



Principal Community Visitor Annual Report 2016-17 Mental Health Services

Community Visitor Scheme

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To:

Hon. Peter Malinauskas, M.L.C.

Minister for Health

Minister for Mental Health and Substance Abuse

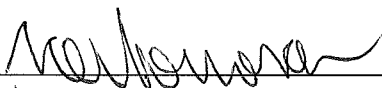
In accordance with Division 2, section 54 of the *Mental Health Act, 2009* (the Act), I present to you the Annual Report of the Principal Community Visitor 2016-17 for presentation to Parliament.

This report provides an account of the work of the South Australian Community Visitor Scheme during the financial year ending 30 June 2017 in compliance with the Act and meets the requirements of Premier and Cabinet Circular *PC013 Annual Reporting*.

Submitted on behalf of the Community Visitor Scheme by:

Maurice Corcoran AM

Principal Community Visitor

Signature		Date	28/9/2017
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Section A: Reporting required under the *Public Sector Act 2009*, the *Public Sector Regulations 2010* and the *Public Finance and Audit Act 1987*

Agency purpose or role

The purpose of the Community Visitor Scheme (CVS) as outlined in the *Mental Health Act 2009* is to protect the rights of people with a mental illness who are receiving treatment and care in hospital, rehabilitation or community settings through the conduction of visits and inspections and the provision of support with advocacy.

Objectives

- To conduct regular visits and inspections of Emergency Departments of hospitals, treatment centres and authorised community mental health facilities in order to assess and report on services provided to patients, identify any gaps in service provision and report on this to improve the quality, accountability and transparency of mental health services;
- To recruit and train enough volunteers to ensure there is a sufficient number of Community Visitors, appointed to undertake the required visits and inspections of facilities;
- To act as advocates for mental health clients to promote the proper resolution of issues relating to their care, treatment or control, including issues raised by a guardian, medical agent, relative, carer, friend or any other person who is providing them support;
- 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 an individual to the Minister, the Chief Psychiatrist or any other appropriate person or body;
- To ensure plans, policy and clinical practise development is influenced by the experience of people with mental illness and their relative, guardian, carer, friend or supporter.

Key strategies and their relationship to SA Government objectives

Implement a monthly visit schedule by community visitors to mental health facilities to observe if clients are being treated with dignity and respect, that services are responsive and appropriate to their needs and that they have been provided with information about their rights and their plan of care and support	We assist people to deal with all forms of illness to live a satisfying life where they can contribute to the community – South Australia's Strategic Plan - Target 86. Psychological wellbeing
Recruit, train, orientate and mentor volunteers to become competent Community Visitors	We value and support our volunteers and carers – South Australia's Strategic Plan - Target 24 Volunteering
Advocate for patients to promote the proper resolution of issues relating to their care, treatment, control and recovery	We advocate for everyone to reach their full potential – South Australia's Strategic Plan - Target 86. Psychological wellbeing
Through interviews, observations, assessments and meetings, refer individual and systemic issues of concern to senior mental health managers, the Chief Psychiatrist (CP), investigative bodies or Minister	Governments demonstrate strong leadership working with and for the community – South Australia's Strategic Plan - Target 32 Customer and client satisfaction with government services
Lead the development of submissions and evidence-based proposals on service improvements that are informed by objective visit assessment, service standards, processes and policy development.	Governments demonstrate strong leadership working with and for the community – South Australia's Strategic Plan - Target 32 Customer and client satisfaction with government services

Agency programs and initiatives and their effectiveness and efficiency

Program name	Indicators of performance /effectiveness/efficiency	Comments
Visits and Inspections	All treatment centres and community settings have been inspected every two months and visit report submitted in a timely manner.	Provided independent, objective scrutiny of mental health services to ensure the rights and needs of people with a mental illness are being met.
Recruitment and training of community visitors	Annual recruitment targets are met Two day training sessions are conducted quarterly	Ensured there are sufficient CV's to undertake visits as per legislative requirements
Advocacy Service	Number of issues identified and resolved. Clients are satisfied with CVS intervention, process and outcome achieved	Provided information and support to individuals, their carers and family in understanding their rights and in the progression of their issues

Program name	Indicators of performance /effectiveness/efficiency	Comments
Issue Referral	Number of matters of concern referred to other external bodies for resolution – Minister, OCP, HCSCC etc. Number of meetings held with managers, Ministers or other statutory officers such as the OCP.	Ensured that people with a mental illness can have confidence their concerns will be appropriately investigated
Consultation	Number of responses to request for submissions or comments Number of advisory committee meetings held	Provide a vital link between frontline service delivery and policy directorates both state and national

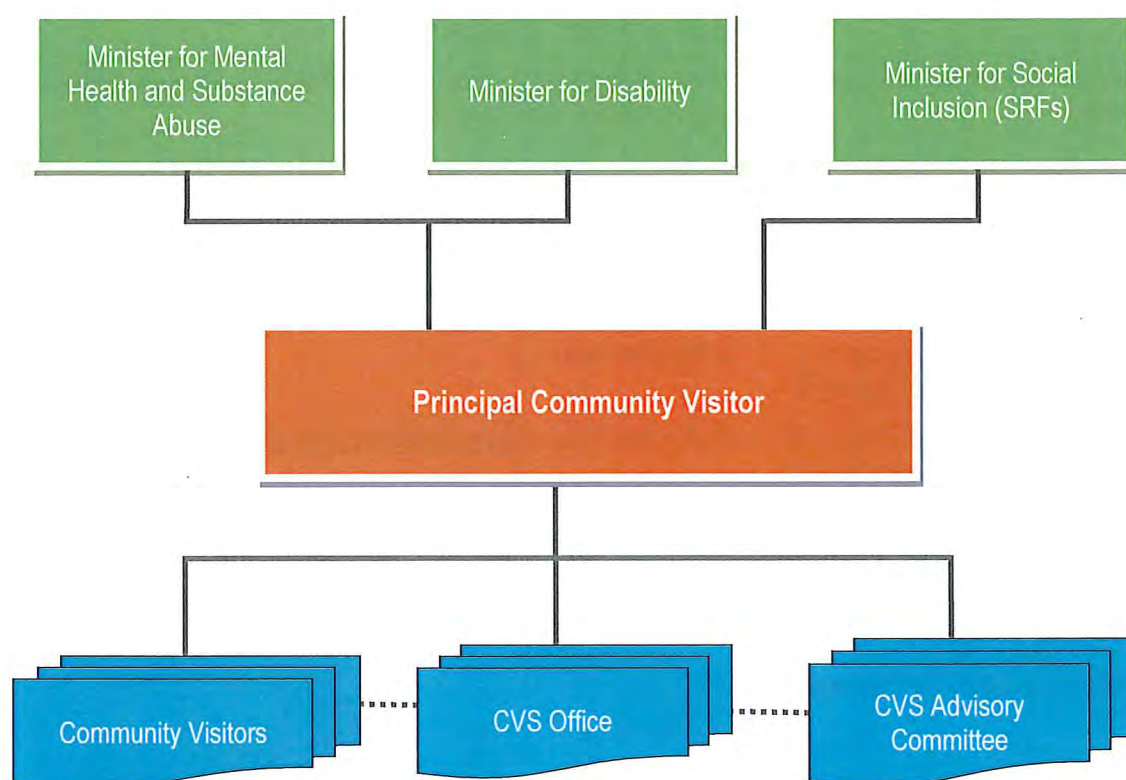
Legislation administered by the agency

The Principal Community Visitor Mental Health is legislated by the *Mental Health Act 2009*.

Organisation of the agency

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 Department for Community and Social Inclusion (DCSI) auspices the Community Visitor Scheme for administrative purposes only.



Other agencies related to this agency (within the Minister's area/s of responsibility)

SA Health – Office of the Chief Psychiatrist (OCP) and mental health services

Department of Communities and Social Inclusion – Disability SA and NDIS Reform

Employment opportunity programs

Program name	Result of the program
Recruitment of Community Visitors (CV's)	<p>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) submitted an application; an increase of 53% on the previous year.</p> <p>28 proceeded to training, the other eighteen (18) applicants either withdrew or were unsuccessful after interview.</p> <p>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.</p> <p>This took the total number of CV's to 52</p>

Agency performance management and development systems

Performance management and development system	Assessment of effectiveness and efficiency
Performance partnership plans	85% of staff have developed a performance partnership plan with their manager
Community Visitors annual reviews	77% of community visitors attended an annual review with the Principal Community Visitor

Occupational health, safety and rehabilitation programs of the agency and their effectiveness

Occupational health, safety and rehabilitation programs	Effectiveness
Staff that support the Principal Community Visitor comply with the DCSI occupational health, safety and rehabilitation programs	Refer to DCSI - https://dcsi.sa.gov.au/home

Fraud detected in the agency

Category/nature of fraud	Number of instances
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Category/nature of fraud	Number of instances
Nil to report	0

Strategies implemented to control and prevent fraud

All staff completed the Code of Ethics Awareness for the South Australian Public Sector which included policies and procedures to prevent fraud

Whistle-blowers' disclosure

Number of occasions on which public interest information has been disclosed to a responsible officer of the agency under the *Whistle-blowers' Protection Act 1993* 0

Executive employment in the agency

Executive classification	Number of executives
Nil	0

Data for the past five years is available at: Refer to DCSI - <https://dcsi.sa.gov.au/home>

For further information, the [Office for the Public Sector](#) has a [data dashboard](#) for further information on the breakdown of executive gender, salary and tenure by agency.

Consultants

The following is a summary of external consultants that have been engaged by the agency, the nature of work undertaken and the total cost of the work undertaken.

Consultants	Purpose	Value
All consultancies below \$10,000 each	Not applicable	\$0
Consultancies above \$10,000 each		
Business name	Not applicable	\$0
Total all consultancies		\$0

See also <https://www.tenders.sa.gov.au/tenders/index.do> for a list of all external consultancies, including nature of work and value. See also the Consolidated Financial Report of the Department of Treasury and Finance <http://treasury.sa.gov.au/> for total value of consultancy contracts across the SA Public Sector.

Financial performance of the agency

Refer to DCSI - <https://dcsi.sa.gov.au/home>

Other financial information

Refer to DCSI - <https://dcsi.sa.gov.au/home>

Other information requested by the Minister(s) or other significant issues affecting the agency or reporting pertaining to independent functions

Not applicable

Section B: Reporting required under any other act or regulation

Mental Health Act, 2009

Division 2 – Community visitor scheme section 54

54—Reports by Principal Community Visitor

(1) The Principal Community Visitor must, on or before 30 September in every year, forward a report to the Minister on the performance of the community visitors' functions during the financial year ending on the preceding 30 June.

I would like to begin this section of the report by apologising to all those people who have an interest in our Annual Reports and 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. This year we have been directed to follow a reporting template and requirements of Premier and Cabinet Circular *PC013 Annual Reporting* which compels us to produce a vastly different report that is also reduced in the number of pages that we can discuss or raise issues of concern. However, we have continued to produce a document that is very similar to previous Annual Reports that includes comparisons with previous year's and will publish this on our website but have been advised that we cannot refer to this as an Annual Report.

Report Outcomes and Themes

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. It also informs this Annual Report.

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.

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/units.

There were 220 comments made regarding Treatment, Services and Care of which 94 were issues and 126 were positive comments. Comments under this category were mostly relating to activities and structured programs and are closely linked with suitable facilities for activities and relate to the activities and stimulation offered within treatment centres. Our data confirms there is a variation across Treatment Centres where in some units there are a range of programs available, while in others, patients regularly report boredom.

The emergence of discharge planning is a significant issue with 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. Inadequate treatment is also an emerging issue related to the increased presentations and admission to mental Health wards of people with alcohol and drug issues or with intellectual disabilities.

Emergency Department Waiting Times

The CVS applauds implementation of the Governments 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 EDs that this has been successfully implemented. 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. It would be useful to know what the overall costs are for this initiative is.

The CVS has evidence of a number of instances where this has not been achieved, in particular the transfer of patients from justice to forensic mental health facilities. This has resulted in the continued shackling of patients to beds in the ED units for several days and where the CVS has referred cases to the SA Ombudsman for investigation. The CVS is extremely hopeful that this will be negated with the opening of the New RAH where the mental health units will be assessed as secure and therefore negating the need to secure patients via handcuffs and shackles.

While the rapid transition of mental health patients through ED's has been positive, 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.

One of the most disturbing issues raised with CVs was where, at the QEH adult mental health unit - Crammond Ward, they had \$1,000 fines imposed on them by the Department as they did not free up a bed by discharging patients when there were patients in the QEH ED needing a bed and at risk of breaching the 24 hour target. This matter was reported to both the Chief Psychiatrist and Deputy Chief Executive by the PCV expressing concerns about the added pressure this places on clinicians adding that it was difficult to see how this improved clinical practice and the several fines imposed simply takes more resources out of the unit.

The following excerpts from a visit report to Glenside highlights this pressure:

"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 and 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 both 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".

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 leading to re-admission.

The following excerpts from reports provide further details of these concerns.

"It was 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 and still with significant health/nursing need that cannot be provided in accommodation models such as SRFs"

SRF owners and managers have provided a range of case examples where hospitals have discharged patients with very little notice, at all times of the day and night and earlier than what was previously agreed to and this leads to high risk of relapse, medical emergencies and critical incidents.

"Staff member in a mental health unit 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".

"Staff 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 subacute 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 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 providers".

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 review and medication management, there is limited opportunity for therapeutic interventions and capacity building to the patients' time on the ward.

Most significantly, the lack of social work services is impacting on discharge arrangements which is 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 Oakden; 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)".

"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 XXX 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."

"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"

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 the MH services, will bring significant gains for the consumer group. Care plans have an intrinsic alignment with the recovery model as adopted by MHS.

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.

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 the 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:

"XXX, 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 punched in the head by a patient during the visit. This patient had previously assaulted other staff members on previous days. CV's were concerned for the safety of other patients and staff in this psychiatric intensive care unit (PICU). It's important to mention that this building design does not contribute to safety due to the fact that the only access in or out of the nurse's 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 to higher acuity levels and the growth of drug-induced psychosis. A number of incidents were reported where clients got violent and safety of staff and other patients were at risk"

The challenge for MHS 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.

Victoria has implemented 'Safewards' 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.

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's (OCP) capacity to finalise and support implementation of these guidelines.

However, 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 directive¹ and policy guidelines² to provide personnel with procedures and tools to identify individuals who might have challenging behaviours and implement

¹ SA Health, 2015. *Preventing and Responding to Workplace Challenging Behaviour, Violence and Aggression Policy Directive*.

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

practices to manage the environmental or personal factors that might effect that individual. CVS visits highlight that there are patients who feel vulnerable within the system.

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 XXX 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"

"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 restraints, both chemical and mechanical. Not all incidences of chemical restraint are recorded in the Safety Learning System"

It is acknowledged that SA Health has significant policy³ and a series of tool kits in place in an effort 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.

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 delivery of such programs resulting in the ongoing expression of frustration by many. The impact of vacancies in positions such as OT's 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."

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

³ SA Health, 2015. *Minimising Restrictive Practices in Health Care Policy Directive*.

products. This is evident in the following excerpt from one of the reports:

"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, and a well-stocked bookcase and 'in progress' jigsaw puzzle were observed."

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.

Oakden Older Persons Mental Health Facility

In last year's Annual Report the PCV highlighted significant concerns regarding Oakden Services for Older People 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 from the acute wards but for an unknown reason, Oakden was classified as 'sub-acute' and therefore received 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 who 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 client ratio, whereas acute units may use 1 staff member to 3 client ratio.

The PCV continued to raise these concerns with management and in a letter to the Minister 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 to ensure that elderly South Australians receive the treatment, care and support they deserve.

The PCV also provided ongoing support to Mrs Barbara Spriggs who contacted the CVS on 1 June 2016, with concerns about the treatment and care of her husband, Bob who had two admissions into Oakden Older persons Mental Health Services. On both occasions, his condition declined markedly, and after the second occasion, he required 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. On admission to RAH, he was also badly dehydrated.

Mrs Spriggs had kept photos and extensive notes of these experiences and she was clear right from this first meeting that her motivation to pursue this matter was because she wanted to ensure that

other families would not have to go through what she and her two adult children, Clive and Kerry had gone through. The CVS office supported Mrs Spriggs and her family through a formal complaint process to management of Oakden and this process took many months as they failed to respond in a reasonable timeframe which led to the PCV eventually escalating the matter to the Minister for Mental Health and reporting to Parliament through the Annual Report.

The PCV and the Spriggs family met with the Chief Executive of the Northern Adelaide Local Health Network (NALHN) in mid-December who indicated that she was not happy with the department response to the complaint and that she intended to instigate a full review of the Oakden services. On 10 April 2017, the Chief Psychiatrist presented a damning report of his independent enquiry.

The CVS has learnt a great deal from the above process which included many CVS visit reports over the years that highlighted the lack of allied health staff and the many challenges that staff had in meeting the complex needs of the clients they were caring for. There was also an inadequate response to these concerns by management during this time which will be further investigated by the ICAC investigation.

In retrospect, there may have been an argument to escalate these matters to the Chief Executive much earlier as it was only then, that a more serious response took place and a directive given to conduct a formal review. I would like to acknowledge Mrs Barbara Spriggs, and Clive and Kerry Spriggs for their courage, persistence and integrity as they sought answers about the care and treatment of their beloved husband and father, Bob Spriggs through a formal complaint.

Conclusion

As indicated earlier, this is a very brief synopsis of the work and performance of the CVS over the past year due to the new DPC requirements for Annual Reporting. A fuller review of our work for the past year will be posted on our website. 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.

I would also like to acknowledge the work of Rebecca Mansfield and John Alderdice in the preparation and initial drafting of this report.

Section C: Reporting of public complaints as requested by the Ombudsman

Summary of complaints by subject

Public complaints received by Controlled Substances Advisory Council	
Category of complaints by subject	Number of instances
Nil to report	0

Data for the past five years is available at: [Data SA](#)

Complaint outcomes

Nature of complaint or suggestion	Services improved or changes as a result of complaints or consumer suggestions
Not applicable	

Appendix: Audited financial statements 2016-17

Refer to DCSI - <https://dcsi.sa.gov.au/home>

