless clients and the problems in placing them after discharge. While they have an onsite Social Worker and do access Allied Health services, it has led to extended

stays in some cases which is not the focus of the unit.

There is a growing concern for clients with complex needs and suitable accommodation at discharge since Oakden closed down. There was a consumer that has been admitted at XX since March 2017 and there is not an ongoing suitable accommodation option for this client with complex care needs. The client is in Palliative care and there is no coordination from the client's family to move the client to a suitable accommodation.

Also the need of more beds in the community that would offer complex and high level of care, at the time of CVs Visit, there was a lady that has been admitted for around a year in XX, due to lack of a facility/agency that would offer the care required.

The issue of accommodation upon discharge is still presenting as a problem. The policy at XX ward is that consumers are not to be discharged into homelessness but this is occupying considerable staff time to implement. The general reduction in SRF beds has exacerbated this. One consumer recently was discharged to couch-surf at a friend's house for a 3-week temporary stay because he had been barred from most of the emergency accommodation services. Finding proper accommodation is an ongoing issue which influence the quality of services. As an emergency unit, they need to maintain their services in a timely manner and for many other services, they rely on referral to XX, who are also under bed pressure.

XX stated that the impact of closures of the Short Stay Unit, regional ICC & nearby Neami Crisis Centre, were considerable. These closures have placed pressure on admittance to medicine wards, Ward 1G or to Woodleigh House, which may not necessarily be in the best interest of the client.

CVs discussed the issue of housing at the staff meeting. Bed availability is a concern. The reduced number of SRF beds is causing people to access rooms in boarding houses which are less suitable for vulnerable people and provide much less support (i.e. no meals or medication support). Staff raised a concern that a lack of bed availability prevented them from being able to offer a respite service as a form of early intervention at the ICC which was important in preventing admissions to EDs and acute units.

During the CV's visit, the facility had 7 clients who had no fixed address (homeless). 1 had been there for the past 2 months and 1 client in the past had been there for 1 year until accommodation was found for them. XX said that the facility is seeing more and more homeless clients, compared to when it first opened in 2011. XX has a waiting list. Most of the people waiting are from the community.

There is a clear conflict between Rehab and Recovery causing some dilemmas in terms of purpose and actual role. Some clients are either rotations from Glenside or IG and one client in particular is finding it difficult to move on to private placement because of behavioural issues. That person, XX has been resident at the facility for 3 years. Management highlighted the difficulty in obtaining an accommodation option that provided 24/7 support to this client. The facility should/was designed to be a short term transitional facility, but this is not always possible to achieve.

The current accommodation shortage needs to be addressed as an urgent priority and requires across sector support and involvement, including a state housing and accommodation strategy to address this.

Recommendation

14. The Government undertake an urgent enquiry into emergency, short-term and long-term accommodation options in South Australia and develop a state housing plan and strategy to address accommodation needs for vulnerable clients.
15. That SA Health invest in a NDIS Psycho-Social support worker who can work with CRC agencies and Community Mental Services and staff to assist individuals in pre-panning initiatives and liaising with the NDIA and Local Area Coordinators to enable as many clients as possible to obtain psycho-social support services through NDIS funding.

3.3.3 Pressure to discharge early and readmissions

In the 2016/17 Special Report, I reported that the CVS was receiving anecdotal evidence from staff regarding the impact of the 24 hour ED target for mental health patients and the pressure this is creating on the mental health units, including a perceived pressure to discharge clients earlier than needed. This was described as becoming a 'revolving door' or increase in readmissions relayed to CVs by staff at visits.

It seems that this trend has continued and the following comments provide examples of the anecdotal pressure on the mental health units and subsequent pressure to discharge early to meet bed flow targets:

At the time of the visit, 6 MH patients were being held in ED and in ward XX's 20 beds were full, with 12 of these

clients under an ITO. There continues to be breaches to the standard of 24-hour target stays in ED for MH patients. There were 4 breaches last week alone. These breaches are caused by a lack of vacant beds in FMC or Morier etc., where these patients can be referred or a lack of ambulances to effect transfers.

Re-admissions from XX Ward discharges are still constant.

ED has been extremely busy over that past month with 180 Mental Health admissions. This, combined with a city-wide shortage of beds generally as well as Ambulance services being too busy to transfer clients who are not emergency patients, has resulted in 4 breaches of the 24 hours-in-ED rule last month and 2 or 3 so far this month. Technically, a mental health nurse is on duty at all times in ED but staff availability has made this difficult to achieve.

We were concerned to learn that pressure to discharge continues to be felt by staff, the unit has a longer than average stay rate resulting in a commendably low re-admission rate. According to staff, a re-admission rate of 12% is deemed acceptable. The unit Psychiatrist prefers to resist the pressure to discharge early and maintain a much lower re-admission rate as he believes this is better practice. We were also concerned to hear of the increasing number of transfers being experienced from Adelaide hospitals in peak times. Most of these people have no connection to the region but are allocated centrally to available beds. This creates many problems, particularly in discharge planning.

There is always a waiting list for beds in XX, and at the time of the CVS visit, two recently vacated beds had already been allocated, with all other beds occupied. The average stay is around two weeks and it was mentioned another challenge can be around access to a step down bed. As there is pressure for beds, at times clients are offered a bed elsewhere in another country area, which may not be in their local area to immediately relieve the pressure. Discussions were held around whether this process is in the client's best interests.

Staff in ED told CVs that XX is having significant issues with bed block as a result of the transition to the new Royal Adelaide Hospital, Glenside and private patients from the Eastern suburbs being directly referred to ED because of the perceived quicker admission. Many of the clients admitted as inpatients are acutely unwell but there is pressure on staff to discharge them and as a result, according to staff we spoke to, clients often return within weeks of being discharged.

Wards XX & XX are at overflow capacity. 15 beds + 2 extra beds. This effects XX as patients are not easily moved into open wards because they are always full.

In addition to the comments reported at CVS visits, I highlighted this pressure on discharge in my 'Special Report' that was tabled in Parliament in May 2018 and reported on via various media outlets soon after. Within days of these reports, I was also contacted by a psychiatrist working in a mental health service in the South who voiced strong concerns about the pressure on clinicians to discharge clients early, in the name of creating bed flow. This psychiatrist highlighted a range of examples where he and colleagues he named, believed it placed clients at high risk.

These concerns were relayed to both the Minister and the Chief Psychiatrist.

My comments and follow up media reports on this issue also prompted the parent of a young man, who was discharged too early from a treatment centre in the South (For privacy reasons, I will refer to this young patient as J). This Father relayed his families' experience where his son had been admitted into an acute mental health unit for just his second admission for extreme anxiety. This was directly after a serious suicide attempt by J through an overdose of prescription drugs. Tragically, J took his own life two days after being discharged from the unit on Easter Saturday.

This parent believed that his son was a victim to this pressure on doctors to discharge clients early and when they may need more time in care if they are still unwell, in this case due to anxiety and at risk of self-harm.

The PCV also spoke to J's Mother who explained that J had moved back to live with her and to get more support. J's Mother relayed a number of key points related to her son's care in the acute mental health unit. After his first admission near Christmas 2017, following an earlier overdose, the treating team asked J's Mother to try and find his prescription medication/drugs that he had used for the overdose so they could see exactly what he had taken. She found these hidden in a bottom draw of a cupboard in his bedroom together with a suicide note addressed to her and a map/diagram.

The note from J indicated that "if I go missing, this map shows where you will find me". She rang the unit and asked whether the team or psychiatrist would want to see these and they said yes! J's Mother took the medications, note and map and handed them over to the team but stressed they were important and wanted them back which they agreed to.

The following days when visiting J, she asked for them back and they initially said they were having difficulty locating them and this went on until discharge from his first stay.

After he was readmitted just prior to Easter in late March, J's Mother again requested the suicide note and map back stating how important it was to her but she never got it back, even when he was discharged on Easter Saturday. She

recalls going to pick J up to take him home and a staff member said to her, "make sure you keep a close eye on him", inferring he was still very unwell and at risk of self-harm.

Two days later, J's mother returned from a brief trip to the nearby shops and he was nowhere to be seen so she rang the unit and their immediate response was for her to call the police. J's body was found the following day. J's Mother relayed to the CVS that if she still had the suicide note, map and diagram, when he went missing, she may have been able to inform the police where J was going and possibly found him before he ended his life. This has compounded her grief and loss.

The impact on this family cannot be described in a few words and therefore I do not intend to try. However, the parents both wanted answers as to why he was discharged, who was ultimately responsible for the discharge and where is the suicide note and map that was handed over to the unit? The PCV wrote on 11 May 2018 to the CEO of SALHN, Susan O'Neill raising a number of their concerns of both parents and asking whether this would be referred to the Coroner given the death occurred within two days of discharge from a mental health unit. Other questions raised were:

1. Whether the matter will be investigated by the Coroner, given J took his life so shortly after an inpatient stay in a mental health treatment centre?
2. Who was the treating Psychiatrist at Morier Ward who discharged J over Easter 2018?
3. Have the notes and diagrams that J's Mother provided to the XX Ward been located? It is highlighted that these very personal documents are returned to her urgently.
4. Are there any notes regarding phone calls J's parents made to Morier Ward, asking for information regarding forward planning and support leading up to J's discharge?

I met with the Minister for Health and Wellbeing on 9th May 2018, where I also informed him that the CVS were attempting to get answers to these concerns and were supporting them through this process.

The CVS felt it was important for J's parents to get as much information as was possible from the treating team as a means of gaining insight and some level of understanding to the questions they raised above.

On the 23rd May, the PCV organised for J's parents to meet with Professor Malcolm Battersby the Clinical Director of Mental Health, J's treating Psychiatrist, and other staff members from our Mental Health Service in which these above questions were discussed in detail. The CVS Mental Health Coordinator, Kate also attended this meeting and recorded notes and outcomes.

At the meeting, J's treating psychiatrist provided full disclosure around his clinical decision-making and J's treatment, in particular his reasons for discharging J after a relatively short admission.

Professor Battersby also gave J's parents a commitment at this meeting, that they would undertake an internal review of this critical incident and forward any outcomes or learnings from how J's care and discharge was managed.

As the time of writing this report near the end of September, the CVS has not received any further information.

The PCV received a formal response from the Chief Executive of SALHN back on 6 June stating the following:

Response to question 1

Unfortunately, I am unable to advise you if J's death will be investigated by the Coroner. All unexplained deaths are reported to the State Coroner for investigation. SA Police were involved in locating J, and it is my understanding they have reported his death to the Coroner's Office. The Coroner will decide upon the type of investigation required and whether or not to proceed to inquest.

Response to question 3

Regretfully I am advised that the notes and diagrams have not been located and that staff are still actively trying to locate them. I can assure you that if these documents are found we will return them to J's Mother as a matter of high priority.

The CVS has relayed this information back to the parents who are understandably, disappointed in this response. We therefore believe that it is very important that the Coroner undertake an inquest into J's treatment, care, discharge and death by suicide on 2 April 2018.

Bed flow data

Whilst this theme has continued to be reported to CVS, I have recently been able to obtain data from SA Health regarding average length of stay and readmissions within 21 days, which are collected as Key Performance Indicators

by the Local Health Networks.

The below table shows the acute average length of stay data for SALHN, CALHN and NALHN for the period of July 2017-May 2018³.

	YTD current (days)	YTD previous (days)
State General Adult Acute total	12	12
State Short Stay total	2	2
State All adult acute total (incl Short Stay)	10	10
State OPMHS total	33	29
State Forensic total (Aldgate ward only)	17	16
State total	12	11

The data provided above shows the average length of stay for acute mental health units has remained fairly consistent with the previous year.

With access to this valuable data, the CVS will continue to monitor the average length of stay and 28-day readmission data and use this evidence in conjunction with the anecdotal evidence being provided at CVS visits.

3.3.4 Impact of drug and alcohol use and specialist services

Another ongoing issue that has been raised at CVS visits, most commonly at visits to Emergency Departments, is the increasing impact of substance use, most commonly methamphetamine, and their effects on patients, who are then transferred to a mental health unit for treatment.

Staff in the EDs and treatment centres have commented to CVs that they often don't have the skills and resources to treat clients who present with the effects of drug and alcohol use, such as drug induced psychosis, and often these clients don't need to be admitted to a mental health unit and instead could utilise the services of a short term detox /sobering up unit within the hospital.

Comments from CVs regarding the impact of drug and alcohol use and the need for specialist training and facilities:

XX commented that amphetamine abuse is a big problem and clients often relapse within weeks of being discharged from the unit. He believes that more specialist services are needed for clients with dual diagnoses - mental health issues plus either substance abuse problems or intellectual disabilities.

Drugs (especially methamphetamine) are a huge problem according to XX in ED, but XX treats only mental health problems such as mood and thought disorders, not any accompanying drug use problems. Staff commented that XX Hospital needs a Psychiatric Intensive Care Unit.

XX expressed concern with the volume of the drug Ice finding its way into the facility. This has severe impact on the clients as well as the staff. There has been an increase in aggression and violence as a result and staff would like to see the engagement of multiple service providers to address the problem, rather than having to resort to calling the police when there's an incident, which can increase fear and trauma.

Methamphetamine usage is still problematic with a lot of clients being affected by it. CVs were told of an incident where a client had taken methamphetamines into XX and had distributed it with the other clients in the ward.

Staff were concerned about the dangers posed by drug-affected patients, especially if several in a fragile state are in the unit at the same time. Their concerns were for themselves and for other patients. Also mentioned, was the need for a Substance Abuse Service due to the increasing demand.

These comments above also highlight concerns around personal safety for clients and staff, when clients under the influence of drugs or alcohol become aggressive.

³ Acute Average Length of Stay July 2017-May 2018 (SALHN, CALHN and NALHN), provided by the Mental Health Information Management and Performance Monitoring Unit, 10 August 2018.

3.3.5 Community Mental Health – ICCs and Rehab Centres

The review of the Mental Health Act 2009 expanded the scope of the CVS to undertake visits and inspections to authorised Community Mental Health facilities. The CVS began the initial roll out of visits to the Community Rehabilitation Centres and Intermediate Care Centres, and the expanded reach of the CVS has already been valuable in seeing the continuum of care across the mental health system.

Some early themes and observations of the community mental health settings include:

- » The value of the Intermediate Care Centres (ICC) to the clients, who have expressed their gratitude for the services and environment they received during their recovery, whether it be as a 'step-up' period when they feel they are becoming unwell, or a 'step-down' admission as they transition from acute stays back to the community. At one visit, clients commented that 'that they hope that there will be more facilities like WICC, as they felt that it is extremely beneficial to their mental health wellbeing to have a supportive facility'. It has also been commented on a number of occasions, how much of a loss has been felt with the closing the Eastern ICC.
- » The models of the inpatient community mental health centres have shifted from the original intended model, with a higher patient acuity and greater lengths of stay.
- » Fewer opportunities for clients to use the ICCs as a 'step-up' admission when they are becoming unwell, due to the demand on beds for those clients transferred from acute units.

Below are comments provided from visit reports to community mental health facilities, describing the positive nature of the settings.

Discussions with XX revealed the pressure on this facility to meet the needs of EDs regarding patient flow. Most admissions are step down and demand for beds is high. During the past 24 hours, the Centre had received 10 new referrals. Many of the patients are higher acuity than has been experienced in the past adding more pressure to limited resources. The CVs were invited to join a therapeutic group during which we heard from patients about their experiences both at Western Intermediate Care and prior to their admission. The feedback about WIC was glowing- patients felt respected, they felt the approach was non-judgemental and person centred and all expressed that they felt they had made great progress whilst there.

Clients shared that they hope that there will be more facilities like WICC, as they felt that it is extremely beneficial to their mental health wellbeing to have a supportive facility. They said that they feel safe and relaxed here. The staff mentioned that most of them have lived experience and hence are able to empathise with the clients. Clients also mentioned that they feel less judged here than in other facilities they had been in.

It appears that the ICCs are far more a community-based model of care verses the acute care settings which are more a medical model.

It was heartening to visit a facility with consumer independence post-discharge as its main goal. The three residents we spoke to were satisfied with this environment and the Manager says overall outcomes are excellent, although they are always seeking ways to improve. Elpida House is one of four such facilities run by SA Health (with a total of 70 beds across the state).

3.3.6 Oakden Older Persons Mental Health Services – ICAC implications

There have been significant lessons learnt from our involvement in Oakden Older Persons Mental Health Services (OOPMHS) investigation and the ICAC Enquiry. This includes that we now ensure there is agendas and notes of all meetings with Ministers, Senior Departmental staff and other Statutory officers. As part of the ICAC enquiry, the CVS was required to submit all visit reports, and any other documents and correspondence including records of meetings, phone conversations and emails related to Oakden.

These went back to when we first visited Oakden in July 2011, so there were thousands of pages and it really tested our record keeping and follow-up on issues arising. As an Independent Statutory office, we have had to continuously improve our information management system and I am extremely proud of what we have achieved, especially given the resources available to us.

Right from 2012 and 2013 our visit reports highlighted concerns about staffing levels and that as a result of the then Government indicating they were intending to tender out the service to the Non-Government sector, many of the permanent staff left positions due to uncertainty. This resulted in higher rates of agency staff being used in Oakden but this also had implications for those permanent staff who remained, as there were less staff who were competent in

documenting and reporting on patient care and medication management.

Another warning indicator was that a number of Allied Health workers (such as social workers, OTs or activity coordinators) were transferred and/or positions became vacant, which again, placed enormous pressure on existing permanent staff, some of which worked tirelessly to try and make up for these gaps. The CVS regularly highlighted these issues to senior management at NALHN via visit reports and wrote specific letters and emails to senior management highlighting these gaps and the pressure it caused to existing staff and the overall service.

The people in these senior management positions reported directly to the Chief Executive of NALHN and were in decision-making roles that could have ensured these positions were filled. They were part of the governance structure for NALHN and would have been directly involved in discussions on budget, savings and resource and staff allocation. This lack of action in making staff allocations to these positions at Oakden also affected staff morale and workplace culture and ultimately, the care and treatment of patients. Our reports and correspondence on all the above, was submitted to the ICAC however, I can only assume that they did not fully understand this governance structure as they did not find fault in the governance of NALHN and made no maladministration findings against them.

Our initial advocacy for families regarding over-medication, unexplained bruising, restraints, neglect and abuse was detailed in a written complaint forwarded to the Interim Nursing Director at Oakden on 7 June 2016. When our complaints were received by the Nursing Director, we spoke directly with him and received a written email reply that evening stating that he “would forward the complaint to our Consumer Liaison Officer who I will work with to coordinate an investigation”.

Over the next three months, the CVS made numerous phone calls and emails to the Nursing Director and Consumer Liaison Officer and were then informed on 10 August 2016 that the investigation report and response was with the NALHN Office of Chief Executive. We then communicated with the Executive Director of Mental Health at NALHN seeking to obtain a response and again were not responded to in a timely manner, so I documented all of this in my Annual Report to Parliament with a recommendation to review the service.

Once our Annual Report was tabled in Parliament, respected ABC journalist, Nicola Gage picked up on these matters and contacted me for comment and requested that I ask the families affected, whether they would be willing to talk.

Our support to families continued throughout the public reporting and during and after the Oakden investigation and report by the Chief Psychiatrist, Aaron Groves and later the ICAC enquiry. Following the ICAC report, the CVS also referred the families to the Commissioner for Victims’ Rights, Michael O’Connell, and met with them to obtain a referral to a suitable legal team for legal advice and assistance.

I would again like to publicly acknowledge the families that we worked with throughout this process for their persistence, bravery and endurance in ‘shining a light’ on older persons in care. This has come at a cost for the families who have been exposed to many media demands over the past two years where they have had to tell their stories and share their grief and loss.

With the announcement of the Royal Commission into Aged Care, it seems likely that they may again have to give evidence about their experiences at Oakden. Some believe that they at last may see a higher level of scrutiny and identification of those directly responsible for the abuse of their loved ones. I sincerely hope that it does not add an even greater level of stress, loss and grief to the families we have had the privilege to work with and alongside of in an attempt to get answers and justice.

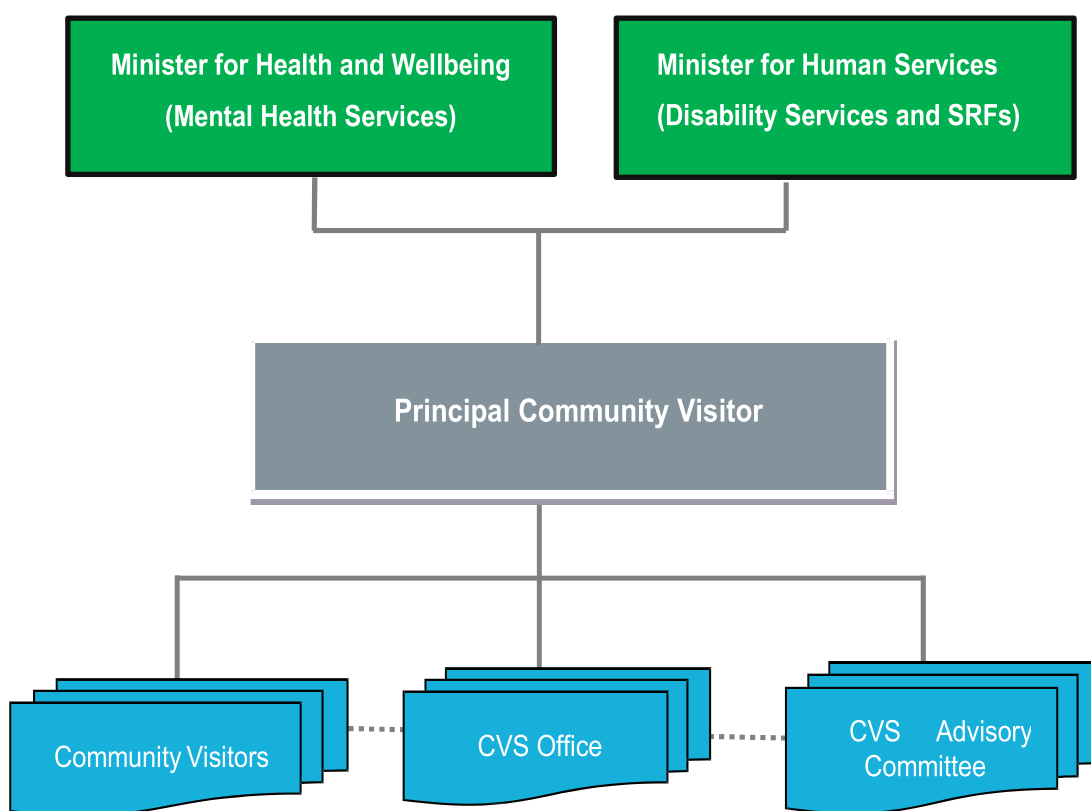
4. Workforce

4.1 Governance of the Community Visitor Scheme

The Principal Community Visitor and Community Visitors are independent statutory appointments by the Governor of South Australia. The PCV reports to the Minister for Health and Wellbeing (Minister for Mental Health Services) on matters related to the Scheme's functions under the *Mental Health Act, 2009*; the Minister for Human Services (Minister for Disability Services) on matters related to the Scheme's functions under the *Disability Services (Community Visitor Scheme) Regulations, 2013* and on matters relating to Supported Residential Facilities.

The independence of the CVS is integral to the program, enabling patients/residents, carers and family members to speak with individuals who are not associated with the provision of support and services.

An Advisory Committee provides strategic advice and support to the PCV, monitors and evaluates the CVS, and contributes to strategic networks and relationships.



The Community Visitor Scheme is auspiced by the Department for Human Services (DHS) for administrative purposes only such as payroll and Human services.

4.2 Staff of the Community Visitor Scheme

Following is a list of paid staff members who worked either full or part time in the Community Visitor Scheme Office during the 2017-18 reporting period:

Principal Community Visitor	Mr Maurice Corcoran AM
CVS Manager	Mr John Alderdice
Mental Health CVS Coordinator	Ms Kate Thomas
Disability Services CVS Coordinator	Ms Michelle Egel
SRF and Day Options CVS Coordinator	Ms Karen Messent
Recruitment and Training Officer	Ms Leanne Rana
Project Support Officer	Ms Rondelle Oster
Administration Officer	Mr Micah Mango

4.3 Advisory Committee

The members of the Advisory Committee during 2017-2018 were:

Ms Anne Burgess	Independent Chairperson
Mr Maurice Corcoran AM	Principal Community Visitor
Ms Niki Vincent	Equal Opportunity Commissioner
Ms Anne Gale	Public Advocate
Mr Steve Tully/Dr Grant Davies	Health and Community Services Complaints Commissioner
Chris Burns	Mental Health Commissioner

Mental Health Representatives:

Dr Aaron Groves/Dr Brian McKenny/Dr John Brayley	Chief Psychiatrist and Director Mental Health Policy
Ms Carol Turnbull	Private Mental Health Services Representative
Mr Ben Sunstrom	Manager, Legislation and Policy – Proxy for Chief Psychiatrist
Mr Jason Cutler	Consumer Representative
Ms Julia Mc Millan	Carer Representative
Tony Rankine	Community Visitor Representative

Disability Representatives:

Mr David Caudrey	Executive Director, Disability SA
Ms Zofia Nowak	Director, NDIS Implementation
Mr Richard Bruggemann	Senior Practitioner, Disability SA
Ms Sandra Wallis	Government Disability Accommodation Representative
Ms Narelle Jeffery/Ms Janine Lenigas	Non-Government Disability Accommodation Representative
Ms Kris Maroney	President, Supported Residential Facilities (SRF) Association
Ms Jayne Lehmann	Disability Carer Representative
Mr Jim Evans	Disability Community Visitor Representative

4.4 Community Visitors

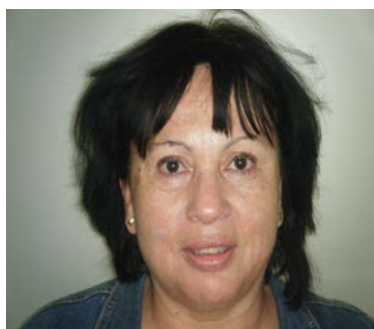
The Community Visitors (CVs) have impressive backgrounds, skills and passion that have helped to deliver the Scheme's key outcomes of monthly visits and inspections and associated reports at a very high level. They are aged between 25 and 82, come from a diverse range of cultural backgrounds, and can speak seventeen (17) languages between them.

They have achieved the following qualifications:

Level of qualification	Number of Community Visitors
PhD	2
Masters - Social Work, Law, Business Admin, Disability	8
Bachelor Hons	4
Bachelor - Social Work, Social Sciences, Psychology, Arts, Architecture, Civil Engineering, Economics, Law	33
RN	1
Grad Dip – OH&S, Education, Technology	5
Grad Cert – Disability, Tertiary Teaching	3
Assoc Dip - Social Work	1
Advanced Dip	1
Diploma - Social Sciences, Education, Counselling, EN, Marketing	18
Advanced Cert - Accounting	1
Cert 4 – Mental Health, Tourism, Training & Assessment, Drug & Alcohol	18
Cert 3 – Small Business Management, Disability, Training & Assessment	3
Cert 2 – Community Services, Auslan, Business, Retail	8
Cert 1 – Assessment & Workplace Training, Hospitality, Counselling	6
Mental Health First Aid	3
Senior First Aid	2
Other eg Child Safe Environments, OH&S, Mediation, Peer Work, Communications, Financial Planning	41

As an integral and valued component of the Scheme, it is with great pleasure that we showcase two of our Community Visitors that have been volunteering with us for many years:

Ingrid Davies – appointed 2/2/2012



I completed studies in politics and economics at University of Chile, completed nursing studies at Caritas Chile Nursing school and worked in Emergency Department of hospital in Chile until coming to Australia in 1986. After working many years in the 'blue collar' sector e.g GMH as vehicle test driver, I then volunteered with the Community Visitor Scheme. My role as a Community Visitor has been very valuable to me in gaining knowledge and experiences to add to my strong humanitarian values and my lived experience caring for adult sons with a mental illness. I enjoy being able to connect with people who often have so much to overcome and endure in their lives.



Ann Rymill has been a Community Visitor for over 5 years, having started with the CVS in March 2013. Ann had many years as a Social Worker where she was part of the Exceptional Needs Unit with interest and expertise in systems and services for forensic clients with a dual disability and has completed research and significant reports in this field. Ann's career has also included substantial time with the Intellectually Disabled Services Council (IDSC) and Monash University. Ann's work with the CVS has predominantly been in the disability sector and she has been a great mentor to others, served on the CVS Advisory Committee and assisted in our training of new CVs through sharing her experiences and knowledge in our training workshops. Ann is committed to human rights and has strong support for advocacy and social justice.

Community Visitors are an integral and valued component of the Scheme and following is a list of all the Visitors who have contributed during the 2017-18 reporting period:

Adele Querzoli	Judy Harvey
Angela Duigan	Julie Margaret
Angela Glenn	Kim Steinle
Angela Koutsidis	Lee Ridge
Ankur Patel	Lindy Thai
Ann Rymill	Marianne Dahl
Anne Burgess	Mark Rogers
Annette Glover	Maurice Corcoran
Brian Day	Michele Slatter
Bryn Williams	Nike Babalola
Cecil Camilleri	Ron Oliver
Chan Panditharatne	Sally Goode
Elle Churches	Sara Elfalal
Erika Davey	Sharon Hughes
Garry McDonald	Shipra Sareen
Helen Winefield	Sophie Dai
Ingrid Davies	Sue Whittington
Jacy Arthur	Sultana Razia
Jenni Kendal	Tony Rankine
Jim Evans	Von Cheng
John Leahy	Wendy Norman

John Lykogiannis	Yinzi He
John Sheehan	Maurice Corcoran AM (Principal Community Visitor)

4.4.1 Community Visitor Recruitment

The CVS is a member of Volunteering SA-NT Incorporated, a non-profit organisation and peak body dedicated to promoting and supporting volunteers and volunteering in South Australia and the Northern Territory.

Recruitment advertising for Community Visitors (CVs) is primarily facilitated through the Volunteering SA-NT website. However, the CVS has also used other career sites such as Seek Volunteer and Go Volunteer. Volunteering SA-NT has provided training to allow for agencies to manage their own online volunteer ads. This has resulted in a better process for managing changes in recruitment procedures.

People interested in applying to become a Community Visitor must be over 18 years of age and be willing to undertake both disability and child-related screening checks with DHS. Before applying, interested people are encouraged to go to the [Community Visitor Scheme](#) website, which outlines the attributes and level of commitment required to undertake the role.

Two hundred and ten (210) Expressions of Interest were received during the reporting period. Of these, thirty-eight (38) applications were received. Thirty (30) Expressions of Interest were followed up because of their potential as Community Visitors, and two (2) responses were received. One respondent was working fulltime and therefore unable to commit to CVS, and the other was found to be unsuitable.

Individuals submit an application form with a current curriculum vitae and three referees. If shortlisted, the applicant is invited to undertake the following activities for further assessment:

- » attend an interview
- » participate in a two-day workshop (see Section 6.4.2)
- » undergo DHS screening checks and referee checks, and
- » undertake a minimum of two orientation visits with the PCV and prepare a written report after the 2nd visit.
- » participate in a final interview with the PCV and recruitment officer.

Sixteen (16) applicants proceeded to training after undergoing a successful interview.

If successful, the applicant is nominated for appointment and required to sign a *Conditions of Appointment* and a *Code of Conduct*.

A cabinet submission is prepared recommending the appointment of the applicant to the role of Community Visitor and endorsed by His Excellency, the Governor of South Australia.

Ten (10) applicants were appointed and (6) did not proceed to appointment after training or orientation due to not attending training, withdrawing, or being unsuccessful after training.

Once appointed, Community Visitors are provided with a photo identification security badge.

4.4.2 Initial and Ongoing Support and Training for Community Visitors

Initial Training and Orientation

Potential CVs are invited to participate in a two-day training program aimed at providing them with the skills and knowledge required to fulfil the legislative functions of the role. The training program is split into 11 modules and assumes no prior knowledge of mental health or disability services. The content is delivered over two consecutive days with values, exercises, role plays and various guest presenters. The modules covered are:

- » **Module One:** Introduction, Overview and History of the Community Visitor Scheme
- » **Module Two:** Role, Functions and Scope of the Community Visitor Scheme
- » **Module Three:** CVS Visits and Inspections
- » **Module Four:** Practical Matters for Community Visitors
- » **Module Five:** Lived Experience
- » **Module Six:** Mental Health

- » **Module Seven:** Communication Strategies
- » **Module Eight:** Disability
- » **Module Nine:** Dual Disability and Gender Safety
- » **Module Ten:** Cultural Competencies, and
- » **Module Eleven:** Values Testing for Disability and Mental Health.

Sessions were held in August 2017 and February and May 2018. Sixteen participants (16) attended training sessions.

On completion of the program, an assessment of the two days is undertaken through an attendee satisfaction survey. Each questionnaire is completed anonymously to ensure all attendees can be open and honest about their comments.

The questions are designed to solicit information from the attendees as to whether they found the information clear, the style of presentation suited their needs, the presenters were knowledgeable, resource notes sufficient, there was opportunity for participation interaction and if they felt confident in meeting the learning objectives of that module.

An online tool, "Limesurvey" was used as the survey tool. Participant use of the tool was high and it provided a clear means of being able to collect and analyse participant feedback.

One hundred percent (100%) of respondents either strongly agreed or agreed to the following 2 questions for 10 Modules:

- The information was clear
- The resource notes were sufficient

Ninety-one percent (91%) of respondents either strongly agreed or agreed to the following 4 questions for 10 Modules:

- The style of the presentation suited my needs
- The presenters knowledge was sufficient
- Participant interaction was adequate
- I feel confident in meeting the learning objectives of this module

Module 10 is presented as information and readings only, and is therefore not assessed in the feedback process.

In addition to rating each module, the attendees are encouraged to provide some written feedback. Following are comments from this reporting periods three series of workshops:

- Overall, this training is well delivered. The 11 modules are extremely important. Inviting the people who are related to Mental Health and Disability sector were the best part of this training. I have met wonderful people during my 2-days training. My knowledge has been challenged and improved at the same time. The content of training is very thorough and helpful
- The training program was put together very well, very informative and helpful. Thank you!
- I think this training was really useful. It might be unconventional at times but really fun and helpful. The speakers' honesty and openness also helps us to better understand the topics discussed. THANK YOU to everyone for putting the training together
- Well-paced and very informative. I learned a lot
- I thoroughly enjoyed the two days training and felt I gained a lot of new information. I also enjoyed the participation with the other members of the group and felt that their diverse backgrounds and thoughtful comments very valuable
- I found the training to be interesting and informative and beneficial to my needs
- Really appreciate for the training and knowledge sharing. Thank you, CVS team

Overall, training session participants "strongly agreed", or "agreed" that the training sessions met their needs and objectives. The CVS team is confident that prospective visitors are receiving the necessary information to prepare them for the role.

A minimum of two observation visits are undertaken with the PCV for further assessment. This provides the trainee Community Visitor with an opportunity to see the practical application of key areas covered in the training program. A total of twenty-eight (28) observation visits were completed with the PCV in this reporting period.

During the training and orientation process, the PCV assesses the applicant's suitability and individual capacity to fulfil all of the functions of a CV, as described in section 51(1) of the *Mental Health Act, 2009*. Orientation feedback meetings were held with 8 prospective CVs.

From the number of participants (16) attending the 2-day training, five (31%) have not progressed through to appointment, providing support that the current recruitment process and training program is thorough and robust in

matching appropriate applicants to the role.

Ongoing Training and Support

Professional development needs are assessed and workshops are developed to ensure that CVs have the necessary skills and knowledge to effectively complete visits and inspections. "Personal safety of clients in Care" training was provided to twenty (20) CVs in April 2017. This included five (5) regional CVs.

Community Visitors have access to ongoing training and professional development opportunities through the SA Mental Health Training Centre (Department of Health and Ageing) and other external agencies such as Volunteering SA&NT, Northern and Southern Volunteering, and local councils.

CVs were offered 7 external training opportunities:

- Responding to Anger - Southern Volunteering
- Open State festival
- Public Speaking and Presentations - Southern Volunteering
- Learning about Autism <http://www.torrens.edu.au/mooc-the-voices-of-autism> The CV that completed this training would "highly recommend it" to others
- Accidental Counsellor - Southern Volunteering
- Volunteering Conference
- Elder Abuse Awareness - Southern Volunteering

In addition, five (5) CVs participated in the National Volunteer Week parade



John, Jacy, Marianne, Sharon and Tony enjoy the sunshine in the grounds of Government House during the National Volunteer Week parade May 2017

Annual development reviews are conducted with the PCV to provide a formal avenue for feedback and development discussions. Thirty-five (35) yearly reviews were conducted throughout the year with CVs participating in performance and development discussions with the PCV. Community Visitors are encouraged to pursue development opportunities and discuss other interests with the PCV.

Underperforming CVs are invited to meet with the PCV and the Recruitment and Training Officer to discuss any concerns and to work through strategies to assist them to improve their performance.

There are presently 42 active CVs, with six (6) being reappointed for a second term of 1 year. Nine (9) CVs have resigned due to gaining work and/or health conditions.

A 'Reflective Practice' session is offered to CVs for the hour before the 'Get togethers'. This enables CVs to share their experiences encountered during visits and any challenges faced. They can share what works for them and provide peer support to one another.

CVs have had the opportunity to meet 5 times during the year to informally discuss their experiences during visits and provide group feedback for service improvement. Some of the ideas discussed have been:

- August 2017 – COMPAS program, Jen Jacobs guest speaker
- October 2017 – Suicide Prevention Plan

- December 2017 – Ideas and planning for 2018
- April 2018 – online Mental Health course
- June 2018 – ICAC findings

There were 60 attendances by CVs across the 5 'Get togethers'. Notes from the August, October, December, April and June meetings have been included in monthly newsletters, which are an important way of passing on relevant information to regional CVs.

These forums have encouraged a cohesive team approach, provided opportunity for shared learning among peers and been highly valued by the CVs.

The CVS Newsletter is distributed to Community Visitors on a bi-monthly basis providing general updates and information regarding strategic direction and issues arising.

The Recruitment and Training Officer uses 'Sharepoint' as another communication strategy for keeping in touch with CVs. Newsletters, policies and key forms are kept on Sharepoint for ease of access and use by CVs.

Community Visitors can also access the SA Government Employee Assistance Program.

4.4.3 Recruitment strategies external to CVS

Attendance at relevant networking, policy and strategic meetings have occurred with the Recruitment and Training Officer attending three Central Volunteer Managers, five Public Service Volunteer Policy, and 2 Volunteering Strategy for South Australia meetings. In addition, the R&T Officer met with 6 interviewers from Volunteering SA-NT to encourage them to look for prospective CVs.

Liaison with the Mitcham chapter of Probus occurred in August 2017 with approximately 70 people in attendance. In addition, training dates are posted on Facebook and CVs are encouraged to talk about their role within their networks to encourage others to take an interest in the Scheme.

5. Conclusion

The past twelve months reporting period has again proved to be a very successful for the scheme with the continued increase in number of visits conducted and a further expansion of the services it provides with the commencement of visits to mental health community settings.

The now well-developed robust process of tracking and following up on all issue raised in reports continues to deliver many positive outcomes for individuals and their families. There continues to be a positive response by the mental health sector when issues are raised and the CVS is continuing to play a role in the progression and solutions of the more systemic issues.

The CVS is committed to improving its quality and practice following the recommendations of the ICAC report and welcomes the forthcoming review of the CVS as previously outlined.

There have been significant lessons learnt from our involvement in Oakden Services investigation and the ICAC Enquiry. This includes but not limited to, that we now ensure there is agendas and notes of all meetings with Ministers, Senior Departmental staff and other Statutory officers. As part of the ICAC enquiry, the CVS was required to submit all visit reports, and any other documents and correspondence including records of meetings, phone conversations and emails related to Oakden. The process of submitting this information and documentation also facilitated vast improvements in our document storage and records management.

Our visit reports went back to when we first visited Oakden in July 2011, when they were in a Word format and our initial storage and record management was not as systematic. There were thousands of pages and it really tested our record keeping and follow-up on issues arising. As an Independent Statutory office, we have had to continuously improve our information management system and I am extremely proud of what we have now achieved, especially given the resources available to us.

As you can see from the various sections of this report, the Community Visitor Scheme, through its very committed visitors has had thousands of interactions with individuals who have been using the mental health services in South Australia over this past year. They have also spoken to many families and staff and from these conversations, observations and scrutiny of services, extracted valuable commentary on what's working well and what needs to be improved. The services we visit are increasing to use this feedback in a range of ways to improve quality and continuous improvement strategies.

I also believe that this report demonstrates that the CVS has made genuine improvements to its responsiveness to issues raised and escalated serious matters much sooner to both the Minister and/or the Chief Psychiatrist. I would hasten to add, that the acknowledgements and responses back to the CVS has also been very re-assuring from both the Minister's office and the OCP. In many instances, the Chief Psychiatrist has acted promptly and initiated an immediate unannounced visit to the facility where the issue or incident occurred and provided in-depth reports and recommendations to address issues.

This is greatly appreciated by all involved and we look forward to building upon this collaborative approach.

I also believe that the instigation of monthly meetings between the key statutory officers i.e. the Public Advocate, Anne Gale, the Mental Commissioner, Chris Burns, the Health and Community Services Complaints Commissioner Dr Grant Davies, the Chief Psychiatrist, John Brayley and myself has been a great initiative to enable better collaboration and address any duplication of efforts.

Lastly, I would like to acknowledge the CVS Advisory Committee and its diverse members across the mental health and disability portfolios where there has been robust discussion, debate and strategies developed to help us address the many issues that arise from our collective work. Our great facilitator and chair, Anne Burgess always enables this forum to explore better ways to collaborate with both committee members and other external stakeholders as a means to extend our influence and ultimately, service improvements for the people we are here to serve.

5.1 Future steps of the South Australia Community Visitor Scheme

The team established the following 10 priority actions for 2018. Progress against these issues and their strategies are presented at each advisory committee meeting.

	Issue	Strategy
1	Roll out of the CVS visitation program to Community Mental Health Services <ul style="list-style-type: none"> The Mental Health (Review) Amendment Act 2016 requires the CVS to visit community MH facilities every 2 months 	<ul style="list-style-type: none"> Meet with MHS community teams to present CVS role and explore how best to deliver this service to their clients Draft the visitation model and present to CVs Draft new report format in line with the different setting
2	Accommodation Shortages in the Community <ul style="list-style-type: none"> SRF closures has reduced accommodation options in the community MHS are experiencing great difficulty in discharging patients due to lack of community accommodation options As highlighted in the Shelter SA report 'The End of the Road' 	<ul style="list-style-type: none"> Continue to present issue to Ministers and relevant government department senior staff Continue to be engaged in the outcomes of the 'Round Table' in response to the Shelter SA report 'The End of the Road' Highlighting the importance of pre-planning for NDIS plans and working with individuals and NGO organisations to ensure people obtain reasonable packages
3	Forensic Services <ul style="list-style-type: none"> The independent review report into forensic care and the response to the report recommendations by SA Health have been completed. CVS has submitted its response to SA Health document CVS needs to closely monitor implementation of the actions agreed to by Health 	<ul style="list-style-type: none"> Ensure regular meetings are held with the Directors of NALHN and that Forensic Services is a standing agenda item Continue through above forum to monitor progress of the SA Health agreed actions in response to the recommendations of the report Offer to participate in or support any of the sub projects that are commenced Monitor progress through visits from both a strategic and consumer perspective Escalate issues as required either to management or the Minister if there is frustration with a lack of progress
4	Focus on Personal Safety of Clients in Care <ul style="list-style-type: none"> Issue highlighted in several years of CVS annual reports CVS continues to lobby DCSI and Health for related policy 	<ul style="list-style-type: none"> Undertook a focus on this topic during visits in May and June Draft review prompt sheet, train CVs, communicate to organisations and conduct focus Produce a report on the outcomes of the focus Present report to Advisory Committee, senior management within DHS and Health and service providers
5	Regular meetings with LHNs <ul style="list-style-type: none"> Meetings with the MH Executive Directors of the LHNs have become inconsistent. These are important to ensure issues are transferred to a responsible officer It is also important to improve their responsiveness to issues raised and hold LHNs to account 	<ul style="list-style-type: none"> Establish meeting schedule for the year Establish agenda with standing strategic items relevant to their area plus the agenda of issues raised in recent visits Where LHN's responses are not provided or inadequate, escalate to Chief Executives and Ministers
6	Policy on Support for Disability Clients whilst in Hospital <ul style="list-style-type: none"> It was revealed that there was in place (now lapsed) an MOU to enable Disability SA to be funded by hospitals to support their clients while an 	<ul style="list-style-type: none"> Establish current policy position for each LHN Lobby for new or amended policy if not in place or inconsistent with other LHNs. Communicate and promote to the broader sector

	<p>inpatient. It was also reported that this had been extended to some of the NGO organisations such as MINDA</p> <ul style="list-style-type: none"> CVS has been advocating for all the LHNs to establish a policy that is in alignment with the MOU but that would also be available to all disability service providers The SRF Dental Program has funded transport and where necessary care worker support for residents who do not have a current NGO package. 	
7	<p>Medication Management</p> <ul style="list-style-type: none"> CVS strongly supported the Chemical Restraints project given the estimated 300 clients that were on psychotropic or polypharmacy (concurrent use of multiple medications) without review. CVS will continue to monitor and support progression of this project 	<ul style="list-style-type: none"> Continue to receive update from the project sponsor and manager Lobby for the allocation of additional resources if required to ensure clients in NGO's have access to psychiatrists, GPs and community MH teams Seek clarity on how this will be continued under the NDIS
8	<p>Specialist Services:</p> <ul style="list-style-type: none"> CVS has highlighted the importance of ensuring continued access to mainstream health services, in particular state funded psychiatry services for clients with Intellectual Disability given rates of mental illness are significantly higher in this population The CVS continues to liaise with both relevant departments the importance of retaining the Centre for Disability Health (CDH), Exceptional Needs Unit (ENU), ASSIST Therapy Services(ATS), SRF Health Access Team, and the SRF Dental Program that they be sufficiently resourced to ensure they remain sustainable. 	<ul style="list-style-type: none"> Continue to monitor the retention and resourcing of these specialist services Seek clarity on how they will be maintained under an NDIS environment
9	<p>Accommodation & Support for Clients with Complex and Challenging Behaviours</p> <ul style="list-style-type: none"> Several disability clients with complex behaviours are being contained in what can best be described as fortress-style accommodation with very expensive support packages It is questionable as to whether this delivers meaningful support/care or provides value for money 	<ul style="list-style-type: none"> Research the range and types of services that best cater for this client group Seek clarity on how this client group will be supported under the NDIS both in service and accommodation Inquire as to whether the NDIA is researching the models of care and how best to fund services to this client group Present to both State and commonwealth governments if there are any perceived/potential gaps in funding and services or they are assessed as lacking quality and value for money
10	<p>CVS Quality Development</p> <ul style="list-style-type: none"> Continue to increase number of Community Visitors Increase number of Disability visits and ensure priority houses are visited 	<ul style="list-style-type: none"> Continue to focus on the recruitment of additional CVs Continue to look at CV retention and utilisation strategies Further develop CVS data base so that houses identified as needing follow up visit or whose residents are assessed as more vulnerable can be identified and given priority during visit scheduling

5.2 Recommendations

Throughout section 3 of this report a range of significant issues that have emerged have been discussed and attempts to arrive at a set of recommendations as a means of continuous improvement reached. These are recommendations from the Principal Community Visitor alone and do not necessarily represent views of the CVS Advisory Committee or the collective views of Community Visitors

1. The CVS continue to monitor interactions and responsiveness between staff and clients and report on any instances of unsatisfactory communication.
2. The CVS continues to monitor the standard and suitability of the mental health facilities and grounds.
3. The long stay mental health facilities obtain the services of a dietician to review the menus, ensuring a nutritional meal plan.
4. That the SA Department for Health and Ageing undertake a detailed risk-assessment into the impact to patients who have smoking addictions and who have been placed into closed units.
5. That the Community Visitor Scheme continues to explore individual patient rights under anti-discrimination legislation and specifically those who have smoking addictions and who have been placed in closed units.
6. The Community Visitor Scheme continues to monitor levels of activities offered to patients and participation rates.
7. That an objective assessment of Treatment Centre activities and programs be undertaken as a means to highlight and promote good practice and explore the impact of the above on patients and their recovery.
8. The Community Visitor Scheme continues to monitor access to allied health services and the availability of these roles within mental health units.
9. The Community Visitor Scheme continues to monitor the incidence of seclusion and restraint and least restrictive practice.
10. The Community Visitor Scheme continues to refer incidences of concern regarding the inappropriate or prolonged restraint of forensic and mental health patients to the relevant agencies.
11. The Community Visitor Scheme monitors the practice of developing and maintaining treatment and care plans, as part of the LHN's reported Key Performance Indicators.
12. The Community Visitor Scheme continues to monitor the level of involvement by clients, their family members and carers in the development and implementation of treatment and care plans.
13. The recommendations of the 2015 Review of the South Australian Forensic Mental Health Service are given appropriate consideration by a high-level cross –agency working group and implemented as a matter of priority.
14. The Government undertake an urgent enquiry into emergency, short-term and long-term accommodation options in South Australia and develop a state housing plan and strategy to address accommodation needs for vulnerable clients.
15. That SA Health invest in NDIS Psycho-Social support workers who can work with CRC agencies and Community Mental Services and staff to assist individuals in pre-panning initiatives and liaising with the NDIA and Local Area Coordinators to enable as many clients as possible to obtain psycho-social support services through NDIS funding.

6. Acronyms

Acronym	Definition
ABF	Activity Based Funding
AGD	Attorney General's Department
AMHS	Area Mental Health Services
APY	Anangu Pitjantjatjara Yankunytjatjara
ATSIMHSPAG	Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group
CALD	Culturally and Linguistically Diverse
CALHN	Central Adelaide Local Health Network
CBIS	Community Based Information System
CCTV	Closed Circuit Television
CEO	Chief Executive Officer
CLCA	Criminal Law Consolidation Act
COAG	Council of Australian Governments
CRC	Community Rehabilitation Centre
CTO	Community Treatment Order
CV(s)	Community Visitor(s)
CVS	Community Visitor Scheme
DASSA	Drug & Alcohol Services South Australia
DCS	Department of Correctional Services
DCSI	Department for Communities and Social Inclusion
ECH	Elderly Home Care
ED(s)	Emergency Department(s)
FFT	Fitness for Trial
FO	Forensic Orders
HCSCC	Health and Community Services Complaints Commissioner
ICAC	Independent Commission Against Corruption
ICCs	Intermediate Care Centres
ICT	Information and Communication Technology
IHPA	Independent Hospital Pricing Authority
IT	Information Technology
ITO(s)	Involuntary Treatment Order(s)
JNH	James Nash House – Forensic Facility
KOB(C)	Kenneth O'Brien Centre
KPI	Key Performance Indicator
MHS	Mental Health Service
NALHN	Northern Adelaide Local Health Network
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme

Acronym	Definition (cont)
NGO	Non-Government Organisation
NHMRC	National Health and Medical Research Council
NHPA	National Health Performance Authority
NMHC	National Mental Health Commission
NRT	Nicotine Replacement Therapy
NSW	New South Wales
OACIS	Open Architecture Clinical Information System
OCF	Office of the Chief Psychiatrist
OPA	Office of Public Advocate
OT	Occupational Therapy
OHWS	Occupational Health, Welfare and Safety
OOPMHS	Oakden Older Persons Mental Health Service
PCV	Principal Community Visitor
PECU	Psychiatric Extended Care Unit
PICU	Psychiatric Intensive Care Unit
QLD	Queensland
RSL	Returned and Service League
S269 Clients	Section 269 of the Mental Health Act, 2009
SA	South Australia
SA&NT	South Australia and Northern Territory
SASP	South Australian Strategic Plan
SICC	Southern Intermediate Care Centre
SRF	Supported Residential Facility
SSU(s)	Short Stay Unit(s)
TAFE	Technical and Further Education
TSI	Torres Strait Islander
UNCRPWD	United Nations Convention on the Rights of Persons with Disabilities
VMIAC	Victorian Mental Illness Awareness Council Australia
VSA&NT	Volunteering South Australia and Northern Territory

7. Appendices

Appendix 1: Mental Health Act 2009, Part 8, Division 2 — Community Visitor Scheme

Division 2—Community visitor scheme

50—Community visitors

- (1) There will be a position of Principal Community Visitor.
- (2) There will be such number of positions of Community Visitor as the Governor considers necessary for the proper performance of the community visitors' functions under this Division.
- (3) A person will be appointed to the position of Principal Community Visitor, or a position of Community Visitor, on conditions determined by the Governor and for a term, not exceeding 3 years, specified in the instrument of appointment and, at the expiration of a term of appointment, will be eligible for reappointment.
- (5) The Governor may remove a person from the position of Principal Community Visitor, or a position of Community Visitor, on the presentation of an address from both Houses of Parliament seeking the person's removal.
- (6) The Governor may suspend a person from the position of Principal Community Visitor, or a position of Community Visitor, on the ground of incompetence or misbehaviour and, in that event—
 - (a) a full statement of the reason for the suspension must be laid before both Houses of Parliament within 3 sitting days of the suspension; and
 - (b) if, at the expiration of 1 month from the date on which the statement was laid before Parliament, an address from both Houses of Parliament seeking the person's removal has not been presented to the Governor, the person must be restored to the position.
- (7) The position of Principal Community Visitor, or a position of Community Visitor, becomes vacant if the person appointed to the position—
 - (a) dies; or
 - (b) resigns by written notice given to the Minister; or
 - (c) completes a term of appointment and is not reappointed; or
 - (d) is removed from the position by the Governor under subsection (5); or
 - (e) becomes bankrupt or applies as a debtor to take the benefit of the laws relating to bankruptcy; or
 - (f) is convicted of an indictable offence or sentenced to imprisonment for an offence; or
 - (g) becomes a member of the Parliament of this State or any other State of the Commonwealth or of the Commonwealth or becomes a member of a Legislative Assembly of a Territory of the Commonwealth; or
 - (h) becomes, in the opinion of the Governor, mentally or physically incapable of performing satisfactorily the functions of the position.
- (8) The Minister may appoint a person to act in the position of Principal Community Visitor—
 - (a) during a vacancy in the position; or
 - (b) when the Principal Community Visitor is absent or unable to perform the functions of the position; or
 - (c) if the Principal Community Visitor is suspended from the position under subsection (6).

51—Community visitors' functions and powers

- (1) Community visitors have the following functions:
 - (a) to conduct visits to and inspections of treatment centres as required or authorised under this Division;

- (ab) to conduct visits to and inspections of authorised community mental health facilities as required or authorised under this Division;
 - (b) to refer matters of concern relating to the organisation or delivery of mental health services in South Australia or the care, treatment or control of patients to the Minister, the Chief Psychiatrist or any other appropriate person or body;
 - (c) to act as advocates for patients to promote the proper resolution of issues relating to the care, treatment or control of patients, including issues raised by a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act;
 - (d) any other functions assigned to community visitors by this Act or any other Act.
- (2) The Principal Community Visitor has the following additional functions:
- (a) to oversee and coordinate the performance of the community visitors' functions;
 - (b) to advise and assist other community visitors in the performance of their functions, including the reference of matters of concern to the Minister, the Chief Psychiatrist or any other appropriate person or body;
 - (c) to report to the Minister, as directed by the Minister, about the performance of the community visitors' functions;
 - (d) any other functions assigned to the Principal Community Visitor by this Act or any other Act.
- (3) A community visitor will, for the purposes of this Division—
- (a) have the authority to conduct inspections of the premises and operations of any hospital that is an incorporated hospital under the *Health Care Act 2008*; and
 - (b) be taken to be an inspector under Part 10 of the *Health Care Act 2008*.

51A—Delegation by Principal Community Visitor

- (1) The Principal Community Visitor may delegate a power or function of the Principal Community Visitor under this Act to another community visitor.
- (2) A delegation under this section—
 - (a) may be absolute or conditional; and
 - (b) does not derogate from the power of the Principal Community Visitor to act in a matter; and
 - (c) is revocable at will by the Principal Community Visitor.

52—Visits to and inspections of treatment centres

- (1) Subject to subsection (2), each treatment centre—
 - (a) must be visited and inspected at least once in every 2-month period by 2 or more community visitors; and
 - (b) may be visited at any time by 2 or more community visitors.
- (2) The Principal Community Visitor may, at any time, visit a treatment centre alone.
- (3) On a visit to a treatment centre under this section, a community visitor must—
 - (a) so far as practicable, inspect all parts of the centre used for or relevant to the care, treatment or control of patients; and
 - (b) so far as practicable, make any necessary inquiries about the care, treatment and control of each inpatient; and
 - (c) take any other action required under the regulations.
- (4) After any visit to a treatment centre, the community visitors must (unless 1 of them is the Principal Community Visitor) report to the Principal Community Visitor about the visit in accordance with the requirements of the Principal Community Visitor.

- (5) A visit may be made with or without previous notice and at any time of the day or night, and be of such length, as the community visitors think appropriate.
- (6) A visit may be made at the request of a patient or a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act.

52A—Visits to and inspection of authorised community mental health facilities

- (1) An authorised community mental health facility—
 - (a) must be visited and inspected at least once in every 2-month period by 2 or more community visitors; and
 - (b) may be visited at any time by 2 or more community visitors.
- (2) However, the Principal Community Visitor may visit an authorised community mental health facility alone at any time.
- (3) On a visit to an authorised community mental health facility, a community visitor must—
 - (a) so far as practicable, inspect all parts of the facility used for or relevant to the care, treatment or control of patients; and
 - (b) take any other action required under the regulations.
- (4) After any visit to an authorised community mental health facility, the community visitors must (unless 1 of them is the Principal Community Visitor) report to the Principal Community Visitor about the visit in accordance with the requirements of the Principal Community Visitor.
- (5) A visit may be made with or without previous notice and at any time of the day or night, and be of such length, as the community visitors think appropriate.
- (6) A visit may be made at the request of a patient or a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act.

53—Requests to see community visitors

- (1) A patient or a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act may make a request to see a community visitor.
- (2) If such a request is made to the director of a treatment centre in which the patient is an inpatient, the director must advise a community visitor of the request within 2 days after receipt of the request.

54—Reports by Principal Community Visitor

- (1) The Principal Community Visitor must, on or before 30 September in every year, forward a report to the Minister on the performance of the community visitors' functions during the financial year ending on the preceding 30 June.
- (2) The Minister must, within 6 sitting days after receiving a report under subsection (1), have copies of the report laid before both Houses of Parliament.
- (3) The Principal Community Visitor may, at any time, prepare a special report to the Minister on any matter arising out of the performance of the community visitors' functions.
- (4) Subject to subsection (5), the Minister must, within 2 weeks after receiving a special report, have copies of the report laid before both Houses of Parliament.
- (5) If the Minister cannot comply with subsection (4) because Parliament is not sitting, the Minister must deliver copies of the report to the President and the Speaker and the President and the Speaker must then—
 - (a) immediately cause the report to be published; and
 - (b) lay the report before their respective Houses at the earliest opportunity.
- (6) A report will, when published under subsection (5)(a), be taken for the purposes of any other Act or law to be a report of the Parliament published under the authority of the Legislative Council and the House of Assembly.

Appendix 2: List of units within Treatment Centres visited by the CVS

Treatment Centre	Units Visited
Adelaide Clinic	Parks Torrens
Flinders Medical Centre	Margaret Tobin Centre – Ward 5J Margaret Tobin Centre – Ward 5H Margaret Tobin Centre – Ward 5K Ward 4G Ward 18V Emergency Department and Short Stay Unit
Glenside Campus	Rural and Remote - Country Mental Health beds Rehabilitation Services Helen Mayo House - Women's and Children's beds Eastern Acute Eastern Psychiatric Intensive Care Unit (PICU) Cedars Acute – now closed and moved to Royal Adelaide Hospital Jamie Larcombe Centre
James Nash House	Birdwood Aldgate Clare Ken O'Brien Centre – East & West
Lyell McEwin Health Service	Ward 1G Ward 1H – Older Persons Mental Health beds Emergency Department
Modbury Public Hospital	Woodleigh House Emergency Department
Noarlunga Health Service	Morier Ward Emergency Department
Oakden Services for Older People	Clements – now closed Makk – now closed McLeay – now closed
Repatriation General Hospital	Ward 18 - now closed and moved to Flinders Medical Centre Ward 17- now closed and moved to Jamie Larcombe Centre, Glenside
Royal Adelaide Hospital	Psychiatric Intensive Care Unit (PICU) Ward 2G Emergency Department Short Stay Unit
The Queen Elizabeth Hospital	Cramond Unit – Open and Closed and NE2A Emergency Department & Short Stay Unit South East (SE) Ward – Older Persons Mental Health beds
Women's and Children's Hospital	Boylan Ward Adolescent Ward Emergency Department
Whyalla Hospital	Integrated Mental Health Unit Emergency Department
Riverland General Hospital	Integrated Mental Health Unit

Emergency Department

Mount Gambier and Districts Health
Service

Integrated Mental Health Unit
Emergency Department

Please note: The Community Rehabilitation Centre's (CRCs) and Intermediate Care Centres (ICCs) are not listed in this section.

Appendix 3: Visit and Inspection Prompt (Mental Health)

The Visit and Inspection Prompt is designed to guide and assist Community Visitors through the visit and inspection process. The areas highlighted within this prompt are in line with the Australian Government's '*National Standards for Mental Health Services, 2010*'.

The prompt should not be used as a 'step-by-step checklist' as this may inadvertently narrow the Community Visitors observations. This document should be read in conjunction of the 'Community Visitor Scheme Visit and Inspection Protocol'.

Prompts to observe whilst undertaking a Visit and Inspection of the Treatment Centre:

Customer Service	Introduction and welcome/reception to the unit Personal interactions between staff and patients/Community Visitors (including attitude) Adequate and accurate information provision (both in discussions with patients and CVs and provided on the ward in pamphlet stands and posters).
Environment	How does the unit feel? e.g. warmth, clinical vs private and personalised spaces for patients Are patient's room and amenities well maintained? e.g. cleanliness and furnishings of the unit Temperature Are patients happy with their food? General maintenance is of a good standard and patients feel any reported concerns are addressed in a timely manner Sufficient provision for private space for patients to spend time in as well as conduct conversations with Visitors in Are patients personal/hygiene needs being met?
Rights	Have patients who are on an order under the <i>Mental Health Act, 2009</i> been given a Statement of Rights regarding that order? Do patients feel they (and their carer, family member or other supporter) are being involved in their treatment and care planning? Do patients feel safe? Are patients treated in the least restrictive environment? Are patients provided with access to advocacy and legal representation?
Access to Information	Is there sufficient information provided for patients in communal areas (regarding the CVS as well as other agencies, events and information)? Do patients whose first language is something other than English have sufficient access to information pertinent to them (including interpreters if required)? Are patients or CVs provided with access to records (when appropriate processes have been undertaken)?
Activity/Entertainment Provisions	Is there provision for entertainment for patients? e.g. television, exercise equipment. Keep in mind, patient who are detained under the <i>Mental Health Act, 2009</i> cannot freely leave the ward and therefore require options for self-entertainment throughout the day Does the unit provide any activities? e.g. music therapy, art and craft, cooking groups
Treatment and Care	Patients feel engaged in their treatment and care? Do patients feel they have been treated in the least restrictive manner? Is there a treatment plan for each patient? How frequently are they reviewed? Seclusion and restraint reports.
Grievances	Do patients feel they are safe to make a complaint if need be (free from any reprisal)? Is the complaint treated confidentially and efficiently? Is the complaints resolution process open and transparent?

Appendix 4: Visit Report – blank form

- (D) = Disability CVS
 (MH) = Mental Health CVS
 (S) = Scheduled Visit
 (R) = Requested Visit
 (SRF) = Supported Residential Facility
 (DOP) = Day Options Programs

REPORT TYPE	
Select report type	
ABOUT THE SITE	
Service Provider	
Address	
ABOUT THE VISIT	
Date of Visit	
Time of Visit	
Details of any Senior Staff spoken to during the visit (Name and Position):	
ABOUT THE VISITOR(S)	
Community Visitor (writer)	
Community Visitor (contributor)	
Community Visitor (other) - Details of any other community visitors present during the visit	
REQUEST DETAILS	
(R) Client Name	
(R) Requester's Name (if different to the above):	
(R) Requester's Contact Details	
(R) Requester's Relationship to Client	
REQUESTED VISIT	
(R) Has the client contacted any other agency regarding their issues?	
(R) Other Agency Contacted	
(R) What were the presenting issue(s)?	
(R) What are the client's desired outcomes?	

ENVIRONMENT AND SERVICES	
Communication (5=Excellent – 1=Poor, Not Observed)	
Communication between staff and client	
Staff responsiveness to client needs	
(SRF) Site/staff relationship with external service providers	
(DOP) Communication between staff at site and disability accommodation	
Quality of Site (5=Excellent – 1=Poor, Not Observed)	
Standard of building facilities	
Standard of equipment within the facilities	
(DOP) Size, suitability and layout of facility for purpose	
Standard of facility grounds	
Appropriate emergency procedures	
Suitable privacy for clients	
(DOP) Provision of equipment within the facilities	
Quality of Services (5=Excellent – 1=Poor, Not Observed)	
Suitable client transport	
Smoking provision for clients	
Quality and choice of food	
Suitable activities available to clients	
Suitable entertainment provision for clients	
Access to Allied Health Services	
(DOP) Individualised activities based on the clients interest and skill level	
(DOP) Sufficient equipment, staffing and facilities to meet the personal hygiene needs of clients	
(DOP) Sufficient staffing to deliver care needs	
(DOP) Sufficient staffing to deliver meaningful activities	
(DOP) Appropriate time spent travelling to site	
Rights and Responsibilities (5=Excellent – 1=Poor, Not Observed)	
Client access to personal documentation	
Access to information regarding rights, complaints and advocacy	

Appropriate family/carer/representative involvement	
(D/MH) Adequate opportunity to access day leave/holidays	
(D) Attention to the independence and training needs of clients	
(D) Opportunity for clients to obtain and maintain suitable employment	
(SRF) Opportunity for clients to access external/community based activities	
(SRF) Attention to the independence needs of clients	
Rights	
Did any clients report not feeling safe in their surroundings?	
Did you observe the use of restrictive practice?	
If yes, did you enquire as to why restrictive practice was utilised?	
(D) (DOP) Was supporting documentation available on the restrictive practice, including a behavioural support plan?	
(SRF) Was a Visitor's Book clearly displayed?	
(SRF) Do residents have access to freely available drinking water?	
(DOP) Does each client have a Communications book?	
Additional comments regarding the rights of clients	
Individual Care Plans	
Do clients have individual care plans?	
How frequently are the plans reviewed?	
Is there evidence of clients participation and knowledge of their plans?	
(D/MH) Is there evidence of family/guardian involvement in development of the plans?	
(D/MH) Is there evidence of the plans being implemented?	
(D/MH/SRF) Do the plans appear to match the expectations and capacity of the clients?	
Additional comments regarding Individual Care Plans	
FINAL COMMENTS	
Please provide any additional comments regarding this visit	
Please outline any issues for CVS office attention	
Please provide a short overview of the visit that can be sent to the site	
Please confirm that both Community Visitors have agreed to the content of this report	

Appendix 5: Compliance with Premier and Cabinet Circular (PC013) on Annual Report Requirements

The following table provide CVS compliance with the Department of Premier and Cabinet Circular (PC013) on Annual Report Requirements.

PC013 Statutory Reporting Requirement	
Employment opportunity programs	Response included in the Department of Human Services Annual Report 2017-18
Agency performance management and development systems	Response included in the Department of Human Services Annual Report 2017-18
Work health, safety and return to work programs of the agency and their effectiveness	Response included in the Department of Human Services Annual Report 2017-18
Work health and safety and return to work performance	Response included in the Department of Human Services Annual Report 2017-18
Fraud detected in the agency	Number of instances - 0
Strategies implemented to control and prevent fraud	Budget and Finances of the CVS is managed by DHS. Requirement to comply with all departmental, Treasury and audit frameworks.
Whistleblowers' disclosure	Response included in the Department of Human Services Annual Report 2017-18
Executive employment in the agency	Response included in the Department of Human Services Annual Report 2017-18
Summary of complaints by subject (table)	Response included in the Department of Human Services Annual Report 2017-18
Complaint outcomes (table)	Response included in the Department of Human Services Annual Report 2017-18