

The South Australian Community Visitor Scheme

Principal Community Visitor

SPECIAL REPORT

Mental Health Services 2016-17





Hon. Peter Malinauskas, MP

Minister for Mental Health and Substance Abuse

Dear Minister

In accordance with Division 2, section 54 (3) of the *Mental Health Act, 2009* (the Act), it gives me great pleasure to submit to you this special report.

This report provides an account of the work of the South Australian Community Visitor Scheme during the financial year ending 30 June 2017.

Yours sincerely

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

Maurice Corcoran AM

8 March 2018

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1. A message from the Principal Community Visitor

In my 2016-17 Annual Report I offered apologies to those who have appreciated the extent of our reports and how both quantitative and qualitative information have both informed and told a story about our visits and the issues that have emerged from the visit reports. This year the reporting template and requirements of Premier and Cabinet Circular PC013 for Annual Reporting was very different to previous years and encouraged agencies to reduce the number of pages which limited our ability to discuss issues of concern. However, following discussions with the Minister, I have produced this Special Report that aligns with our previous Annual Reporting format and that includes narrations from those we have met and issues we have encountered. The report also draws comparisons with previous years.

This report represents the work of the South Australian Community Visitor Scheme (CVS) for 2016-17 and is prepared on behalf of the great team of Community Visitors that I have the pleasure to work with and alongside of, as well as the dedicated team in the office who coordinate and manage the Scheme as a whole. Although this is a Special Report of the Principal Community Visitor, it is without doubt, the culmination of combined efforts of all our Community Visitors and staff.

Maurice Corcoran AM

2. Highlights and achievements

The Community Visitor Scheme has again been successful in achieving its objectives. While it was able to meet its legislative requirement to visit all treatment centres once per month, the recruitment of sufficient volunteer community visitors to achieve its target of visiting every disability group home (over 600) twice per year remains a challenge.

Our improved more robust process of tracking and following up every issue raised in reports has delivered many positive outcomes for individuals and their families. Ninety four (94) issues were raised in reports that required follow up with mental health services management with sixty three (63) (65%) being resolved during the reporting period.

The level of contact to the office from patients, their families and from staff seeking support with both individual and systemic advocacy has been significant. The office has responded to 97 calls of concern covering a vast range of issues. While not always able to deliver on the expectations of those seeking support with orders or discharge, they have in most cases, expressed appreciation that an external agency outside the treatment system is aware of their situation. Further, they have been appreciative that we have listened to them and presented their concerns to the treatment team and ensured they are aware of their rights and options available.

While the CVS is not able to make sole claim for achieving systemic change around any specific issue, I am confident that the CVS is a strong and influential voice that delivers evidential value from a service consumer perspective. I am also confident that our reports and the issues raised are used by management at a range of levels to present and drive the need for change. We are now able to witness improvement in some of the more long term systemic issues such as ED waiting periods and the standard of accommodation.

Closure of Oakden Older Persons Mental Health Services and the opening of the new Royal Adelaide Hospital and new mental health units at the Flinders Medical Centre, will deliver improved environments for consumers and staff. The more secure setting at the RAH will also negate the need for the shackling of forensic or corrections patients, an issue that has been on the CVS agenda since its inception. Highlighting the need to retain specialist psychiatric services for people with disabilities has for the short term, delivered a positive outcome for many individuals who have been on long-term antipsychotic medications.

The CVS has previously advocated for the release of the independent review and report into forensic care in South Australia and is pleased to acknowledge the release of this report together with the government's response and commitment to progress recommendations contained in the report.

There is no doubt that the raising of concerns and complaints regarding the quality of care being provided at the Oakden Older Persons Mental Health Service, leading ultimately to an extensive review and damning report by the Chief Psychiatrist, Aaron Groves, was the most significant achievement during this reporting period. Leaving aside the process, which is covered in more detail throughout the report, it is with pleasure that I can report that many of the

previous residents are now receiving significantly improved care in an environment that is vast improvement on the old Oakden site. The report has brought to the forefront that consumer and carer engagement is paramount to achieving quality outcomes for individuals. While this notion has been around for a long time, it has in many areas been paid little more than lip service.

I would like to acknowledge Mrs Barbara Spriggs, and Clive and Kerry Spriggs for their courage, persistence and integrity as they worked with us to seek answers about the care and treatment of their beloved husband and father, Bob Spriggs through a formal complaint. It was this complaint and passionate representation to the Chief Executive of the Northern Adelaide Local Health Network, that led to the decision to undertake the review of Oakden.

I would like to acknowledge the incredible dedication and contribution to the visit inspections and reports that have been undertaken by our outstanding team of Community Visitors. I would also like to acknowledge our dedicated office team who have again coordinated the many visits throughout the year, followed up on the many issues arising, and further developed our systems, protocols and processes to ensure that we are responsive and accountable to the users of these services and their families.

3. Recognition of Community Visitors

Another highlight during this past year has been the ongoing recruitment and retention of exceptionally qualified and experienced Community Visitors (CVs). The CVs have impressive backgrounds, skills and passion that have helped to deliver our key outcomes of monthly inspections and associated reports at a very high level. A number of them have relayed to the office how much they appreciate being involved, with examples of their feedback below.

"It is very satisfying to know that our collective effort actively contributes towards peoples' lives being that little bit more comfortable and enjoyable 😊."

"Thanks for your feedback. It is nice to know we have some currency in the community which we can spend in future visits. AND it emboldens me to believe that we are actually making a difference."

With the expansion into Day Options settings and the increase to bi-annual visitation to disability accommodation, SRFs and Day Options (where required), the demand for CVs has grown and targeted recruitment campaigns are continuing to increase our workforce.

Community Visitors are an integral and valued component of the Scheme and it is with great pleasure that we showcase 2 of our Community Visitors that have been volunteering with us since the scheme commenced in July 2011.

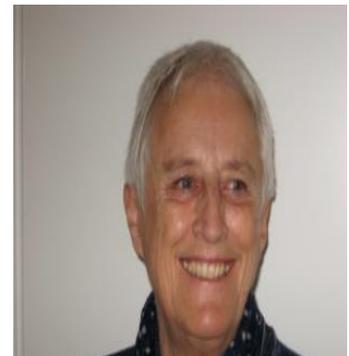
Carly Luzuk – appointed 7/7/2011



As a Community Visitor I enjoy being able to provide support and understanding to those in the community who are unwell and in some cases, feeling very vulnerable. It is a privilege to be able to provide feedback, with the aim of improving government health policies and facilities. The ultimate goal is for each and every person to receive the best care possible.

Joanie Cunningham – appointed 7/7/2011

Until recently, I worked in the mental health area only, however I am currently on a steep and rewarding learning curve in beginning to undertake some disability visits as well. I am lucky enough to have some brilliant CVS 'buddies' and CVS staff, mentoring me in these. This collaborative feature of working together is a very important, strengthening and organic part of what we do, as well as advocating for the rights of some of the most vulnerable people in our society. Being involved in the CVS program is a way of affirming the importance of the values that are incorporated in the Act under which we operate. It is also personally fulfilling, to be working alongside some wonderful people who hold human rights and wellbeing as a priority.



In *Chapter 6 Workforce* you will find a list of all the Visitors who have contributed during the 2016-17 reporting period.

4. 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.

4.1 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 conduct visits to and inspections of authorised community mental health facilities as required or authorised under this Division
- » to refer matters of concern relating to the organisation or delivery of mental health services in South Australia or the care, treatment or control of patients to the Minister, the Chief Psychiatrist or any other appropriate person or body
- » to act as advocates for patients to promote the proper resolution of issues relating to the care, treatment or control of patients, including issues raised by a guardian, medical agent, relative, carer or friend of the patient or any other person who is providing support to a patient under the Act, and
- » any other functions that may be assigned to them by the *Mental Health Act, 2009* or any other Act.

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

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

4.2 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.

Recent changes to the Act to accommodate visits to community mental health facilities now mandate that treatment centres and community mental health facilities must be visited and inspected at least once in every 2 month period.

In the 2016-2017 financial year there were 12 facilities within South Australia that were gazetted as approved treatment centres for the purposes of administering the Act. They were:

- | | |
|-------------------------------|------------------------------------|
| » 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. |

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

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

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

Treatment centres may have a number of units within them as seen in Figure 4.2.1

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 –
Lyell McEwin Health Service	Ward 1G Ward 1H – Older Persons Mental Health beds Emergency Department
Modbury Public Hospital	Woodleigh House Emergency Department
Noarlunga Health Service	Morier Ward Emergency Department
Oakden Services for Older People	Clements – now closed Makk – now closed McLeay – now closed
Repatriation General Hospital	Ward 18 - now closed and moved to Flinders Hospital Ward 17- now closed and moved to Jamie Larcombe Centre, Glenside
New Royal Adelaide Hospital	Psychiatric Intensive Care Unit (PICU) Open Acute Unit Emergency Department
The Queen Elizabeth Hospital	Cramond Unit – Open and Closed 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

Table 4.2.1. List of treatment sites and their units

4.3 Referring matters of concern

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

- » ninety four (94) issues were raised in reports that required follow up with mental health services management with sixty three (63) (65%) being resolved during the reporting period
- » concerns regarding the quality of care being provided at the Oakden Older Persons Mental Health service were raised in a specific letter on 14 October 2016 from the Principal Community Visitor (PCV) to the Minister for Mental Health and Substance Abuse. The PCV stated that given the number of issues and incidents that had arisen, staffing issues, and limited availability of staff and allied health services, an investigation was required to understand the current operations and management of Oakden. The PCV recommended that an independent review of services be undertaken to ensure that elderly South Australians receive the treatment, care and support they deserve
- » this combined with similar concerns that the Spriggs family raised with the Chief Executive of the Northern Adelaide Local Health Network (NALHN), who then requested an extensive review of the service be undertaken and be led by the Chief Psychiatrist
- » concerns regarding the restraint & shackling of a woman in the Flinders Medical Centre ED for a number of days, was referred by the PCV to the Ombudsman for investigation. The Ombudsman's report was released in February 2017, finding that she was unreasonably restrained and that the Department of Correctional Services (DCS) should formally apologise. In recent months the CVS has been advised that she had received an apology letter from DCS.

4.4 Advocacy

4.4.1 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. While the CVS is not a complaints resolution body or an investigation unit, it will refer individuals to other agencies and support them through formal complaints processes as needed.

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

Community Visitors and the CVS office received concerns from three families regarding the treatment and care of their loved ones at Oakden Older Persons Mental Health Service. These included reported frequent falls, observed bruising, serious medication errors, increased sleepiness, drowsiness, and reported decline of daily functioning. The PCV and Mental Health Coordinator provided ongoing support to Mrs Barbara Spriggs who contacted the CVS on 1 June 2016, with her concerns about the treatment and care of her husband, Bob who had two admissions into Oakden.

On both occasions, his condition declined markedly, and after the second occasion, he required urgent treatment at Royal Adelaide Hospital (RAH). He had, on at least 3 occasions, been given 10 times the required dosage of an anti-psychotic drug. He also had extensive bruising, unexplained, but consistent with the use of restraints and was badly

dehydrated.

4.4.2 Systematic advocacy

While the CVS is not able to make sole claim for achieving systemic change around any specific issue it is confident in its ability to present a strong and influential voice that delivers evidential value from a service consumer perspective.

During this reporting period it has become evident that a number of key issues it has advocated for are now being realised. As exemplified by:

- » long ED waiting periods have been eliminated in alignment with the health department's 24 hr policy
- » the standard of accommodation continues to rise with closure of Oakden and the opening of a new unit at Northgate. The opening of the new Royal Adelaide Hospital and new older persons mental health units at the Flinders Medical Centre and the Jamie Larcombe Centre at Glenside
- » it is anticipated that the shackling of forensic patients will in large be negated with the newly opened secure mental health facilities at the new RAH, an issue that has been on the CVS agenda since its inception.
- » the decision to retain the specialist psychiatric services for people with disabilities through Dr Tomasic and her team at the Centre for Disability Health (CDU) is acknowledged and welcomed by the CVS. This enables the ongoing review of more than 300 clients with disabilities who were previously discharged from various institutional care facilities many years ago on a range of psychotropic medications, which has been maintained without appropriate monitoring and review for 20 years or more. This matter has been raised by CVS with both relevant departments as a means of trying to increase resources and timeliness of these reviews of this large group of vulnerable clients who have been chemically restrained. This enables the ongoing review of clients with disabilities identified to be on a range of psychotropic medications, in order to ensure they are not being used inappropriately for restraint, are required for a current diagnosis, and ultimately to reduce the use of medication
- » the release of the independent review and report into forensic care and commitment to progress recommendations contained in the report an outcome strongly advocated for by CVS over the past few years.

4.5 Policy, strategy and clinical practice development

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

- » SA Mental Health Act Review
- » Disability inclusion Bill
- » NDIS Quality and Safeguarding 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 has an important role to play to ensure policy and clinical practise development is influenced by the experience of people with mental illness and their relative, guardian, carer, friend or supporter. The CVS therefore takes every opportunity to communicate issues on committees, through its own advisory committee and through input and comment on planning, policy and clinical practice documentation as listed below:

- » measuring impact of NDIS expert group in Melbourne
- » NDIS Independent Advisory Council
- » healthy eating seminar with a focus on disability clients
- » NDIS stakeholder forum SA - key influencers
- » meeting with the Ombudsman and Chief Psychiatrist regarding the shackling of prisoners

- » discussions regarding the draft Euthanasia Bill
- » contribution to the HCSCC paper re systemic issues in mental health
- » ICAC investigation in to Oakden
- » Attorney-General's department assessment of the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)
- » National survey of Community Visitor Schemes
- » Disability Inclusion Bill
- » SA Health Oakden Oversight committee
- » Mental Health Act Implementation group
- » The End of the Road – Rooming Housing in SA Roundtable with Minister Bettison

5. Report outcomes and themes

5.1 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 at times, the Office of the Chief Psychiatrist and the Minister.

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 CVS Advisory Committee meetings. The Advisory Committee is made up of a range of statutory officers, senior officials from services, and consumer and carer representatives. This committee makes recommendations to the PCV about the appropriate actions and referrals to be undertaken to address the issues that are tabled for discussion.

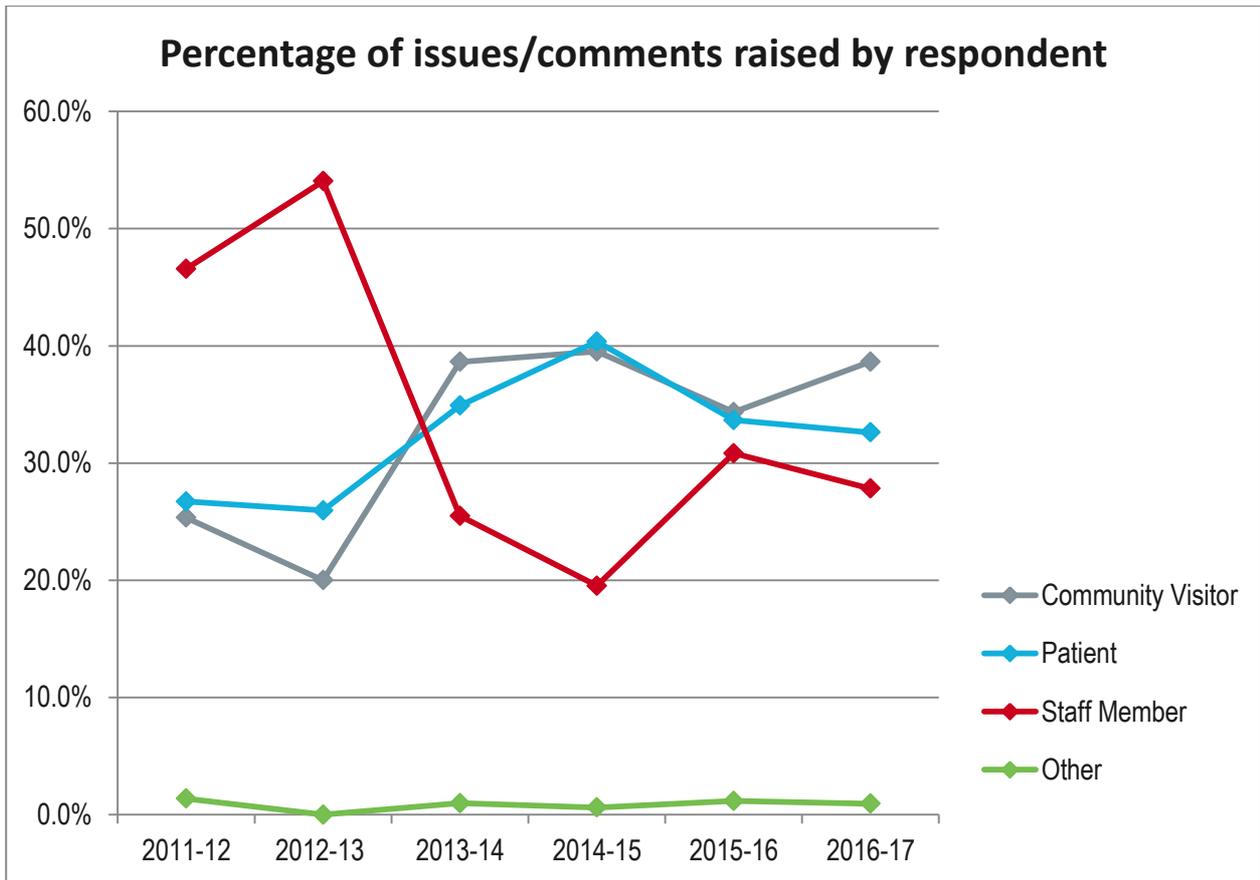
Issues of concern or positive comments are reviewed and classified against a set of six level 1 standards and a range of level 2 subset classifications. Table 5.1.1 details by percentage issues or positive comments raised by either patients, Community Visitors, treatment centre staff, and patients' families each financial year from 2011-2012 until 2016-2017.

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Patients	26.7%	26.0%	34.9%	40.4%	33.7%	32.6%
Community Visitors	25.3%	20.0%	38.6%	39.5%	34.3%	38.6%
Staff Members	46.6%	54.0%	25.5%	19.5%	30.8%	27.8%
Other eg patients' families	1.4%	0.0%	0.98%	0.6%	1.2%	0.9%

Table 5.1.1 Comparison of annual percentages of comments made by person who reported from 2011-12 through 2016-17

Figure 5.1.1 provides a graphical presentation of table 5.1.1 data. It highlights evenness (approx. 30%) in issues/comments raised by the different groups.

Figure 5.1.1 Comparison of annual percentages of comments made by person who reported from 2011-12 through 2016-17



Of the 647 reported comments during 2016-17, it is pleasing to note 306 (46%) 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 and units.

The number of issues raised by the respondent category 'Other' (carers/family members) continues to be considerably low as they are rarely in attendance. It is anticipated this is largely due to visits and inspections being conducted during the day, on weekdays and only on a monthly basis. The CVS continues to work with Carer Consultants and other staff to ensure families and carers are aware of the CVS' role and visit dates and times. The CVS also promotes the service by ensuring there are CVS posters in units.

5.1.1 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 5.1.2 presents a comparison of comments made by Level 1 category annually for each reporting period.

Figure 5.1.2 Number of comments made each reporting period for each Level 1 Category.

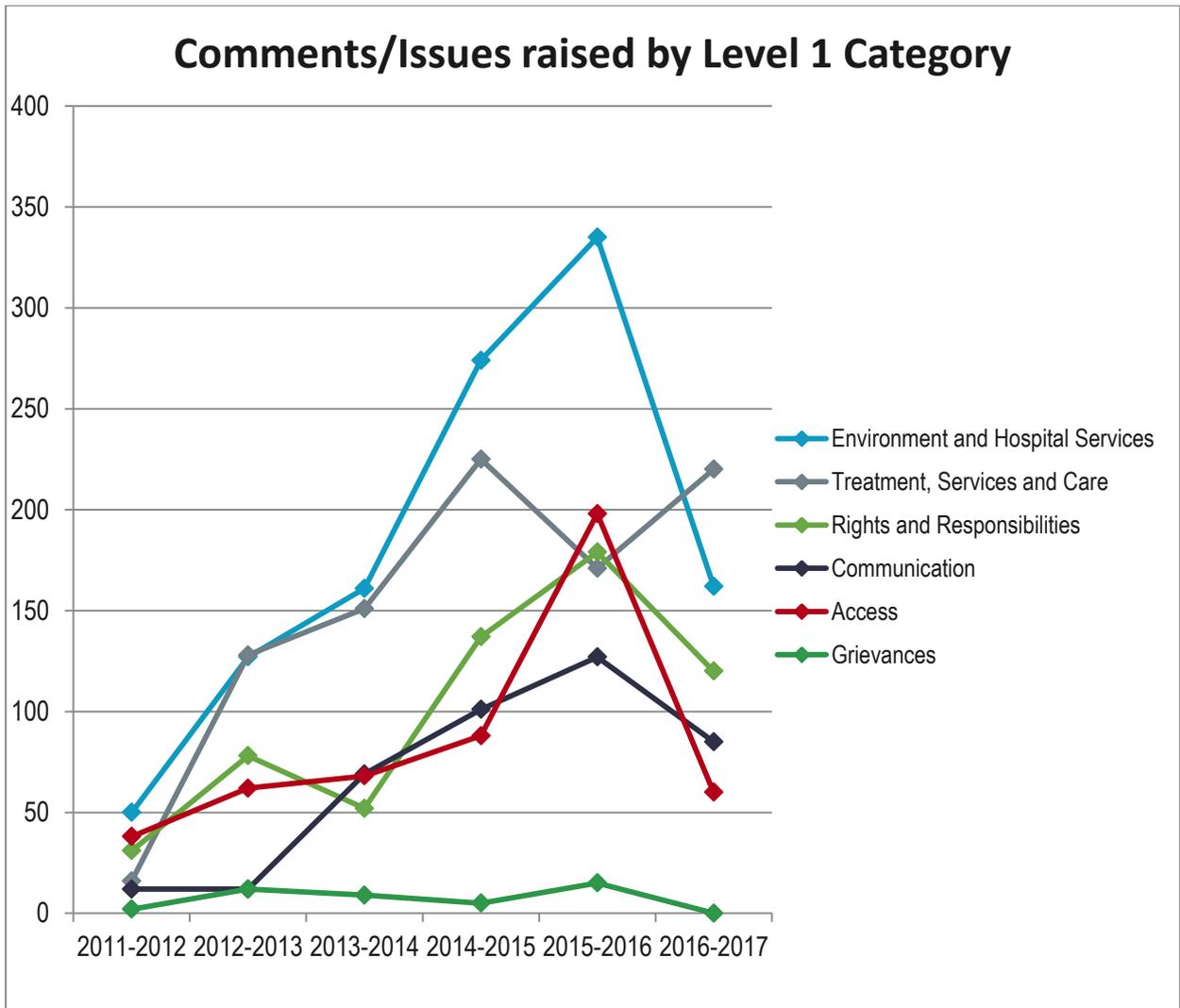


Figure 5.1.2 Number of comments made each reporting period for each Level 1 Category

The most reported Level 1 category was **Treatment, Services and Care**.

There were 220 comments made regarding *Treatment, Services and Care* of which 94 were issues and 126 were positive comments.

Comments reported under *Treatment, Services and Care* were mostly relating to *Activities and structured programs* as seen below in Figure 5.1.3. *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 in some units there are a range of programs available, while in others, patients regularly report boredom. (See Section 5.5)

The emergence of discharge planning as a significant issue by staff reflects pressure on the system to free up beds to meet the 24hr Emergency Department (ED) policy and the lack of community accommodation exacerbated by the closure of SRF's. (See Section 5.2.1 & 5.2.2)

Inadequate treatment is also an emerging issue related to the increased admission to mental health wards of people with alcohol and drug issues or with intellectual disabilities. Explored further in 5.2.3

Figure 5.1.3 Proportion of issues and positive comments for Treatment and Support Level 2 Categories

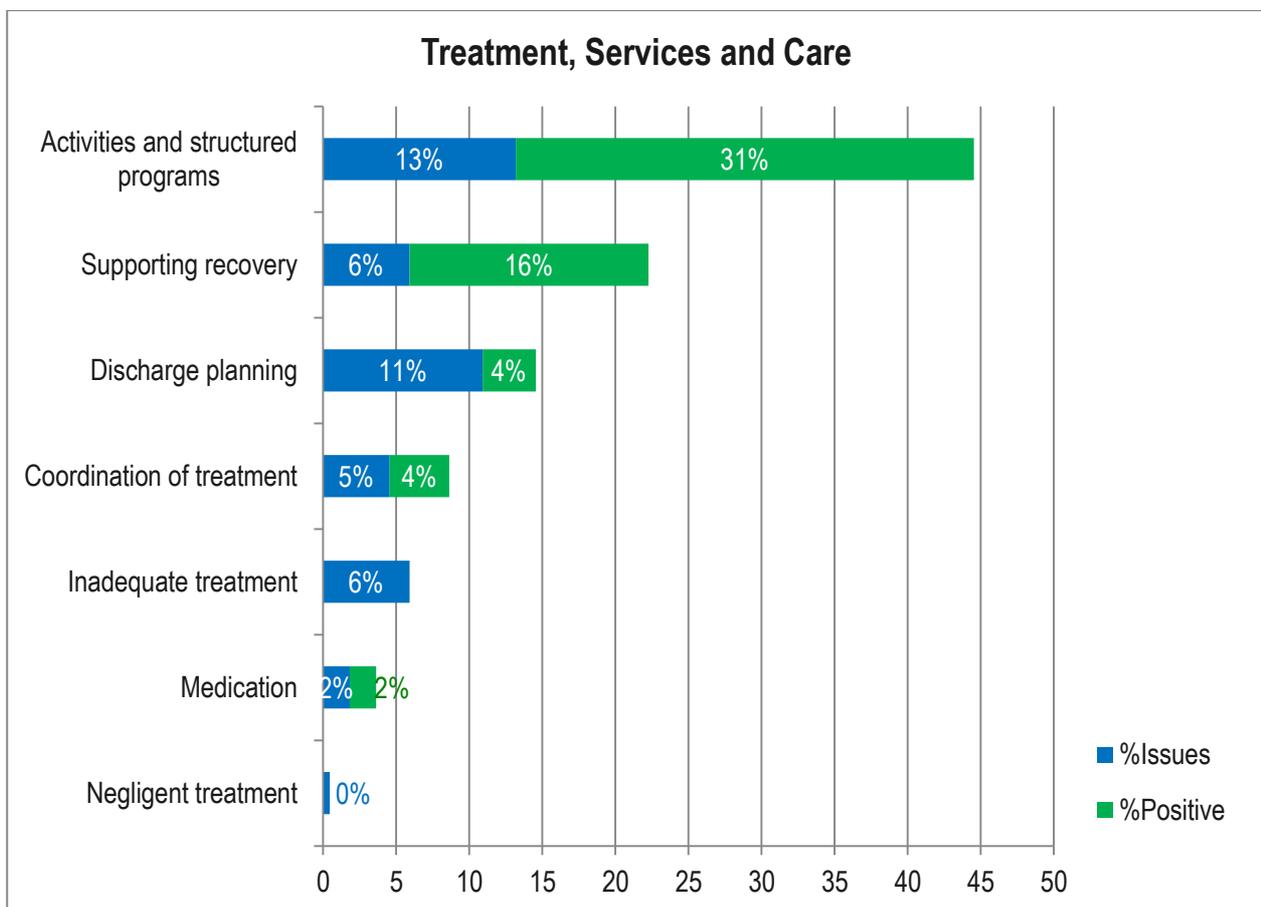


Figure 6.1.3 Proportion of issues and positive comments for Treatment and Support Level 2 Categories

Environment and Hospital Services was the second most commented on classification.

Figure 5.1.4 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 and smoking.

Figure 5.1.4 Proportion of issues and positive comments for Environment and Hospital Services Level 2 Categories

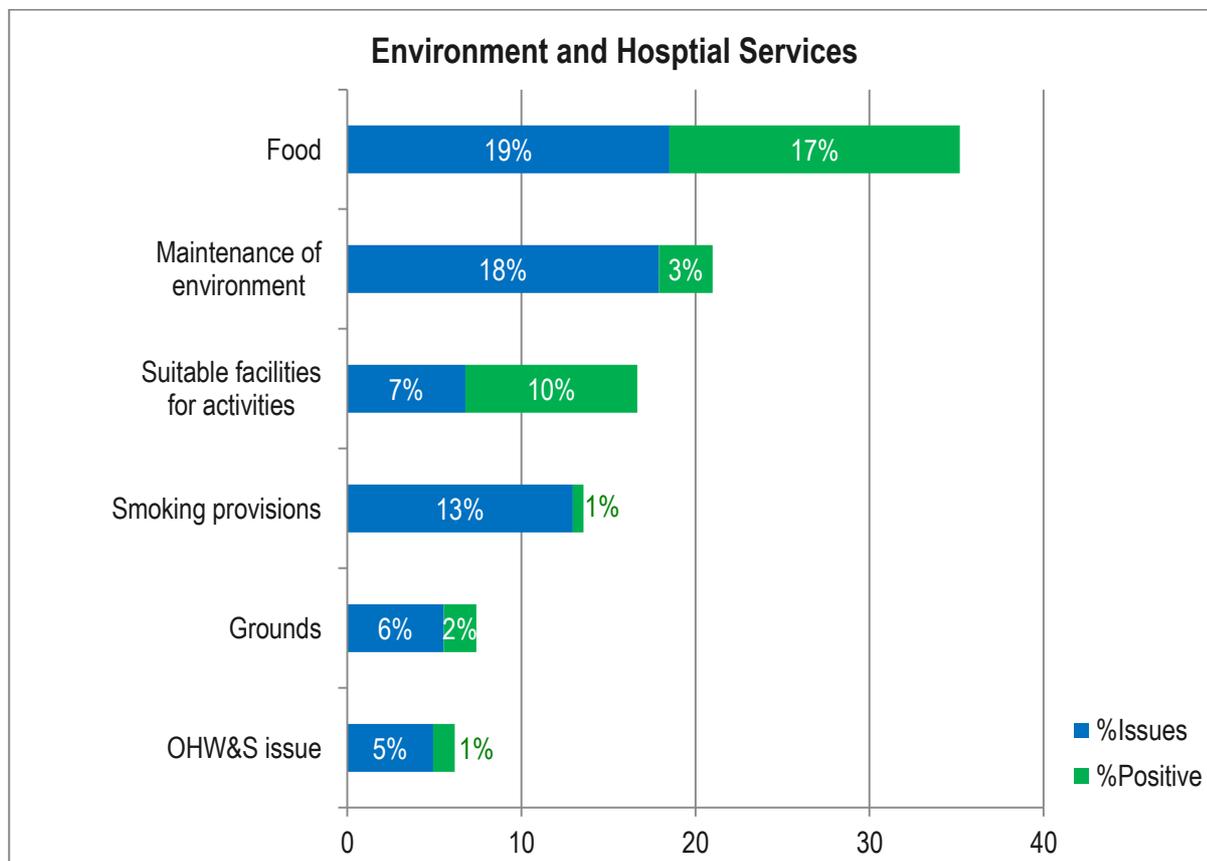


Figure 5.1.4 Proportion of issues and positive comments for Environment and Hospital Services level 2 categories

Food remains a highly commented on topic with a relatively even split between positive and negative comments. The negative issues were raised more in the long term accommodation with concern about the repetitive nature and nutritional value of the meals. Further discussed in section 5.6.2

There were a number of negative issues raised in regards to *Maintenance of the Environment* as there was in relation to *Grounds*. Poor lighting, poor air-conditioning, facility being run down and smelly is an example of issues raised. Issues with the security system at James Nash House has impacted on visits and led to patients being locked in their rooms or unable to go outside.

In relation to grounds, it would appear that often the external areas are used for smoking by patients and are stark and bare rather than being a friendly landscaped environment to provide an escape from the ward and a comfortable informal place to meet with family.

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. Concerns also raised by staff and consumers regarding the location of smoking areas on boundaries in some facilities which can create safety issues and exposure to other drugs. Further discussion of this matter is reported in sections 5.6.1

Rights and Responsibilities was the next most reported category. While there has been an increase in positive comments under this heading, there remains a high number of issues made regarding *Least Restrictive Environment*, *personal safety/assault/gender safety* and *privacy and confidentiality* as per Figure 5.1.5

Figure 5.1.5 Proportion of issues and positive comments for Rights and Responsibilities - Level 2 Categories

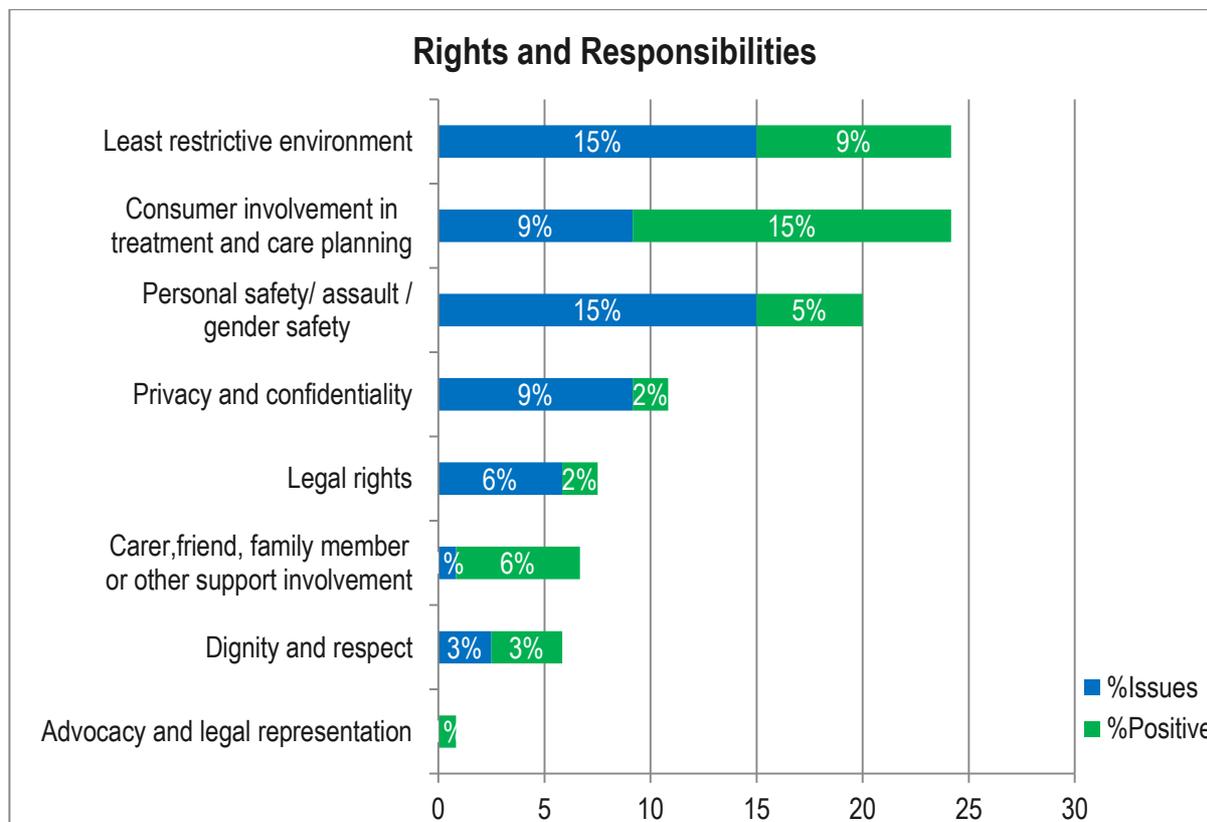


Figure 5.1.5 Proportion of issues and positive comments for Rights and Responsibilities Level 2 Categories

Reported issues related to *Least Restrictive Environment* primarily identify situations where justice patients are shackled to beds awaiting placement in a secure mental health unit, wards locked down due to security concerns or the overuse of security staff where there is some concern about patients absconding.

Personal safety/assault/gender safety details feedback provided by staff and clients regarding safety concerns on the wards due to a higher level of patient acuity relative to that assigned to the facility, increased admission of clients with drug and alcohol issues and evidence of assaults.

Issues around *Privacy and Confidentiality* have risen during this reporting period with the lack of space for private consultations or meetings with family and friends a significant concern for staff and patients.

While **Access** did not receive as many comments as other categories, issues around *Service availability* and *Delay in admission or treatment* drew the highest number of complaints. Figure 5.1.6 presents this category in more detail.

Figure 5.1.6 Proportion of issues and positive comments for Access Level 2 Categories

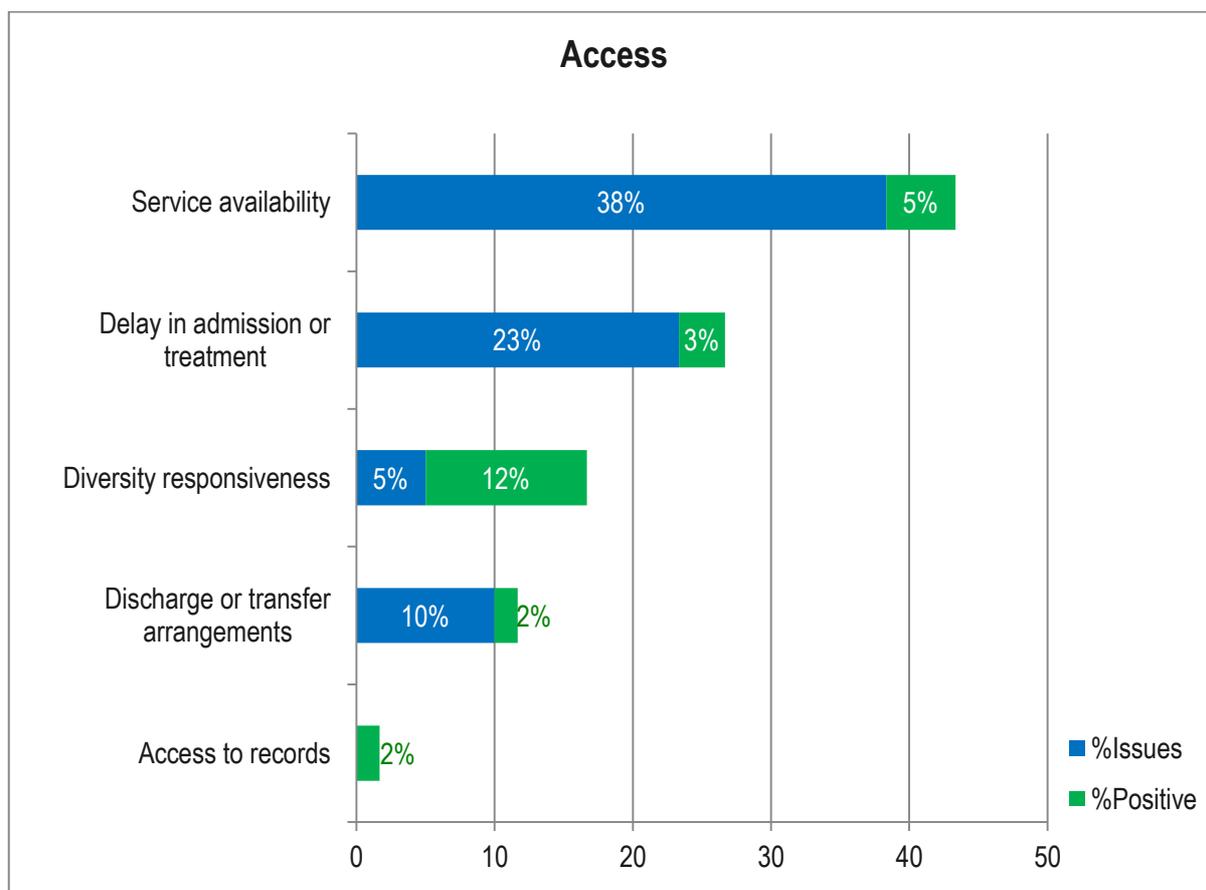


Figure 5.1.6 Proportion of issues and positive comments for Access Level 2 Categories

Comments regarding *Service Availability* predominantly related to the lack or limited accessibility to medical staff and allied health services. The lack of community based beds/accommodation for discharge combined with pressure to admit is highlighting the lack of services. Staff shortages were also raised as a significant contributor.

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. However, these SSUs are better than the high stimulus environments of EDs where lights are on 24 hours per day. Furthermore, there are clients staying longer in closed wards despite being assessed as ready to transfer to open wards and this is due to patients from an ED being given priority to prevent them breaching the 24-hour target. (See Section 5.2)

Discharge or Transfer Arrangements were impacted by a lack of appropriate accommodation options to discharge to, especially for people who are homeless or who have co-occurring addiction issues.

Communication was the least commented on category and these again were primarily positive as seen below in Figure 5.1.7

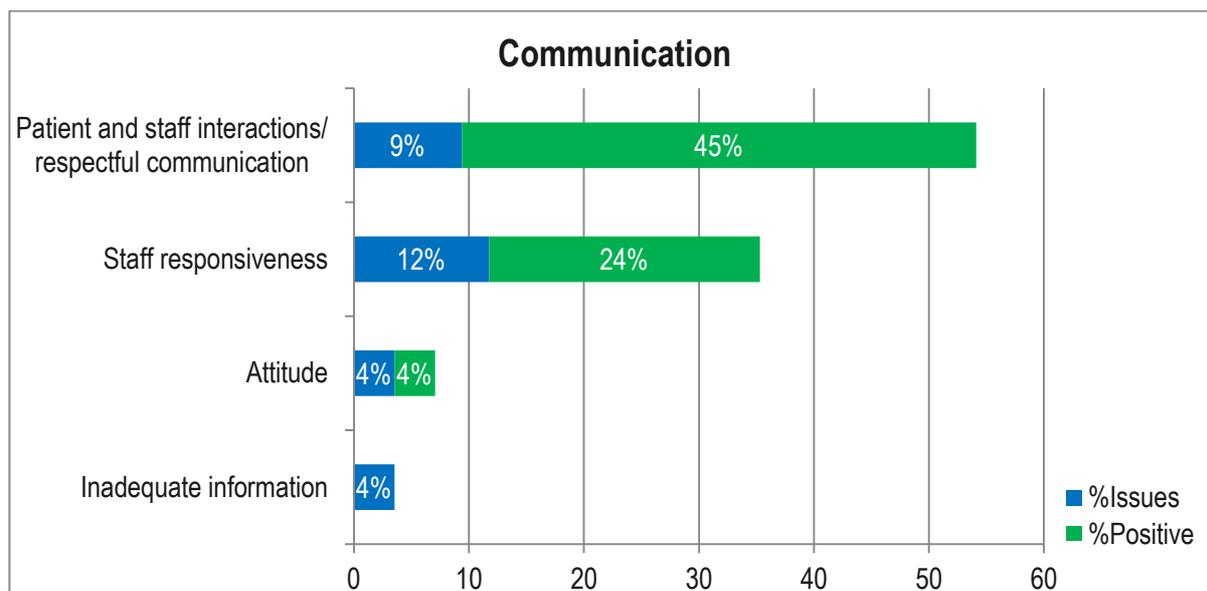


Figure 6.1.7 Proportion of issues and positive comments for Communication Level 2 Categories

Patient and Staff Interactions/Respectful Communication and *Staff Responsiveness* was the most positively commented elements of this category. Given that each facility was visited 12 times in the year it was clear that a few of the facilities contributed significantly to the total number.

There remained a number of clients who raised issues against all the subcategories including *Patient and Staff Interactions/Respectful Communication* and *Staff Responsiveness*. Two of the most regular issues were nursing staff always located in nursing station and not interacting with patients and limited transition of care at shift change.

The next section provides more detailed discussion of the identified issues raised during the 2016-2017 monthly visits and inspections to mental health units, and will cover the following topics:

- 6.2 access to services
- 6.3 treatment and care plans
- 6.4 personal safety
- 6.5 activities and stimulation in treatment centres
- 6.6 environment
- 6.7 dignity and respect, and
- 6.8 Oakden Older Persons Mental Health Facility.

Extracts from CVS reports are used extensively to highlight and give detail to the issues raised and provide perspective to the discussion.

5.2. Access to services

5.2.1 Emergency Department waiting time

The CVS applauds implementation of the government's policy that no mental health consumer should wait in Emergency Departments (EDs) more than 24 hours for admission to an acute hospital bed. It appears from visits to ED's, that this has been successfully implemented, with only a few exceptions. The introduction of Psychiatric Extended Care Units (PECUs) and Short Stay Units (SSUs) have proved effective in moving mental health patients from the busy and noisy EDs to a calmer environment provided by the SSUs.

There has been evidence where this has not been achieved, in particular the transfer of patients from the department of Correctional Services to a bed in forensic mental health facilities. This has resulted in the continued shackling of

patients to beds in the ED units. The CVS is extremely hopeful that this will be negated with the opening of the new RAH where security in the closed mental health units is sufficient and therefore negates the need to individually secure patients via mechanical restraints. Excerpts from visit reports:

Senior staff expressed concern at system delays in being able transfer patients requiring ongoing treatment to facilities at Glenside and elsewhere because of accommodation shortages. Breaches of the 24 hour policy ED often occur. At time of our visit there were a number of patients in that category with one being in the ED unnecessarily for 62 hours.

While the rapid transition of mental health patients through ED's has been positive, some staff have identified that this has created problems downstream, most notably patients in closed wards unable to transition to open wards as priority of admission to these wards is given to ED patients. When there are increased demands, there is added pressure to discharge patients earlier and as a result of this, staff within these units claim that this results in a revolving door situation. There is also evidence that if admitted to a major hospital such as the RAH, that transfer back to your local network service is virtually impossible as priority is given to ED admissions in that region. The following report extracts illustrates the concerns raised:

A staff member raised the issue that sometimes patients although ready for an open ward, are delayed as the department wants to keep some beds open for clients that may come through emergency or short stay. This is not in keeping with the "least restrictive environment" policy.

Attempts are made to keep one bed free to provide flexibility between the units and consumers' needs. There are a number of consumers in the closed ward on a wait list for the open ward. Some of the consumers in the closed ward have been there for many weeks.

While the 24hour ED time limit is achieving a positive outcome in relation to the time patients are in the ED, it continues to create downstream problems such as:

- » *pressure to release patient early to create a bed for patients in the ED*
- » *bed allocation being based on bed flow priority, not clinical need*
- » *patients being held longer in HDU while patients from ED take priority on beds in open*
- » *ED patients being given bed priority over direct admissions possibly requiring a patient who could be brought directly to Morier ward from the community, being required to present to ED first.*

Staff raised concern about the pressure to discharge patients due to the demand for admissions into the Acute Unit. This situation has the potential to reduce the effectiveness of treatment required by individual patients if it is cut short or discontinued because of the early discharge.

Staff advised that they do not have enough time to properly engage with patients. Patients are often discharged before they are well enough. The Psychiatric Intensive Care Unit (PICU) is often forced to transfer patients to Eastern Acute who are very unwell and this puts enormous pressure on Eastern Acute to discharge 'the least unwell patients' to create a bed-space. Staff at these units state that this also means there is a revolving door of patients. Staff feel that patients are not getting the care that they require and they are not comfortable with that.

There also remains patient and staff concern regarding the environment of these units. Sharing of the SSU space with a surgical unit; limited activities for clients; limited client access to allied health services to commence their journey to wellness have been highlighted:

PECU was at full capacity (5 clients), some for 5 days in a very confined unit with no other option than stay in bed, little privacy as the beds are only separated by a curtain. Clients have to share the 1 bathroom/toilet in the unit - they do that taking turns for showers or using the toilet (more of an issue when there is 5 clients in the unit). There is no area to discuss privacy issues with clients. There are no lights above beds for clients to read etc. No appropriate provision for client's belongings.

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 are concerned about the high turnover of consumers to make room for others. Pressure to not breach the 24

hours in ED rule is seeing some consumers being admitted before they have been properly stabilised, resulting in higher incidences of code blacks and an incident at Woodleigh House the week prior resulted in 7 broken windows. Staff are also concerned that very unwell consumers are not being admitted to high dependency wards, rather to an open ward with a security guard.

While staff have relayed to CVS that they believe this has resulted in a 'revolving door' or increase in re-admissions within a specified timeframe, the CVS has attempted to obtain evidence of this through the various Local Health Networks (LHNs). Re-admission data is collected as part of the Key Performance Indicators (KPIs) that services have to report against and at this point of time, we have not been able to obtain this data from all LHNs but have requested this and recommend that this information also be distributed to senior staff at all mental health units.

5.2.2 Discharge and accommodation options

The issue of service access is amplified in the community, and the lack of appropriate accommodation discharge options adds to the pressure on inpatient beds. It is presented by staff that this is also leading to readmissions. The following excerpts from reports provide further details of these concerns:

It was also pointed out that accessing supports in the community for discharged patients is problematic and sometimes people are discharged without optimum levels of community supports in place. Another pressure is patient flow through and the increase in people being discharged earlier than is preferred.

X has been a resident at the ward for over 90 days because he has nowhere to go. Prior to his admission, X was at Ward 1G open unit for over 50 days. Upon discharge he allegedly became homeless. X's mental health is currently stable but the staff are reluctant to discharge him because they cannot find appropriate accommodation for him. X has an intellectual disability and is being provided with 1:1 support whilst at Ward 1G.

There is a need for sub-acute beds to be re-established to care for people who are not well enough for discharge but no longer need acute care, Step-down units such as the Intermediate Care Centres (ICCs) was a key recommendation of the Social Inclusion Board's 'Stepping up Report 2007-12' and implementation plan. The CVS now visits the two remaining ICCs which are highly valued by both the clients that use them and their families, others have expressed concern about the loss of the Eastern ICC that was located at Glenside but has since been closed to accommodate the new Jamie Larcombe Centre.

Recently, they managed to undertake two successful discharges. One of them was in the ward for more than six years and another one was there for the last four years. It was a long challenging journey to find appropriate accommodation for them. Both of them are now accommodated in the community with constant support from community mental health agencies and also assigned case workers to get supports.

Staff member highlighted the difficulties in meeting the needs of people with both mental health and intellectual disability issues particularly with regard to securing suitable accommodation and support post discharge.

Reiterated the ongoing concern that due to shortages of beds, some patients are being discharged earlier than is ideal. This often results in re-admission to acute care. There is a need for sub-acute beds to be re-established to care for people who are not well enough for discharge but no longer need acute care

Staff and a doctor in all the units explained that accommodation at discharge has become a huge problem since the 24 Crisis Respite beds are no longer available. Discharge planning has the added burden of a growing shortage in accommodation places since the closure of a number of SRF providers.

These included several matters of direct concern to the patients, such as the lack of respite care received by the patients on discharge. A number of patients are reportedly not taking up the opportunity of respite care when discharged to a location such as a motel unit, but rather they are effectively returning to a state of homelessness (even though discharge to homelessness is not permitted). The staff state that they see a very high percentage of returning patients and have direct experience in this unfortunate cycle.

5.2.3 Specialist services

As raised in last year's report, the lack of allied health specialists available for clients, as well as the lack of other supporting roles such as Activities Coordinators remains a significant issue. Given the observation of visitors that medical and nursing staff time is primarily consumed with the day to day running of the ward, patient observations, patient reviews and medication management, there is limited opportunity for therapeutic interventions and capacity building to the patient's time on the ward.

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. Most significantly, the lack of social work services is impacting on discharge arrangements which are already extremely difficult due to the lack of accommodation options. These concerns are articulated in the following report extracts:

A part-time dietitian is the only allied health professional in the Oakden facility; the lack of social workers, OTs, a physiotherapist, psychologist and speech pathologists etc., is keenly felt. The RMO described how she had recently become aware that a previous CVS report of inadequate staff had reached the Executive, which had responded that some of these allied health services are available from Ward 1H. However, staff have been told to call on these only in exceptional circumstances and indeed, only two referrals have been made in the last 18 months (one forensic).

Clients explained that the social worker did a wonderful job of helping the consumers but was swamped with work as this position was only part time and clients believed that there was a need for a full time social worker.

The Clinical Nurse Consultant pointed out the lack of allied health professionals like physiotherapists during the visit. Due to funding issues, certain positions are not back-filled upon becoming vacant. Patients staying for longer time do not have enough activities.

A full time social worker was supposed to be appointed to support patients with accommodation and other social support needs however, this has happened and as a result, nursing staff are spending a lot of their time trying to find accommodation for patients. There is a number of homeless consumers that have mental health issues that regularly are admitted at the RAH ED and C3. This makes the discharge of these patients more difficult and admissions longer.

There is no OT, Social Worker or Psychiatrist. Filling the position of Social Worker is now on the radar. The physio gap is being filled through NALHN one day per week, with two days seen as preferable by staff.

Lack of staff is an ongoing issue. Recruitment is currently on hold and therefore any vacancies are not backfilled. In X ward, there is still a high use of agency nursing staff. When the activity coordinator was on leave there was no replacement hired for that period.

On several wards, the lack of access to Medical staff was raised as a concern. The CVS recognises this will be a challenge in rural areas where the recruitment and retention of medical staff will be problematic.

This unit is still without a regular consultant which affects the quality of treatment, care and rapport with the health team/consumer. Delay on reviews, assessments, treatment, discharge plans were reported. There was a day that the consultant just worked for a half day.

Medical cover continues to be a problem for the Unit and this needs addressing at a senior level with Country Health as this has the potential to place mental health patients at risk.

A patient expressed concern that her treating psychiatrist only saw her once per fortnight and missed her scheduled appointment with her today because she was on sick leave. She stated that she was concerned that this interaction was too far apart and that she was not benefitting from such long gaps between appointments. Enquires with medical staff on duty at the time revealed the possibility of short-staffing in this area (down from 3 to 2 with a senior consultant) and information that X's psychiatrist was responsible for about 30 of maximum 40 patients within Rehab at any one time.

The changing profile and complexity of the patients being admitted to the wards is creating a new dynamic and a challenge for staff. Mental health staff are expressing concerns about the lack of specialist skills and environment to support the treatment of those admitted with co-occurring drug and alcohol and mental illness. This appears further compounded by the lack of community based drug and alcohol treatment and accommodation services to receive referrals.

The increase of substances abuse induced psychosis presenting in ED has created a higher levels of aggression, increased the numbers of code blacks and physical harm. The need for a proper detox care and service has become matter of need within the mental health acute centres.

The majority of patients are admitted to the short-term unit with comorbidity issues of drugs and mental illness. Around 80% of admissions are due to drug issues. One patient had been in the unit for 15 days. Seclusion areas

requiring 24/7 supervision are used as a last resort and the seclusion room in Eastern PICU is also used by Eastern Acute, Cedars Acute and Rural and Remote. There are 2 such rooms on the entire campus.

A nurse commented that more professionally-trained therapists would be helpful to clients' need to develop skills and strategies for life after discharge, including specific Drug and Alcohol interventions.

Although amphetamine use is a huge problem there are no specialised programs for users who are motivated to change, all admissions are to mental health wards. .

5.2.4 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 monitor access to allied health services and the availability of these roles within mental health units.

5.3 Treatment and care plans

Whether patients have a current and active treatment plan remains a priority issue for review by the CVS as part of its visitation program. It is the view of the CVS and its advisory committee that this one key element if implemented and applied consistently across mental health services, will bring significant gains for consumers. Care plans have an intrinsic alignment with the recovery model as adopted by mental health services.

Visit reports indicate that there remains inconsistency 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. As raised in last year's focus report, the delivery of plans electronically remains problematic.

When inquiries were made regarding treatment plans, it was explained that a plan would ideally arrive with community based patients, however these were not feasible for acute patients. A problem exists with the newly introduced EPAS computer program not containing all relevant information for some patients, some of which was recorded on the old CBIS computer program, requiring staff to access both computer programs to get a complete patient history

X and her team are aware that the support and discharge plans are not as thorough as they should be. However, X commented that the emphasis on medically 'stabilising' the condition of the residents was appropriate particularly since the average residency was 8 days.

Patients did not have an understanding of care plans. The team leader explained that all the clients are offered to be provided with a printed copy of their care plan but the response is usually that they do not need a copy.

On a positive note there was evidence that care planning and the use of the formal documentation is leading the delivery of care in several units. Some units also scheduled meetings with family members to ensure their involvement in the development of such plans.

Staff told CV's of a major change in care planning process which began two weeks ago. Care plans are now developed in conjunction with having a care plan meeting with each consumer individually. Taking a client focused approach. Consumers have the option to have their family involved in the second half of the meeting.

Staff explained that client's families were involved in formulating the care plans which were updated weekly, and the CVs were shown detailed care plans in hard copy.

Staff also demonstrated how each patient's clinical and therapeutic needs are summarised on a whiteboard that almost runs across the width of the staff room. The needs identified on the whiteboard summarise many (and ideally all) of the activities in the treatment and care plans. The whiteboard treatment and care plan is an active document which is available to all staff, and which can be easily updated as the need arises.

5.3.1 Recommendations

5. That all treatment centres, as part of their key performance indicators, report on their practice of developing and maintaining mental health care plans.
6. 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.

5.4 Personal Safety

It is important that staff and patients in acute mental health units, PICU units or EDs feel safe as these are therapeutic environments aimed at assisting patients to recover. There is much publicity around growing workplace violence in hospitals which became more evident for the CVS when one of its visitors was subject to an assault during a visit. It is an issue raised often in reports as exemplified below:

X, who has been a nurse for many years, spoke to us of the increasing levels of violence staff face on the ward. The increase in the use of ice is impacting and she highlighted the lack of safe seclusion spaces on the unit when behaviour becomes dangerous.

One of the CV's was hit by a patient during the visit. The patient had previously hit other staff members. CV's were concerned for the safety of other patients and staff. Is important to mention that this building design does not contribute to safety due to the access into the nurse station is through the patient's common area for 10 highly acute clients.

All senior staff raised concern about the physical safety of patients and staff due higher acuity levels and the growth of drug-induced psychosis. A number of incidents were reported where clients got violent and safety of the staff and other patients were at risk.

The challenge for mental health services is to ensure there is balance between providing safety and a therapeutic environment. Excessive focus on safety and the over application of safety controls can at times heighten anxiety for all concerned.

Woodleigh House is an open unit that cannot accommodate clients who are acutely unwell and who are at risk of harming others or themselves or absconding. However, there have been occasions where a number of these at-risk clients have been admitted and security guards are used for 1:1 supervision to manage these situations.

At times this can create certain feelings of unsafety amongst other clients in the unit as they jump to a range of assumptions as to why the guards are needed. That was the case at the time of visit, when a young male in his first admission was closely supervised by security staff. CVs observed that one of the more mature guards was able to do this more discreetly from a distance whereas the younger guard stayed within a few metres of the patient at all times and followed him around all over the place. This must have felt quite restrictive and intrusive?

Whether the door will be locked or unlocked is reviewed each morning and a decision is made based on the current patients. This does result in greater restrictions for some patients if their co-patients are considered "at risk". ED Patient reported feeling unsafe and feeling uneasy due to the behaviour of another patient. However, she advised nursing staff who were quick to calm her and advise her of the presence of security and that she was safe.

Victoria has implemented 'Safewards'¹ which is based on a successful evidence-based model used in the United Kingdom that aims to reduce harm to patients, staff and families caused through conflict in health services. It identifies situations that lead to conflict and provides practical strategies to avoid it. Safewards empowers staff to de-escalate conflict situations and reduces the need for stressful interventions. The program was successfully piloted in 2016 across 18 Victorian inpatient units. The pilot program reported a downward trend in seclusion episodes and up to 50% of staff reported feeling safer in the workplace following its introduction. The Safewards model is a community and consumer-driven project where wards are driving the care and practices they believe will work best for them and their patients.

Through Safewards, the patients and staff created a real sense of belonging and form a small community in their environment. This community setting can positively impact their overall experience, reduce extreme measures of

¹ Safewards Victoria - <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/safewards>

containment and result in a happier work place for all involved as well as their families. (The Office of the Chief Mental Health Nurse (OCMHN) Vic Health)

5.4.1 Gender Safety

An area of personal safety that has been raised as a concern in previous annual reports is gender safety including the call for Gender Safety Guidelines, similar to those developed and implemented in Victoria. While the CVS has had opportunity to comment on the draft guidelines, implementation of the new mental health act and the review of Oakden has limited the Office of Chief Psychiatrist (OCP) capacity to finalise and support implementation of these guidelines.

While the CVS encourages the implementation of guidelines as a first line strategy, it remains concerned as detailed in last year's annual report, that there is strong evidence that mixed gender wards have failed women with a mental illness as highlighted in the Victorian Mental Illness Awareness Council Australia (VMIAC) Report. A further study by VMIAC, revealed shocking statistics on psychiatric admission experiences for women including 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'.

In response to this issue, SA Health 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 directive² and policy guidelines³ 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 affect that individual. CVS visits highlight that there are patients who feel vulnerable within the system.

A young pregnant client expressed her concern about not feeling safe and felt that she was treated differently and believed this was racially-based. She also had a conflicting relation with a male consumer, staff is aware and trying to manage this issue. All her concerns were discussed with the staff by the CVs and she was reassured and supported by staff.

Patient X(f) complained that she had been touched by a male nurse who was injecting her medication the day before our visit and that another patient (male) had been treating her aggressively and had opened her bedroom door on occasions. Discussed both issues with unit manager who was aware of situation and advised that they were monitoring interactions between her and male patient to ensure her safety. The injection incident was related to a tutor nurse instructing a new member on the correct way to place and inject the medication. In doing this, the tutor nurse had briefly but physically touched X on the upper buttock close to the small of her back. There was no allegations of sexual assault by the patient, it was just X feeling uncomfortable being touched on skin by male. In any case, a female staff member was present and it is highly unlikely that this event will take place again. The CVs spoke briefly to X on leaving and she appeared at ease that the matter had been discussed with staff and that there was no further need for her to be concerned about the male nurse actions or the other patient's aggression.

5.4.2 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 this report 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.

Male forensic patient X had been in ED for 5 days at the time of the visit because he was waiting for a bed in James Nash as that is seen to be the only appropriate option for him. He had hard shackles on his wrists, plus 2 correctional officers were guarding him. This consumer has been shackled to his bed for 5 days

Patient had been admitted to Aldgate within the last 24 hours, after a transfer from RAH, where he was taken after

² SA Health, 2015. *Preventing and Responding to Workplace Challenging Behaviour, Violence and Aggression Policy Directive.*

³ SA Health, 2015. *Preventing and Responding to Workplace Challenging Behaviour, Violence and Aggression Policy Guideline.*

his arrest. He advised that during his 24 hour stay in RAH, he was cuffed to a bed by one hand and both ankles. He was required to use a bottle for urination. He did not suggest that he had been mistreated.

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.

ED staff reported an increase in the number of patients presenting with manic symptoms and advise that this had required an increase in the use of restraint both chemical and mechanical. Not all incidences of chemical restraint are recorded in the Safety Learning System

A number of people were observed to be alone in their rooms, restrained (for safety), and in various states of distress.

Patient X asked specifically to talk with us. He is on an ITO patient who had been admitted 4 days prior. He was extremely articulate, and had a long written list of his grievances relating to forcible administration of medication, incarceration and feeling unsafe in the Unit.

ED staff had advised CVs that one consumer was shackled for a short period due to aggressive/threatening behaviour.

The use of security staff to supplement low staff levels is an emerging theme that raises concerns. The evidence is strong that this is counter intuitive to good clinical practice and questions whether resourcing and safety is the prime objective of inpatient mental health services with a reliance on therapeutic interventions being implemented on discharge.

Management denied allocating more than one security personnel in cases where the unit is having more complex consumers with a high risk of absconding and doing harm (to self or others). According to staff, it is challenging to manage more than two unwell clients by one security personnel and to avoid risk, they were advised to lock the courtyard and other entrance. Staff also informed CVs this is a campus centred management plan, where management assesses the needs for allocating staff to manage 'unwell' consumers and last weekend, staff were advised to lock this open unit.

This is obviously imposed restrictions on the consumers who are meant to be treated in an open ward. Frequently, consumers who need closed beds were sent to this unit with security personnel. Lack of adequate security personnel can add more complexity in those situations. To manage more consumers with challenging behaviour, security guards seem to be used more frequently

It was disturbing to note that a security guard was posted just inside the door of Crammond open ward and two others were inside the unit. The atmosphere was tense and the staff on the floor appeared stressed.

It is acknowledged that SA Health has a significant policy⁴ and a series of tool kits in place, in an effort to reduce restrictive practices. This includes 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.

5.4.3 Recommendations

7. That SA Health staff working in Emergency Departments and mental health units complete SA Health online training regarding restrictive practices.
8. 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

⁴ SA Health, 2015. *Minimising Restrictive Practices in Health Care Policy Directive.*

9. 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
10. 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.
11. 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.

5.5 Activities and stimulation in treatment centres

Consumers and families continue to articulate that activities and structured programs within acute inpatient and rehabilitation centres are essential for people to learn and develop skills in moving towards wellness. These programs break the boredom and provide opportunity for engagement by staff and opportunity 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.

Ward function and design and reduced staffing continues to present barriers to the delivery of such programs resulting in the ongoing expression of frustration by many. Section 5.2.3 highlights the impact vacant OT positions and activities coordinators is having on access to services. These issues are evident in the following excerpts from a number of reports.

Consumers commented on the lack of activities available. Craft supplies were decreasing and going to be replenished on the day of the CVS visit. Appointment of an activities coordinator is in progress.

There doesn't appear to be any activities happening at the unit, there is a TV, newspaper but no other structured activity appears to be happening.

Staff noted activities area is also used for family visits and when the area is being used for visits it is unavailable to other patients to do activities.

Patients complained about the lack of stimulating activities in the wards (i.e. in addition to those in the shared activity area), boredom, sitting around watching TV, etc. Patient suggestions for improvement included access to computers (games, etc), talks on topics including mental health conditions/relationships, and a 'therapy' dog. One patient, a recent admission, was not aware of all existing activities (eg X-box, jigsaw puzzles). The peer support worker takes patients for walks, but not those who are more unwell.

The table tennis table which was broken in August has still not been replaced with a new one or alternative physical exercise equipment. Previous reports have identified residents asking for exercise equipment.

Patients on SE made comment that there was a lack of activity available to them during afternoons and on weekends. OT Julie agreed that most activities occurred during morning but said that coloured pencils, games and puzzles were available at any time in common room area. She agreed that weekend activity probably needed attention but because she was not able to work on Saturday and Sunday it depended on the time and availability of nursing staff to organise that. She also stated that there was no one to organise activities on a regular basis while she was on leave.

She had recently taken 3 weeks leave during which no staff replaced her to provide activities for patients. Additionally she stated that although some activities were left for the weekend, patients needed motivation from staff, and this had not been forthcoming. At the time we visited, Julie was not able to provide activities for the afternoon, as she had been asked to prepare a staff holiday roster. CV's thought that the lack of stimulation from an activities person might have a negative impact on patient care and recovery progress.

There were no activities listed for the week. There was a general list of what is available but no instruction as to how clients can avail themselves of these activities. As previously mentioned, one client said boredom was an issue. One client was watching TV. The notice boards looked dirty and disused.

Patients again raised their concerns in relation to activities. Staff acknowledge patients' concern, but say that in striking a balance between providing sufficient stimulation for patients who are bored and ensuring a calm environment for those needing a quiet place, the latter takes priority. Discussion with a recent admission suggests patients may not be well informed on the range of activities available or encouraged to use them - many of which are stimulating but would not impact on the calm environment (eg jigsaw puzzles)

5.5.1 Evidence of Better Practice

CVS reports submitted during the last year indicate that there continues to be evidence of good practice in terms of activities and stimulation. Activities designed to develop everyday skills and responsibilities in clients are noted to be implemented in some units and there is evidence of strategies to communicate to patients what activities are available. Most notably, there is evidence of staff engaging with the consumer group to determine what they would prefer and there is a move to provide sensory rooms or areas to provide clients with a calming environment and calming tactile products.

At the time of the CVS visit, there were few consumers present. Many were involved in activities in the gym and elsewhere. There is a large whiteboard near the nurses' station which contains details of various activities available each day. Some consumers were playing billiards, while a well-stocked bookcase and 'in progress' jigsaw puzzle were observed.

Following a client survey, Morier Ward is looking at which items can be installed after reconstruction and especially integrating with a Rotary group to provide the necessary facilities. The outdoor area continues to be a work in progress but interaction between this and the vegetable garden is active and valued. The limited space available is being constantly assessed and adapted for maximum use. Arts/crafts are in evidence.

Discussion with staff about future plans to change the interview room to a 'sensory' room with appropriate furniture and items to provide a calm and relaxed environment.

There is a 'sensory' room where patients can feel various objects to assist with anxiety reduction. The atmosphere, amenities, cleanliness, space and temperature was assessed as being conducive to provision of quality care. There is a very broad range of activities in the general ward: art and craft, daily activity. There are limited activities in HDU, but when patients are well enough, the OT tries to engage them in group or one-on one activities.

The courtyard garden is a peaceful place to relax. The vegetables growing were well cared for and thriving. A very healing environment

An activity therapist has been recruited on a full time basis for Boylan unit and she plans different project and theme based activities for the clients. She also provides one to one support and engages the clients in meaningful way. The focus room in Boylan is equipped with sensory modulation with things like weighted blankets and massage chair to help clients to be more relaxed and calm. According to the staff, this room has proven to be very useful and provides a therapeutic space for the clients.

In summary, 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. 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. 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.

5.5.2 Recommendations

12. 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.
13. 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.
14. That the Community Visitor Scheme continues to monitor the levels of activities offered to patients.

5.6 Environment

5.6.1 Impact of SA Health No-Smoking Policy

The issue of smoking and no-smoking policies within acute inpatient mental health and emergency settings continued to be raised during the 2016-17 reporting period, in particular, not being able to smoke in closed units. Staff also expressed frustration of needing to implement the policy and its impact on patients who are already in a state of stress.

In previous annual reports, the CVS has called upon the SA Department for Health and Ageing to undertake a detailed risk-assessment into the impact to patients who have smoking addictions and who have been placed into closed units. This has been a genuine request so that there can be a better understanding of the overall impact on clients such as the number of assaults or aggressive acts against staff and other clients that are directly attributed to frustration at not having access to cigarettes, and the number of physical and chemical restraints/seclusions applied following requests/demands for access to cigarettes.

One of the most memorable comments the CVS received on this topic was from a young woman in her first admission to a closed unit. She was a non-smoker but stated that she “wished that the service would allow all those with smoking addictions to smoke in the open courtyard because she was sick and tired of being assaulted and threatened by other patients who became angry and aggressive at not being able to have access to their smokes”. However, to date, there has never been any attempt at better understanding the depth of the impact of this policy on those in closed units yet those clients in open wards across the state continue to smoke in their courtyards and directly outside entrances to the facilities. The inequity is obvious for all to see.

The Community Visitor Scheme will continue to lobby for individual patient rights under anti-discrimination legislation and specifically those who have smoking addictions and who have been placed in closed units and continues to put forward from a consumers’ perspective the challenges they face with the policy.

The CVS most certainly does not want to promote tobacco use in any way shape or form, however it does need to honour the desperate pleas from many consumers in closed units who believe that there is blatant inequity in the manner in which the policy is being implemented. Our observations over past years clearly demonstrates that it is only in the closed units, that consumers’ tobacco is forcibly denied, consumers in open units across South Australia continue to smoke in close proximity to their units and in some cases directly outside in the courtyards or at the entrances to the unit where everyone has to walk through.

Following is an extract of the concerns raised during visits.

Smoking still a big issue, patients smoke outside the reception area to the building. The area is littered with cigarette butts. CV's did not observe an appropriate disposal unit for the butts. Further, this does not appear to be the most appropriate area for smoking as people entering the unit need to walk through the smoke. One patient had moved the door mat and was using it as a makeshift "picnic blanket". The no smoking policy is almost impossible to apply to heavy smokers, as this group of consumers very often are. For safe practices and what is described above should be a designated area where disposal and fire risk is contained and the safety of clients is considered, many of them wander away from the safety of the grounds to smoke.

Smoking bans/restrictions have led to increased angst and concerns amongst some patients in closed unit.

Staff advised unit was no smoking and this increased patient distress. Many patients were supplied with nicotine patches to assist with withdrawal symptoms.

Staff advised that the inability for patients to smoke was currently a point of tension in the closed ward. For one patient (who has a history of aggression and confrontational behaviour) the smoking rules had been a trigger for confrontational behaviour.

5.6.2 Menu Options

Food remains a highly commented on topic with a relatively even split between positive and negative comments. The period of admission provides opportunity to engage with clients about diet, provide advice and training on menus and meal preparation. Unfortunately for ease of preparation, cost and distribution, meals are in general produced in mass and reheated at the unit. The negative issues were raised more in the long term accommodation with concern about the repetitive nature and about the nutritional value.

One young mum mentioned that hospital food is unpalatable and probably not the best nutrition for a woman caring for a small child. This is a frequent comment at Helen Mayo and it would be great if some special arrangements could be made to meet the needs of people whilst they are inpatients.

Although only one patient in KOB made adverse comments in relation to food provided to them, the common theme in other wards visited that day was that the food variety, quality and nutritional content was very poor. CV's were told

that the meals provided were delivered in frozen batches, thawed out and reheated. All patients that we spoke with looked forward to the times and days that they engaged in ward cook ups but that this opportunity had been significantly reduced in recent times.

Most patients at Glenside complain about the standard of food provided to them. It is generally a thawed out reheated product from the RAH kitchens

One patient commented that lactose and gluten free choices were limited. Other patients commented food was good. One patient also commented she was enjoying working with the OT to develop cooking/independent living skills which would assist her after discharge.

In the short-stay area, where the space is shared with surgical, it was surprising to find that the menu availability is different for the two groups. This was illustrated by the request by one patient for cheese and crackers. This is available to surgical patients but not mental health patients. We were told it was because of differing budget lines. A small matter perhaps but a preventable source of irritation for folk under stress. Perhaps consistency across the ward would be an improvement.

In contrast there were many patients who expressed satisfaction with the quality and range of meals.

Patients were all satisfied with the quality and choice of food. One patient commented she had been pleasantly surprised and another told of how the staff went out of their way to ensure appealing food options was always available. CV's were told by a patient that she appreciated the effort staff went to find an alternative fruit for her, as opposed to the banana that she had been given.

Consumers were generally happy with the food. Some commented that servings were small but they could ask for seconds.

CVs spoke to another consumer in the dining area who was having breakfast, he was happy with the treatment he was receiving and the food was good. This consumer felt relatively safe and said he was spiritually good.

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.

5.6.3 Maintenance of environment and grounds

During visits, CV's received a lot of criticism about the standard of facilities and their ongoing maintenance. The residents of the RAH and Oakden in particular raised issues about their accommodation. Given that both facilities will have been closed by release of this report the CVS is optimistic that there will be significant gains for this client group. It should be noted that provision to outdoor areas that are nice and comfortable is extremely important when confined to a unit with little other activity. Opportunity for long term residents to develop and maintain a garden area is also important.

The ongoing use of this temporary accommodation and its general condition and seemingly unstimulating environment has been well documented for some time now.

The external yard, which also serves as a smoking area, is stark! The high walls that make up the perimeter are visually imposing. Appropriate landscaping may contribute positively to the surroundings.

Staff commented that the 'yard' is very unappealing and stark. He explained he has obtained a grant to turn the yard into a family-friendly, landscaped, sensory area where residents could practice gardening if they so wished. The staff felt that this plan would provide another dimension to the therapeutic activities available at Woodleigh House.

A courtyard that in the past was a smoking area, appears neglected and with little use. Staff presented a project to NALHN that involve a recovering the area as a therapeutic garden.

Ward 1H continues to request 'colour' (eg, pictures or 'paint-work') for the corridors, bedrooms and yard. The yards need to be weather-proof. Appropriate music would also help create a 'calm' environment. The acting nurse unit manager explained that she has been making representations on behalf of her patients and staff to management and the CVS office for seven years and has not witnessed any significant change. Ward 1H closed unit in particular has needs that must be addressed to improve the therapeutic environment.

There was little evidence of maintenance other than the basics required to keep the facilities in operation.

We were told that the air conditioning is inadequate to cope for the demands placed upon it. We observed that the external door to the nurses' station was propped open to get fresh air of an acceptable temperature throughout the time of our visit. It was reported that patients' windows are locked (to prevent smokers setting off the fire alarms), to the discomfort of residents. Staff reported that patient complaints on the air conditioning were common (one side of the building being too hot, central facility caters for the entire building).

The unit is rather dark and shabby, with worn floor coverings and very basic furniture; several of the bedrooms are shared. The main activity and dining area was rather untidy with craft materials scattered on tables, but there is a pleasant outdoor area with herbs and vegetables growing and chickens which looks well-maintained.

CV's conversed with 2 females and 1 male in smoking area. Issues brought up were that the smoking area was not cleaned often enough, that once the ashtray caught on fire and clients put in out with a glass of water, that they would prefer a nicer smoking area.

Unsatisfactory rating relates to failure to provide or make repairs to the audio system to bedrooms in Aldgate ward. This situation has existed for just over 18 months. It is said to have a negative impact on patient care and wellbeing while they are isolated in their individual rooms.

The CVS continues to raise identified issues with facilities and their maintenance with management as the present.

5.6.4 Recommendations

15. 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.
16. 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.
17. An independent review of the menu provisions in mental health units be undertaken with a particular focus on the needs of long stay patients.

5.7 Recovery-oriented mental health practice

The most significant component of any visit is for community visitors to observe the level of interaction between staff and their patients. This gives insight into how in tune the service is with the delivery of a recovery-oriented mental health service. National recovery principles that support recovery-oriented care, incorporate the uniqueness of the individual, provide real choices, give attention to attitudes and rights, dignity and respect and demonstrate partnership and communication.

It would appear to the CVS that some services such as the acute wards, aged care services and forensic services that place themselves in a different service paradigm do not perform well against these principles and do not in general, meet the needs and the expectations of the consumer.

1G: (closed ward) There are no therapeutic activities that would contribute to the recovery/management of clients mental health condition, in fact lack suitable options, over crowded environment, restricted freedom (ITO, no smoking areas, confined to a ward) and very acute clients is a contributing factor for aggressive behaviour that we saw at the time of our visit. (We would like to clarify that CVs understand that restricted freedom and ITOs, are to protect the client and community and prevent possible regrettable events)

Due to time constraints, often patients do not receive the time from staff that they might require at a particular point in time. When a chat to a staff member may be what is required, if it doesn't occur, the patient's behaviour may escalate and they may then require PRN. This is of great concern to staff who wish to provide the best treatment for their patients and feel they cannot provide this at all times largely due to the rapid 'flow-through' of patients. Staff feel that patients generally need longer in care than they currently might receive.

X still waits on the decision for his request to have his dog Emma visit him. This is a continual source of frustration to him and it is hard to understand why this simple goal cannot be achieved-particularly in the light of anecdotal evidence of other visits from dogs to the ward.

Short stay unit again started sharing space with surgical patients, which makes the place noisy. Sharing a room with surgical client is also adding stigma. One client reported that, she has no privacy here in the SSU. Mental health clients need a calm and quite environment and a good sleep. In this present transforming health plan, the quality of

care is frustrating. Especially sharing a room with surgical clients actually compromised quality of care for both.

However, it appeared that staffing shortages contribute to the provision of "maintenance and basic personal care" rather than offering an enriching and stimulating home for those who live there.

For those facilities such as the rehabilitation wards that align and share this new vision and apply recovery-oriented practice, there is a measurable positive response from their consumers. Following is just a few extracts from reports which support the model of care and the patients' positive experience.

Most of the patients we spoke to said how lovely this unit is because the staff are so interactive and show a lot of care. One patient said that it is a great place of healing.

An atmosphere of acceptance by patients characterised the facility at the time of visit. Staff are engaged and committed. Patients' well-being seems paramount. Quiet conviviality was evident amongst patients

It is worth highlighting that the patients who conversed with the CVs provided very good feedback on the staff's person centred approach and on the quality of treatment. Morier ward is implementing the use of Solutions Focused Therapy and Hearing Voices approach to recovery, acceptance and psycho-education.

The staff approach is clearly considered and caring and the atmosphere of the ward certainly reflects this. A trauma-informed person centred approach is used which, together with the staff's long service, has provided a sense of camaraderie and respect throughout the ward. Older patients tend to mentor the younger cohort and there is a palpable sense of 'ownership' and pride.

All feedback from patients about their care and treatment in the unit and interactions with staff were spoken of very highly. One patient was from Port Pirie and was given the choice of Adelaide or Whyalla for treatment. She mentioned that she had been to Glenside in Adelaide on a past occasion, and that she was much happier being in Whyalla and that it worked better for her.

The small private areas and garden facility are excellent and provide a very pleasant environment. The unit works on the minimisation of restraint, with diversionary and sensory approaches being employed. There is a review of restraint on a quarterly basis to highlight alternative approaches, identify conditions which may have contributed and develop ongoing minimisation strategies. The use of fabrics and other tactile approaches to reduce stimulation is being undertaken. The activity program is quite extensive ranging from cooking, art, Tai Chi, exercise and gym, art etc. The only comment made from a carer was that visitors are unable to eat with clients in the dining room, however this does not prevent them from eating together in other areas which may not intrude on other clients space.

5.8 Oakden Services for Older Persons mental health facility

In last year's report the CVS highlighted that it held significant concerns regarding the Oakden Services for Older Persons facility, which had arisen from both visit reports and a range of individual investigations that had been undertaken in response to specific complaints raised by the CVS on behalf of individuals and families.

Staff at Oakden had explained that they receive the most challenging clients of the acute wards but for an unknown reason, Oakden is classified as 'sub-acute' and therefore attracts less funding than the other older persons acute units. In addition, the unit had lost a number of allied health roles, particularly the social worker role that was responsible for securing appropriate discharge accommodation for clients and the psychologist who had worked on the development of behavioural plans.

Community Visitors and the CVS office had received concerns from three families regarding the treatment and care of their loved ones at Oakden. These had 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 clients ratio, whereas acute units may use 1 staff member to 3 clients ratio.

The PCV continued to raise these concerns with management and in a letter to the then Minister, Leesa Vlahos, expressed his belief that given the number of issues and incidents that had arisen, staffing issues, and limited availability of staff and allied health services, that a further investigation is required to understand the current operations and management of Oakden. He recommended that an independent review of services be undertaken as he believed this was required to ensure that elderly South Australian citizens continue to receive the treatment, care and support they

deserve.

Barbara Spriggs and her family in particular were incredibly resilient, patient and determined to get answers about the treatment of their beloved husband and father, Bob. After months of long delays in not getting responses to complaints that the CVS had lodged with Oakden management, continuous communication and pressure on the Minister, and the Executives at NALHN, we finally got to meet with the Chief Executive of NALHN who listened and agreed to instigate a full review of the Oakden service. On 10 April 2017 the Chief Psychiatrist presented to the Minister the findings of his investigation. The report raised many areas of significant failure in the care and treatment of patients under the *Mental Health Act 2009*.

From the CVS perspective the key learnings from Oakden experience is that although standards may be in place, compliance that results in good clinical practice and service delivery is ultimately driven by good governance, and the establishment of a positive culture that includes consumer/family input.

In combination with many other examples it has become evident to the CVS that staff, family and individuals will become accepting of substandard care. This is particularly strong in mental health and disability institutional care. Vulnerable individuals will become accepting and will not be empowered to challenge and many families felt threatened and vulnerable about lodging complaints.

Unless families are actively engaged and are confident to challenge and are encouraged to provide feedback, they will also become accepting of sub-optimal care, especially where they have been told there are no other options available to them. Many families, including the Spriggs family were told that Oakden was the only place available to them. Most alarmingly, is that it appears that the non raising of complaints has for some reason been adopted as a standard. The family of an Oakden resident was told that theirs was the only complaint received, with some expectation this would be received as a counter balancing positive.

Response to complaints both at management level and at service level were less than satisfactory with concerns raised by family brushed off as normal behaviour for that type of diagnosis – no individualisation and therefore exploration of potential causal reasons for the symptoms or behaviour. There was no practice of open disclosure policy/process which would have significantly improved the management of concerns raised about over-medication and restraint.

If it were not for the strength of the Spriggs family to stand up to passive resistance by senior management in not responding to their complaint and their willingness to go public with the ABC journalist, Nicola Gage who investigated the details of the CVS Annual Report and the Spriggs complaint. It was ultimately through this public exposure that the Spriggs family were able to share their horrible experience at Oakden with the public. This then led to many others coming forward and whistle blowers who were previously raising issues about Oakden spoke out and all of this contributed to many more having their say in the investigation process led by Dr Aaron Groves.

5.9 Forensic care

In South Australia, forensic care is provided at James Nash House (JNH) and Kenneth O'Brien Centre (KOB). 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, and 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 cases 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.

In 2015, the SA government commissioned a review of the South Australian Forensic Mental Health Service by a team of experts in the field of forensics. It has only recently come to the attention of the CVS that the report from this review

has been released together with SA government response.

The CVS is encouraged by the report's recommendations to address the whole service model and the staffing structure at JNH. The CVS has offered to work closely with management to encourage adoption and implementation of all the recommendations.

5.9.1 Recommendations

18. That the recommendations from the independent review into forensic care are fully implemented.

6. Workforce

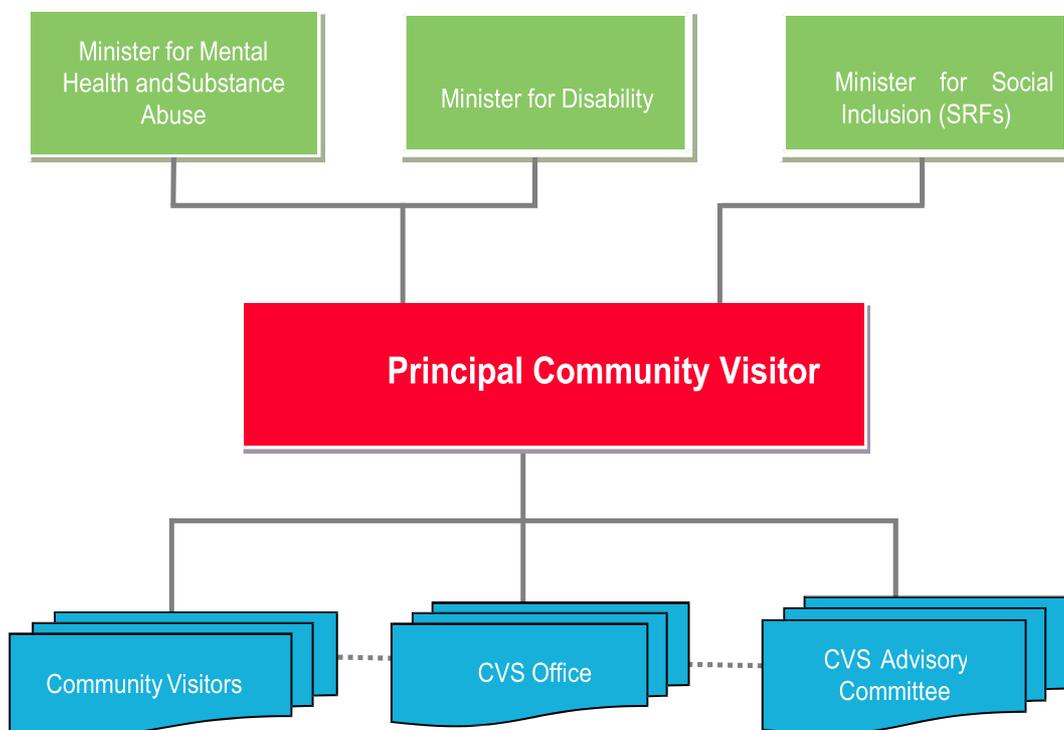
6.1 Governance of the Community Visitor Scheme

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 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.

6.2 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 2016-17 reporting period:

Principal Community Visitor	Mr Maurice Corcoran AM
CVS Manager	Mr John Alderdice
Mental Health CVS Coordinator	Ms Connie Migliore
Disability CVS Coordinator	Ms Michelle Egel
SRF CVS Coordinator	Ms Karen Messent
Recruitment and Training Officer	Ms Leanne Rana
Project Support Officer	Ms Rondelle Oster
Administration Officer	Ms Lisa Margrie & Mr Micah Mango

6.3 Advisory Committee

The members of the Advisory Committee during 2016-2017 were:

Ms Anne Burgess	Chairperson – The CVS Advisory Committee
Mr Maurice Corcoran AM	Principal Community Visitor
Ms Anne Gale	Public Advocate
Niki Vincent	Equal Opportunity Commissioner/Public Advocate
Mr Steve Tully	Health and Community Services Complaints Commissioner
Chris Burns	SA Mental Health Commissioner

Mental Health Representatives:

Dr Aaron Groves	Chief Psychiatrist
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)

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/Kris Maroney	Supported Residential Facilities Sector Representative
Ms Jayne Lehmann	Disability Carer Representative
Ms Ann Rymill	Disability Community Visitor Representative

6.4 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 2016-17 reporting period:

Adil Saleem	Alfred Piu
Angela Duigan	Angelikh Koutsidis
Ankur Patel	Ann Rymill
Annette Glover	Anthony Rankine
Anwitha Allam	Brian Day
Bryn Williams	Carly Luzuk
Cecil Camilleri	Chandani Panditharatne
Colleen Gavan	Elle Churches
Erika Davey	Fiona Pullen
Garry McDonald	Gregory Wilton
Hannah Allison	Helen Winefield
Ingrid Davies	Jacy Arthur
Jim Evans	Joan Cunningham
John James Leahy	John Lykogiannis
John Sheehan	Judith Harvey
Julie Margaret	Karen Atkins
Kim Steinle	Lindy Thai
Marianne Dahl	Mark Rogers
Michele Slatter	Mitali Chand
Ron Oliver	Sally Goode
Sara Elfalal	Sharon Hughes
Shipra Sareen	Sophie Dai
Stephanie Keightley	Sultana Razia
Susan Whittington	Tracy Haskins
Wendy Norman	William Zhao
Yinzi He	Maurice Corcoran AM (Principal Community Visitor)

6.5 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. Volunteering SA-NT has provided training to allow for agencies to manage their own online volunteer ads. This has resulted in a better process for managing changes in recruitment procedures.

People interested in applying to become a Community Visitor must be over 18 years of age and be willing to undertake both disability and child-related screening checks with 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.

Two hundred and twenty-eight (228) Expressions of Interest were received during the reporting period. This was an increase of 83% compared to the previous year. Of these, forty-six (46) applications were received; an increase of 53% on the previous year.

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 7.5)
- » undergo the screening checks and referee checks, and
- » undertake a minimum of two orientation visits with the PCV.

Eighteen (18) applicants did not proceed to training 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.

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.

Twelve (12) applicants were appointed; five (5) were awaiting appointment; eleven (11) did not proceed to appointment after training and orientation due to not attending training, withdrawing, or being unsuccessful after training.

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

6.6 Initial and ongoing support and training for Community Visitors

Initial training and orientation

Potential CVs are invited to participate in a two-day training program aimed at providing them with the skills and knowledge required to fulfil the legislative functions of the role.

The training program is split into 11 modules and assumes no prior knowledge of mental health or disability services.

The content is delivered over two consecutive days with values, exercises, role plays and various guest presenters. The modules covered are:

- » Module One: Introduction, Overview and History of the Community Visitor Scheme
- » Module Two: Role, functions and scope of the Community Visitor Scheme
- » Module Three: CVS visits and inspections
- » Module Four: Practical matters for Community Visitors
- » Module Five: Lived experience

- » Module Six: Mental health
- » Module Seven: Communication strategies
- » Module Eight: Disability
- » Module Nine: Dual disability and gender safety
- » Module Ten: Cultural competencies, and
- » Module Eleven: Values testing for disability and mental health.

Sessions were held in September and November in 2016 and February and May 2017. Twenty (20) attended training sessions.

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

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

An online tool, "Limesurvey" was used as the survey tool for the first time during the February 2017 training. Participant use of the tool was high and it provided a clearer means of being able to collect and analyse participant feedback.

One hundred percent (100%) of respondents either strongly agreed or agreed to the following 6 questions for 9 Modules:

- » the information was clear
- » the style of the presentation suited my needs
- » the presenters knowledge was sufficient
- » the resource notes were sufficient
- » participant interaction was adequate
- » I feel confident in meeting the learning objectives of this module.

Sixty-seven percent (67%) of respondents either strongly agreed or agreed to the above questions for Module 5. One respondent felt the style of this presentation did not suit their needs, and one respondent would have liked resource notes.

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 comments from this reporting periods four sessions:

Very informative and enjoyable to listen and learn

The training content was very in formative and stimulated a very high level of interaction, as for me the training left me feeling very excited for the future. Thank you Leanne and team for such a great professional team effort in putting together such an excellent package

Really interactive which made it more interesting and loved the personal experiences

I loved listening and talking to Anne and Michele. Really appreciated their feedback

It became very clear to me that because of the work done within the community visitors scheme, it would be pivotal in highlighting areas within the services areas that were in need of change and or further monitoring. Regular reporting lends itself to maintaining and improving standards across the board

Absolutely excellent! Well presented. Margie was excellent

I enjoyed how it was broken up into different speakers and various videos/activities, however it was still a long two days of being in an office, any more variety possible would be fantastic but I understand it is limited given

the nature of the training

I seriously could not fault this training. It was fun and I learnt so much. All the staff and trainers were so lovely and I really took a lot away with me. 10/10

It was a very informative and inspiring workshop. Well done to all involved!

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

A minimum of two observation visits are undertaken with the PCV for further assessment. This provides the trainee Community Visitor with an opportunity to see the practical application of key areas covered in the training program. A total of thirty (30) 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 15 prospective CVs.

From the number of viable applicants, 24% 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.

Ongoing Training and Support

On 16th March 2017 a Day Options workshop was held for CVs to increase their knowledge of the sector. There was a range of guest speakers including Professor Richard Bruggemann, Senior Practitioner, Disability SA. Fifteen (15) CVs attended.

CVs continue to receive support with the online reporting tool either over the telephone, via email or in person. There were major changes to the online reporting tool with CVs being offered training on the new tool and report writing tips on the 7th June during a scheduled get together. Twenty (20) CVs attended.

CVs are invited to participate in the Restrictive Practices, and Mental Health & Communication training modules during training workshops. Twelve (12) CVs have participated in the training to date, and they have reported that attending the sessions has been very helpful in refreshing their knowledge in both the disability and mental health sectors.

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

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 10 external training opportunities with twenty (20) CVs taking up the offer:

- » Northern Volunteering: Mental Health Awareness, Cultural Diversity, Mental Health First Aid – no CVs advised that they had attended any of these sessions
- » Southern Volunteering: Mental Health First Aid, Responding to Anger and Challenging Behaviours – 5 CVs attended
- » VSA-NT: Working in Teams – no CVs advised they they attended this session
- » NDIS introductory session – 1 CV attended
- » Southern Volunteering: Professional boundaries and volunteer self-care – no CVs advised that they had attended this session
- » HCSCC: Lorna Hallahan presentation – 11 CVs attended
- » Marion City Council: Child Safe Environments – 2 CVs attended
- » City of West Torrens: 2 day Provide First Aid – 1 CV attended

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



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

Annual development reviews are conducted with the PCV to provide a formal avenue for feedback and development discussions. Forty (40) yearly reviews were conducted throughout the year with CVs participating in performance and development discussions with the PCV. Community Visitors are encouraged to pursue development opportunities and discuss other interests with the PCV.

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

There are presently 48 active CVs, with 7 being reappointed for a second term of 3 years. Four (4) CVs have resigned due to gaining work and/or moving overseas.

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 2016 – Challenges and Issues during visits – small group activity
- » October 2016 – Introduction to Day Options programs
- » December 2015 – Lorna Hallahan seminar
- » April 2016 – Training and development ideas for CVs
- » June 2016 – Updated online reporting tool

There were 75 attendances by CVs across the 5 'get togethers'. Notes from the August, October, December, April and June meetings have been included in monthly newsletters, which 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 bi-monthly basis providing general updates and information regarding strategic direction and issues arising.

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

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

6.7 Recruitment strategies external to CVS

Networking meetings continue with Volunteering SA-NT and Southern Volunteering. Attendance at relevant meetings has occurred with the Recruitment and Training Officer attending three Central Volunteer Managers meetings, and one Southern Volunteering meeting.

Local government offices in Port Augusta, Whyalla and Naracoorte Limestone Coast have been contacted regarding the recruitment of local CVs. Resources have been posted, and the CVS promoted in newsletters where appropriate. There has been interest from Whyalla and Peterborough with one regional trainee awaiting appointment.

Community Centres SA, the South East Junction Centre and COTA have been contacted with resources being sent for distribution through their networks, as well as a CVS recruitment ad developed for use in relevant publications. Liaison with Probus – Mitcham chapter has occurred and a date arranged for CVS to present to their members.

There has also been a call for volunteers through the DCSI Disability Update.

Training dates are posted on Facebook and CVs are encouraged to talk about their role within their networks to encourage others to take an interest in the Scheme.

7. Public Complaints

7.1 Public Complaints

No public complaints in relation to the Scheme were received by the Principal Community Visitor in 2016-17.

8. Conclusion

The Community Visitor Scheme has again been successful in achieving its objectives. While it was able to meet its legislative requirement to visit all treatment centres once per month the recruitment of sufficient volunteer community visitors to achieve its target of visiting every disability group home (over 600) twice per year has not been achieved thus far.

Our improved more robust process of tracking and following up every issue raised in reports has delivered many positive outcomes for individuals and their families. There has already been improvement in some of the more long term systemic issues such as ED waiting periods and the standard of accommodation. It is anticipated that the opening of the new Royal Adelaide Hospital and new mental health units at the Flinders Medical Centre will deliver improved environments for consumers and staff. The more secure setting at the RAH will also negate the need for the shackling of forensic patients.

8.1 Future steps of the South Australia Community Visitor Scheme

The new *Mental Health (Review) Amendment Bill, 2015* has been enacted and visits to mental health community centres and mental health rehabilitation centres in South Australia have commenced. These visits will be done in addition to the existing visits and inspections of all mental health treatment centres.

Implementation of the NDIS is having a significant impact across all the service streams. From a mental health perspective the delayed intake of those with psycho social disabilities until 2018 will create challenges during these transitional years and it will be incumbent on the CVS to refer issues of concern to the appropriate committees, forums or meetings. As example, the challenges of finding discharge options already identified in this report will be further exacerbated should roll out of the NDIS accommodation model result in closure of SRFs.

8.2 Community Visitor workforce

The targeted recruitment of community visitors in regional areas has continued with mixed results. The Riverland is now well serviced with 4 visitors in that region. Over the 12 months recruitment in the Whyalla and Mt Gambier regions has gone through both positive and challenging periods. As indicated above, the capacity to build the number of active community visitors above the 50 mark has proved challenging and therefore further strategies to build the workforce will need to be considered. The CVS will continue its endeavouring to recruit Community Visitors from an Indigenous background.

8.3 Development of a new CVS information management system

The community visitor scheme has had in place an ITC system to provide a centralised place for the CVS to access personnel information pertinent to the management of Community Visitors and 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.

During this reporting period the system has been further developed to manage the coordination and recording of visits including the matching facilities to CVs based on their location.

8.4 Implementation of focus projects

During the 2015-2016 the Community Visitor Scheme Advisory Committee commenced the process of focussing on an element of service delivery for a period of time with treatment and care plans an example of a successful review. Preparation for these reviews provides an opportunity to deliver further training to Community Visitors and expand their knowledge of daily practices in both the disability and mental health sectors.

During the 2017-2018 reporting period, 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.

8.5 Recommendations

This report discusses a range of significant issues that have emerged in section five 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.

9. 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
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

10. Appendices

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

50—Community Visitors

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

Appendix 2: 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 3: Issues classification scheme

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

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