



PRINCIPAL COMMUNITY VISITOR

Annual Report

MENTAL HEALTH SERVICES 2015-16



THE SOUTH AUSTRALIAN
**COMMUNITY
VISITOR SCHEME**



Front cover artwork **Red blooms against the drought** by Jason Cutler, Consumer

It shows red flowers opening in an otherwise desolate and dry Australian desert, proving beauty can form even in the most desolate places.

FOR FURTHER INFORMATION:

Community Visitor Scheme

GPO Box 292

Adelaide SA 5001

Phone 1800 606 302

Fax 08 7424 7239

Email cvs@sa.gov.au

Web www.sa.gov.au/CVS

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Hon. Leesa Vlahos, MP
Minister for Mental Health and Substance Abuse
Minister for Disability

Dear Minister

In accordance with Division 2, section 54 of the *Mental Health Act, 2009* (the Act), it gives me great pleasure to submit to you the Annual Report of the Principal Community Visitor 2015-2016 for presentation to Parliament.

This report provides an account of the work of the South Australian Community Visitor Scheme during the financial year ending 30 June 2016, in compliance with the Act and the Department of Premier and Cabinet Circular (PCO13) on Annual Reporting Requirements.

Yours sincerely

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

Maurice Corcoran AM
30 September 2016

Contents

Contents.....	1
1. Introduction	3
1.1 A Message from the Principal Community Visitor	3
1.2 The Context of Mental Health Services	4
1.3 Data Caveat	5
1.4 Annual Reporting Requirements	5
2. Executive Summary.....	6
2.1 Highlights and Achievements	6
2.2 Recognition of Community Visitors.....	6
2.3 Governance and Strategic Influence	6
2.4 Tracking and Resolution of Issues	6
2.5 Visits.....	7
2.6 Summary of Report Outcomes and Themes.....	7
2.7 Recommendations	9
3. Supporting Legislation and Policy	11
3.1 United Nations Convention on the Rights of People with Disabilities	11
3.2 National Legislation and Policies.....	12
3.3 South Australian Legislation and Policies	18
4. Strategic Partnerships	21
4.1 Minister for Mental Health and Substance Abuse.....	21
4.2 SA Health Chief Executive.....	21
4.3 Chief Psychiatrist	21
4.4 Director Mental Health Strategy	21
4.5 Mental Health Directors within each of the Local Health Networks	21
4.6 Staff of Approved Treatment Centres and Emergency Departments.....	21
4.7 The Community Visitor Scheme Advisory Committee	21
4.8 The Public Advocate and Health and Community Services Complaints Commissioner.....	22
4.9 The Equal Opportunity Commissioner	22
5. Functions of the Community Visitor Scheme	23
5.1 Community Visitor Functions	23
5.2 Monthly Visits and Inspections	23
5.3 Advocacy.....	26
5.4 Disability and Supported Accommodation Facilities	28
5.5 Policy, Strategy and Clinical Practice Development	29

6. Report Outcomes and Themes	30
6.1 Summary of Reporting Outcomes	30
6.2 Access to Services.....	38
6.3 Treatment and Care Plans.....	43
6.4 Forensic Care.....	47
6.5 Personal Safety.....	51
6.6 Activities and Stimulation in Treatment Centres	54
6.7 Impact of SA Health No-Smoking Policy	57
6.8 Menu Options.....	59
6.9 Evidence of Good Practice	60
6.10 Specific Concerns	62
6.11 Issue comparison with other Jurisdictions.....	62
7. Workforce	64
7.1 Governance of the Community Visitor Scheme	64
7.2 Staff of the Community Visitor Scheme.....	65
7.3 Community Visitors	65
7.4 Advisory Committee.....	66
7.5 Community Visitor Recruitment.....	66
7.6 Initial and Ongoing Support and Training for Community Visitors.....	67
7.7 Recruitment Strategies External to CVS	71
8. Public Complaints.....	72
9. Conclusion.....	73
9.1 Future Steps of the South Australia Community Visitor Scheme	73
9.2 Community Visitor Workforce	74
9.3 Development of a New CVS Information Management System.....	74
9.4 Further Implementation of Monthly Focus Projects	74
9.2 Recommendations	74
10. References.....	77
10.1 Community Visitor Scheme	77
10.2 External References	77
11. Glossary of Acronyms	78
12. Appendices.....	81
Appendix 1: Visit and Inspection Prompt (Mental Health).....	81
Appendix 2: Issues Classification Scheme.....	82

1. Introduction

1.1 A Message from the Principal Community Visitor

It is with great pride I present this report, which represents the work of the South Australian Community Visitor Scheme (CVS) for 2015 -16. I do so on behalf of the great team of Community Visitors that I have the pleasure to work with and alongside of as well as an outstanding team in the office who coordinate and manage the Scheme as a whole. Although this is the Annual Report of the Principal Community Visitor, it is without doubt, the culmination of combined efforts of all our Community Visitors and staff.

Our Community Visitors are the backbone of the Scheme and, who once again have made an exceptional contribution to the CVS throughout this year. They have an extensive range of experience, skills and abilities they bring to the role and work as a collective. As one of our experienced Community Visitors said recently; they *"applied for a job as a Community Visitor and found a Community"*. From my perspective, it genuinely feels like a community in the true sense of the word, a community of like-minded, passionate people committed to safeguarding the rights of people living with a mental illness or disability (see Section 7.6 *Volunteer Contribution*).

We have a vigorous screening process for appointing Community Visitors and make no apology for this, as we need to be confident each individual will undertake visits and inspections diligently and respectfully, appropriately deal with issues that arise, and provide a written report to myself as the Principal Community Visitor (PCV).

Our Community Visitors have collectively volunteered 2,024 hours carrying out monthly mental health visits and reports – an outstanding contribution to mental health services in South Australia. During this reporting period there were 1,025 individual issues/comments reported by CVs, compared to 830 during 2014-2015, which represents an increase of over 20%.

Our online reporting tool assists CVs to improve the quality of visit reports and more consistently capture the issues and positive comments raised during visits and this data then informs this Annual Report.

I would like to acknowledge and thank the CVS Advisory Committee members for their contribution to working strategically on many of the systemic issues over this past year. These Committee meetings have provided us with a forum for well-informed discussion on issues of importance that are identified, and strategies to improve or progress such issues.

I would particularly like to acknowledge and thank Anne Burgess, Committee Chairperson who has provided great facilitation to this group and continues to provide wise advice to myself throughout this period.

I especially want to acknowledge the many patients and families who have raised issues with us and trusted us to follow up and advocate on their behalf. This takes considerable courage, especially when individuals may feel vulnerable due to their specific circumstances.

It would be negligent of me if I did not acknowledge and express concern about the length of time it has taken to get investigation reports back from public mental health services. In two individual complaints that the CVS referred to Local Health Networks, relating to serious allegations of physical and chemical restraints, it has been over three months and the CVS have still not received the reports/responses into these investigations.

This has not only been frustrating for the CVS but also the individuals and the family that the complaints have been made by. In particular, the widow of a man who was a patient in a mental health unit who is simply wanting resolution of the issues she was brave enough to raise with us. These delays and allegations have also been raised with the Chief Psychiatrist but we are yet to receive the investigation reports.

I would like to take this opportunity to acknowledge many of the staff in treatment centres and emergency departments who have given their time to provide Community Visitors with briefings during visits and shared their concerns about the wellbeing and treatment of patients. I remain incredibly impressed with many staff throughout the disability and mental health sectors that are committed to improving the services they provide and have been willing to educate and share concerns.

To the various staff who have had the opportunity to work in the CVS office in this reporting year and who have maintained and supported the Scheme to enable Community Visitors and myself to undertake our respective roles, thank you. Our CVs regularly comment on what an exceptional team we have to support and coordinate the many visits, reports and issues that arise.

Maurice Corcoran AM

1. INTRODUCTION

1.2 The Context of Mental Health Services

Mental illness has a profound impact on many Australians and their families. The *National Survey of Mental Health and Wellbeing 2007*¹ found one in five Australian adults experience some form of mental illness in any year, and one in four may experience more than one mental disorder. Almost half of the Australian population (45.5%) will experience mental illness at some point in their lifetime².

In late 2014, the National Mental Health Commission released the *Report of the Review of National Mental Health Programs and Services*³, which included the following statistics:

Each year, it is estimated that 3.6 million people will experience mental illness (20% of adult population).

Over a lifetime, nearly half the population will experience mental illness and less than half of them will access treatment.

There are an estimated 9,000 premature deaths each year among those with severe mental illness with the gap in life expectancy for people with psychosis compared to general population being between 14 and 23 years.

In 2012, more than 2,500 died by suicide and in 2007, 65,000 attempted to end their life (48 people per week or 7 per day take their own lives and 1,250 per week or 178 per day attempt to).

Suicide is the leading cause of death for those aged between 15 and 44 years and is far more likely among men, Aboriginal and Torres Strait Islander people and those living outside of major cities.

In 2011-12, 30% of Aboriginal and Torres Strait Islander people had high or very high levels of psychological stress which is almost three times the rate for all other Australians and their suicide rates were double that of other Australians.

The financial cost is enormous, \$28.6 billion and a further loss of productivity of \$12 billion.

During 2016, the Australian Institute of Health and Welfare released the results of the *Australian Burden of Disease Study*⁴. The analysis noted that mental health and substance abuse account the most to non-fatal burden in Australia (24% of non-fatal burden). This means that they are chronic diseases that last for long periods of time with a significant impact on daily life. Furthermore, mental health and substance abuse impacts the most on individuals aged 15 through to 44 years of age, and for women aged 45 through 64 years of age.

Stigmatic attitudes around mental illness can interfere with the dignity of those with mental illness and their ability to be included and to participate in their communities. The majority of individuals experiencing mental health problems have also been discriminated against on the basis of their mental illness and there has been a general lack of acceptance or inclusion from within the community.

In recent years, there has been a shift in the philosophical and clinical management of mental health conditions in Australia and other western countries. The Recovery Model refers to the belief that people can and do improve their mental health and wellbeing if they receive the right support at the right time. The Recovery Model aims to empower people to work in partnership with mental health services to learn the knowledge and skills to understand their illness, including early warning signs, symptoms, triggers and strategies to stay well. The Recovery Model assists individuals to develop new meaning and purpose in life that goes beyond the effects of mental illness and maximises wellbeing.

The Australian and South Australian Governments recognise this need and there has been significant progress at an international, national and state level to develop legislative frameworks and both policy and program reform to better address a recovery approach.

1 National Survey of Mental Health and Wellbeing: Summary of Results - Australian Bureau of Statistics

2 Australian Government National Health and Medical Research Council - <http://www.nhmrc.gov.au/grants/research-funding-statistics-and-data/mental-health-1>

3 Report of the Review of National Mental Health Programmes and Services Summary, November 2014 - National Mental Health Commission

4 Australian Institute of Health and Welfare. 2016. Australian Burden of Disease Study: Impact and causes of Illness and Death in Australia 2011.

All States and Territories in Australia promote a recovery framework and in 2013, the Australian Government released a *National Framework for Recovery Oriented Mental Health Services*⁵. The framework has been developed to assist mental health settings to align practice with recovery principles and encourage a review of the skill mix of the mental health service workforce. The value of lived experience will be heightened in services as a result of this framework to enhance the use of 'experts by experience'.

The framework philosophy also guided the revision of the *National Practice Standards for the Mental Health Workforce (2013)*, and it is anticipated this will enhance services' abilities to operate from a recovery-oriented framework. The *Roadmap for National Mental Health Reform (2012-22)*, promotes the importance of good mental health and maximises opportunities to reduce the impact on individuals, families and carers with a greater emphasis on human rights and independent review.

1.3 Data Caveat

This report contains an analysis and presentation of data regarding the South Australian Community Visitor Scheme throughout the fifth full reporting period of operation.

Where possible explanatory narrative has been included, however interpretation must be informed by context.

1.4 Annual Reporting Requirements

The Annual Reporting requirements of the South Australian Department of the Premier and Cabinet outlines the requirements for the content of South Australian Government Annual Reports, within the statutory obligations of any relevant Acts.

Section 12(1) of the *Public Sector Act, 2009* requires that all public sector agencies make an Annual Report to that agency's Minister. Section 12(3) provides that a public sector agency that is also under another statutory obligation to make an Annual Report may incorporate those reports.

Accordingly, information regarding the finances, service agreements and workforce of the Mental Health CVS are contained in the Department for Communities and Social Inclusion Annual Report 2015-2016.

⁵ A National Framework for Recovery Oriented Mental Health Services Policy and Theory Commonwealth of Australia 2013 – Australian Health Ministers Advisory Council – National Mental Health Strategy

2. Executive Summary

2.1 Highlights and Achievements

Over the last 12 months the Community Visitor Scheme has expanded, particularly with the commencement of visits to Disability Day Options Programs and the targeted increase in scheduled visits to Disability Accommodation Services and Supported Residential Facilities (SRFs) in South Australia. This increase in activity has been supported with additional staff to ensure we nurture our relationships with our ever-growing network, can schedule visits to various locations across South Australia and respond to client issues to ensure the people who are recipients of these services are treated respectfully and fairly.

Due to our growing presence in the mental health and disability arena, we have also implemented a new database that assists the Coordinators organise monthly visits and identify disability houses and SRFs which are due for a visit.

2.2 Recognition of Community Visitors

The significant increase of visits done by the Community Visitor Scheme, particularly to Day Options, Disability Accommodation and SRFs, has been welcomed by our senior and most experienced Community Visitors (CVs) who have offered extra time for these visits and provided mentoring to our newly recruited CVs.

It is also pleasing that there has been ongoing recruitment and retention of exceptionally qualified and experienced CVs. The CVs have impressive backgrounds, skills and passion that have helped to deliver our key outcomes of monthly inspections and associated reports to mental health facilities and at a very high level. Many come from non-English speaking backgrounds and over 70% of our CVs have a 'lived experience' of either disability or mental illness. By this, we mean that they have experienced a disability or mental illness or have a direct family member such as a son, daughter or sibling who lives with a disability/mental illness. We believe this positively influences their passion and commitment to improve services and safeguarding the rights of people using disability or mental health services.

2.3 Governance and Strategic Influence

The CVS Advisory Committee consists of senior managers from public and private mental health and disability services, a range of Statutory Officers including the Public Advocate, Chief Psychiatrist, Health and Community Services Complaints Commissioner, association delegates, and representatives with lived experience. The role of the CVS Advisory Committee is to provide strategic advice and support to the Principal Community Visitor in resolving issues, assist in the monitoring and evaluation of the Community Visitor Scheme, and contribute to strategic networks and relationships.

In addition, the CVS also liaises with the Office of the Chief Psychiatrist and senior leadership teams of various Mental Health Directorates in South Australia. Further details of the CVS' networks are available in Chapter 4.

2.4 Tracking and Resolution of Issues

During this fifth year of operation, there were 1,025 individual issues/comments reported by CVs, compared to 830 during 2014-2015, 510 during 2013-14, 420 during 2012-13 and 146 in 2011-12. Of the 1,025 reported issues/comments, it is pleasing to note that 453 (44%) highlighted innovative and positive actions that have taken place in units for which we have been able to commend staff/units. This has been a considerable increase compared to previous years. The online reporting tool has a range of set questions that prompts the CVs to highlight issues and this may have led to this significant increase in comments/issues.

In addition to this work, the CVS through the Mental Health Coordinator and Principal Community Visitor respond to individual issues raised directly with the office by clients, their families and staff. Of particular importance, is the advocacy undertaken to support forensic and Department for Correctional Services clients who were restrained in hospital emergency departments for several days, this is partly due to a lack of beds available in James Nash House. The CVS has brought these cases to the attention of the South Australian Ombudsman, who has prepared reports after investigating these cases and presented them to the Department for Correctional Services for their action. The Ombudsman has also released a number of these reports to the public.

It would be negligent of me if I did not acknowledge and express concern about the length of time it has taken to get investigation reports back from both CALHN and NALHN. There were two individual complaints that the CVS referred that related to serious allegations of physical and chemical restraints applied to patients in mental health units. It has been over three months and the CVS has still not received the reports/responses into these investigations despite the Mental Health Coordinator and PCV making several follow up calls and emails to the services concerned.

This has not only been frustrating for the CVS but also the individuals and the family that the complaints had been made by. In particular, the widow of a man who was a patient in a mental health unit who is simply wanting resolution of the issues that she was brave enough to raise with us.

These delays and allegations have also been raised with the Chief Psychiatrist but we are yet to receive the investigation reports.

Individual issues that are identified during visits are also tracked through an issues register database and raised with the relevant service providers. Our ability to monitor and track all issues through these tools has significantly improved during this reporting period and not only holds the CVS to account but the various units where these issues were identified.

These may be escalated to senior management if there is frustration with their progress. Issues of significance or issues identified as systematic are documented on an Issues Register for further research and action. The Issues Register is tabled at the CVS Advisory Committee where robust and well-informed discussions occur about how best to advance these issues. There are, on occasions, shared issues experienced by the other Statutory Officers, which enables a coordinated approach to achieve resolution. This has influenced many of the successful outcomes that the CVS has already achieved, including the implementation of a focus project reviewing Treatment and Care Plans.

Visit reports are provided back to the Mental Health Executive Directors on a monthly basis seeking action on outstanding issues and where appropriate, highlighting good practices to ensure staff are acknowledged. Copies of these reports are also provided to Treatment Centre staff.

2.5 Visits

During 2015-16, there were 234 scheduled visits to mental health treatment centres. Five visits did not occur due to extreme weather and CVs' personal emergencies. 138 individuals the CVs spoke with identified as non-Australian. 77 identified as Aboriginal or Torres Strait Islander, 61 identified as being from Culturally and Linguistically Diverse (CALD) backgrounds.

As part of the CVS' legislative mandate (section 53 of the *SA Mental Health Act 2009*), requests can be made for a CV to visit individuals while in a treatment centre. A request to see a CV can be made by the patient, family member, staff, friend or other supporter by contacting the CVS office directly. If a patient requests a visit from a Community Visitor through a treatment centre staff member, the Act requires the staff member to notify the CVS office within two business days of the request being made to them.

There were 129 requests for a visit and/or advocacy during the 2015-16 reporting period, of which 100 requests came directly from patients within emergency departments and treatment centres and 17 were from family members, friends or carers. There were 12 requested visits from other referrals including staff in treatment centres, community mental health workers, and other statutory bodies such as Health and Community Services Complaints Commissioner (HCSCC) or Office of Public Advocate (OPA).

2.6 Summary of Report Outcomes and Themes

Environmental and hospital services continue to be the most reported category raised in monthly visits and inspections to mental health units. This has been consistent since the implementation of the CVS in 2011, with food being the most raised topic in this category. It was pleasing to note there has been an increase in positive comments made about food as clients have appreciated the availability of healthy snacks, fresh fruit, vegetarian and vegan meals. However, lack of smoking provisions continues to be one of the most raised issues within mental health units, particularly in closed wards. The report discusses feedback from patients on the significant impact SA Health's 'No Smoking Policy' has on their current mental health status and their experienced frustrations.

Since the introduction of Short Stay Units (SSUs) in many hospitals, there has been a decline in the number of reported instances a client has been waiting in the Emergency Department for 24 hours or longer for a bed in a mental health unit. However, there continues to be situations when clients are waiting over 24 hours in Emergency Departments and the CVS has also been alerted to the stagnant and clinical environments of SSUs where many clients have complained there is limited access to Allied Health Services to support commencement of their recovery.

2. EXECUTIVE SUMMARY

Furthermore, the 24-hour Emergency Department Policy has reportedly placed increased pressure on nursing staff to manage beds with concerns raised by staff that clients are being discharged or transferred to less acute units too early when assessed as not yet stable enough to cope. This has resulted in concerns amongst staff of the potential for a 'revolving door' issue to develop.

During this reporting period, there was a significant improvement regarding comments on the availability of activities and structured programs for clients. Community Visitors observed many units notify clients of a daily program of activities, with staff also becoming more involved in leading or participating in activities. This has immense benefits for clients including developing trusting and collaborative relationships to maximise their recovery. Unfortunately, clients and staff raised that Allied Health roles have declined in many mental health units, with delays in Social Worker, Psychologist, Activity Coordinators and Occupational Therapist roles being advertised and filled, or in some instances, abolished.

A focus project to ascertain the utilisation of Treatment and Care Plans was implemented by the CVS with the assistance of our Community Visitors during May and June visits. Treatment and Care Plans are an essential element of a client's recovery and are governed by the *National Mental Health Service Standards (2010)*, *Clinical Guide Code of Practice and the South Australian Mental Health Act, 2009*. The focus project identified that few units in South Australia have a model practice for developing, reviewing and updating Treatment and Care Plans. The units who performed poorly in this area, cited many barriers including insufficient time due to other demands on staff such as risk-assessments and reporting, difficulty collaborating with acutely unwell clients, uncompliant patients and lack of seeking input from the client's family and carers.

One unit (Ward 18 at the Repatriation Hospital) was identified to have a model of best practice in place, and demonstrated their ability to go above and beyond. This same unit adopted a practice where all nursing staff are required to read through the Treatment and Care Plans for each patient they are allocated at the beginning of their shift, and to then refer back to these at the end of the shift and make any necessary amendments. This unit feels that the above practice is not only consistent with good practice but saves time in the long term. The multidisciplinary team then reviews all Plans each week. The unit also implements customer satisfaction surveys with all patients and their families, as part of their service and outcome evaluation for their own continuous improvement practices, and specifically asks how involved and consulted they felt in relation to Treatment and Care Plans.

Personal safety issues continue to be raised, with the addition now of concerns regarding availability and access to illicit drugs in mental health units. This has been particularly noted in relation to smoking areas for open ward clients, as many smoke or 'hang out' in community areas around the facility. The CVS has been made aware from clients, their families and staff of illicit drug trade in these areas.

Staff have had to set boundaries and consequences for clients they are aware of who are likely to access such substances, as consumption of illicit substances has a significant detriment on the speed of recovery for clients. This is not an issue unique to South Australia, as the Victorian Community Visitors Scheme⁶ also noted this is an issue within their jurisdiction.

Forensic mental health continues to present as an area requiring significant CVS advocacy and support. During the 2015-2016 financial year, the CVS was made aware of forensic and Department for Correctional Services clients being restrained in hospital EDs and wards. SA Health staff have reported to the CVS significant concerns about the welfare of such clients, and as such, the CVS has reported these matters on to the South Australian Ombudsman for investigation. In addition to this, the CVS also provides advocacy and assistance to clients in James Nash House and Kenneth O'Brien Centre who seek the liberties they are entitled to as S269 clients under the *South Australian Mental Health Act*. Improvements to accommodation with the opening of the Kenneth O'Brien Centre has been welcomed by the CVS. Of note, the significant gain for some clients in this centre through the introduction of a range of activities aimed at recovery and rehabilitation such as an individual tailored IT program to develop their skills for their reintegration back into the community.

6 Victoria Department of Health (2015). Mental Health Statewide Report and Recommendations: Community Visitors Annual Report 2014-2015.

2.7 Recommendations

The recommendations reflect proposed strategies by the Principal Community Visitor in response to issues drawn from monthly reports of visits to all mental health units in South Australia and are as follows:

Access to Services

1. That the Community Visitor Scheme continue to independently monitor the length of stays of mental health patients in emergency departments to ascertain whether there is improvement or otherwise.
2. That the Community Visitor Scheme continues to monitor the incidence of seclusion and restraints and least restrictive practices.
3. That the Community Visitor Scheme continues to monitor the policy and practice response from the department of Correctional Services to the Ombudsman's report.
4. That the Community Visitor Scheme continues to advocate for and monitor the service response to patients' cultural needs.
5. That the Community Visitor Scheme continues to monitor access to Allied Health Services and the availability of these roles within mental health units.

Treatment and Care Plans

6. That all Treatment Centres, as part of their key performance indicators, report on their practice of developing and maintaining Mental Health Care Plans.
7. That the Community Visitor Scheme continue to monitor the level of involvement by patients, their families and carers in the development and revision of Treatment and Care Plans.



Ward 18 Tree of Hope

Coming to hospital can be very daunting. There are many ways to help people regain hope and get a sense of purpose. Please share a leaf... what you liked about the Ward, a positive experience during your stay and a helpful piece of advice for new patients.

Forensic Mental Health and Dual Diagnosis Clients

8. That the independent review and report into forensic care be released to the public and the Parliament to ensure that South Australia's forensic care and resources applied in this area are getting the outcomes deserved.
9. That the service improvement initiatives for responding to forensic clients with disabilities continue to receive serious consideration by the departments that have shared responsibility for this outcome.
10. That individual case planning occurs with all clients with disabilities who are currently within the forensic care services and corrections so that a collated profile of need is identified.
11. That there are more activities made available to clients to develop daily living skills to facilitate their reintegration back into the community and have more chance to be independent and self-reliant once they are released.
12. That the SA Government considers establishing a dedicated Mental Health Review Panel by reviewing models in effect in NSW and QLD.

Dignity and Respect

13. That SA Health staff working in emergency departments and mental health units complete SA Health online training regarding restrictive practices.
14. That the Community Visitor Scheme continue to monitor the use of restrictive practices in mental health units and continue to report incidents of this nature to executives and senior management for investigation.
15. That the Community Visitor Scheme continue to advocate for clients who speak up against being restrained in mental health units and advocate that they receive a response regarding their complaint.

Personal Safety

16. That further action be taken by SA Health to provide safe ground for clients in open wards to mitigate their exposure to illicit drugs that impact on their treatment and recovery in mental health units.
17. That further action be taken by each local health network to provide safe, monitored areas where patients have access to fresh air outside of units and emergency departments.

Activities and Stimulation in Treatment Centres

18. That all mental health units be required to post their weekly activities and sessions on their respective notice boards, keep appropriate documentation of participation rates and report on structured activity plans to the Office of the Chief Psychiatrist.
19. 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.
20. That the Community Visitor Scheme continues to monitor the levels of activities offered to patients.

Impact of SA Health No Smoking Policy

21. 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.
22. That the Community Visitor Scheme continue to explore individual patient rights under anti-discrimination legislation and specifically those who have smoking addictions and who have been placed in closed units.

Menu Options

23. An independent review of the menu provisions in mental health units be undertaken with a particular focus on the needs of long stay patients.

Specific Concerns

24. That a review is undertaken of the clinical hours in contrast to patient acuity at Older Persons Mental Health Services at Oakden to ensure the provision of quality and safe care to patients residing in this facility.

3. Supporting Legislation and Policy

3.1 United Nations Convention on the Rights of People with Disabilities

The Australian and the South Australian governments have 'signed up' to uphold the rights of people with a disability and ensure there is legislative and policy reform to address any form of discrimination. Australia has ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPWD) and has signed the Optional Protocol, which ensures that Australians with disabilities have rights and avenues to lodge complaints.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Under the UNCRPWD, discrimination on the basis of disability 'means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination. The Convention aims to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

The UNCRPWD sets out clear obligations that governments must undertake in order to address rights and remove discriminatory legislation, policies and practices to develop appropriate services. The obligations include:

- a. To adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the present Convention;
- b. To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities;
- c. To take into account the protection and promotion of the human rights of persons with disabilities in all policies and programs;
- d. To refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention; and
- e. To take all appropriate measures to eliminate discrimination on the basis of disability by any person, organisation or private enterprise.

Article 16 of the UNCRPWD is particularly relevant to mental health services and the role of the Community Visitor Scheme to independently monitor services;

1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.
2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognise and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive.
3. In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that **all facilities and programs designed to serve persons with disabilities are effectively monitored by independent authorities.**
4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs

3.2 National Legislation and Policies

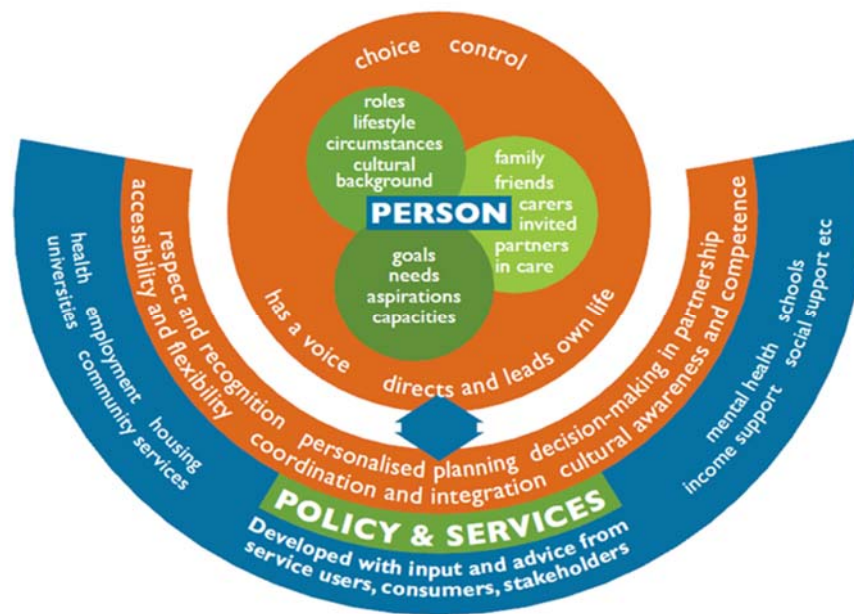
The *Disability Discrimination Act, 1993* is administered by the Australian Human Rights Commission who also has a monitoring role on the implementation of the UNCRPWD in Australia.

3.2.1 Roadmap for National Mental Health Reform

The Council of Australian Governments (COAG) reaffirmed its commitment to mental health reform as an ongoing national priority with release of the Roadmap for National Mental Health Reform 2012-22. The Roadmap emphasises that the voices of consumers and carers should be heard, and that policy should be guided by and respond to people's lived experience

The Road Map identifies six principle-based, goal-oriented and action-focused priorities for reform. These will act as building blocks for ongoing reform in the decade ahead.

- Priority 1:** Promote person-centred approaches.
- Priority 2:** Improve the mental health and social and emotional wellbeing of all Australians.
- Priority 3:** Prevent mental illness.
- Priority 4:** Focus on early detection and intervention.
- Priority 5:** Improve access to high quality services and supports.
- Priority 6:** Improve the social and economic participation of people with mental illness.



Strategies to achieve these priorities include:

1. Increase opportunities for people with mental health issues, their families and carers, to determine the most appropriate services and supports, including through individualised funding mechanisms such as the National Disability Insurance Scheme, as well as their capacity to contribute to the design, implementation and evaluation of mental health policies, programs and services.
2. Increase the availability of prevention and intervention activities appropriate to each person's life-stage and circumstances, including for children, young people, new parents and older people.
3. Support people to access natural supports, such as family and friends, community groups, and self-help groups, and provide services that assist people in accessing and maintaining these supports.
4. Support integrated and recovery-oriented approaches to service delivery, including through the Mental Health Recovery Framework, to help reduce the recurrence of mental illness and, where possible, prevent future episodes of such illness.

3.2.2 National Standards for Mental Health

The *National Standards for Mental Health Services* (the standards) were first introduced in 1996 to assist in the development and implementation of appropriate practices in order to guide continuous quality improvement in mental health services. A review of the standards was commenced in November 2006, in consultation with the sector, and with consumers and carers and a new recovery standard was added to the revised 2010 National Standards.

The Standards focus on:

- » How services are delivered;
- » Whether they comply with policy directions;
- » Whether they meet expected standards of communication and consent; and
- » Whether they have procedures and practices in place to monitor and govern particular areas especially those that may be associated with risk to the consumer, or which involve coercive interventions.

The key principles that informed the development of the National Mental Health Standards are as follows:

- » Mental health services should promote an optimal quality of life for people with mental health problems and/or mental illness.
- » Services are delivered with the aim of facilitating sustained recovery.
- » Consumers should be involved in all decisions regarding their treatment and care, and as far as possible, the opportunity to choose their treatment and setting.
- » Consumers have the right to have their nominated carer(s) involved in all aspects of their care.
- » The role played by carers, as well as their capacity, needs and requirements as separate from those of consumers is recognised.
- » Participation by consumers and carers is integral to the development, planning, delivery and evaluation of mental health services.
- » Mental health treatment, care and support should be tailored to meet the specific needs of the individual consumer.
- » Mental health treatment and support should impose the least personal restriction on the rights and choices of consumers taking account of their living situation, level of support within the community and the needs of their carer(s).

All standards, except the consumer standard, have been designed to be assessed along nine domains from the *Key Performance Indicators for Australian Public Mental Health Services (2005)*.

The Key Performance Indicators are as follows:

Effectiveness: Care, intervention or action achieves desired outcome in an appropriate timeframe.

Appropriateness: Care, intervention or action provided is relevant to the client's needs and based on established standards.

Efficiency: Achieving desired results with the most cost-effective use of resources.

Accessibility: Ability of people to obtain health care at the right place and right time irrespective of income, physical location and cultural background.

Continuity: Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time.

Responsiveness: The service provides respect for all persons and is client orientated. It includes respect for dignity, cultural diversity, confidentiality, participation in choices, promptness, quality of amenities, access to social support networks, and choice of provider.

Capability: An individual's or service's capacity to provide a health service based on skills and knowledge.

Safety: The avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered.

3. SUPPORTING LEGISLATION AND POLICY

Sustainability: System or organisation's capacity to provide infrastructure such as workforce, facilities, and equipment, and be innovative and respond to emerging needs.

CVS Assessment Tool: These performance indicators have been an important consideration for the CVS and have been used to develop the assessment tool for visit and inspection reporting. The CVS visit and inspection prompt sheet has been designed to guide and assist Community Visitors through the visit and inspection process and specifically considers the following standards:

- (1.1) The Mental Health Service (MHS) upholds the right of the consumer to be treated with respect and dignity at all times.
- (1.4) The MHS provides consumers and their carers with a written statement, together with a verbal explanation of their rights and responsibilities, in a way that is understandable to them as soon as possible after entering the MHS and at regular intervals throughout their care.
- (1.8) The MHS upholds the right of the consumer to have their privacy and confidentiality recognised and maintained to the extent that it does not impose serious risk to the consumer or others.
- (1.9) The MHS upholds the right of the consumer to be treated in the least restrictive environment to the extent that it does not impose serious risk to the consumer or others.
- (1.10) The MHS upholds the right of the consumer to be involved in all aspects of their treatment, care and recovery planning.
- (1.11) The MHS upholds the right of the consumer to nominate if they wish to have (or not to have) others involved in their care to the extent that it does not impose serious risk to the consumer or others.
- (1.12) The MHS upholds the right of carers to be involved in the management of the consumer's care with the consumer's informed consent.
- (1.13) The MHS upholds the right of consumers to have access to their own health records in accordance with relevant commonwealth, state/territory legislation.
- (1.15) The MHS upholds the right of the consumer to access advocacy and support services.
- (1.16) The MHS upholds the right of the consumer to express compliments, complaints and grievances regarding their care and to have them addressed by the MHS.
- (1.17) The MHS upholds the right of the consumer, wherever possible, to access a staff member of their own gender.

3.2.3 National Health Reform Agreement

The National Health Reform Agreement was signed by the Commonwealth, State and Territory Governments of Australia in July 2011, in order to build on the National Healthcare Agreement. This Agreement supersedes the National Health and Hospitals Network Agreement and the Heads of Agreement on National Health Reform. The National Health Reform Agreement introduces new financial and governance arrangements for Australian public hospitals and new governance arrangements for primary health care.

Key initiatives agreed under the Agreement include:

- » The introduction of a Performance and Accountability Framework.
- » The utilisation of Activity Based Funding (ABF) based on a national efficient price for admitted acute services; emergency department and non-admitted patient services from 1 July 2012, and admitted mental health and sub-acute services from 1 July 2013.
- » The establishment of a National Health Funding Pool.
- » The establishment of the National Health Performance Authority (NHPA) which has developed four performance indicators, two for Local Hospital Networks and two for Medicare Locals. The performance indicators include unplanned hospital readmission rates for those discharged following the management of depression and schizophrenia; the rates of community follow up within the first seven days of discharge from a psychiatric admission; the rates of contact by children and young people for primary mental health care and; the percentage of the population who receive primary mental health care.

- » The establishment of the Independent Hospital Pricing Authority (IHPA).
- » The establishment of Local Hospital Networks.
- » The development of an integrated primary health care system and the establishment of Medicare Locals.

3.2.4 National Partnership Agreement on Improving Public Hospital Services

This National Partnership Agreement supports the National Health Reform Agreement and the previous work under the National Health and Hospitals Network Agreement and the National Health Reform - National Partnership Agreement on Improving Public Hospital Services. The Agreement was signed in July 2011, and aims to improve public patient access to elective surgery, Emergency Department (ED) and sub-acute care services by improving efficiency and capacity in public hospitals. Under the Agreement the Commonwealth Government agreed to provide up to \$1.623 billion in capital and recurrent funding from 2010–11 to 2013–14 to States and Territories to deliver and operate over 1,300 new sub-acute care beds in hospital and community settings, by the end of this period. The Agreement is designed to increase access to sub-acute care services including rehabilitation, palliative care, mental health and geriatric services in both hospitals and the community.

3.2.5 National Mental Health Commission

In the 2011–12 Federal Budget, \$32 million was allocated to establish a National Mental Health Commission (NMHC), which commenced operation in January 2012. Their vision is '*all Australians achieve the best possible mental health and wellbeing*' with the mission to ensure that there is national attention on mental health and suicide prevention, and influence mental health reform. The strive to achieve the following:

- » Ensuring mental health and wellbeing is a national priority.
- » Increasing accountability and transparency through credible and useful public reporting and advice informed by collaboration.
- » Providing leadership and information that helps to empower people with lived experience, their families and support people.
- » Working with others to influence decision-making, set goals and transform systems and support to improve people's lives.

The NMHC produces an annual National Report Card on Mental Health and Suicide Prevention. The first National Report Card⁷ presented 10 recommendations to achieve their vision for a contributing life for people with mental health difficulties and their families. This was reviewed again in 2013, whereby 18 recommendations were proposed⁸.

During 2014, the NMHC⁹ sought feedback from Federal and State and Territory Governments to provide advice on local progress against those 18 recommendations. What follows is a brief overview of the findings and further recommendations:

1. Nothing About Us Without Us, there must be a regular independent survey of experiences and access to all mental health services

A National Consumer Experience of Care measure was developed, and various states evidenced that they implemented customer satisfaction surveys and included people with lived experience in the planning and decision making of mental health services.

2. Increase access to timely and appropriate mental health services and support from 6-8 per cent to 12 per cent of the Australian population.

South Australia was commended for having a policy directive, which includes procedures for equitable and timely access to mental health services.

7 National Mental Health Commission, 2012: A Contributing Life: The 2012 National Report Card on Mental Health and Suicide Prevention, Sydney: NMHC

8 National Mental Health Commission, 2013: A Contributing Life: The 2013 National Report Card on Mental Health and Suicide Prevention, Sydney: NMHC

9 National Mental Health Commission, 2014: A Contributing Life: The 2014 Report Back on the 2012 and 2013 National Report Cards on Mental Health and Suicide Prevention, Sydney: NMHC

3. SUPPORTING LEGISLATION AND POLICY

3. Reduce the use of involuntary practices and work to eliminate seclusion and restraint.

It was noted that most jurisdictions are working to reduce the use of seclusion and restraint; Australia remain a long way from eliminating the use of these practices. The Commission committed to work on this issue.

4. All governments must set targets and work together to reduce early death and improve the physical health of people with mental illness.

The Commission noted further development is required in this area particular to measure service outcomes of clients.

5. Include the mental health of Aboriginal and Torres Strait Islander peoples in 'Closing the Gap' targets to reduce early deaths and improve wellbeing.

An Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) has been established to guide the development of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

6. There must be the same national commitment to safety and quality of care for mental health services as there is for general health services.

The Commission is working with the Australian Commission for Safety and Quality in Health Care to develop national standards for mental health services.

7. Invest in healthy families and communities to increase resilience and reduce the longer-term need for crisis services.

The Commission noted that nationally further work is required to invest in children and families earlier to prevent mental health problems from developing.

8. Increase the levels of participation of people with mental health difficulties in employment in Australia to match best international levels.

The Commission initiated the Mentally Healthy Workplace Alliance to encourage and support business in creating mentally healthy workplaces. The Alliance is a coalition of government, business and community working together.

9. No-one should be discharged from hospitals, custodial care, mental health or drug and alcohol related treatment services into homelessness. Access to stable and safe places to live must increase.

It was cited that in South Australia the Pathways to Care policy include that mental health services exit no person to homelessness. It also cited that an evaluation of the South and Support Programme demonstrated improvements in people's quality of life.

10. Prevent and reduce suicides, and support those who attempt suicide through timely local responses and reporting.

The Commission acknowledged the significant effort across jurisdictions to target suicide in the community, however reported that suicide rates are no longer falling. The Commission recommended extra effort be placed into suicide prevention.

11. People with co-existing mental health difficulties and substance use problems must be offered appropriate and closely coordinated assessment, response and follow-up for their problems.

The Commission noted that improvements have been made across Australia to integrate mental health care and comorbid substance abuse to better assist clients. Investment into training and improved service models were noted, however more still needs to be done to ensure clients are not turned away.

12. National, systematic and adequately funded early intervention approaches must remain. This must be accompanied by robust evaluation to support investment decisions, with a focus on implementation, outcomes and accountability.

There was evidence that jurisdictions were implementing promotional activities, however the Commission noted further work is required to ensure there is a national approach to guide implementation and evaluation of such activities.

13. A National Mental Health Peer Workforce Development Framework must be created and implemented in all treatment and support settings. Progress must be measured against a national target for the employment and development of the peer workforce.

A National Framework remains outstanding, however most states and territories employ peer workers in mental health services, and the numbers of peer workers are growing.

14. A practical guide for the inclusion of families and support people in services must be developed and implemented, and this must include consideration of the services and supports that they need to be sustained in their role.

The Commonwealth Government has funded three national projects to develop new survey measures to capture consumer and carer perspectives of health care services.

15. The Commission calls for the implementation and ongoing evaluation of a sustained, multi-faceted national strategy for reducing discrimination.

The Commission noted that there are a variety of organisations including StigmaWatch and SANE Media Centre who are funded to monitor how mental health is portrayed in the media, however Australia needs more targeted anti-discrimination initiatives. The Commission has implemented The Mentally Healthy Workplace Alliance to reduce stigma and discrimination of employees.

16. All Australians need access to alternative (and innovative) pathways through school, tertiary and vocational education and training.

The Commission stated that Australian governments must collect data, and report nationally on the educational participation of people experiencing mental health difficulties.

17. Where people with mental health difficulties, their families and supporters come into contact with the criminal justice system and forensic services, practices which promote a rights and recovery focus and which will reduce recidivism must be supported and expanded.

State and territory governments must provide better mental health programmes to those who come into contact with the justice system, so that people have their mental health improved rather than diminished.

18. Governments must sign up to national targets to reduce suicide and suicide attempts and make a plan to reach them. These targets must be based on detailed modelling.

Australia needs a national picture of the contributing factors to suicide attempts, starting with those most at risk, so we can work out sensitive responses to those groups. Existing community-based suicide bereavement support activities for families and support people must be scaled up and new ones encouraged – particularly in Aboriginal and Torres Strait Islander communities.



Painting of Jetty Road Glenelg

Joanne Kerkemeyer a nurse in Ward 18, Repatriation General Hospital. This stunning painting is in the closed section of Ward 18

3.3 South Australian Legislation and Policies

3.3.1 The South Australian Strategic Plan

The *South Australian Strategic Plan* (SASP)¹⁰ has been developed to guide individuals, community organisations, governments and businesses to secure the wellbeing of all South Australians. The SASP contains our community's visions and goals; its 100 measurable targets reflect the State's priorities.

The Community Visitor Scheme contributes to the following targets set out within the SASP:

- » **Target 23: Social Participation** – Increase the proportion of South Australians participating in social, community and economic activities by 2020.
- » **Target 24: Volunteering** – Maintain a high level of formal and informal volunteering in South Australia at 70% participation or higher.
- » **Target 30: Boards and Committees** – Increase the number of women on all State Government boards and committees to 50% on average by 2014 and maintain thereafter by ensuring that 50% of women are appointed, on average, each quarter.
- » **Target 31: Chairs of Boards and Committees** – Increase the number of women chairing State Government boards and committees to 50% by 2014.
- » **Target 86: Psychological Wellbeing** – To improve psychological wellbeing in South Australia that it is equal or lower the Australian average for psychological distress by 2014 and maintain thereafter.

3.3.2 Transforming Health

The Transforming Health initiative is the beginning of ongoing transformation of the South Australian healthcare system. The aim is to provide a high quality healthcare service that focuses on putting the patient first and ensuring this aspect is central to Government's health values, decision-making and standards of care. Its vision is to ensure *best care, first time, every time*.

Transforming Health Values are centred on six quality principles:

- » Patient Centred;
- » Safe;
- » Effective;
- » Accessible;
- » Efficient; and
- » Equitable.

The Delivering Transforming Health Summary¹¹ outlines the next steps for Transforming Health, which are based on extensive input, feedback and ideas provided by the community, our staff and the industry. The next steps for mental health include:

- » Aligning mental health services and bed management processes primarily with Local Health Network boundaries and systems;
- » Significantly improving emergency department waiting times for mental health consumers by better understanding the reasons for these delays and improving efficiency within emergency departments and wards;
- » Improving access for consumers with chronic and complex needs to rehabilitation beds, sub-acute beds and supported accommodation;
- » Improving the transition from hospitals to community mental health services for mental health consumers;
- » Improving the efficiency and comprehensiveness of community mental health services; and
- » Improving the interface and shared care arrangements between primary care and state mental health services.

10 South Australian Strategic Plan, 2011. Department of Premier and Cabinet, Government of South Australia. www.saplan.org.au

11 Delivering Transforming Health - Summary (Community Information), SA Health 2015 www.transforminghealth.sa.gov.au

The SA Government has already:

- » Set new targets for mental health sector. By January 2016, no mental health consumer should wait more than 24 hours for admission to an acute hospital bed. By July 2018, 75 percent of mental health consumers should be admitted within four hours and 90 percent within eight hours;
- » Committed to introducing new governance structures for mental health services so that they are clinician led, in line with other medical specialties;
- » Established a new Mental Health Advisory Group with mental health clinicians to focus on reducing patient waiting times in hospital Emergency Departments, improve access to acute mental health beds and resolve system blockages; and
- » Started implementing the transformation of Child and Adolescent Mental Health Services, to deliver an integrated, system-wide approach to care, focused on prevention, early intervention, recovery and social inclusion.

3.3.3 South Australia's Mental Health and Wellbeing Policy

The *South Australia's Mental Health and Wellbeing Policy* (2010-2015) sets out a number of key policy directions aimed at improving South Australia's mental health care system and supporting the recovery process for everyone who experiences mental ill health. The policy builds on the strategic reforms and developments outlined in *Stepping Up: A Social Inclusion Plan for Mental Health Reform* (2007-2012) and the *Review of Community Mental Health Services in South Australia* (2008).

The policy aligns with the key strategic objective of the SA Health Strategic Plan to reform mental health care in South Australia and contributes to the South Australia's Strategic Plan. South Australia's *Mental Health and Wellbeing Policy* is consistent with the direction of the *National Mental Health Strategy and the National Mental Health Plan* (2009-14).

3.3.4 The Mental Health Act, 2009

The *Mental Health Act, 2009* (the Act) provides a legislative framework to articulate the rights of people with mental illness in South Australia. The Act aims at facilitating recovery oriented service provision and improved participation in community life. The Act aims to incorporate provisions that bring South Australia in line with contemporary approaches to the management of serious mental health issues.

The Act includes provisions designed to assist people to obtain clinical assistance while protecting their rights and minimising the restriction of freedoms. The Act is primarily regarding the use of powers to treat people with serious mental illness against their will, and provides for the checks, balances and protections necessary for the transparent and accountable exercise of these powers.

Part 8 Division 2 of the Act established a Community Visitor Scheme in South Australia, which aims to provide further protection to the rights of people with a mental illness who are admitted to treatment centres including Emergency Departments and forensic settings in South Australia.

During 2013 and 2014, the Office of the Chief Psychiatrist undertook a review of the *Mental Health Act, 2009* which included course of public submissions and focused consultations. The review was tabled in Parliament on 1 July 2014, and four weeks of public consultation was undertaken. Feedback received was collated and discussed in detail with the 'Mental Health Act User Group' which the Chief Psychiatrist chairs and the Principal Community Visitor is a member of.

The role of the Community Visitor Scheme was examined as part of the review and the following recommendations were relevant to the CVS:

- » The Principal Community Visitor should have the capacity to conduct visits and inspections of facilities alone;
- » The Principal Community Visitor may delegate a power or function of the Principal Community Visitor to another Community Visitor;
- » Community-based services and facilities should be included in the scope of the Community Visitor Scheme; and
- » The limit of two terms for people appointed to the position of Community Visitor or Principal Community Visitor be removed.

3. SUPPORTING LEGISLATION AND POLICY

As such, the amendments were presented in the *Mental Health (Review) Amendment Bill, 2016* and were approved by the House of Assembly and the Legislative Council during the 2015-2016 financial year. It is anticipated the approved amendments will come into effect during the first half of 2017. The changes will enable the CVS to visit Intermediate Care Centres (ICCs), Rehabilitation Units and Community Mental Health Services. Further information is presented in Chapter 9 of this Report.

3.3.5 Advanced Care Directives

The *Advance Care Directives Act, 2013 (SA)* came into effect on 1 July 2014. It empowers adults to make legal arrangements for their future health care, end of life, preferred living arrangements and other personal matters, and/or appoint one or more Substitute Decision Makers to make decisions on their behalf when they are unable to do so themselves.

It promotes a rights based patient centred approach to health care and supports the National Safety and Quality Service Standards:

- » Standard 2 - Partnering with Consumers; and
- » Standard 9 - Recognising and Responding to Clinical Deterioration in Acute Health Care.

3.3.6 Volunteering Strategy for South Australia

The *Volunteering Strategy for South Australia* was launched in January 2014. This is a critical document for the Sector and the State as a whole. It was developed by a unique partnership of Volunteering SA&NT, the State Government and the Local Government Association and Business SA.

The Strategy provides a vision and action plan for volunteering in South Australia from 2014 through 2020. The Strategy aims to ensure that the number of volunteers continues to grow, despite pressure from changing norms such as increasing urbanisation, evolving technology, complex legislation, access to insurance cover, volunteer rights, and recruitment and recognition.



Tony Picollo, then Minister for Disabilities and Nat Cook MP, with Maurice Corcoran, staff and Volunteers from the Community Visitor Scheme celebrating morning tea on International Day of People with a Disability

4. Strategic Partnerships

4.1 Minister for Mental Health and Substance Abuse

In accordance with Part 8, Division 2 of the Act, the PCV is required to report to the Minister for Mental Health and Substance Abuse on the functions of the Community Visitors. The PCV has met with the Parliamentary Secretary for Health, Leesa Vlahos on a three monthly basis during 2015 and in January 2016, Ms Vlahos was appointed Minister for Mental Health and Substance Abuse and Minister for Disabilities. These three-monthly meetings have enabled the PCV to discuss issues of concern, provide regular updates on key matters, and discuss reports and observations by Community Visitors. The PCV has also communicated to the Minister's office between meetings when and if issues or concerns arise.

4.2 SA Health Chief Executive

The PCV has met with the SA Health Chief Executive on a three monthly basis during the 2015-16 reporting period. This has proven to be a valuable opportunity to discuss issues of concern or highlights from visits. The Chief Executive and Deputy Chief Executive, System Performance have both been very supportive and have been able to facilitate solutions and agreements at times when there appeared to be encumbrances.

4.3 Chief Psychiatrist

Throughout the year the PCV has met with the Chief Psychiatrist on a bi-monthly basis. This has been important to discuss issues of concern or highlights from visits but also to seek advice about strategies to address some of the issues that the PCV wants to pursue. The Act identifies the Chief Psychiatrist as a key person to refer matters of concern to and in this context, the PCV has often referred matters of significant clinical importance to the Chief Psychiatrist.

4.4 Director Mental Health Strategy

The PCV has sought advice from Professor Tarun Bastiampillai, Director, Mental Health Strategy, Department for Health and this has been in relation to data trends or clarification on data and whether it is consistent with anecdotal information the CVS receives.

4.5 Mental Health Directors within each of the Local Health Networks

The CVS Mental Health Coordinator provides a copy of the visit reports to Mental Health Executive Directors outlining the issues raised and recommended action. This opportunity is also taken to highlight good practice occurring within units. A summary of this correspondence is also provided to unit staff for their information. Regular reporting has improved the relationship between the CVS and staff/management resulting in the prompt resolution of issues.

4.6 Staff of Approved Treatment Centres and Emergency Departments

Many of the staff in approved treatment centres and Emergency Departments (EDs) have assisted and engaged in a helpful manner when Community Visitors are conducting visits and inspections. Some staff have ensured patients are aware of their right to access the Scheme and supported them to share their issues with Community Visitors. The CVS would like to acknowledge this very important contribution that greatly assists Community Visitors to carry out their role.

4.7 The Community Visitor Scheme Advisory Committee

The CVS Advisory Committee was established in September 2011, to provide strategic advice and support to the PCV. In late 2013, the Committee was expanded to include representation from the disability sector in accordance with the CVS expansion into Disability Accommodation and Supported Residential Facilities.

The CVS Advisory Committee meets bi-monthly and provides an opportunity for vigorous discussion which regularly involves recommendations on how best to resolve issues. This may include assistance determining priorities, suggestions on who to refer the matter to and identifying areas for further research.

The Terms of Reference for the Advisory Committee are available on the CVS webpage www.sa.gov.au/cvs

4. STRATEGIC PARTNERSHIPS

4.8 The Public Advocate and Health and Community Services Complaints Commissioner

Given the legislative requirement for the referral of matters of concern to appropriate people or bodies, the CVS have jointly developed Memorandum of Understanding with the Health and Community Services Complaints Commission, and the Office of the Public Advocate. These Agreements provide the framework for communication between the statutory officers and a process for referring matters or patients to respective agencies. The PCV would like to acknowledge and thank the Public Advocate and the Health and Community Services Complaints Commissioner for their ongoing collaboration and support.

4.9 The Equal Opportunity Commissioner

There has been a number of occasions during this past year where the PCV has needed to consult with the South Australian Equal Opportunity Commissioner and refer matters for follow up. The Commissioner has ensured that these matters have received appropriate consideration and action where necessary.

5. Functions of the Community Visitor Scheme

The Community Visitor Scheme (CVS) is an independent statutory body, reporting to the Minister for Mental Health and Substance Abuse on matters related to the Scheme's functions under the *Mental Health Act, 2009* and to the Minister for Disability 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 facility or a Supported Residential Facility (SRF).

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

5.1 Community Visitor Functions

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 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 has the following additional functions:

- » To oversee and coordinate the performance of the Community Visitors functions;
- » To advise and assist other Community Visitors in the performance of their functions, including the reference of matter of concern to the Minister, the Chief Psychiatrist or any other appropriate person or body;
- » To report to the Minister, as directed by the Minister, about the performance of the Community Visitors functions; and
- » Any other functions that may be assigned to the PCV by the *Mental Health Act, 2009* or any other Act.

5.2 Monthly Visits and Inspections

The Act mandates each approved Treatment Centre will have a visit and inspection by two or more Community Visitors once a month. There are 12 facilities within South Australia that are gazetted as approved Treatment Centres for the purposes of administering the Act. They are:

- | | |
|-------------------------------|------------------------------------|
| » Adelaide Clinic | » Noarlunga Health Services |
| » 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. |

5. FUNCTIONS OF THE COMMUNITY VISITOR SCHEME

The Act provides for a new classification of treatment centre known as limited treatment centres or Integrated Mental Health Units. The Integrated Mental Health Units will be visited and inspected by Community Visitors and have been gazetted to the following centres:

- » Whyalla Hospital and Health Service (opened April 2014 and visits commenced July 2014);
- » Riverland Regional Health Service (opened June 2014 and visits commenced September 2014);
- » Mount Gambier and Districts Health Service (opened July 2015 and visits commenced August 2015); and
- » Port Lincoln Health Service (under development).

Community Visitors inspect all areas of the Treatment Centres used to provide treatment, care and rehabilitation to people experiencing mental illness.



'Personal Power-What's in my Hands'

Mixed media work on canvas by art therapy group participants. This image expresses aspects of values, interests & aspirations which give meaning & hope. It shows that even when choices are limited at times, we can still recall the power that is in our own hands & try to do the things which nourish this.

5. FUNCTIONS OF THE COMMUNITY VISITOR SCHEME

Treatment Centres may have a number of units within them as seen in Figure 5.2.1

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 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 – formerly Ward C3, Royal Adelaide Hospital
James Nash House	Birdwood Aldgate Clare Ken O'Brien Centre – formerly Grove Closed, Glenside Campus
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 Makk McLeay
Repatriation General Hospital	Ward 18 Ward 17
Royal Adelaide Hospital	Psychiatric Extended Care Unit (PECU) Emergency Department
The Queen Elizabeth Hospital	Cramond Clinic and NE2A Emergency Department 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

Figure 5.2.1 – Break down of units visited by Community Visitors.

5. FUNCTIONS OF THE COMMUNITY VISITOR SCHEME

5.3 Advocacy

5.3.1 Individual Advocacy

On a daily basis, the CVS provides information regarding patient rights and supports individuals via phone and in-person. In addition, the Principal Community Visitor (PCV) responds to individual advocacy requests as per examples provided below. Note: The CVS is not a complaints resolution body or investigation unit and will refer individuals to other agencies and support them through formal complaints processes as needed.

It would be negligent of me if I did not acknowledge and express concern about the length of time it has taken to get investigation reports back from both CALHN and NALHN. In two individual complaints the CVS referred which related to serious allegations of physical and chemical restraints, it has been over three months and the CVS have still not received the reports/responses into these investigations.

This has not only been frustrating for the CVS but also the individuals and the family that the complaints have been made by. In particular, the widow of a man who was a patient in a mental health unit who is simply wanting resolution of the issues that she was brave enough to raise with us. These delays and allegations have also been raised with the Chief Psychiatrist but we are yet to receive the investigation reports.

The CVS holds significant concerns regarding Oakden Services for Older People which has arisen from both visit reports and a range of individual investigations that have been undertaken as a result of specific complaints that we have made on behalf of individuals and families. The CVS has a strong working relationship with the senior leaders and managers of Oakden Services for Older People, and commends the dedication these staff have to care for acutely unwell older people transferred from other acute mental health units. Yet for reasons unknown, Oakden is classified as 'sub-acute' and therefore attracts less funding than the other older persons acute units.

Staff at Oakden have explained they receive the most challenging clients of the acute wards, yet the mental health unit has lost a number of Allied Health roles, particularly the Social Worker role who was responsible to secure appropriate accommodation for clients and the psychologist who has worked on behavioural plans. This has placed pressure on the leadership to take on additional responsibilities to fulfil what these Allied Health roles offered.

Community Visitors and the CVS office have received concerns from three families regarding the treatment and care of their loved ones at Oakden. These have included reported frequent falls, observed bruising, medication errors; increased sleepiness, drowsiness, and reported decline of daily functioning. It was also commented that there are not enough staff available on wards, and it has been reported that Oakden use 1 staff member to 4 client ratio, whereas acute units may use 1 staff member to 3 client ratio. Staff and senior leaders within this unit are highly dedicated and strive to do the best they can with the limited resources available.

Some examples of the advocacy done by the CVS office include:

- » A female patient disclosed to the Principal Community Visitor (PCV) at a requested visit she was sexually assaulted by another patient in a Psychiatric Intensive Care Unit. She reported when she disclosed this to her mental health nurse the evening before, the response she received was "what do you want us to do, keep the other patient locked away in seclusion?" The PCV immediately reported the matter to the Unit Manager and Chief Psychiatrist and requested the woman who was assaulted be moved to a 'safe place' outside of the unit and the assault and initial response be formally investigated. The woman was moved out later that day, police were informed and a formal investigation took place. The Chief Psychiatrist engaged the Health and Community Services Complaints Commissioner and together they conducted an investigation into the assault and initial response.
- » A mental health patient who also had autism and who was a patient in the Royal Adelaide hospital sought CVS advocacy when her registered assistance dog was taken away from her. The CVS assisted the patient with a formal complaint of disability discrimination under the *SA Equal Opportunity Act* against the Central Adelaide Local Health Network (CALHN). The complaint could not be conciliated and has been forwarded to the Equal Opportunity Tribunal.

5. FUNCTIONS OF THE COMMUNITY VISITOR SCHEME

- » A Social Worker contacted the CVS to report concerns about the involvement of a deaf client and their family in the client's treatment and care. The CVS met with the family who disclosed significant limitations regarding communication and the lack of involvement and understanding the client had about the treatment they were receiving. Later, the PCV met with the client along with an Auslan interpreter to explain to the client their rights and what information they could access regarding their treatment. It was noted that the client was not receiving ongoing access to an Auslan interpreter, did not understand what her treating medical team were discussing with her and as such, was largely not involved in her treatment. The CVS advocated that the client has access to an interpreter for all medical consultations and meetings. This resulted in an investigation and in addition to an apology, confirmation that the client would receive ongoing Auslan interpreter support during key discussions regarding their treatment and care, as well as activities within the Treatment Centre.
- » The CVS received a complaint from a consumer who was advised she was well enough to be moved to an open ward but had to remain in the closed ward due to a lack of bed availability in the open ward. The client said she felt scared as a lot of the clients were very unwell and she felt unsafe. As such, she was spending a lot of time in her room to keep safe. She also was concerned that the hospital psychologist had not come to meet with her nor had her private psychologist been consulted. The CVS facilitated contact between the client and her private psychologist, and also advised staff at the unit to consider allowing her access to the open ward until such time a bed in the open ward was available.
- » A consistent issue raised by staff at a mental health unit was that the Activities Coordinator role remained vacant for more than 18 months and this was affecting the consistent delivery of programs on offer to clients to keep them active, engaged and supported. Staff reported when they could, they would bring items to work to facilitate activities with the clients, but noticed something more consistent was required. This issue was consistently reported by Community Visitors on a monthly basis, and was discussed in a meeting between the CVS and senior management of that unit. As of the end of the 2015-2016 financial year, the Activities Coordinator role was advertised for this unit.
- » The CVS has assisted individuals and patient family members raise their concerns and make complaints about their treatment and care during an admission to a mental health unit. The CVS has assisted a number of individuals request investigations within mental health units and local health networks to have their complaints formally investigated in order for them to receive answers regarding the rationale behind their treatment.
- » Community Visitors met with the mother of a client who was upset about the progress of her adult child's mental health recovery in a mental health unit. The mother's first language was not English, and she told the Visitors she did not understand a lot when she attended medical appointments with her child. The Visitors asked the staff to organise an interpreter so the mother could be involved and understand her child's treatment and care. When the CVS office followed up on this, it was noted that this had not occurred nor had the mother been provided with a Statement of Rights in her first language. The CVS Coordinator collaborated with senior leadership to ensure this service was provided and also sent a copy of the Statement of Rights to the mother in her first language.
- » Community Visitors met with a patient who was upset about the prospect that her Involuntary Treatment Order (ITO) might be continued and believed the medical team were not listening to concerns and the personal story which resulted in the patient's admission. Community Visitors supported the patient during a meeting with the intern and consultant psychiatrists so that they felt supported to share their perspective and concerns with the psychiatrists. Although it was evident that the psychiatrist was fully aware of the client's personal and psychiatric history, the meeting resolved that the client and psychiatrists would review and change the Treatment and Care Plan, and it was also agreed that the client would be placed on a Community Treatment Order (CTO) should they agree to the psychiatrists' proposed medical plan. The patient felt they were listened to and decided they would agree to the medical plan, be placed on a CTO and later discharged. They appreciated the moral support provided by the Community Visitors to be involved in their treatment and made a decision that was best for them self.

5. FUNCTIONS OF THE COMMUNITY VISITOR SCHEME

5.3.2 Systematic Advocacy

The CVS is also involved in a level of systematic advocacy and during 2015-16, the CVS was particularly involved with:

- » **Length of Stay for Mental Health Patients in Emergency Departments (EDs):** The CVS continues to monitor the length of stay and provide support to patients/families affected by the delays. Since the introduction of Short Stay Units (SSU) within EDs, the CVS has commenced monitoring the length of stay in these units and the length of stay of clients in closed wards waiting for open ward beds. This is due to a priority for clients in EDs to be promptly moved to other units to adhere to the 24-hour policy (Refer to Section 6.2). This appears to have resulted in patients in closed units who are ready for transfer to an open ward, being delayed in their transfer due to ED patients being given a priority.
- » **Restrictive Practices:** Issues have been raised where staff and Community Visitors have observed forensic and Department for Correctional Services clients being shackled to beds for multiple days waiting for a secure bed to be available. The CVS has referred these cases to the South Australian Ombudsman for investigation, and have also discussed these cases with senior leaders in the relevant local health networks.

In addition, the CVS has received complaints from clients who have come into the mental health system via EDs and have reported they were restrained. This has included chemical and physical restraints. Clients in disclosing these complaints to Community Visitors, the Principal Community Visitor or the CVS Mental Health Coordinator, have reported staff have treated their disclosure with suspicion and disbelief. Some clients have wanted to formally action their complaint by lodging it with the Health and Community Services Complaints Commissioner, and reported staff at mental health units have not provided any assistance to the client to do so. The CVS has provided these individuals with assistance in lodging their complaints and seeking responses from senior managers at the relevant local health network where the incident occurred.

5.4 Disability and Supported Accommodation Facilities

Expansion of the South Australian CVS into Disability Accommodation and Supported Residential Facilities has provided opportunity to provide further protection and support to people with a mental illness or a dual disability living in a community setting. A description of this service can be found in the Principal Community Visitors Disability Annual Report 2015-16.

5.5 Policy, Strategy and Clinical Practice Development

A significant and important role the CVS plays is its contribution to Policy, Strategy and Clinical Practice Development 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:

- » Attorney General Department's Disability Justice Plan;
- » SA Mental Health Act Review;
- » Parliament of SA Social Development Committee Inquiry into Comorbidity;
- » The Review of South Australian Forensic Mental Health Services;
- » SA Transforming Health Strategy;
- » NDIS Quality Framework; and
- » Commonwealth Senate Community Affairs References Committee Inquiry into Violence, Abuse and Neglect Against People with Disability in Institutional and Residential Settings.

In addition, the CVS supports the implementation of the *Disability Justice Plan* led by the South Australian Attorney-General's Department. The Plan documents priority actions for South Australia to achieve by 2017, to provide people with disability with opportunity to be an equal partner in the criminal justice process. The Plan ensures that South Australia provides access to justice for people with disability and is aligned with the United Nations Convention on the Rights of Persons with Disabilities.

The Plan challenges the organisational culture of criminal justice agencies through offering professional development programs to the judiciary, police and other agencies. The Plan is delivering training programs to criminal justice professionals to develop their skills to appropriately engage and speak with people with disability about criminal matters. The intention of this program is to ensure that people with disability provide an accurate statement and eyewitness testimony about an offence in which they were involved. As such, it will ensure they are active participants involved in the justice process.



'Uplift'

Mixed media work on canvas by art therapy group participants which expresses movement and rising of energy again and the beauty which is there to see & experience every day.

6. Report Outcomes and Themes

6.1 Summary of Reporting Outcomes

Following all scheduled visits, Community Visitors (CVs) prepare written reports to the Principal Community Visitor (PCV). Information documented in these reports informs feedback to treatment centre staff, senior management and the Office of the Chief Psychiatrist.

Significant issues of concern or re-occurring concerns indicating a possible systemic issue, are escalated to the CVS Issues Register, which is tabled and discussed at every CVS Advisory Committee meeting. The Advisory Committee makes recommendations to the PCV about the appropriate actions and referrals to be undertaken.

Within the online reporting system, CVs now have the ability to identify who raised or commented about treatment and care in mental health treatment units. During 2015-2016 there were 737 individuals recorded by CVs who commented about some element of mental health treatment.

Furthermore, each report details issues of concern or positive comments. Comments are reviewed against a set of six themes to ensure consistent annual analysis of the current trends reported in treatment and care centres detailed in each Community Visitor Scheme Annual Report (see Appendix 2).

Table 6.1.1 details the annual number of issues or positive comments raised by patients, Community Visitors, treatment centre staff and patients' families each financial year from 2011-2012 until 2015-2016.

Table 6.1.1. Annual number of issues and positive comments raised by classification of person, 2011-2012 through 2015-2016.

	2011-12 Total	2012-13 Total	2013-14 Total	2014-15 Total	2015-16 Total	2015-16 (Issues)	2015-16 (Positive)
Patient	39	109	178	335	345	228	116
Community Visitor	37	84	197	328	352	155	197
Staff Member	68	227	130	162	316	185	131
Carer/Family/Other	2	0	5	5	12	10	3
TOTAL	146	420	510	830	1025	578	447

Table 6.1.1 Annual number of issues and positive comments raised by classification of person, 2011-2012 through 2015-2016.

Of the 1,025 reported comments during 2015-16, it is pleasing to note 447 (43.6%) were positive comments/reports which highlighted innovative and positive actions that have taken place in units, for which we have been able to commend staff/units.

Figure 6.1.1 presents an annual comparison of who made comments during scheduled visits. It is noted that approximately a third each of patients ($N = 345$, 33.7%), CVs ($N = 352$, 34.3%), and staff ($N = 316$, 30.8%) encountered during a visit commented about an issue or a positive action.

Figure 6.1.1. Comparison of annual percentages of comments made by person who reported from 2011-12 through 2015-16.

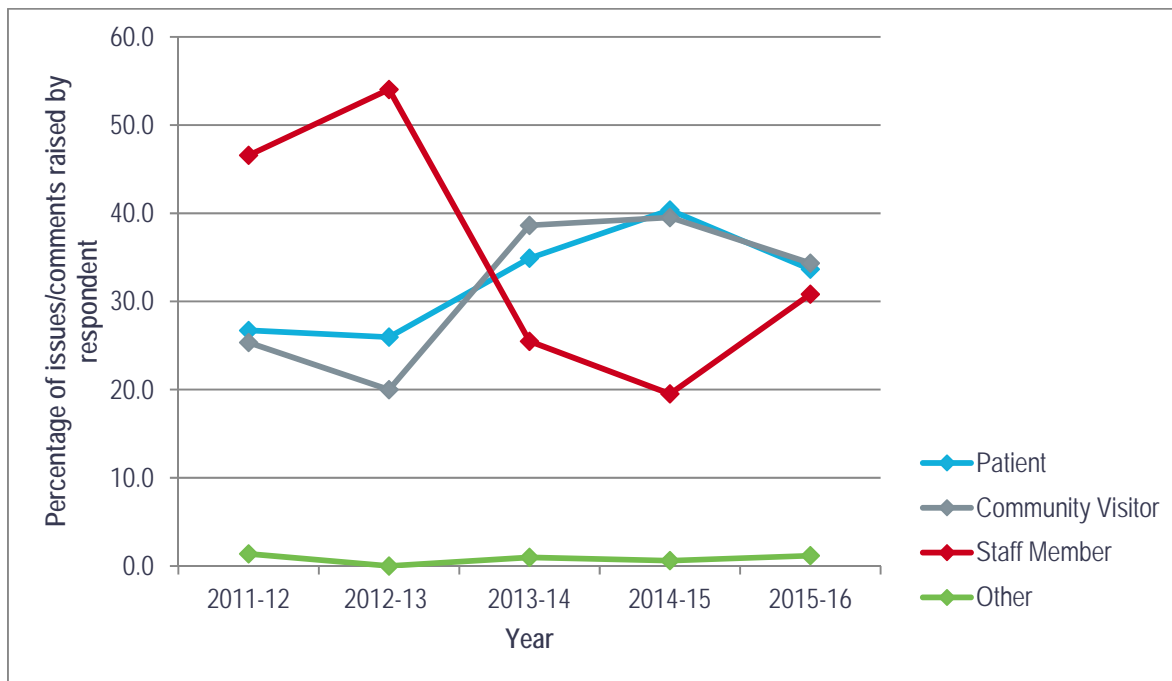


Figure 6.1.1. Comparison of annual percentages of comments made by person who reported from 2011-12 through 2015-16.

However, the number of issues raised by the respondent category 'Other' (carers/family members) continues to be considerably low. This may be due to the limited contact family members and carers might have with the CVS, as inspections occur on a monthly basis and family members/carers may not be present. While advising wards of the visit this may not be relayed onto family by the patient or the organisation.

As such, the CVS continues to work with Carer Consultants and other staff to ensure families and carers are aware of the CVS' role. The CVS also promotes the service by ensuring there are CVS posters in units. On a monthly basis, the Mental Health Coordinator distributes to each unit information about their monthly visit, and requests that posters detailing the date and time of the CVS' next visit are posted on public notice boards throughout the units.

6. REPORT OUTCOMES AND THEMES

6.1.1 Reporting Classification

Issues identified in written reports are assessed by staff within the CVS office and are classified against a two level issues classification scheme (see Appendix 2). Figure 6.1.2 presents that comparison of comments made by Level 1 Category annually for each reporting period.

Figure 6.1.2. Number of comments made each reporting period for each Level 1 Category.

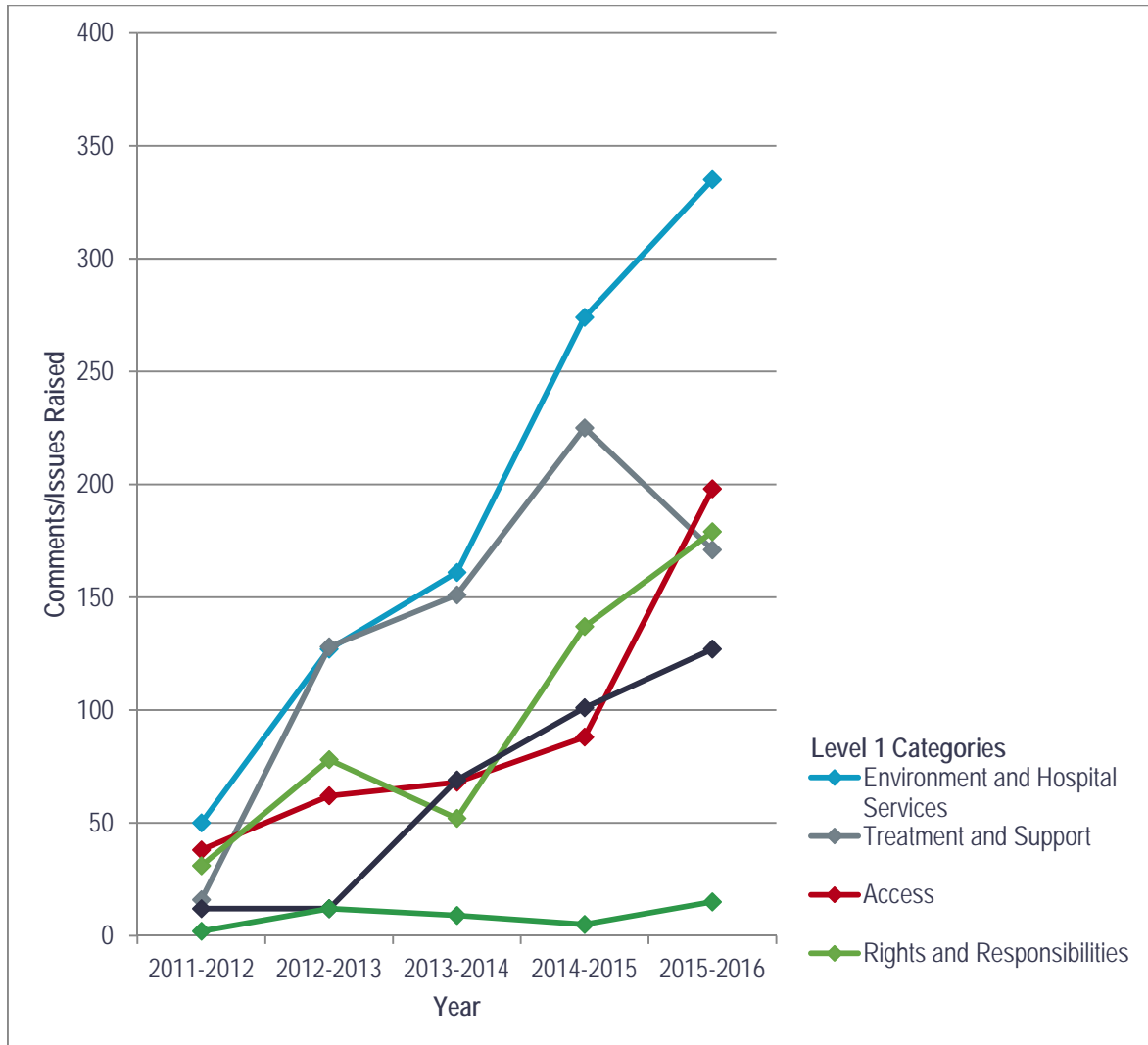


Figure 6.1.2. Number of comments made each reporting period for each Level 1 Category.

The most reported Level 1 Category continues to be Environment and Hospital Services of which, were 334 comments made (193 issues, 141 positive comments).

Figure 6.1.3 presents a detailed breakdown of commonly reported themes within this category. Both positive and negative proportions are reported. Consistent with previous years, food continues to be a strong topic, followed by maintenance of environment and suitable facilitates for activities.

Figure 6.1.3. Proportion of issues and positive comments for Environment and Hospital Services Level 2 Categories

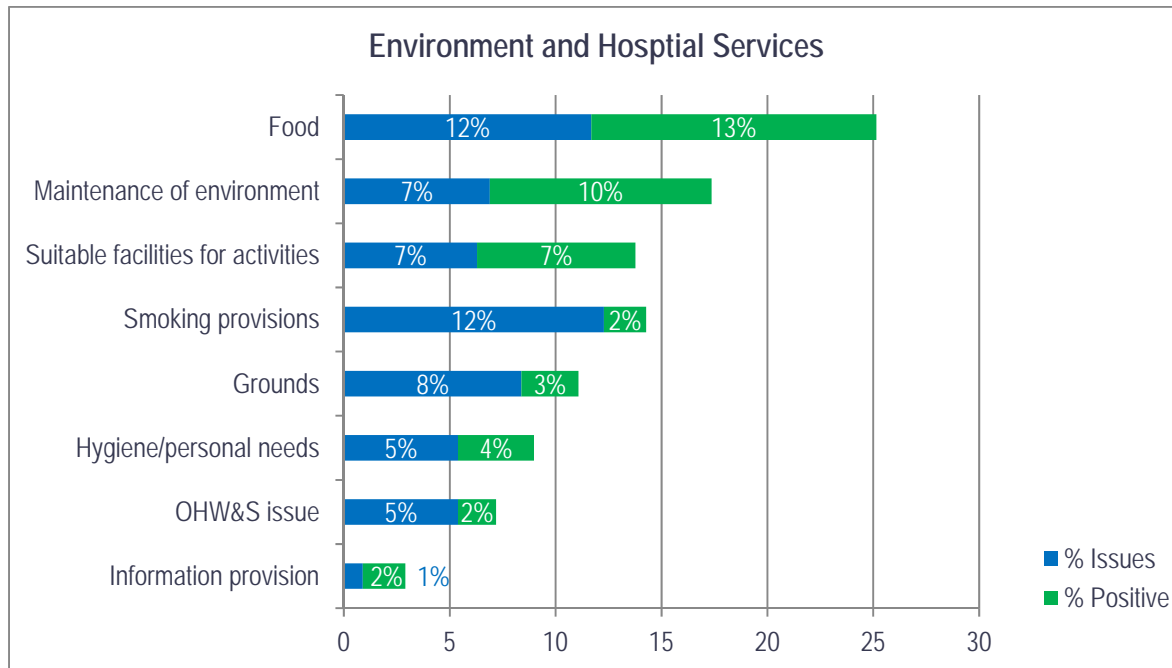


Figure 6.1.3. Proportion of issues and positive comments for Environment and Hospital Services level 2 categories

During 2014-2015, there were more issues raised (18%) regarding food than positive comments (5%). However, during the 2015-2016 financial year, there were slightly more positive comments (13%) than issues raised (12%) regarding Food. Improvements included more variety of healthy options available for clients, availability of vegetarian and vegan meals, and availability of healthy snacks.

Maintenance of Environment noted that the ambiance of units was welcoming and supportive for clients. Comments included staff demonstrating interest and investing time into patient recovery resulting in a sense of safety, support and warmth amongst clients. This was particularly noted for the Repatriation General Hospital Ward 17, where there is a strong comradery and national pride due to it being a veteran's unit. Negative comments within this area were particularly evident for busier units such as Emergency Departments (EDs) that have noisy environments and tend to be a hub of activity.

There were slightly more positive comments (8%) made regarding suitable facilities for activities than issues (7%), with clients noting Access to Recreational Facilities (e.g., snooker tables, walking groups, PlayStation consoles), and there was clear notification within units about the availability of daily activities. Negative comments within this area concerned lack of Access to Activities as staff are not skilled to supervise gym activities, or the activities were not interesting to clients within the unit.

Issues relating to smoking provisions continues to be one of the most reported issues, particularly amongst patients in closed wards with limited or no access to smoking provisions. In some treatment centres, clients in closed wards can smell cigarette smoke from clients in the open wards, which increased their frustration. There have also been concerns raised by staff and consumers regarding the location of smoking areas in some facilities. In some units, smoking areas are located off-site and there are concerns amongst staff and clients that this affects personal safety. Further discussion of this matter is reported in sections 6.5 and 6.7.

6. REPORT OUTCOMES AND THEMES

Comments reported under **Treatment and Support** were mostly relating to *Lack of activities and structured programs* as seen below in Figure 6.1.4

Figure 6.1.4. Proportion of issues and positive comments for Treatment and Support Level 2 Categories

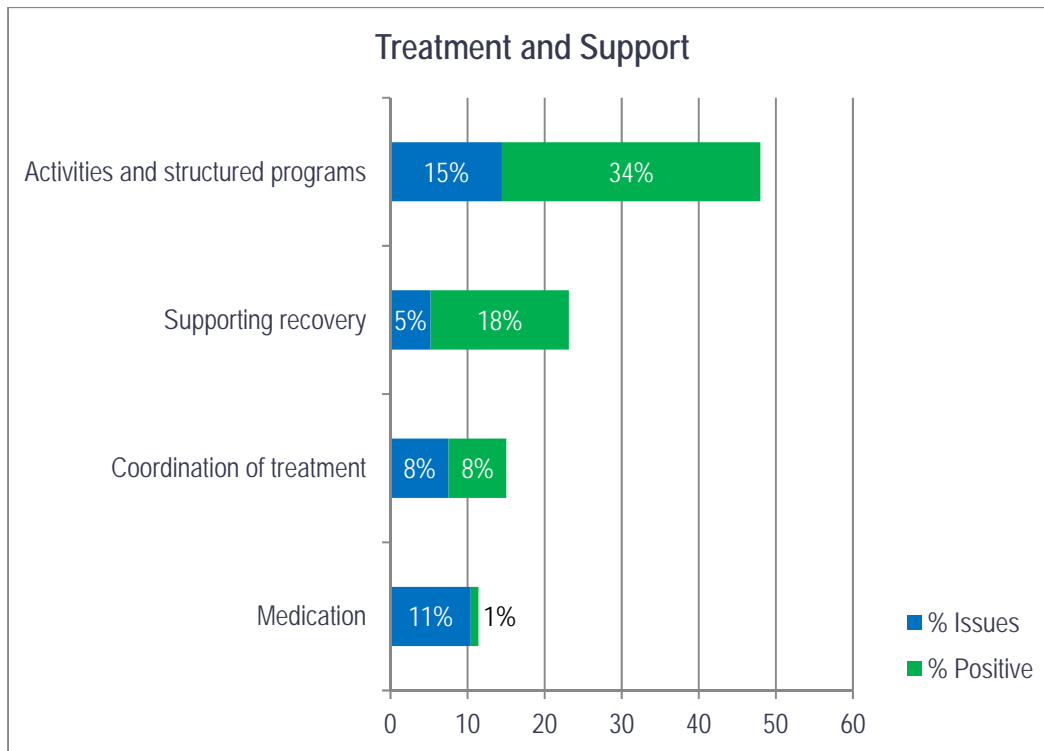


Figure 6.1.4. Proportion of issues and positive comments for Treatment and Support Level 2 Categories

There were 169 comments made regarding *Treatment and Support*, of which 66 were issues 103 were positive comments. *Activities and Structured Programs* are closely linked with *Access: Services*, and *Environment and Hospital Services: Suitable Facilities for Activities*. These additional factors relate to the activities and stimulation offered within treatment centres and explains the variation across Treatment Centres where there are various programs available, while in others patients are repeatedly reporting boredom (See Section 6.6).

Access was the next most reported category of comments (198 comments), of which the majority of comments were issues (144 issues, 54 positive comments). Figure 6.1.5 presents this category in more detail.

Figure 6.1.5. Proportion of issues and positive comments for Access Level 2 Categories

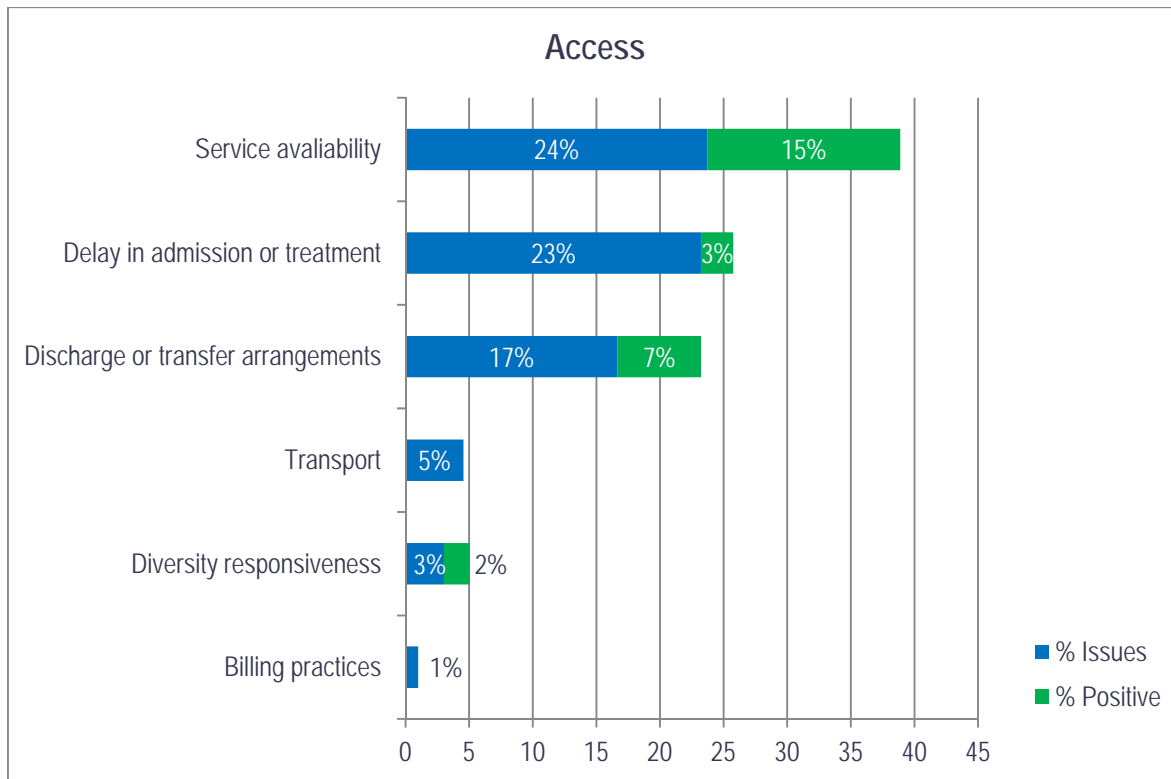


Figure 6.1.5. Proportion of issues and positive comments for Access Level 2 Categories

Comments regarding *Service Availability* related to the lack or limited accessibility to Allied Health services within mental health units, as well as the decline in Activities Coordinators. It is also important to be aware that the reduction of Activities Coordinators was also related to comments concerning a lack of *Activities and Structured Programs* from the *Treatment and Support* category.

Delay in Admission and Treatment was associated to longer time spent in Short Stay Units (SSUs) which have been established to provide a temporary bed for clients coming through the Emergency Departments. To ensure clients are moved within the 24-hour time period, many clients are sent to the SSUs where they can wait days to be admitted to a ward. Furthermore, there are clients spending longer in closed wards, as beds in open wards can be prioritised for patients promptly admitted from an ED. (See Section 6.2).

Discharge or Transfer Arrangements were impacted by a lack of appropriate accommodation options to discharge to, especially for people who are homeless.

6. REPORT OUTCOMES AND THEMES

There were 181 comments (114 issues and 67 positive comments) regarding **Rights and Responsibilities**. The majority of issues made were regarding *Least Restrictive Environment*, *Consumer Involvement in Treatment and Care Planning*, *Consumer Involvement in Treatment and Care Planning* and *Legal Rights* as seen below in Figure 6.1.7.

Figure 6.1.7. Proportion of issues and positive comments for Rights and Responsibilities Level 2 Categories



Figure 6.1.7. Proportion of issues and positive comments for Rights and Responsibilities Level 2 Categories

Least Restrictive Environment primarily relates to patient reports where they did not feel they were being treated in the least restrictive environment or were observed to have been restrained. In such instances, Community Visitors provided information to patients on how they could appeal their treatment orders to ensure they knew their *Legal Rights*.

Consumer Involvement in Treatment and Care Planning details feedback provided by clients and their carers regarding staff motivation and action to ensure that clients are involved in the development of their Treatment and Care Plans (See Section 6.3).

Comments relating to **Communication** were primarily positive comments (78 positive comments, 48 issues raised) as seen below in Figure 6.1.8

Figure 6.1.8. Proportion of issues and positive comments for Communication Level 2 Categories

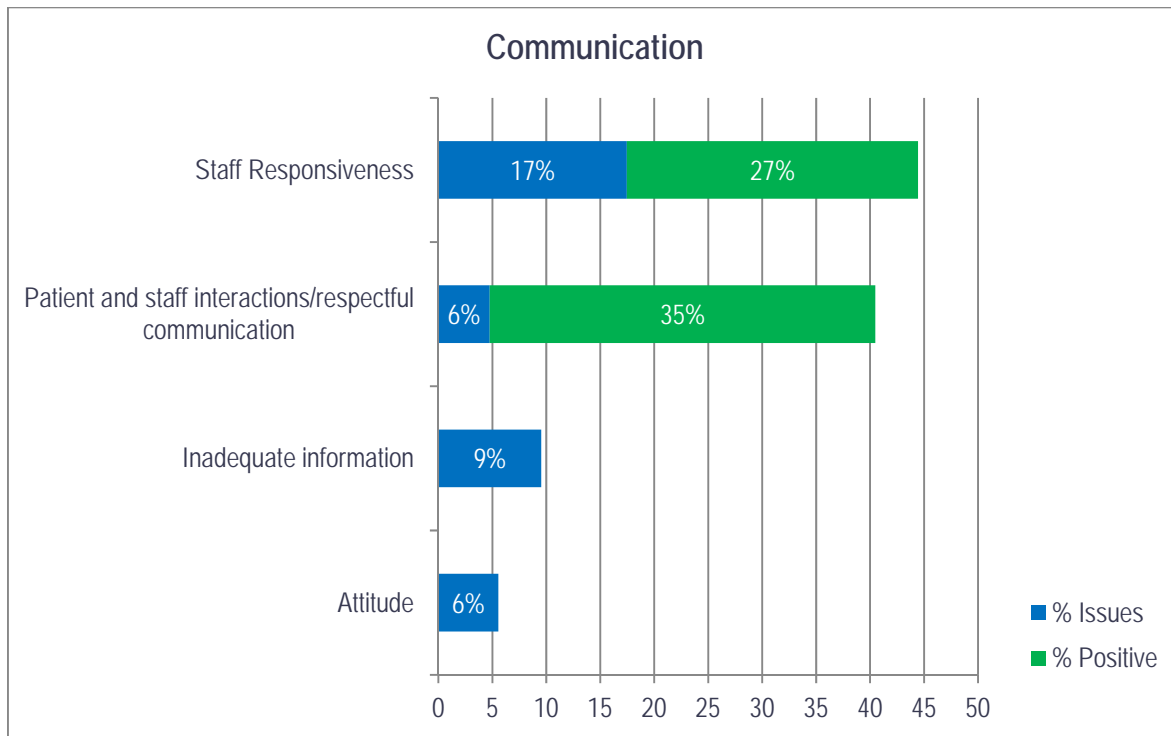


Figure 6.1.8. Proportion of issues and positive comments for Communication Level 2 Categories

Patient and Staff Interactions/Respectful Communication and *Staff Responsiveness* were the most positively commented elements of this category. It is important to note that issues raised by clients regarding staff responsiveness were related to *Inadequate Information* because clients reported they did not understand elements of their Medication and Treatment Plan. Of concern from the visits conducted this year, was the increase in reported comments from staff and clients regarding an *Attitude* in some locations. It was reported to the CVs that staff outside of mental health units openly displayed unsupportive attitudes regarding mental health clients.

The next section provides a detailed discussion of the identified trends that occurred during the 2015-2016 monthly visits and inspections to mental health units, and will cover the following topics:

- » Access to Services;
- » Treatment and Care Plans;
- » Forensic Care;
- » Personal Safety;
- » Activities and Stimulation in Treatment Centres;
- » Smoking;
- » Menu Options;
- » Evidence of Good Practices Occurring within Units; and
- » Comparison of the Identified Trends and Issues with other Jurisdictions.

6. REPORT OUTCOMES AND THEMES

6.2. Access to Services

6.2.1 Emergency Department Waiting Time

The previous Minister for Mental Health, The Hon Jack Snelling, set a target that by January 2016, no mental health consumer should wait in EDs more than 24 hours for admission to an acute hospital bed and by July 2018, 75 percent of mental health consumers should be admitted within four hours, and 90 percent within eight hours.

During the last 12 months, there has been an improvement of the number of instances where a mental health client has been left waiting for a bed in the Emergency Department for over 24 hours. However, the CVS has been alerted to situations where clients have been waiting for longer than 24 hours, or days in EDs. The introduction of Psychiatric Extended Care Units (PECUs) and Short Stay Units (SSUs) were implemented to move mental health patients from the busy and noisy EDs to a calmer environment provided by the SSUs. Community Visitors include visits to SSUs during their monthly inspections to the following Treatment Centres: Flinders Medical Centre (8 beds in SSU), Lyell McEwin Hospital (8 beds in SSU) and the Royal Adelaide Hospital (8-10 beds). There is also a PECU at the Royal Adelaide Hospital that CVs noted has 5 beds available. The reported benefits of these units has been the establishment of a less restrictive environment, evident in the following report except:

CVs visited C3 which has been in operation as an 8-10 bed short stay ward for approximately 2 months. CVs spoke to a staff member in C3. Based on the information provided by him, they have introduced new guidelines at C3 that use least restrictive practice, allowing visitors to meet patients and allowing patients to move within premises and freedom to go outside for fresh air or to smoke. In the past month at C3, the average and maximum length of stay is around 4 and 10 days respectively. Out of 8 rooms available at C3, 7 rooms are open for patients while one is used as Sensory Modulation Room which the OT is currently setting up. A peer specialist is anticipated to start work there soon.

Despite the intention and intended benefits of these units, the CVS has been made aware of patient and staff concerns regarding the environment of these units. Concerns raised included: sharing the SSU space with a surgical unit; limited activities for clients; limited client access to Allied Health Services to commence their journey to wellness. The following report extract illustrates the concerns raised:

SSU is currently very busy as the surgical ward had shifted and is sharing half of the ward. Staff had to share their workstation also. There is a big screen which is constantly beeping from the surgery area calls. There is a lot of noise, and people are always on the go as is expected in a surgical ward, with a fair number of visitors. Calm and quiet atmosphere of the SSU was missing, whereas it was the priority of the SSU to provide a peaceful environment to the consumer for having rest and to settle down. Visitors were also concerned that privacy is also compromised and stigma relating to mental health consumers is also reflected on the interactions.

An additional issue reported by staff to the CVS is clients placed in SSUs are often moved too quickly into open wards in order for the ED to adhere to the 24-hour policy. Staff consider these patients are not ready to cope with open ward environments, and thus have been noted to be placed back into closed units. The concerns and reported implications have been documented in reports and evident in the following excerpts:

Staff in ED and PECU expressed concerns regarding patients being moved out of PECU to open wards too quickly so patients presenting in ED are moved into PECU within the 24-hour timeframe.

Comments expressed by ED staff and PECU staff were the push to not exceed the 24 hour ED time limit is putting patients at risk. Patients are being moved out of PECU to the open ward before they are ready, and most of them end up back in there.

There were 10 patients in PECU on the day of visit and the common area was so busy and noisy. Patients were bored, arguing...The environment was overstimulating and busy. Other than their room for quiet space there is nowhere else for them to go. There is not enough tables and chairs for 10 patients. There is barely enough for 8.

The push to not exceed the 24 hour ED time limit is putting patients at risk. Patients are being moved out of PECU to the open ward before they are ready, and most of them end up back in there. This has been to get the ED patient into the closed ward before the end of the 24-hour period. On this day the open ward doors were locked. As a patient from PECU was in open ward to make room, they had a security guard in place...Having the door locked increased work for staff.

An additional issue has been the increased time patients in closed wards are waiting for a bed to be available in an open ward. The CVS has assisted clients assessed as well enough to be moved into an open ward but are waiting for an available bed. Thus, these patients are left in the more restrictive environment of the closed ward, which increases their frustration. The CVS has assisted these patients by recommending to staff that they be located in the open ward during the day and return to the closed ward during the evening.

The maximum of 24 hours in ED Bed Flow Policy, while having a positive impact in ED, is creating issues downstream. Patients from ED are given priority to beds in Morier open over patients who are ready to transition from Morier Closed to Morier Open to continue their progression towards discharge. This has resulted in a number of patients being held in Morier Closed for extended periods resulting in them being held in a more restrictive environment than is required.

6.2.2 Least Restrictive Environment

We are also aware that there seems to be a correlation between stays in SSUs and the increased likelihood of patients being restrained either physically or chemically. Clients have made CVs and the CVS office aware of reported chemical restriction during hospital stays, and the clients who experienced such procedures were upset by their treatment and in some instances, reported that this experience traumatised them. In addition to this, the CVS has received complaints regarding the use of physical restraints on clients and the use of security to staff to monitor them in EDs and PECU units.

Clients have commented on feeling like they are being treated as dangerous when they have security guards sitting at the end of their beds or just outside their rooms or ED cubicle. This practice appears to occur without individual risk assessments. CVs have observed security guards at the end of beds that are occupied by mental health patients that are so heavily sedated that they cannot stay awake. This seems to be overly risk averse at times and some would argue promotes the myth and stigma that all mental health patients are dangerous. There are also complaints from clients when wards have more restrictive practices or the ward experiences a temporary closed situation in order to manage the behaviour of other clients.

At the time of our visit, the situation in the unit was challenging. There was a risk of one consumer absconding - which she actually did towards the end of our visit. There were some consumers upset that doors were locked because of this risk - and other consumers who were nervous of the doors being opened because of a perceived risk of someone dangerous entering. There had been a code black incident the day before, where a consumer had harmed himself...This incident, witnessed by at least one other consumer, had caused a high level of agitation.

The work of the ED department, by definition, has a priority of giving lifesaving interventions, rather than holistic care. The CVS Visitors were confronted and upset at seeing the degree of distress that one young mental health patient was experiencing. She was waiting for a bed to become vacant in a closed unit. In the meantime, she was held in a sparse room, with a gurney in it. There was a bright overhead light, no fresh air and a security guard outside the door. She was desperate for a cigarette and at one point tried to abscond.

A female client was shackled to her bed at ED...her wrists ended up with bruises. At ED she was in a secluded room with medical equipment connections, and shackled to her bed to avoid self-harm. She was also heavily sedated...and there is not a safe quiet room for them to be safe and avoid to be shackled.

The reduction and, where possible, elimination of seclusion and restraint is a key national safety priority outlined in the *National Safety Priorities in Mental Health: A National Plan for Reducing Harm, 2005* and *National Standards for Mental Health Services, 2010*. The *Mental Health Act, 2009* and the *South Australian Mental Health and Wellbeing Policy (2010-15)* require that care and treatment be provided in the least restrictive way within the least restrictive environment. The Act also mandates the Chief Psychiatrist to monitor all incidences of restraint and seclusion.

The CVS has continued to monitor the policy and practice response from the Department of Correctional Services (DCS) to the Ombudsman's Report (as per the 2012-13, 2013-14, and 2014-2015 PCV Annual Report recommendations). During this reporting period, the PCV has referred shackling and restraining cases of DCS clients to the Ombudsman who has commenced an investigation.

A further restrictive practice that the CVS continues to be made aware of through clients and senior staff is the non-smoking policy and its impact in EDs, PECUs, SSUs and closed ward patients. A significant complaint amongst patients who contact the CVS in these settings is there are no opportunities to have a cigarette. Although many report they are offered nicotine replacement therapy patches and inhalers to help reduce their cravings, clients report this is not enough with many wishing that they could see the sky or have access to open air. It has been further observed that clients have been punished due to issues relating to access to smoking.

6. REPORT OUTCOMES AND THEMES

Smoking was raised again in the Closed Unit. Visitation rights were stopped for all visitors to Closed Unit due to tobacco and lighters being smuggled in. Patients were quite agitated by this decision and CVs were advised not to enter Closed Unit for this reason.

No smoking is a subject of conflict when consumers are in the closed area or under ITO, there is not enough time for staff to take them out if they demand to have a smoke.

CVs were presented with a petition from some patients asking that evening lock-up on Open Wards be later than the present 7pm. This is framed as a restrictive practice: patients are on Open Wards but cannot go out after 7pm - for a smoke, for some fresh air etc.

Section 6.7 provides further details and information regarding the impact of the SA Health no smoking policy for clients within mental health units.

6.2.3 Discharge and Accommodation Arrangements

Closely linked with the issue of access and service availability, is the difficulties with discharge and the lack of appropriate accommodation options to discharge to, especially for people who are homeless. The National Mental Health Commission's first report card developed ten recommendations and included *no one should be discharged from hospitals, custodial care, mental health or drug and alcohol related treatment services into homelessness, there must be increased access to stable and safe places to live*. However, it is not uncommon for patients to be staying in acute mental health beds for very long periods, as there are no suitable accommodation options for them to be discharged to. Unfortunately, when people become unwell prior to admission to EDs or acute units, their behaviours and interaction with other residents or staff at a SRF or another facility can result in an eviction.

Patients have also raised concerns regarding issues relating to finding suitable accommodation following discharge including concerns about previous and current living situations in shared or public housing, safety concerns around how they will be able to self-manage following their discharge. Clients have also told CVs about the lack of support they feel they have following discharge from mental health facilities, particularly to adhere to medication plans, attending appointments and maintaining their own self-care. The following excerpts from reports provide further details of these concerns.

Young male patient asked to speak to the CV as he is concerned about the lack of support for when patients are discharged back into the community. He believed that more could be provided to ensure that patients didn't fall into a heap and then become unwell very quickly. He said that just having someone coming around to check up on you every few days would be a good thing.

There appears to be a lack of support and follow up for consumers upon being discharged back into the community, hence a majority of consumers are re-admitted to mental health care and this becomes a regular cycle. One patient believes that there is no incentive to attend appointments and believes a financial penalty or part payment of benefits for non-attendance e.g. to DASSA would certainly encourage more clients to attend. Patient also advised CVs that he has a residence through Housing SA but is reluctant to return to the house since he had a violent home invasion two years ago and since that incident he has been staying at his mother's and friends' houses.

Staff also reported that they feel pressured to discharge clients at a point in their treatment when they are not particularly ready to be independent. Staff reported that this pressure has been the result of aiming to adhere to the 24-hour ED policy, so more beds are available in units outside of the ED and thus patients from EDs can be transferred into these beds.

Staff expressed their concern about the discharge policy that required a quick turnaround of patients to make beds available for 'other' patients. A comment was made that patients were being discharged when they were not yet capable of being 'functional' in the general community. This meant that the likelihood of their return to hospital was high.

Staff member said that things were very difficult at this time for staff on the Ward because of the 24-hour limit policy for EDs. She said patients were being pushed through and she felt that this meant that they were not really ready for discharge and potentially meant that this might result in re-hospitalisation for many clients. Also, the impact of no ICC beds for step-down patients would increase problems.

It is important to note that staff are feeling pressure to 'push' clients through the system, to ease bed block and satisfy statistical numbers. Staff feel that they are not able to perform their jobs properly, and provide the standard of patient care that they would like to. In many instances, clients have been discharged after a short period of time on medication which might take a longer time to monitor for the reaction and appropriate dosage for the client. This practice is not only affecting the client's, who will often then end up back in the ward again, it is causing stress for the staff who have a duty of care to uphold.

The PCV made contact with the Director of Mental Health Strategy, Professor Tarun Bastiampillai to clarify whether their data provided evidence supporting such concerns. He was able to confirm that as of April 2016, there was no evidence to suggest a revolving door concerning discharge to readmission. It was noted that during the 2014-2015 financial year, the readmission rate was 9.5% - between July 2015 and January 2016, the rate was 10% which represented an increase of just 0.5%. The KPI target is <12% readmission rate.

6.2.4 Service Availability and Diversity of Responsiveness

Also linked with the issue of access to services, is the response to cultural needs of patients. This was raised with CVs on a number of occasions, especially for Aboriginal people. It is an essential part of an individual's recovery journey that their cultural needs are acknowledged and met.

Aboriginal consumers should have ready access to appropriate Indigenous support workers, without being made to feel any shame. Where the treating team is aware of trauma, as described in all major Government reviews and reports on Aboriginal health and wellbeing, consumers should be invited to request appropriate Indigenous Allied Health support. If members of the treating team are unaware of the relevant issues, training in cultural competency should be offered. The CVS is aware that some staff members are cynical about the existence of any particular needs that Aboriginal patients might have. Given the disproportionate numbers of Indigenous patients in forensic care, it is an important issue to address and monitor.

Of further note are comments staff have made regarding the lack of Allied Health specialists available for clients, as well as the lack of other supporting roles such as Activities Coordinators. These roles provide further specialist care for recovery and most importantly offer services and engagement to clients during their time in treatment centres. Many clients complain of boredom, lack of interesting activities, or limited availability of activities and services to provide clients with meaning to their days. In some instances, the limited availability of specialist services means that clients are often left waiting until Allied Health personnel who work across several sites are rostered to attend their treatment centre. As a result, when there is an escalation of an individual's treatment needs they can be left waiting for specialised assistance.

Consumers agreed that the lack of activities or support therapy groups at the ward is a major issue, they get bored and do not feel supported through the recovering process.

There is still no Activity Coordinator, a position which has not been filled since this time last year. This is a significant issue, which directly affects consumers. Nurses have been trying their best to take clients for walks and participate in activities, which is difficult with their already high workload. Volunteers come in once a week.

We note how important the OT is for consumers and there are units where its availability is very limited. This is partly an equipment and materials issue - but also related to organisational issues in terms of staffing. Ideally, we would like to see OT included in the Treatment Plan of each consumer.

Concern was raised by a staff member of there only being a Social Worker for two days a week. The Social Worker is working excessive hours unpaid and two days is not enough to do everything required for acceptable levels of care for residents and families.

Overall, it has been noted that Allied Health services that are particularly focused on behavioural and cognitive treatment has been impacted by staffing cuts and budgets. Clients may not be receiving the various forms of counselling and clinical therapies that can be individually tailored to their specific needs to assist with their ongoing recovery. Clients and their families, as well as staff, are concerned that the decline in these services is not supporting long term recovery, as many clients are concerned about what difficulties they might face to independently monitor and manage their mental health after they are discharged.

6. REPORT OUTCOMES AND THEMES

6.2.5 Recommendations

1. That the Community Visitor Scheme continue to independently monitor the length of stays of mental health patients in Emergency Departments to ascertain whether there is improvement or otherwise.
2. That the Community Visitor Scheme continues to monitor the incidence of seclusion and restraints and least restrictive practices.
3. That the Community Visitor Scheme continues to monitor the policy and practice response from the Department of Correctional Services to the Ombudsman's Report.
4. That the Community Visitor Scheme continues to advocate for and monitor the service response to patients' cultural needs.
5. That the Community Visitor Scheme continues to monitor access to Allied Health Services and the availability of these roles within Mental Health Units.

6.3 Treatment and Care Plans

The 2014-15 CVS Mental Health Annual Report noted the creation and execution of Treatment and Care Plans required some improvement within mental health units. During the 2015-2016 financial year, the Community Visitor Scheme Advisory Committee recommended there be a focus on Treatment and Care Plans. The purpose of this focus was to understand how many Plans were in place and if they were developed in accordance with the National Standards, Clinical Guidelines and the South Australian *Mental Health Act 2009*.

6.3.1 National Standards and the Mental Health Act, 2009

The purpose and use of Treatment and Care Plans in mental health treatment centres is prescribed by the *National Mental Health Service Standards (2010)*, Clinical Guide Code of Practice and the South Australian *Mental Health Act, 2009* (the Act). These three documents determine who requires a Treatment and Care Plan, how they should be developed and managed.

The National Mental Health Standards stipulate how treatment centres are to review clients' treatment and care whenever they receive involuntary treatment or are removed from involuntary treatment; are transferred between service sites or are about to exit from a service. SA Health's *Clinicians Guide and Code of Practice* specifies it is best practice that a client's treatment and care should be governed by a comprehensive Treatment and Care Plan that is developed in a multi-disciplinary framework. It also stresses that Treatment and Care Plans are developed in consultation with the patient and their family or others that support them. Finally, *Clinicians Guide and Code of Practice* stipulates Treatment and Care Plans are either reviewed or commenced from the time a patient presents to care. The Clinicians Guide and Code of Practices also stipulates that all patients should have a Treatment and Care Plan.

These guidelines have developed to what is known as the *Mental Health Care Plan*, an electronic document that is kept on the Community Based Information System (CBIS) and is to be printed out as a hard copy for the patient to retain for their own records and information. The SA Mental Health Care Plan tool has been carefully developed to ensure that all issues that impact on mental health (not just medication and risk management) are addressed and is focused on recognising early warning signs, planning for relapse and ensuring a focus on strengths and goals. The aim of a consistent format was to assist services to ensure they are operating from a recovery oriented service provisional framework.

The Care Plan is an opportunity for the service and the patient to work in partnership and set goals for the future that may be empowering. The *Mental Health Act, 2009* states *the Care Plan must, as far as practicable, be prepared and revised in consultation with the patient and any guardian, medical agent, relative, carer or friend of the patient who is providing support to the patient under this Act*.

The Community Visitor Scheme believes that Treatment and Care Plans are an important document that all treating teams should be referring to, no matter where they are in their treatment journey. Staff in emergency departments, closed units, open units and in the community should all be referring to such plans.

Any treating team should benefit from referring to the patient's Care and Treatment Plan because if it has been completed as it should be, it will have vital information such as:

- » 'Advanced directives' as determined by the patient;
- » Who is involved in the patient's treatment and care;
- » Things the patient would and would not like to happen if they become unwell;
- » Who they would like contacted when they become unwell; and
- » Medication information including benefits and side effects.

However, there continues to be evidence that the development and monitoring of these plans is inconsistent across treatment centres in South Australia, as clients, their families and carers continue to report lack of involvement in the development of their treatment, and also limited knowledge and understanding of the treatment they are receiving.

Upon leaving the facility, the CVs encountered a male consumer and his mother in a seating area. The mother was visibly distressed, Visitors approached the mother and learnt that she was confused and frustrated that her son had been in Rural and Remote for over 2 months. The woman was from a CALD background, therefore communication was more difficult. The woman travelled from her home in a country location almost daily to bring food for her son, and is heavily involved with his care and support. Visitors queried with a Social Worker, as to why an interpreter had not been offered to the woman, and were assured that this service would be made available to her.

6. REPORT OUTCOMES AND THEMES

CVs spoke with one male voluntary patient who stated that he did not have a Care and Treatment Plan and was not offered same. When the matter was referred to staff they produced a single page hard copy of an email that contained five points for his treatment and a blank Mental Health Care Plan for him to fill out his relevant sections if he desired to do so.

Two patients were unsure what a 'Care Plan' was when asked if they had been involved in theirs.

6.3.2 Treatment and Care Plan Focus Project

Findings from the Treatment and Care Plan Focus Project identified that there are variations across treatment centres regarding the development, review and implementation of Plans. In many EDs and acute wards, the development of Treatment and Care Plans were not a priority as the focus is to stabilise the client in order to relocate them to a ward to progress their treatment. In some instances, staff reported that they might check if the client has an existing Treatment and Care Plan in the system and will update the existing plan to document the patient presented to the ED. However, within EDs and many acute units there was limited evidence that a Treatment and Care Plan was commenced. Staff attributed this due to the instability of client's moods, thoughts and behaviours, although it was evident that staff knew that the implementation of these plans was a priority.

CVs found that the construction and use of Treatment and Care Plans is at best inconsistent ...Conversations with staff and consumers confirmed this view. One staff member said that if you get a refusal from a consumer to help complete the Plan then it generally not done. Another said that they had received no training or information about their construction and use during treatment.

We were concerned that there did not appear to be Treatment and Care Plans that the nurses were aware of, or worked from, for individual consumers. This concern also raises questions about whether relevant activities and therapeutic interactions are standard practice.

Even though it was a mandatory requirement and on the admission checklist for admissions, that their [Treatment and Care Plans] use was inconsistent and generally completed and monitored when, and if, the consumers cooperatively engaged in their completion.

It should be noted that technology issues were reported as a barrier for storing and accessing Treatment and Care Plans. Not all treatment centres in South Australia use the CBIS system or have access to edit records on CBIS. It was noted that some rural hospitals reported they have read only access to CBIS. It was reported that there are some treatment centres who, due to the demographics of their clients, do not have access to place Treatment and Care Plans on the CBIS system. Therefore, the Treatment and Care Plan would not be accessible electronically for staff outside those units (e.g., Statewide Eating Disorders System, Veterans Affairs, and OACIS in the Women's and Children's Hospital).

Weekends were reported to be the best time to develop Treatment and Care Plans with clients as there is less activity on the ward and more time for staff to overcome barriers. Reported barriers are overcoming the attitudes amongst patients about the usefulness of the Plans, working with patients' unstable behaviours and moods, and the lack of time to convince clients of the Plan's importance. Staff also reported that it takes a lot of time to develop a Plan because the template asks questions that can be overwhelming for clients.

Further encouragement in mental health units is required to promote the implementation of Treatment and Care Plans, and also offer supportive activities to ensure that clients achieve recovery goals to facilitate their reintegration into the community. Guidelines published by the Australian Institute of Family Studies¹² argues the most ideal recovery of a client occurs in social contexts that include the family's understanding and acceptance of the client's current mental health.

The guidelines encourage mental health practitioners to consider the family context of the client from the time of assessment through to providing treatment. To maximise outcomes for clients, it is recommended that clinicians identify the family strengths and use these as motivators and tools for positive change, and facilitate discussion between the client and their family about their perspectives and experiences about living with mental illness.

12 Australian Institute of Family Studies (2016). *Child Family Community Australia Practice Resource: Supporting Recovery in Families Affected by Parental Mental Illness*. Commonwealth of Australia.

When the Wheels Fell Off

by Garth

*My billy cart got broken
On some gnarly twisted bend
So I called up ICC
My billy cart they will mend.*

*Yasmin booked it in
Ivan was the engineer
Deb painted it purple
And Wayne made it steer.*

*Michelle mapped its progress
Teian brought tin and wood
Privilege watched over it
And Mandy fixed the hood.*

*Now my billy cart is working
Better than before
Everything is tight
And bolted to the floor.*

*So now I can navigate
Those gnarly twisted bends
I race it on weekends
With my new found friends.*

*Races I am winning
Prizes I have won
The best part of the journey
Has only just begun.*

*She is a sturdy cart
But I want a faster one
With better ride and handling
For the homeward run.*

*So I went on riding
All about the town
Until I came across someone
Looking sad and down.*

*Their face was marked with pain
And their shoes were old with wear
They did not have a billy cart
And had to walk here and there.*

*So I came up with a solution
To this person's trials
I would give them my old billy cart
To help them with their miles.*

*So now I see them out riding
They're going really quick
Around gnarly turns and twisted bends
Their cart is fully SICC.*



Dedicated with gratitude to the staff and residents of the Southern Intermediate Care Centre (SICC), who walk with me when my cart is in the shop.

Thanks to Garth for his wonderful poem published in the October edition of the Lived Experience eNews newsletter – update from the Statewide Mental Health Lived Experience Register, SA Health

6. REPORT OUTCOMES AND THEMES

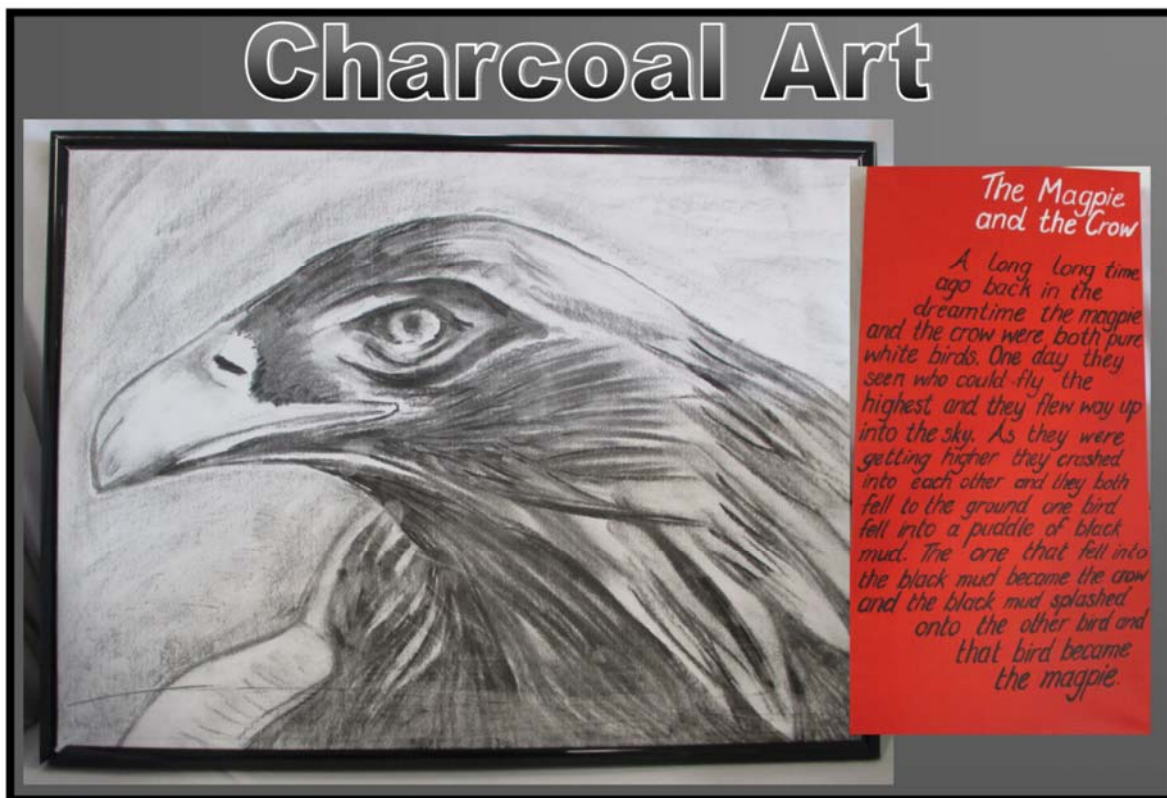
6.3.3 Evidence of Best Practice Regarding Treatment and Care Plans

There was evidence of best practice noted by some units where staff actively collaborated with clients to develop, review and amend Treatment and Care Plans. Some units also scheduled meetings with family members to ensure their involvement in the development of such Plans. One treatment centre required all staff prior to commencing their shift, to read their clients' Treatment and Care Plans before interacting with them. They also were encouraged to review at the end of the shift or at handover to identify if any changes were required to be made to that document based on what occurred during that shift. The multidisciplinary team, as a group, then reviewed all the patients Plans each week.

Finally, the implementation of satisfaction surveys in some treatment centres has further encouraged the implementation of Treatment and Care Plans and staff engagement with clients. Units who have implemented these surveys request clients and their families complete a survey prior to discharge. The survey asks questions about how clients and their families perceived the treatment, their involvement in making decisions about their treatment and care, staff engagement and the quality of services made available to them. These surveys are reviewed quarterly and contribute to continuous improvement practices within that organisation.

6.3.4 Recommendations

6. That all Treatment Centres, as part of their key performance indicators, report on their practice of developing and maintaining Mental Health Care Plans.
7. That the Community Visitor Scheme continue to monitor the level of involvement by patients, their families and carers in the development and revision of Treatment and Care Plans.



The Magpie and the Crow by Deklan – Mental Health Consumer

6.4 Forensic Care

6.4.1 Understanding the Nature of Forensic Care

It is important to understand within mental health services a forensic client is determined by placing an individual who has committed an offence on a license as per Section 269C of the *Criminal Law Consolidation Act, 1935 (CLCA)*. This section provides that a person is mentally incompetent to commit an offence if, at the time of the offence, the person was suffering a mental impairment and in consequence of that mental impairment, the defendant:

- » Did not know the nature and quality of the conduct; or
- » Did not know the conduct was wrong; or
- » Was unable to control the conduct.

Section 269A of the Act defines 'mental impairment' as including a mental illness, an intellectual disability, or a disability or impairment of the mind resulting from senility. 'Mental illness' means a pathological infirmity of the mind including a temporary condition of short duration.

There are approximately 300 clients in South Australia within this category. The majority of them are living in the community under 'license' conditions (similar to parole) which specify what they can and cannot do and include such things as taking medication, attending appointments and not consuming illicit drugs.

All those classified under Section 269 of the *CLCA* (forensic clients) come under the responsibility of the Minister for Mental Health and Substance Abuse. There is no alternative legislative or service arrangements for people with an intellectual disability, brain injury or autism who require secure care due to an offence they have committed but have been found not guilty due to mental impairment.

In South Australia, forensic care is provided at James Nash House (JNH) and Kenneth O'Brien Centre (KOBIC). The step down facility, Ashton House is located near JNH, and has four two bedroom units and two single room units.

The CVS believes the number of forensic beds available does not meet the current demand. This puts further pressure on the system as there have been circumstances when all the beds at JNH are full, forensic clients were frequently placed in Psychiatric Intensive Care Unit (PICU) beds. This is because PICU units were considered secure by the Department of Corrections. However, these clients do not require intensive mental health treatment and this has created bottleneck situations where extremely unwell mental health clients in need of psychiatric intensive care have spent extended periods (up to seven days) in EDs or SSUs waiting to get a bed in a PICU.

Of further concerns to the CVS, are situations where forensic and correctional clients were shackled to beds in EDs and guarded by correctional staff from the Department for Correctional Services. Nursing staff and Community Visitors who witnessed such incidents have reported these occurrences to the Principal Community Visitor who has then referred the case to the South Australian Ombudsman for investigation.

These cases were reviewed against Standard Operating Procedures used by the Department of Correctional Services. A number of recommendations were proposed by the Ombudsman to ensure forensic and corrections clients are treated respectfully and humanely. These recommendations have included that the Department for Correctional Services review their policies and procedures to ensure that all individuals in their care are treated with dignity, respect and as a fellow human being.

6.4.2 Community Visitor Scheme Findings

During the course of visits and inspections over the last five years, a variety of issues have been brought to the attention of the CVS regarding the treatment and care of forensic and corrections clients. This has included issues regarding client involvement in their care and treatment, access to activities and services to facilitate their rehabilitation and safety issues.

Many clients within forensic settings want to be involved and informed about their treatment and care, but also are seeking the opportunities to be involved in various activities to help them transition into the community once their limited term has been completed. For this reason, many seek to be involved and participate in programs that facilitate the development of skills in the activities of daily living. Clients within these transition programs have raised concerns that they are experiencing difficulty receiving the opportunities to be involved in such activities, including cooking meals that are shared with the other clients in the facility. The CVS has advocated that these activities should be increased for these clients, as they will provide them with functional skills to be independent and cope when they are integrated back into the community.

6. REPORT OUTCOMES AND THEMES

During the past 12 months, the CVS has advocated that clients from Kenneth O'Brien Centre have access to computer facilities and a computer skills program. This proposal was initiated by some of the dedicated forensic staff who recognised this need amongst their clients. During April 2016, the computers were set up and a program run by TAFE was introduced for these clients and was received with much enthusiasm.

6.4.3 Dual Diagnosis with Intellectual Disability, Brain Injury or Autism Spectrum Disorders

During the course of visits and inspections over the last five years, the CVS is aware of numerous examples in relation to people with co-morbid disabilities and the inappropriateness of mental health services as they currently stand to adequately meet the needs of this group. Within secure settings, there is a mix of clients with intellectual disability and those with a mental illness who must cohabit because of their security status despite having quite different support needs and management requirements. Skill levels for staff for both groups vary, and the mix leads to incidents and a failure to cater for differing needs. This situation is clearly driven in part because of the absence of a suitable secure facility specific to the needs of those with a disability.

The situation of clients with an intellectual disability being housed in a mental health unit is inadequate for them and unfair on staff. There are some clients who are not necessarily receiving medication or treatment interventions, but there is no suitable (safe) accommodation for them. It is encouraging to note that the Birdwood Unit in James Nash House was refurbished to be a discrete area for clients with disabilities and mental health issues including Intellectual Disability, Traumatic Brain Injuries and Autism Spectrum Disorder.

The CVS looks forward to continuing visits to these units to observe how this refurbishment has improved the services and outcomes for clients with comorbidities. The CVS also acknowledges that forensic services acknowledged the need for staff to have specific training in working with people with intellectual disabilities and facilitated a developmental educational course for approximately 10 staff.

While it is appreciated that setting up specialised services for clients with intellectual disability, brain injury or autism has significant financial implications and we live in challenging times of fiscal restraint, the costs associated with flow-on effects into the intensive care units and emergency departments of hospitals is significant and should be recognised.

Outside of the inpatient models of secure care, the CVS has observed multiple cases of residents with intellectual disability released on license into community services with support by a Non-Government Organisation (NGO) to live in the community (often under strict license conditions). This community based model could be considered as an alternative to the resource-intensive inpatient models.

The CVS is aware of an external and independent review of forensic services that was conducted during the 2014-2015 reporting period. As part of that independent review, PCV met with the interstate consultants undertaking the review. It was clear from this meeting that the consultants had completed a thorough assessment and were aware that there are clear service improvements that could be implemented in South Australia to ensure better outcomes for the clients in forensic care. The PCV believes it is extremely important that this report is released to the public and that everyone has the opportunity to see what has been recommended as a means of improving forensic care.

6.4.4 Stigma for Forensic Patients Transitioning to the Community

An ongoing issue identified since the 2013-2014 CVS Annual Report, is the stigma against forensic patients transitioning back to the community. There have been many incidents of public stigma/reporting against patients, especially those from James Nash House.

Such stigma is not uncommon and has a very detrimental effect on the recovery and transition process for patients and their families. Individual articles were referred to StigmaWatch by the CVS for inappropriate and stigmatising reporting of mental illness.

CVs have had many conversations with patients and families who have to go before the courts to seek permission to transition back to the community and the effect of these media reports on patients and families is traumatic. They dread seeing the sensational headlines that portray them as 'murderers or violent offenders' who are going to be 'released' or 'have conditions' related to their care.

6.4.5 Practice in Other Jurisdictions

The following excerpt is from a New Zealand Law Commission Report *Mental Impairment Decision - Making and the Insanity Defence*¹³:

Most jurisdictions require certain factors to be considered on a review of patient status. While the factors vary, in broad terms they tend to require the decision-maker to weigh the need for public protection against the right to liberty of the accused and his or her other needs, such as the need for care or treatment.

In Tasmania, Victoria and South Australia, the court is required to apply the principle that interference with the accused's freedom and personal autonomy should be kept to the minimum consistent with the safety of the community. In Ireland, England, Wales, Scotland, and Canada the safety of the public is the paramount consideration.

New South Wales (NSW) Mental Health Review Tribunal is a specialist quasi-judicial body constituted under the *NSW Mental Health Act, 2007*. It has a wide range of powers that enable it to conduct mental health inquiries, make and review orders, and to hear some appeals about the treatment and care of people with a mental illness.

Most tribunal panels consist of three members: a lawyer who chairs the hearing, a psychiatrist, and another suitably qualified member. All tribunal members have extensive experience in mental health, and some have personal experience with a mental illness or caring for a person with mental illness.

The tribunal also reviews the cases of all forensic patients. The tribunal's decisions can involve the consideration of quite complex issues, and can impact directly on people's lives, health and liberty. In making its decisions, the tribunal seeks to balance several sets of often competing rights - the individual's right to liberty and safety and to freedom from unnecessary intervention, the individual's right to treatment, protection and care, and the right of the community to safety and protection. Importantly, the tribunal is not a public process and therefore avoids the media reporting and the stigma and fear that many of these articles promote.

The Queensland *Mental Health Act, 2000* has resulted in the establishment of a Mental Health Court and Mental Health Tribunal.

The Mental Health Court can make decisions about whether a person was affected by mental illness at the time of an offence and whether they have a mental health defence, and decides if a person:

- » Is not criminally responsible for an offence if, at the time of the offence, the person was in such a state of mental disease or natural mental infirmity that they were deprived of the capacity to:
- » Understand what they were doing and/or
- » Control their actions and/or
- » Know that they should not do the act, or make the omission.

The Court may make a forensic order requiring the involuntary treatment for the patient. The Mental Health Court is constituted by a Supreme Court judge who may seek advice from two assisting psychiatrists.

Queensland Mental Health Tribunal is an independent statutory body that comprises of the President and other members including lawyers, psychiatrists and other people with relevant mental health experience. For a hearing to take place, three members must sit on the panel though sometimes there may be five members. Urgent cases may be decided by less than three members if it is in the patient's interests to do so. Each panel must have a lawyer, a psychiatrist or other doctor, and a community member. The community member is an experienced mental health worker or someone with other skills and experience that are relevant to the decisions the Tribunal must make.

The Mental Health Tribunal automatically reviews Involuntary Treatment Orders (ITO), Forensic Orders (FO) and Fitness for Trial (not permanent) (FFT), and young persons with mental illness who are detained in high security for treatment.

The NSW Mental Health Review Tribunal and Queensland Mental Health Court are both better qualified and more sensitive to forensic clients' rehabilitation prospects and needs as they consider the progressive transition back to the community. Importantly, there is far less public humiliation and opportunities to stigmatise individuals as they progress through their respective rehabilitation programs.

¹³ *Mental Impairment Decision-Making and the Insanity Defence* (New Zealand Law Commission report; 120) Section 13.17

6. REPORT OUTCOMES AND THEMES

The CVS is hopeful that when the SA Government releases its independent report into forensic services, it will adopt a model similar to Queensland or NSW. The model will allow for appropriate assessment and balancing of often competing rights - the individual's right to liberty and safety and to freedom from unnecessary intervention, the individual's right to treatment, protection and care, and the right of the community to safety and protection.

6.4.6 Recommendations

8. That the independent review and report into forensic care be released to the public and the Parliament to ensure that South Australia's forensic care and resources applied in this area are getting the outcomes deserved.
9. That the service improvement initiatives for responding to forensic clients with disabilities continue to receive serious consideration by the departments that have shared responsibility for this outcome.
10. That individual case planning occurs with all clients with disabilities who are currently within the forensic care services and corrections so that a collated profile of need is identified.
11. That there are more activities made available to clients to develop daily living skills to facilitate their reintegration back into the community and have more chance to be independent and self-reliant once they are released.
12. That the South Australian Government considers establishing a dedicated Mental Health Review Panel by reviewing models in effect in NSW and QLD.

6.5 Personal Safety

It is not acceptable that people in acute mental health units, PICU units or EDs do not feel safe in what is meant to be a therapeutic environment aimed at assisting them to recover. Feeling unsafe or at risk of assault would clearly have a negative impact on their wellbeing and increase anxiety. It is imperative that people with mental health issues that require hospitalisation, are not fearful of the service, put at risk or worse, re-traumatised.

Previous Annual Reports have documented that issues regarding gender safety were frequently raised during the CVS visit and inspections with many patients. Community Visitors have been monitoring such things as room allocation and practices that are in place to safeguard against abuse and assault of patients. Various units and staff have tried a range of strategies to minimise risks, e.g. males located in bedrooms in one corridor and females in another. There were reports of new policies and an openness about the gender diversity developing within treatment centres.

The ward was just finalising a policy for caring for transgender clients which has been formulated following a wide consultation process.

However, the most pertinent issues regarding safety raised this year regarded reports of assaults, a history of assault or victimisation contributing to a person's admission to a mental health facility and a sense of a physically safe environment, and trusting environment regarding personal interactions between clients and staff.

Community Visitors were made aware of situations where clients either have witnessed or experienced violence from another client. It was also reported by clients that they have witnessed abuse toward staff by other clients, and staff have also reported such incidents during visits.

There is a male consumer that had randomly assaulted other consumers in the unit. At the moment he is under permanent security.

Staff at PICU had requested approximately 17 months ago for an intercom and alarm to be installed at entrance to PICU unit due to a violent attack on a staff member entering the unit by a consumer. This occurred some time ago.

There have been incidents of patients assaulting staff in recent times. For example, one patient had used a pencil to stab a security guard in the back in one incident. Another staff member had been head-butted by a patient. There have been other assaults inflicted on staff by patients too.

The issue of personal safety and the sense that clients can trust staff with disclosures about personal issues was raised by both male and female clients. The CVS is aware of situations where clients have experienced a history of abuse and trauma that has contributed to their mental health. Some clients raised historically, when they have wanted to discuss these experiences with staff, the response towards them was a sense of disbelief regarding such claims. Others have reported that they choose not to discuss such matters with staff due to a sense of distrust.

A patient had made a report to staff/police about an alleged incident of sexual assault in a taxi she was taking from school back. She said detectives had interviewed her the day of CVs visit and had told her the CCTV did not show any evidence of the assault. She was extremely distressed and said that she was not supported by staff after the interview.

Family members, clients, and staff have also raised a concern about the access of illegal substances that are allegedly available in the public areas of mental health units, which has resulted in some clients regressing in their treatment. Staff are particularly concerned that community members target mental health clients because of their vulnerability particularly once they move into open units. There seems to be some suggestion that the smoking activities of clients have attracted community members to 'hang around' treatment centres offering clients access to illegal substances. The major concern of this issue is that should a client consume illegal substances it creates other effects with this prescribed medication. This causes their treatment to regress, and adds additional workload to staff to manage the client's current intoxication to get them back on track.

The staff are aware that the patient has a tendency to abscond and to find 'access' to drugs whilst a resident at the treatment centre and whilst he is in the community after absconding. Staff are aware of the contraband and have continued to take practical steps to stop the patient's access to drugs from external sources.

Concern raised about safety of smokers accessing smoking areas - including exposure to people selling drugs.

6. REPORT OUTCOMES AND THEMES

CVs were told that there had been several incidents involving patients using drugs and smoking within the wards.

Access to contraband drugs. It should be noted that some patients tend to be more recalcitrant than others and may be quite innovative in the manner they manage to have access to drugs.

One patient commented that the facility has problems with stopping the illegal availability of illicit drugs.

Of additional frustration to this issue is that many clients congregate in certain open areas, including the major entrances to treatment centres to smoke. This creates an unpleasant environment for other clients, staff members and visitors. There are also additional health issues associated with this, including passive smoking. It has also been reported interactions between clients in these public smoking areas has at times become heated, impacting on the sense of safety amongst clients.

The entrance to the wards still attracts many smokers who litter the area and create a passive smoking hazard for those wishing to enter or exit the premises. The CVs believe that a designated smoking area should be located away from any area that might negatively impact on others or enter the building through opening doorways or air-conditioning.

Female client reported that there had been incidents in the grassed area out the front of the centre, where many patients sit and interact socially. On many occasions, client's had aggressive verbal and physical outbursts, and other client's had to go inside to find a staff member to control the situation. There was a lack of staff supervision outside, which left some client's feeling vulnerable and unsafe in that environment. Clients and family members also raised concerns regarding safety of the environments outside of treatment centres, which are technically public spaces. In some treatment centres, clients tend to 'hang out' outside main entrances to smoke, which family members and other clients have raised creates a sense of unsafety and fear.

6.5.1 Gender Safety

Other areas of personal safety that have been raised as concerns in previous annual reports, have included policies and practices concerning gender safety. Previous Annual Reports have highlighted the need for Gender Safety Guidelines, similar to what were developed and implemented in Victoria - The Office of Chief Psychiatrist (OCP) agreed to do this work but due to considerable staff cuts to the OCP (from 16 positions to 12), the guidelines are yet to be released.

However, in Victoria there is now a strong campaign led by Professor Jayashri Kulkarni and Ms Sue Armstrong to reinstate female only psychiatric wards and mental health services in the community. Despite the Gender Safety Guidelines being implemented, they believe there is strong evidence that mixed gender wards have failed women with a mental illness and cite the Victorian Mental Illness Awareness Council Australia (VMIAC) Report.

A study by the VMIAC, the peak body for people with mental illness or emotional problems, has revealed shocking statistics on psychiatric admission experiences for women. Data gathered from nine Area Mental Health Services (AMHS) across the state showed that 85% of women felt unsafe during hospitalisation, 67% reported experiencing sexual or other forms of harassment from male patients and 45% had experienced sexual assault. Just over 60% reported the assault to nurses, but 82% indicated the nurses' responses were 'not at all helpful'.

This campaign has argued that the level of abuse suffered by women in psychiatric inpatient units would not be tolerated in any other area of health, strategies such as female-only corridors, women's lounges and gender-sensitive training have had no real impact on improving the rights of women to feel safe and be safe.

It is noted that SA Health has implemented a policy, *Same Gender Accommodation Policy Directive*. This policy mandates that all patients staying overnight in a South Australian public hospital are to be placed in same gender accommodation, use same gender accommodation facilities, and are not required to move through mixed gender areas to reach their own facilities (except when considered clinically appropriate). However, clients have continued to raise feelings of unsafety within mental health wards particularly when there are aggressive or highly vocal males in the unit.

In response to this issue, SA Health has released the *Changing Behaviour Strategy* as they recognise that consumers, carers, volunteers and workers all want health services in which health care can be both delivered and received without personal threat or risk. It is acknowledged that clients with mental health issues (including substance abuse) experiencing clinical conditions are more likely to present with challenging behaviours.

The causes of these behaviours can be intrinsic (relating to the client's feelings, emotions or their physical or mental health status) or extrinsic (environmental factors including people around them). SA Health has provided a policy directive¹⁴ and policy guidelines¹⁵ to provide personnel with procedures and tools to identify individuals who might have challenging behaviours and implement practices to manage the environmental or personal factors that might effect that individual.

6.5.2 Restrictive Practices

Restrictive practices are potentially harmful non-therapeutic interventions, and their use must be a last resort after alternative strategies to manage a client's behaviour have been exhausted or there is an imminent risk or threat to the patient's safety. As previously raised in the forensic section, the CVS is aware of instances where restraints have been used to manage Corrections and forensic clients experiencing a mental health issue while in custody or remand. In addition, the CVS has received complaints from clients on ITOs who reported that they were either physically and/or chemically restrained in hospital due to their mental health. The CVS takes all reports from clients, staff or other individuals seriously and has raised these cases with executives and senior management for investigation.

It should also be highlighted that SA Health has significant policy¹⁶ and a series of tool kits in place to ensure restrictive practices are minimally used. This includes clearly detailing the types of restrictive practices, how to report and review incidents, clinical strategies to minimise the use of restrictive practices, safety practices concerning the use of restrictive practices, and the legalities of restrictive practices. SA Health personnel are encouraged to complete an online training program to increase their knowledge and clinical skills regarding this area.

6.5.3 Recommendations

Dignity and Respect

13. That SA Health staff working in Emergency Departments and mental health units complete SA Health online training regarding restrictive practices.
14. That the Community Visitor Scheme continue to monitor the use of restrictive practices in mental health units and continue to report incidents of this nature to executives and senior management for investigation
15. That the Community Visitor Scheme continue to advocate for clients who speak up against being restrained in mental health units and advocate that they receive a response regarding their complaint

Personal Safety

16. That further action be taken by SA Health to provide safe ground for clients in open wards to mitigate their exposure to illicit drugs that impact on their treatment and recovery in mental health units.
17. That further action be taken by each local health network to provide safe, monitored areas where patients have access to fresh air outside of units and Emergency Departments.

14 SA Health, 2015. *Preventing and Responding to Workplace Challenging Behaviour, Violence and Aggression Policy Directive*.

15 SA Health, 2015. *Preventing and Responding to Workplace Challenging Behaviour, Violence and Aggression Policy Guideline*.

16 SA Health, 2015. *Minimising Restrictive Practices in Health Care Policy Directive*.

6. REPORT OUTCOMES AND THEMES

6.6 Activities and Stimulation in Treatment Centres

The Community Visitor Scheme believes that activities and structured programs within acute inpatient and rehabilitation centres are essential for people to learn and develop skills in moving towards wellness. Such programs provide a useful function to monitor patients' response to treatment or readiness for discharge. Basic daily living skills can also be developed through such activities to encourage independence post discharge.

The issue of lack of activities and stimulation within treatment centres has been an ongoing issue identified during the course of Community Visitor Scheme inspections in mental health units. It has been noted that although there has been improvement regarding the availability and notification of activities available in treatment centres, there has been a decline in the employment of Activities Coordinators within treatment centres. In some situations, the Activities Coordinator is required to organise activities for multiple wards in a treatment centre, which is difficult as each ward has differing client profiles and therefore differing needs to accommodate.

It should be noted that CVs are regularly told by patients they *"are bored and there is nothing to do"*. In some units, there is gym equipment but staff cannot supervise, as they have no training to use the equipment. In other units, staff bring resources from home that they have purchased with their own money to facilitate an activity, or celebrate a holiday or special day (e.g., Pancake Tuesday, Easter, ANZAC Day). These issues are evident in the following excerpts from reports.

Due to lack of funding, staff members provide art supplies to enable clients to be able to participate in art and craft activity.

Boredom remains a major issue with not one patient we saw being engaged in anything meaningful. The issue of activities needs to be addressed.

Staff member mentioned that some patients were disappointed when they found out that there was no gym facilities at the treatment centre. Questions were asked if facilities were available in the hospital and if there was potential for patients to use public/private facilities in the local area but it was deemed this would be difficult to implement and manage.

The OT was running relaxation sessions, cooking sessions were scheduled and a sensory group session was planned. Lack of personnel had reduced the options available to patients over a long period of time. Present activities seem quite limited.

6.6.1 Evidence of Better Practice

There was an improvement regarding clients being notified about the variety of activities available in some units. Staff with personal interests in fitness, craft, music or cooking were reported to be leading activities with clients. Not only does this provide something meaningful and interesting for clients to be involved with during the day, but staff participation in activities also fosters meaningful relationships between staff and clients to break communication barriers.

Activities design to develop everyday skills and responsibilities in clients are noted to be implemented in some units. This has included asking clients to prepare meals, look after chickens, or maintain a garden. One unit that the CVS observed positive improvement was Ken O'Brien Centre who introduced a computing program. The CVS supported a number of forensic staff who recognised the need and advocated for the installation and introduction of a computer skills program for these clients. This program was introduced to clients in the final quarter of this financial year.

Interaction in KOB Centre and Clare was high. Consumers were very positive about their care and had optimism for their rehabilitation outcomes. Specifically, consumers were enthusiastic about having programs and learning opportunities and appreciative of staff treating them with dignity, friendliness and respect.

In other settings, a weekly client and staff meeting was established to provide clients with the opportunity to directly feedback to staff what resources they needed to maximise their outcomes. The design of these meetings has facilitated more transparent communication between clients and staff and demonstrated that staff are invested in the outcomes of clients.

The activity hub is excellent. It includes a well-equipped art room, music room, IT room (currently looking for volunteer IT teachers) and multi-faith room. There is a quiet/sensory room where patients can access hand massage and manicures. There are large message boards near the nurse's stations in both open and closed wards that display the various daily/weekly activity that is available to patients. Every Monday there is a consumer meeting which feeds into staff meetings for appropriate follow up and feedback to consumer meeting is provided.



Lake Bonney – Photo by Jim – Community Visitor as an example for Sensory Modulation

There was discussion in one unit that a multi-disciplinary approach will be used to develop and facilitate a variety of activities to clients. Each Allied Health discipline will be responsible to facilitate an activity specific to their skillset to develop clients' skills to self-manage their illness and cope post discharge. Activities mentioned included mindfulness skills, social skills, and various daily life skills.

Other examples of best practice have included volunteer run programs in music, art and yoga, and programs by the RSL and Guide Dogs Association for dog therapy visits with clients. Colouring books and mandala activities have also become more common to promote feelings of calmness and a state of flow within the clients. Furthermore, sensory carts and the development of sensory rooms are tending to become more popular within units to provide clients with a calming environment and calming tactile products.

6.6.2 Discussion

There are varying levels of activities and structured programs across mental health units and services in South Australia. Some treatment centres have indicated that since there has been a loss of Activities Coordinators, there is no one dedicated to develop a more extensive activities program. Others have developed activities programs and consider it important that staff collaborate within each other to deliver structured activities for clients' recovery. Some of the units have been able to engage non-government organisations to come in and facilitate activities and others have used volunteers and/or their lived experience staff.

Group activity topics are determined by the needs of the patients at the time and may include a focus on coping with depression or anxiety, or some other area that is relevant to the current patient mix.

Examples of activities that are taking place in units include:

- » Patient morning meetings to discuss activities for the day (some units do every day);
- » Orientation group meetings for new patients;
- » Facilitated group activities i.e. coffee groups, solving the newspaper word puzzles or group discussion on articles (some units do this each morning);
- » Morning or afternoon walk (some do every day, others do occasionally);
- » Art, craft and cooking activities (these happen a few times each week in some units);

6. REPORT OUTCOMES AND THEMES

- » Gym sessions (some offer morning and afternoon sessions daily, others occasionally, others say equipment can't be used because staff aren't trained to use the equipment – despite the expenses purchasing the equipment);
- » Relaxation and meditation classes/sessions;
- » Structured groups focusing on coping with anxiety, depression, stress, medications, Treatment and Care Plans.
- » Offsite outings - bowling, swimming, fishing, bus trips, boat tours etc.; and
- » Other special activities/programs from other organisations i.e. Delta Dogs.

From an analysis of all reports it is obvious that some units are doing really well while other units are struggling to provide any meaningful activities.

In units where patients are regularly reporting boredom, it is obvious during visits that no activities have been planned or organised, or the activities are not targeted to the interests of the clients. Additionally, there are circumstances where there are planned activities happening, but information about these activities are not communicated with clients on a notice board, or there is little active encouragement.

6.6.3 Recommendations

18. That all mental health units be required to post their weekly activities and sessions on their respective notice boards, keep appropriate documentation of participation rates and report on structured activity plans to the Office of the Chief Psychiatrist.
19. 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.
20. That the Community Visitor Scheme continues to monitor the levels of activities offered to patients.

6.7 Impact of SA Health No-Smoking Policy

The issue of smoking and no-smoking policies within acute inpatient mental health and emergency settings arose again as a key issue in the 2015-16 reporting period. In particular, not being able to smoke in closed units and the inequity between the implementation of the no-smoking policy in open units versus closed units was again raised.

The SA Health Smoke-Free Policy aims to protect the health of all persons entering the premises of SA Health entities by prohibiting smoking, and providing assistance to patients who wish to address their tobacco use. From 31 May 2010, smoking was prohibited at all South Australian public health services and SA Health entities including all buildings, structures, outdoor areas, and government vehicles. The policy applies to all South Australian Department for Health employees, patients, visitors, contractors and all other persons entering Department of Health premises.

The policy states that all South Australian public health services will provide assistance to staff and patients who wish to address their tobacco smoking. This includes providing information, advice and referral, as well as nicotine replacement therapies (NRT), where appropriate. Nicotine withdrawal management will be provided for nicotine dependent patients who are unable to smoke tobacco while receiving an inpatient service.

Many treatment centres have worked with patients in an effort to help them quit through education and alternatives such as nicotine replacement therapy, inhalers and lozenges. In open units, it is noted that clients in open wards are able to go outside and smoke cigarettes, but clients in EDs, SSUs, PECUs and closed wards are rarely granted this with the supervision of a staff member. It is particularly frustrating in some locations where clients in closed wards can smell the cigarette smoke from outside, causing them to become more agitated and upset.

Patients in closed or psychiatric intensive care units are arguably in a significant level of stress and at a confused point of their lives, that is why they are in a closed unit. Unwell patients have stated on a range of occasions that being forcibly prevented from having a cigarette is a denial of their basic human rights and unfair when other patients directly outside of their units are allowed to smoke in their open air courtyards. As stated in previous Annual Reports, it is not fair that it is only those in closed units that are forced to stop smoking, especially when other patients in nearby open units are able to go into courtyards and smoke. All closed units do have courtyards similar to open wards and many used to have fixed lighters so that patients could go to designated areas in these courtyards and smoke.

Unfortunately, for those who are very unwell, closed/intensive care units are the only areas where it is enforced. Staff report to CVs that patients in closed units get so frustrated and agitated by not being able to smoke and are far more likely to be placed in seclusion, be given extra medication and get involved in verbal or physical altercations with staff or other patients. As highlighted in previous Annual Reports, the consequences of seclusion, increased medication or assaults do appear to be relatively more detrimental to recovery and treatment than allowing individuals to be able to continue smoking in a safe outdoor courtyard.

The no-smoking policy in hospitals, according to staff and patients, also means that many patients in the open units who continue to smoke are placed at risk when they go to the boundary of hospitals to have a cigarette. A number of the units have reported that patients have been exposed to drugs, assaults and other personal safety issues and are not in an area observable by staff.

In some open wards, doors are closed at a certain hour, which clients have complained restricts their ability to step outside be it for a cigarette or fresh air during the evenings. This complaint tends to increase particularly in the warmer months. Clients in one unit decided to take some action and independently implemented a petition amongst clients that requested senior management reconsider the hour doors are locked during the evening. The CVS presented this to the Director of Mental Health responsible for that unit and the hours were successfully reviewed. It was unfortunate that a month following this, Community Visitors learned that staff reverted back to the original hours because they reported difficulty managing distribution of medication during the evenings.

It is recognised that there are well documented higher rates of morbidity and mortality from smoking related illnesses for people with mental health issues than for the general population. We acknowledge that all efforts should continue as part of the Treatment Plan, to assist patients to reduce tobacco use and in the long term, to work towards ceasing use altogether. However, the current situation is unfair and there is a need for serious consideration of this issue given the above consequences is surely more detrimental to mental health recovery and treatment.

It was generally reported when patients are acutely unwell and distressed, it is not the most appropriate time to forcibly prevent them from smoking. This again was the most reported issue by patients in closed units, where they have pleaded with staff to be able to have a cigarette and eventually become agitated, angry and aggressive when the request is denied.

6. REPORT OUTCOMES AND THEMES

The ongoing issue of smoking remains a major problem for patients and staff in the Morier Closed Unit. While CVs were present, one patient was overheard threatening his mother that if she didn't bring him cigarettes (in her bra) he would 'bash her'. The patients, who have transition time in the Open Ward, are not able to smoke during their transition time - causing some of them to not participate as they don't see any benefit. There has been confusion regarding the approach to e-cigarettes throughout units... The CVS has been made aware that the use of e-cigarettes is not permitted on hospital grounds.

Smoking is an ongoing concern that affects clients and causes more significant anxiety and medication levels. Inability to smoke is a major cause of client aggression and is more significant in the closed wards when the acuteness won't allow clients to understand that smoking is a health hazard.

Smoking is a big issue, clients demand to have a smoke and when refused escalate to aggression. Both patients we met with find it very frustrating and causes them greater anxiety not being allowed to smoke. One was inhaling 2x Nicabate inhalers at the same time to try and get some relief. Both patients would like to go to an open ward ASAP just for the freedom to be able to go and have a cigarette.

As noted in previous PCV Annual Reports, the Government of Western Australian, Department of Health has provided a partial exemption to their no-smoking policy for involuntary mental health patients for the same reasons mentioned above and in April 2013, issued Guidelines for Mental Health Services.

This checklist is again quite extensive and includes a nicotine withdrawal management plan, a nicotine dependence test and details about medication interactions with smoking and smoking cessation.

While Western Australian Government has granted this partial exemption for involuntary mental health patients, the Guidelines do seem to provide considerable focus on a smoking cessation plan and ensuring that patients are well informed about the effect on their medication.

There are many staff in mental health services that are not aware that the SA Health Smoke-Free Policy Directive actually has an exemption clause for crisis situations.

The CVS has brought this to the attention of nursing staff when there are cases where unwell clients have been denied access or supervision for a cigarette. The CVS has encouraged staff to consider further options for the care and treatment of mental health patients in distress to consider the overall benefits versus detriment.

CVs reminded staff of exemption clause in 'no smoking' policy which allows them to exempt patients from not smoking or allow them to smoke where the alternative has implications to their recovery. The clause states: "Crisis Situations - SA Health entities recognise that discretion is required when enforcing the policy for consumers and visitors in distress. If smoking takes place on SA Health premises by consumers and visitors who are highly distressed, it is recommended that staff apply the policy in a flexible way that does not add further distress to the situation. Managers and staff are encouraged to discuss ways to address such situations appropriately. This clause will enable services to consider further options for the care and treatment of mental health patients in distress."

However, staff within EDs say that this raises a further dilemma about how this is managed within the unit – i.e. if staff are required to escort patients outside for a cigarette it has a chain effect on services back in the ED. Further discussion and education for staff is required to adequately address this issue and work through possible alternative options especially for patients in closed units.

6.7.1 Recommendations

21. 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.
22. 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.

6.8 Menu Options

Fundamental to improving the physical health of people with mental illness is good nutrition and exercise. Providing nutritious food is an important part of caring for people in mental health inpatient facilities. Knowledge of how the food we eat is associated with mood, behaviour, and cognition is fundamental to understanding how diet and mental health are intricately related.

The issue of nutritious food and appropriate menu provision is important especially for long stay patients. Community Visitors have identified many units are receiving their meals from the Royal Adelaide Hospital which is a two weekly rotating menu. However, such a menu is designed for units with an average length of stay of 4-5 days and is not suitable for long stay patients. Oakden Older Persons Mental Health Services receive their food from ECH Group, which offers their menu on a four weekly rotating cycle, providing much more variety for patients.

Food preparation through a group approach is seen as an activity that is valuable for patients as they have to work collaboratively, divide the tasks and ultimately enjoy the outcome. When patients and staff are involved in such exercises it can assist to build therapeutic relationships, patients are able to develop personal competencies in independent living skills and also enjoy the experience.

Unfortunately, in some units, these group activities have ceased or have been reduced in frequency due to fiscal and resource restraints. Clients within James Nash House reported that they used to be involved in preparing a meal that was shared with their peers. Many valued this activity as it provided opportunities to be responsible, accountable, and a sense of accomplishment. Cooking a meal also facilitated skills required to be self-sufficient and independent upon release from the treatment centre.

Other issues relating to food were mainly raised by patients, specifically that there was a lack of variety, a lack of nutritional content and they were being offered overcooked and distasteful food.

Patients indicated that they would like to get involved with cooking/food preparation. More opportunities could be opened to better engage patients in therapeutic activities.

One consumer was dissatisfied with the quality and choice of food especially for her one-year-old. She felt that she could put up with hospital food - but that in a unit specifically designed for care of infants, it was poor that poor meals were served. The example she gave, was mini meat pies - which she would never serve herself. The point has been made by the CVS before, that new mothers and their infants have particular needs for good nutrition.

CVs asked an Aboriginal man from the APY Lands about the quality of the food on offer. He said to us that it was not so good, that he missed home and the food he would eat at home. As health care provided to clients should be culturally appropriate and considerate, CVs wonder why there have been no attempts to extend this philosophy to the food that is offered to Aboriginal/TSI and CALD clients.

However, it should be noted that there were considerably more positive comments made about food, with many praising the availability of healthy options made available throughout the day, and the availability of vegetarian and vegan meals.

Patients were eating lunch - a variety of freshly made sandwiches, fruit and yoghurt. There were bowls of fruit available for patients.

There is now a choice of three main meals at night and a broader range of options at other times. A range of condiments is also available as are various spreads for toast or bread.

There was a table containing named menu selections for the next day for each consumer. Consumer D commented that there was no shortage of food and extra was provided if requested. The table with menu selections also contained loaves of bread and facilities for making jam sandwiches, and a bowl of fruit for snacks. Facilities for making tea, coffee and milo were also on hand in a small kitchen.

6.8.1 Recommendation

23. An independent review of the menu provisions in mental health units be undertaken with a particular focus on the needs of long stay patients.

6. REPORT OUTCOMES AND THEMES

6.9 Evidence of Good Practice

During visits, the CVs have been told stories by clients about staff members who have assisted their recovery by genuinely being interested and supporting them. CVs also see evidence of good practice occurring and such instances are documented in the reports and reported back to senior staff to ensure that such individuals are acknowledged and 'good practices' are promoted. Comments from the reports include:

One of the important issues we discussed during this visit, was the complex nature of the needs of mothers - many of whom have experienced abuse, violence, sexual violence, child sexual abuse, neglect or chaotic life experiences generally. Then becoming mentally unwell, and dealing with pregnancy, birth and becoming a parent. Staff are extremely well informed about all of these issues - and staff member was very impressive in talking about the programs and philosophy of the unit. It was very clear that there are approaches and priorities that are understood and shared by all staff. - Helen Mayo House, Glenside Campus.

CVs were very impressed with the quality of Treatment and Care Plans, they are reviewed on a daily basis by nursing staff and on a weekly basis with the multi-disciplinary team. They then conduct patient surveys with all patients and the level of satisfaction with their care and their level of involvement in their Care Plans. Staff showed CVs these surveys and the results, which indicated the level of satisfaction was very high. These surveys are tallied every quarter and are compared against the previous quarter. - Ward 18 Inpatient Unit, Repatriation General Hospital.

The multi-disciplinary team also reviews the survey results to explore continuous improvement strategies. Staff provided a copy of their strategic improvement framework which is very impressive and is an example of best practice. It is called The Complex Care Needs Project and was developed in response to staff realising that patient needs weren't being identified at an earlier stage, thus compromising a timely discharge. One staff member said that of the patients they have trialled this project on, the evidence shows that their length of stay will be reduced and patient outcomes are improved. A patient is assessed as having Complex Care Needs once they have met certain criteria. Staff also provided information about the WRAP program that workshops with consumers a detailed Care and Support Plan for individuals. - Ward 18 Inpatient Unit, Repatriation General Hospital.

Patient CH is a 29-year-old female who has been in the ward for 2 weeks. She said that the staff are very friendly and caring. She is able to do activities every day and is able to go for walks outside. CH said that both doctors and nursing staff were very transparent and open with her about her Treatment Plan. The ward will also follow up with a phone call once she leaves. - Margaret Tobin Centre, Flinders Medical Centre.

The clinical team, the resident and their carers/family/significant others are involved with the development and the review of the Treatment/Care Plans. There is also a clinical case review by the clinical team on a fortnightly basis. The resident is not directly involved with these. Each resident has a daily activity-plan and a person-centred Treatment/Care Plan. Three examples of treatment/care plans were shown to CVs. These examples demonstrated that each plan is unique and not all questions are completed. Some clients find the number of questions and the very specific content of some of the questions daunting. It was also explained that each resident demonstrates their own specific level of interest in the exercise of completing a Treatment/Care Plans. The observation was made that daily, measured, respectful and meaningful resident-clinician/allied health communication was significantly more important than the Treatment/Care Plan. Notwithstanding, staff commented that there was a role for a simple, resident-specific Treatment/Care Plan, but the importance of such plans should not be overstated. Rehabilitation Services - Glenside Campus.

We were delighted to see that there is a TAFE program in place for computer learning and skills. The TAFE teacher visits regularly and currently has 6 participants in a program that will assess skills and provide relevant practice. It is to be hoped that some participants will use this opportunity to form a bridging connection with TAFE and continue later, to enrol in a course. All individuals were involved in tailored programs and sessions that seemed both challenging and enjoyable. - James Nash House.

The Unit has a part time Occupational Therapist, part-time Social Worker and part-time Psychologist and excellent liaison with the Aboriginal Health Unit and the Aboriginal Health Officer. It is fortunate that the Aboriginal Health Unit is immediately adjacent to the Mental Health Unit, and their response is always speedy. An Aboriginal Drug and Alcohol program has been started. Staff have frequent training opportunities to participate in therapeutic activities. - Riverland General Hospital

A group of Nursing Students from Adelaide studying Sensory Therapy have, with the patients, drawn up comment pages for ideas to improve recovery. The pages are up on the wall for all to see and add to. Jo (Nurse) left a message for us to say there is a Mental Health and Art Workshop coming up in Whyalla. – Whyalla Local Treatment Centre

Staff and Care Consultant are providing some planned activities for clients, as we saw there is a morning staff/clients meeting, there is a pancakes morning where clients and staff cook (staff donate the ingredients), music day and the cans collection for collect money still happening. In all the important events also is some celebration as Australia Day, Melbourne Cup. – Woodleigh House Modbury Hospital.

Non-Violent Intervention Training program is being implemented and predominantly junior staff are being rotated to undertake the training with a focus on de-escalation. – The Queen Elizabeth Hospital.

The ward has recently acquired 4 chickens and clients assist with their care. The eggs are collected for cooking scrambled eggs etc. There are also planter boxes ready for planting with vegetables. This improves the environment and provides opportunity for patients to acquire skills etc. – Cedars Acute Glenside Campus



Charcoal Art by Deklan – Mental Health Consumer

6.10 Specific Concerns

The CVS holds significant concerns regarding Oakden Services for Older People which has arisen from both visit reports and a range of individual investigations that have been undertaken as a result of specific complaints that we have made on behalf of individuals and families. The CVS have a strong working relationship with the senior leaders and managers of Oakden Services for Older People, and commends the dedication these staff have to care for acutely unwell older people transferred from other acute mental health units. Yet for reasons unknown, Oakden is classified as 'sub-acute' and therefore attracts less funding than the other older persons acute units.

Staff at Oakden have explained that they receive the most challenging clients of the acute wards, yet the mental health unit has lost a number of Allied Health roles, particularly the Social Worker role who was responsible to secure appropriate accommodation for clients and the psychologist who has worked on Behavioural Plans. This has placed pressure on the leadership to take on additional responsibilities to fulfil what these Allied Health roles offered.

Community Visitors and the CVS office have received concerns from three families regarding the treatment and care of their loved ones at Oakden. These have included reported frequent falls, observed bruising, medication errors, increased sleepiness, drowsiness and reported decline of daily functioning. It was also commented that there are not enough staff available on wards, and it has been reported that Oakden use 1 staff member to 4 client ratio, whereas acute units may use 1 staff member to 3 client ratio. Staff and senior leaders within this unit are highly dedicated and strive to do the best they can with the limited resources available.

6.10.1 Recommendation

24. That a review is undertaken of the clinical hours in contrast to patient acuity at Older Persons Mental Health Services at Oakden to ensure the provision of quality and safe care to patients residing in this facility.

6.11 Issue Comparison with Other Jurisdictions

As we reflect on the identified issues and themes from this fifth year of operation, it is interesting to note that many of the general issues and themes raised through our processes are similar to other jurisdictions, specifically the issues outlined in the Victorian and NSW Community Visitors Program Annual Report¹⁷ including:

- » Increased waiting times in emergency departments;
- » Increased presentation of people entering emergency departments under the influence of drugs;
- » Lack of patient engagement in Treatment Plans;
- » Lack of understanding amongst clients regarding their treatment and medication;
- » Lack of appropriate accommodation options for discharge, especially for patients with dual disability;
- » The lack of meaningful and therapeutic activities noted due to cuts in Allied Health funded roles;
- » Reports of aggressive behaviour by acutely unwell patients towards other patients and/or staff;
- » The availability of illicit drugs in public spaces and the dangerous impact this will have on the health and mental stability of clients;
- » Use of restrictive practices to lock doors and shared spaces after certain hours to manage absconding, smoking and general patient safety at night; and
- » Better support for dual disability patients.

Hence, many of the issues documented in this report are neither specific nor unique to South Australia. The issues reflect current social issues experienced within Australia, particularly the increased presentation of people entering emergency departments due to consuming ice or other drugs that significantly affect their mental stability. Unfortunately, for those individuals who have a pre-existing mental health issue the consumption of illegal drugs exacerbates their symptoms and increases the efforts of medical teams to bring them to a manageable state. The CVS have received frequent comments from staff regarding this matter, and the CVS office has also received phone calls from patients and their families concerned about the availability of drugs around treatment centres.

¹⁷ Victorian Office of the Public Advocate Community Visitors Annual Report 2014-2015.

Of additional interest is that similarly to Victoria, there is a lack of meaningful therapeutic activities to engage clients. In Victoria, this has been caused by the lack of employment of Allied Health personnel to facilitate these roles. The issue of funding and budget cuts effecting the number of Allied Health roles available in treatment centres has impacted on the availability of coordinated activity programs, and increased the expectations of nursing staff to fill these gaps. Furthermore, with increased funding costs there will be a decline in the service and support available to clients, including how staff will engage with clients to establish meaningful Treatment and Care Plans in order to support clients in their recovery.

7. Workforce

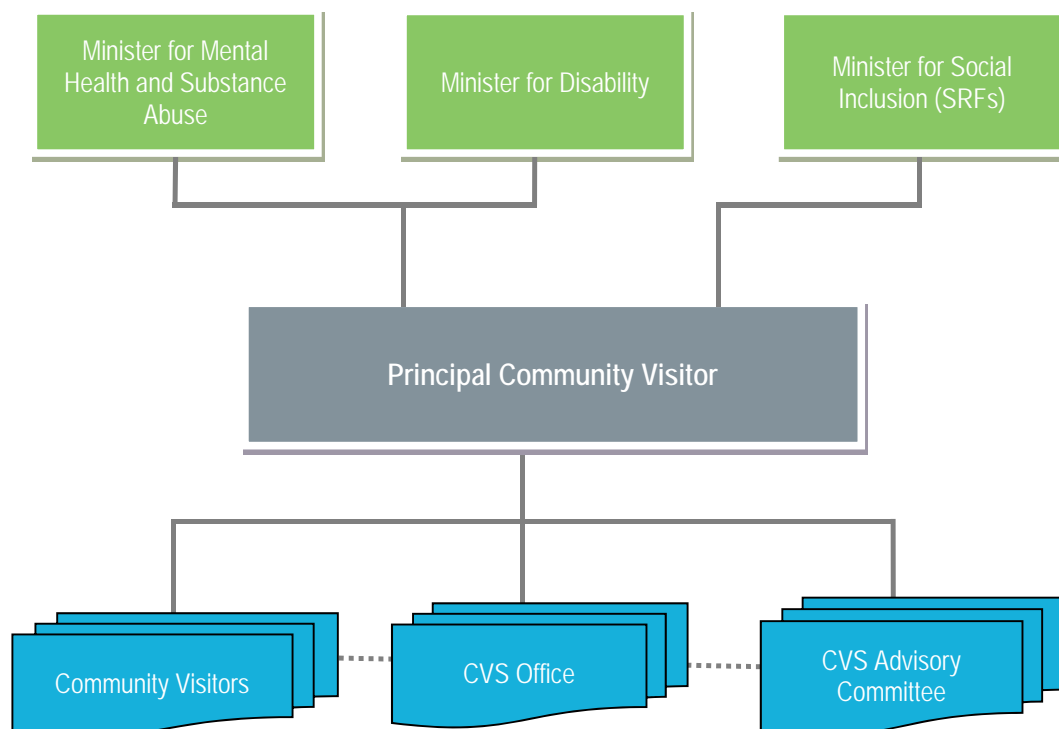
7.1 Governance of the Community Visitor Scheme

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

Amalgamation of the Ministerial portfolios of Disability and Mental Health and Substance Abuse under Minister Vlahos has created a unique opportunity to discuss and progress Comorbidity issues.

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 CVS and contributes to strategic networks and relationships.



Effective 1 July 2014, the Community Visitor Scheme is auspiced by the Department for Community and Social Inclusion (DCSI) for administrative purposes only.

7.2 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 2015-16 reporting period:

Principal Community Visitor	Mr Maurice Corcoran AM
CVS Manager	Mr John Alderdice
Mental Health CVS Coordinator	Mr Jarrid Brunton and Ms Connie Migliore
Disability CVS Coordinator	Ms Michelle Egel
SRF Coordinator	Ms Karen Messent
Recruitment and Training Officer	Ms Leanne Rana
Administration Officer	Ms Lisa Margrie

7.3 Community Visitors

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 2015-16 reporting period:

Adil Saleem	Jim Evans
Alfred Piu	Joan Cunningham
Angela Duigan	John James Leahy
Angelikh Koutsidis	John Lykogiannis
Ankur Patel	John Sheehan
Ann Rymill	Judith Harvey
Annette Glover	Julie Margaret
Anthony Rankine	Karen Atkins
Anwitha Allam	Kim Steinle
Baile Bonokwane	Lindy Thai
Brian Day	Marianne Dahl
Carly Luzuk	Michele Slatter
Cecil Camilleri	Elle Churches
Chandani Panditharatne	Sara Elfalal
Colleen Gavan	Stephanie Keightley
Fiona Pullen	Sultana Razia
Gail Stubberfield	Susan Whittington
Gregory Wilton	Tracy Haskins
Hannah Allison	William Zhao
Ingrid Davies	Maurice Corcoran AM (Principal Community Visitor)

7. WORKFORCE

7.4 Advisory Committee

The members of the Advisory Committee during 2015-2016 were:

Ms Anne Burgess	Chairperson – The CVS Advisory Committee
Mr Maurice Corcoran AM	Principal Community Visitor
Ms Anne Gale	Equal Opportunity Commissioner/Public Advocate
Dr John Brayley	Public Advocate
Mr Steve Tully	Health and Community Services Complaints Commissioner
David Christley	Interim SA Mental Health Commission

Mental Health Representatives:

Dr Aaron Groves	Chief Psychiatrist and Director Mental Health Policy
Ms Carol Turnbull	Private Mental Health Services Representative
Mr Ben Sunstrom	Manager, Legislation and Policy – Office of Chief Psychiatrist
Mr Jason Cutler	Consumer Representative
Ms Julia McMillan	Carer Representative
Ms Joan Cunningham	Community Visitor Representative
Ms Marianne Dahl	Community Visitor Representative (Proxy)
Mr Ian Bidmeade	Community Visitor Representative

Disability Representatives:

Mr David Caudrey	Executive Director, Disability SA
Mr Richard Bruggemann	Senior Practitioner, Disability SA
Ms Sandra Wallis	Government Disability Accommodation Representative
Ms Narelle Jeffery	Non-Government Disability Accommodation Representative
Mr Geoff O'Connell	Supported Residential Facilities Sector Representative
Ms Jayne Lehmann	Disability Carer Representative
Mr Nigel Baker	Disability Consumer Representative
Ms Ann Rymill	Disability Community Visitor Representative
Mr Tony Rankine	Community Visitor Representative (Proxy)

7.5 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. Five (5) interviewers from Volunteering SA&NT were met and updated on the CVS recruitment requirements.

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 DCSI. Before applying, interested people are encouraged to read the *Introduction to the Community Visitor Scheme* booklet, which outlines the attributes and level of commitment, required to undertake the role.

One hundred and twenty-four (124) Expressions of Interest were received during the reporting period. Of these, thirty (30) applications were received.

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 7.6.1);
- » Undergo the screening checks and referee checks; and
- » Undertake a minimum of two orientation visits with the PCV.

Fourteen (14) applicants did not proceed due to withdrawing or being unsuccessful after interview.

If successful, the applicant is nominated for appointment and required to sign a *Conditions of Appointment* and a *Code of Conduct*. Sixteen (16) applicants were recommended for appointment representing 53.33% of viable applicants. Compared with 2014-2015, there was a 3.33% increase in the number of viable applicants going through to appointment.

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. Fourteen (14) CVs were appointed through four (4) Cabinet Submissions (2 withdrew before Appointment).

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

7.6 Initial and Ongoing Support and Training for Community Visitors

7.6.1 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 and restrictive practices;
- » **Module Nine:** Dual Disability and Gender Safety;
- » **Module Ten:** Cultural Competencies; and
- » **Module Eleven:** Values Testing for Disability and Mental Health.

7. WORKFORCE



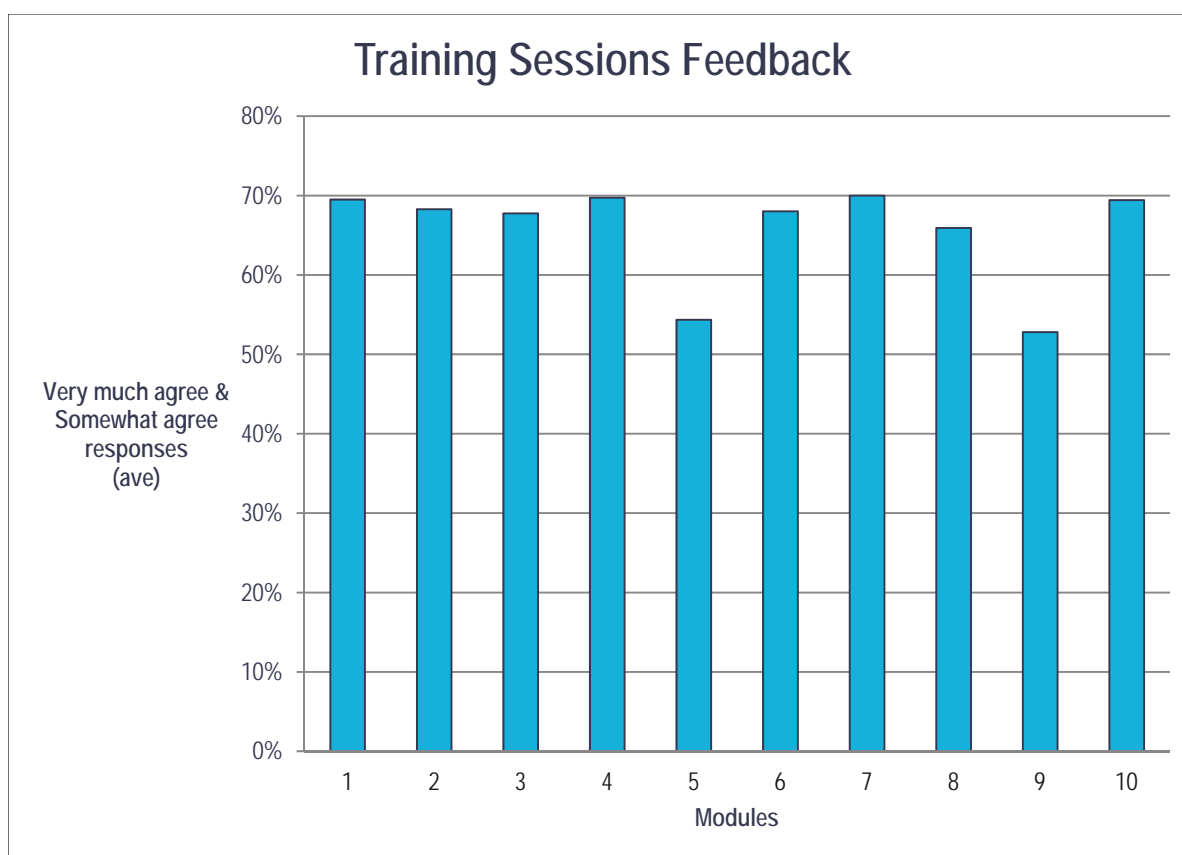
Training Session for potential Community Visitors

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.

A summary of the feedback obtained over those five two-day sessions are as displayed in the chart below.

Figure 7.1. Orientation training overall feedback satisfaction. Note: Module 10 is presented as information and readings only, therefore not assessed in feedback process.



In addition to rating each module, the attendees are encouraged to provide some written feedback. Following are some comments from this reporting periods five sessions:

"Very informative."

"Good information shared."

"Well explained, comprehensive, well-structured and also inspiring."

"Guest speakers experience was very vital to learning and information."

"Good info, helped to understand the role better."

"Always amazing to hear someone's life story."

"Most informative and sensitive to the clients, and volunteers. Delightful, illustrative stories sensitively delivered."

"Inspirational! Thank you."

"Great practical advice."

"Sessions were very interactive and insightful."

"Real eye opener, presentation challenged, informed and encouraged."

"Enjoyed the case studies and group activities."

"The whole course was excellent and well thought out and delivered."

"Felt confident and encouraged with the participations and interaction and sharing of experience and knowledge."

7. WORKFORCE

Overall, training session participants 'very much agreed' or 'somewhat 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 forty-seven (47) observation visits were completed with the PCV.

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 19 prospective CVs.

From the number of viable applicants, 46.67% did not progress through to appointment, providing support that the current recruitment process and training program is thorough and robust in matching appropriate applicants to the role.

7.6.2 Ongoing Training and Support

CVs continue to receive support with the Online Reporting Tool that was implemented in January 2015. This is either over the telephone, via email or in person. Online reporting refresher training was offered in November 2016 to all CVs with four (4) taking up the offer.

In March 2016, a workshop was held for CVs to refresh their knowledge about Treatment and Care Plans to assist them with the focus on Treatment and Care Plans during May and June visits. Fifteen (15) CVs attended.

CVs are invited to participate in the Restrictive Practices and Communication training modules during training workshops. One (1) CV has participated in the Communication training to date.

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 and local councils.

CVs were offered 6 external training opportunities:

- » Cultural Awareness Marion City Council – 1 CV attended;
- » Child Safe Environments – 3 CVs attended. Feedback included *"Child Safe Environments Training I did through City of Marion.....was a good day.....trainer was very engaging. Thanks for letting us know about it. It was a good opportunity."*
- » Public Speaking VSA&NT; and
- » Communication Partner Service-AGD – 2 CVs have applied.

In addition, 5 CVs participated in National Volunteer Week events e.g. Volunteer Congress, Office for Volunteers, Thank you and Adelaide City Council forum.

Annual development reviews are conducted with the PCV to provide a formal avenue for feedback and development discussions. Seventeen (17) yearly reviews were due throughout the year with ten (10) 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.

There are presently 37 active CVs, and 11 inactive CVs who are no longer participating in the CVS.

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 2015 – Online Reporting Tool;
- » October 2015 – Mental Health Week: Looking after your own mental health;
- » December 2015 – Morning tea with (then) Minister for Disability, Hon Tony Piccolo;
- » April 2016 – Guest speaker Dr David Caudrey, Executive Director Disability SA; and
- » June 2016 – Focus on Treatment and Care Plans.

There were 71 attendances by CVs across the five 'Get Togethers'. Notes from the December, April and June meetings have been included in monthly newsletters, which has been 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 the Community Visitors on a monthly basis providing general updates and information regarding strategic direction and issues arising.

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



Community Visitor Get Together with guest speaker, Dr David Caudrey presenting on the NDIS

7.7 Recruitment Strategies External to CVS

Networking opportunities have occurred with Volunteering SA&NT, Country Health SA and Southern Volunteering. Attendance at relevant meetings has happened with the Recruitment and Training Officer attending the National Volunteering Standards workshop, Adelaide City Council National Volunteer Week meeting, Central Volunteer Managers meetings (4) Disability, Ageing and Lifestyle Expo, and the Adelaide University Volunteer Expo.

The PCV has officially thanked the CEO of Volunteering SA&NT via letter, for their ongoing support of the CVS and for the number of referrals of potential CVs.

8. Public Complaints

8.1 Public Complaints

No public complaints in relation to the Scheme were received by the Principal Community Visitor in 2015-16.

9. Conclusion

As can be seen throughout this report, the Community Visitor Scheme has been able recruit, maintain and support an exceptional team of Community Visitors to undertake the legislative required visits to our mental health treatment centres. In doing so, our visits and inspections have identified an increased number of issues arising as well as positive commendations (1,025) that we have been communicate back to Mental Health Directors on a regular basis.

The CVS has significantly improved our methods of tracking issues that arise from visits with our Coordinators and Manager regularly meeting to review progress and status of all the issues arising from visits. The Coordinators and Manager also keep the PCV informed of all these individual issues that are numbered and coded through monthly tracking meetings. The Coordinators have also 'locked' in meetings with Mental Health Directors to follow up on all issues that have been referred to them and have forwarded a summary of visit reports each month to each of the Local Health Network Mental Health Directors. This keeps both the CVS and Mental Health Services accountable to both the individual complaints the CVS has advocated for and some of the systems issues that have been raised.

It would be negligent of me if I did not acknowledge and express concern about the length of time it has taken to get investigation reports back from both CALHN and NALHN. In two individual complaints that the CVS referred that related to serious allegations of physical and chemical restraints, it has been over three months and the CVS have still not received the reports/responses into these investigations.

This has not only been frustrating for the CVS, but also the individuals and the family that the complaints have been made by. In particular, the widow of a man who was a patient in a mental health unit who is simply wanting resolution of the issues that she was brave enough to raise with us. These delays and allegations have also been raised with the Chief Psychiatrist but we are yet to receive the investigation reports.

Over this past reporting year, I believe the CVS has continued to improve scheduling and coordinating of visits and many of its operational procedures such as the monitoring and tracking of issues. The State Government has committed through its Bi-Lateral Agreement with the Commonwealth related to the transition to the full roll out of the NDIS, to continue funding the CVS until 30 June 2018, which includes both the mental health and disability areas of the Scheme.

The future of the Scheme in mental health is assured, due to the legislative requirement under the revised *Mental Health Act, 2009*.

9.1 Future Steps of the South Australia Community Visitor Scheme

The *Mental Health (Review) Amendment Bill, 2015* was presented and read for a first time to the House of Assembly on 2 December 2016. This Bill proposes a variety of change and some will affect the Community Visitor Scheme in a positive way, including the commencement of visits to Mental Health Community Centres and Mental Health Rehabilitation Centres in South Australia. The CVS will be liaising with the Office of the Chief Psychiatrist to develop a visit and inspection practice and policy for Community Visitors to visit these centres bimonthly. These visits will be done in addition to the existing visits and inspections to all Mental Health Treatment Centres.

Community Mental Health Centres are central contact points where a team of mental health professional work to collaborate with clients to develop a personalised model of care. Clients are registered to a community mental health centre and will have their own Care Coordinator who will manage their treatment during the client's involvement in the centre. Services available in these centres include:

- » Mental Health Information;
- » 'Walk In' Advice and Support;
- » Assessment;
- » Crisis Response;
- » Outreach Services;
- » Assistance to People Who Present in Hospital EDs;
- » Assistance to People Who Require Rehabilitation Services; and
- » Counselling.

9. CONCLUSION

9.2 Community Visitor Workforce

The CVS has undertaken targeted recruitment in some of the regional areas, and have been able to appoint great local people. This however, will need to continue, otherwise travelling and associated costs will remain a significant burden. It is anticipated these Visitors will be able to undertake visits to the Integrated Mental Health Units in Whyalla, Berri and Mt Gambier and also the rural disability accommodation sites in those areas. The CVS will also be endeavouring to recruit Community Visitors from an Indigenous background.

9.3 Development of a New CVS Information Management System

The team has historically used spreadsheets to manage its business processes and to manage its data. This creates many challenges that the team projects could be resolved through the design and implementation of a custom designed Information Management System.

During the 2014-2015 financial year, business process mapping was completed and DCSI's ICT design team has commenced developing a system for the CVS utilising the application 'Salesforce'. During 2015-2016 financial year, Salesforce has been put in place to provide a centralised place for the CVS to access personnel information pertinent to the management of Community Visitors and coordinating visits in all streams of the CVS.

The system has also been established to record information about the location and regions of disability houses, Support Residential Facilities and Day Options providers, as well as information about all Mental Health Treatment Centres and community mental health providers. These have been matched with the NDIS regional boundaries, and will assist the CVS Coordinators organise monthly visits in all the regions by matching facilities to Visitors based on their location.

Further investigation is underway to continue to develop the Salesforce system to further assist the Coordinators manage monthly visits and reduce the use of Excel spreadsheets, which historically are used to manage daily business.

9.4 Further Implementation of Monthly Focus Projects

During the 2015-2016 financial year, the Community Visitor Scheme Advisory Committee actioned the CVS implement a two-month focus on the development and implementation of Treatment and Care Plans in both the disability and mental health sectors. This was implemented with the assistance of Community Visitors. This opportunity also provided Community Visitors with further development opportunities to understand daily practices in both the disability and mental health sectors, and research and evaluation skills.

During the 2016-2017 financial year, the CVS aims to implement further focus projects to investigate other issues pertinent to the disability and mental health sectors regarding themes identified in this current and previous Annual Reports. The focus projects will provide information regarding current practices, development areas and barriers experienced by service providers to support clients. Potential focus projects could include activity programs and gender safety.

9.5 Recommendations

This Report discusses a range of significant issues that have emerged in section six of the Report and attempts to arrive at a set of recommendations as a means of continuous improvement. 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.

It is important for any reader of this report to refer to section six to appreciate the context of the below recommendations:

Access to Services

1. That the Community Visitor Scheme continue to independently monitor the length of stays of mental health patients in Emergency Departments to ascertain whether there is improvement or otherwise.
2. That the Community Visitor Scheme continues to monitor the incidence of seclusion and restraints and least restrictive practices.
3. That the Community Visitor Scheme continues to monitor the policy and practice response from the Department of Correctional Services to the Ombudsman's Report.
4. That the Community Visitor Scheme continues to advocate for and monitor the service response to patients' cultural needs.
5. That the Community Visitor Scheme continues to monitor access to Allied Health Services and the availability of these roles within mental health units.

Treatment and Care Plans

6. That all Treatment Centres, as part of their key performance indicators, report on their practice of developing and maintaining Mental Health Care Plans.
7. That the Community Visitor Scheme continue to monitor the level of involvement by patients, their families and carers in the development and revision of Treatment and Care Plans.

Forensic Mental Health and Dual Diagnosis Clients

8. That the independent review and report into forensic care be released to the public and the Parliament to ensure that South Australia's forensic care and resources applied in this area are getting the outcomes deserved.
9. That the service improvement initiatives for responding to forensic clients with disabilities continue to receive serious consideration by the departments that have shared responsibility for this outcome.
10. That individual case planning occurs with all clients with disabilities who are currently within the forensic care services and corrections so that a collated profile of need is identified.
11. That there are more activities made available to clients to develop daily living skills to facilitate their reintegration back into the community and have more chance to be independent and self-reliant once they are released.
12. That the SA Government considers establishing a dedicated Mental Health Review Panel by reviewing models in effect in NSW and QLD.

Dignity and Respect

13. That SA Health staff working in Emergency Departments and mental health units complete SA Health online training regarding restrictive practices.
14. That the Community Visitor Scheme continue to monitor the use of restrictive practices in mental health units and continue to report incidents of this nature to executives and senior management for investigation.
15. That the Community Visitor Scheme continue to advocate for clients who speak up against being restrained in mental health units and advocate that they receive a response regarding their complaint.

Personal Safety

16. That further action be taken by SA Health to provide safe ground for clients in open wards to mitigate their exposure to illicit drugs that impact on their treatment and recovery in mental health units.
17. That further action be taken by each local health network to provide safe, monitored areas where patients have access to fresh air outside of units and Emergency Departments.

9. CONCLUSION

Activities and Stimulation in Treatment Centres

18. That all mental health units be required to post their weekly activities and sessions on their respective notice boards, keep appropriate documentation of participation rates and report on structured activity plans to the Office of the Chief Psychiatrist.
19. 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.
20. That the Community Visitor Scheme continues to monitor the levels of activities offered to patients.

Impact of SA Health No Smoking Policy

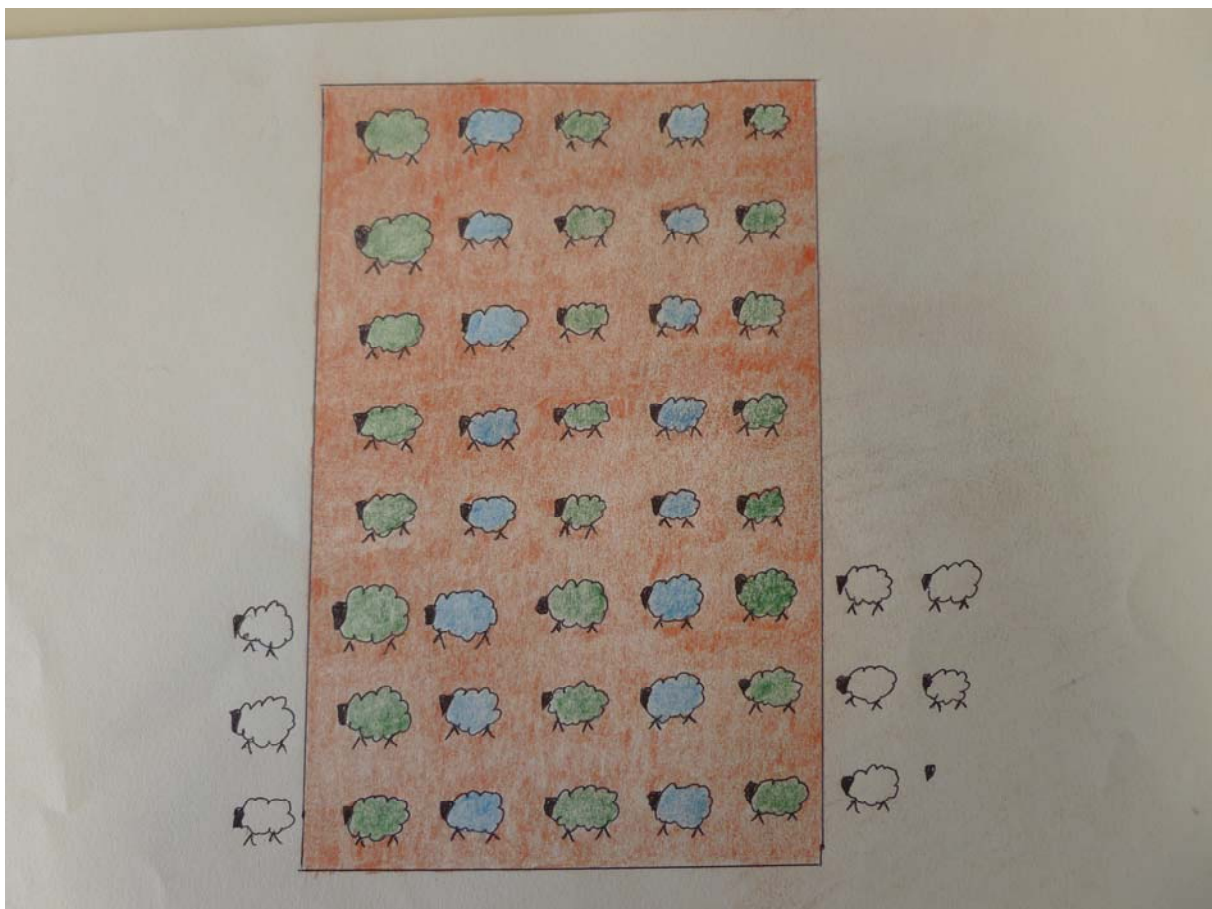
21. That the SA Department for Health and Ageing undertake a detailed risk-assessment into the impact to patients who have smoking addictions and who have been placed into closed units.
22. That the Community Visitor Scheme continue to explore individual patient rights under anti-discrimination legislation and specifically those who have smoking addictions and who have been placed in closed units.

Menu Options

23. An independent review of the menu provisions in mental health units be undertaken with a particular focus on the needs of long stay patients.

Specific Concerns

24. That a review is undertaken of the clinical hours in contrast to patient acuity at Older Persons Mental Health Services at Oakden to ensure the provision of quality and safe care to patients residing in this facility.



By Glenn – Mental Health Consumer

10. References

10.1 Community Visitor Scheme

The following documents can be found on the CVS website www.sa.gov.au/cvs

- » Community Visitor Scheme brochure;
- » Introduction to the Community Visitor Scheme booklet (Mental Health);
- » Community Visitor Conditions of Appointment and Code of Conduct;
- » Community Visitor Scheme Advisory Committee Terms of Reference.

10.2 External References

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11. Glossary of 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
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
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
NDIS	National Disability Insurance Scheme
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
OCP	Office of the Chief Psychiatrist
OPA	Office of Public Advocate
OT	Occupational Therapy
OHW&S	Occupational Health, Welfare and Safety
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

11. GLOSSARY OF ACRONYMS

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

12. Appendices

Appendix 1: 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	<p>Introduction and welcome/reception to the unit</p> <p>Personal interactions between staff and patients/Community Visitors (including attitude)</p> <p>Adequate and accurate information provision (both in discussions with patients and CVs and provided on the ward in pamphlet stands and posters).</p>
Environment	<p>How does the unit feel? e.g. warmth, clinical vs private and personalised spaces for patients</p> <p>Are patient's room and amenities well maintained? e.g. cleanliness and furnishings of the unit</p> <p>Temperature</p> <p>Are patients happy with their food?</p> <p>General maintenance is of a good standard and patients feel any reported concerns are addressed in a timely manner</p> <p>Sufficient provision for private space for patients to spend time in as well as conduct conversations with Visitors in</p> <p>Are patients personal/hygiene needs being met?</p>
Rights	<p>Have patients who are on an order under the <i>Mental Health Act, 2009</i> been given a Statement of Rights regarding that order?</p> <p>Do patients feel they (and their carer, family member or other supporter) are being involved in their treatment and care planning?</p> <p>Do patients feel safe?</p> <p>Are patients treated in the least restrictive environment?</p> <p>Are patients provided with access to advocacy and legal representation?</p>
Access to Information	<p>Is there sufficient information provided for patients in communal areas (regarding the CVS as well as other agencies, events and information)?</p> <p>Do patients whose first language is something other than English have sufficient access to information pertinent to them (including interpreters if required)?</p> <p>Are patients or CVs provided with access to records (when appropriate processes have been undertaken)?</p>
Activity/Entertainment Provisions	<p>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</p> <p>Does the unit provide any activities? e.g. music therapy, art and craft, cooking groups</p>

Treatment and Care	<p>Patients feel engaged in their treatment and care?</p> <p>Do patients feel they have been treated in the least restrictive manner?</p> <p>Is there a treatment plan for each patient?</p> <p>How frequently are they reviewed?</p> <p>Seclusion and restraint reports.</p>
Grievances	<p>Do patients feel they are safe to make a complaint if need be (free from any reprisal)?</p> <p>Is the complaint treated confidentially and efficiently?</p> <p>Is the complaints resolution process open and transparent?</p>

Appendix 2: Issues Classification Scheme

LEVEL ONE	LEVEL TWO
Rights and Responsibilities	<p>Legal Orders</p> <p>Legal Rights</p> <p>Dignity and Respect</p> <p>Consumer Involvement in Treatment and Care Planning</p> <p>Consumer decision Making and Support</p> <p>Carer, Friend, Family Member or other Support Involvement</p> <p>Personal Safety/Assault</p> <p>Least Restrictive Environment</p> <p>Privacy and Confidentiality</p> <p>Advocacy and Legal Representation</p>
Access	<p>Diversity Responsiveness (Interpreters, Alternative Languages and Discrimination)</p> <p>Delay in Admission or Treatment</p> <p>Discharge or Transfer Arrangements</p> <p>Referral</p> <p>Refusal to Admit or Treat</p> <p>Service Availability</p> <p>Transport</p> <p>Exit and Re-entry</p> <p>Billing Practices</p> <p>Information on Costs</p> <p>Private/Public Election</p> <p>Access to Records</p> <p>Private/Public Election</p>
Environment and Hospital Services	<p>Smoking Provisions</p> <p>Lost Property</p> <p>Food</p> <p>Hygiene/Personal Needs</p> <p>Grounds</p> <p>Suitable Facilities for Activities</p> <p>Maintenance of Environment</p> <p>Information Provision (e.g. brochures, info stands)</p> <p>OHWS Issues</p>

LEVEL ONE	LEVEL TWO
Treatment and Support	Involuntary Treatment and Practices Assessment, Reviews and Diagnosis Adverse Outcome Coordination of Treatment Activities and Structured Programs Inadequate Treatment Medication Negligent Treatment Rough/Painful Treatment Withdrawal/Denial of Treatment Supporting Recovery Wrong/Inappropriate Treatment Discharge Planning
Grievances	Inadequate/No Response to Complaint Reprisal/Retaliation Inconsiderate Service Accuracy/Inadequacy of Records Assault Competence Illegal Practices Sexual Misconduct
Communication	Staff Responsiveness Patient/Staff Interactions/Respectful Communication Attitude Inadequate Information Wrong/Misleading Information



The South Australian Community Visitor Scheme

GPO Box 292
Adelaide SA 5001

P 1800 606 302
F 08 7424 7239
E cvs@sa.gov.au
W www.sa.gov.au/CVS



**Government
of South Australia**