



The South Australian Community Visitor Scheme

Principal Community Visitor

ANNUAL REPORT

Mental Health Services 2018-19



FOR FURTHER INFORMATION:

PRINCIPAL COMMUNITY VISITOR

South Australian

Community Visitor Scheme

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

Dear Minister

In accordance with Division 2, section 54 (1) of the *Mental Health Act, 2009* (the Act), it gives me great pleasure to submit to you this Mental Health Services Annual Report of the Principal Community Visitor 2018-19 for presentation to Parliament.

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

This report provides an account of the work of the South Australian Community Visitor Scheme during the financial year ending 30 June 2019. I would like to draw to your attention our individual and systemic advocacy as they are core to the role and function of Community Visitors, as is the issues and outcomes arising from visits and the associated reports. You will see that we have again collated a range of comments out of these reports which gives specific insights into the effect of mental health service provision on the individuals and families we are there to serve and safeguard.

Yours sincerely

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

Maurice Corcoran AM

13 September 2019

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1. Introduction

1.1 Message from the Principal Community Visitor

This report represents the work of the South Australian Community Visitor Scheme (CVS) for 2018-19 and is prepared on behalf of the great team of Community Visitors that I have the pleasure to work with, and alongside of, as well as our very committed team in the office who coordinate and manage the Scheme as a whole. Although this is the Annual Report of the Principal Community Visitor (PCV), it is without doubt, the culmination of combined efforts of all our Community Visitors and staff.

Given that my resignation takes effect on 13 September 2019, this is my final annual report as the Principal Community Visitor. It has been a great honour and privilege to serve in this position over the past 8 ½ years - since July 2011. I have stated many times over the years how much I loved this role. It has had the perfect match of roles that I enjoy, such as building and maintaining high performing, loyal teams who have a shared passion of human rights protections for vulnerable people. Being able to monitor, report, advocate and speak out on individual and systemic injustices or unfair or unreasonable treatment of people with disabilities including those with a mental illness has indeed been an amazing role to play with a great team of exceptional Community Visitors.

We have been able to do this collectively and celebrate our achievements and changes made for the better through our many visit reports that are relayed back to services for a response and service improvements. The culmination of all our visit reports and related work is compiled into our Annual Reports to Parliament which have included the matters that have not been addressed or resolved.

To quote Sir Ronald Wilson, the first President of the Australian Human Rights Commission, "I can think of no greater role in life than advocating on behalf of those unable to speak for themselves" and we have done this as a team.

At this time last year, we were just coming to terms with the recommendations made by the Independent Commissioner Against Corruption (ICAC) in his report on the Oakden Older Person's Mental Health Service and some of the key questions the Commissioner had of the CVS, especially in relation to our rates of unannounced visits and the training and qualifications of our CVs. These were important questions to ask and the independent review of the CVS was also very important as a means to respond to these questions and provide objective advice back to the Minister about the scheme and its overall performance.

I would like to acknowledge the very open and transparent process that has been undertaken to address, consider and respond to the recommendations made by the ICAC. The Office of the Chief Psychiatrist (OCP) that has led this work have been exceptionally open and genuinely consulted us throughout this process and have been respectful of our independent, statutory role and function. Likewise, Julian Gardner AM (the inaugural Public Advocate of Victoria who established their Visitor Scheme), who was the independent consultant tasked with conducting the review of elements of the CVS, was very clear and open with us on the review process and consultation opportunities. He kept us informed throughout the review and shared copies of his draft report and key findings. Mr Gardner has had many years of experience in the human rights field and had an outstanding way with words that captured complex key findings but in simple language.

This resulted in us trusting and valuing this opportunity to have independent scrutiny of what we do as a scheme and actually expanding the independent review into our processes for recording, referring and monitoring of issues identified by our visits and/or complaints that individuals and their families have disclosed to us about services. As a result of this and our own continuous improvement strategies, I can genuinely and confidently state that we now have a far better internal system that is efficient and effective for being accountable and responsive to our safeguarding role and our functions and powers described under the *Mental Health Act 2009, Part 8, Division 2 – Community Visitor Scheme*.

The review was a positive outcome from the ICAC recommendation 7 and the process of the review allowed us to look closely at all aspects of the scheme including recruitment and training of CVs, visit processes and our issues tracking and follow up. The independent reviewer found that: "*The process for resolving issues applied by the CVS is methodical, timely, has appropriate steps for the escalation of serious or urgent matters and ensures that the appropriate persons do provide a response*". I am confident that the final review report will showcase the strengths of the SA CVS and I look forward to the release of the report in the near future.

I believe that the mental health sector as a whole has also reflected on Oakden and the findings of both the initial investigation report by the previous Chief Psychiatrist and the ICAC report, and is far more conscious of their governance responsibilities. Local Health Networks (LHNs) responses to the CVS visit reports has improved considerably. Their

individual and collective responses to these reports and the way in which they now use this feedback as part of their quality assurance and continuous improvement strategies, is great to see.

I would also like to reiterate the relationship between the CVS and the OCP, which has continued to strengthen and the responsive approach to concerns raised by the CVS to the OCP has been important. The collaboration and referrals between the CVS visits and reports and those of the OCP has significantly improved and there is recognition of their similarities and differences. The reviewer confirmed that the CVS apply 'community standards', sometimes described as *"would I be happy with the care and treatment I observe if it were for my family member and are said to provide an early warning system for the Minister"*.

The reviewer also found that *"it is not the CVS role to conduct clinical reviews and assessments of a facility or of the treatment provided. That is the role of the Chief Psychiatrist. The clinical nature of inspections conducted by the OCP differs from but complements those by the CVS. The effectiveness of the combination of inspections is ensured by the positive level of co-operation and collaboration between the two agencies which was evident. I am satisfied that the combination of CVS and OCP inspections is sufficiently comprehensive"*. The CVS has benefitted from both the independent review, greater awareness across the sector in relation to our role and function and improved collaboration with the OCP.

In respect to the CVS visitation to disability supported accommodation and Supported Residential Facilities (SRF), it is with great concern that these interactions with individuals will significantly decrease in the future year(s) due to a reduction in scope as directed by the Department of Human Services (DHS) and based on advice they sought from Crown Law office. In essence, this means the CVS can no longer provide our services to individuals and families within Non-Government Organisations (NGOs) and Supported Residential Facilities (SRFs) as individuals are funded via the National Disability Insurance Scheme (NDIS). The safeguards for these clients are now through the NDIS Quality and Safeguards Commission (NDIS QSC) who have a range of quality checks such as audits, registration and complaints handling and will visit these individuals and/or facilities if concerns are raised through a combination of these checks. This reduction is particularly concerning for the vulnerable clients that live in SRFs, many of whom are also consumers of the mental health services the CVS visits.

1.2 Highlights and achievements

The 2018-19 year again saw a successful year of visiting mental health treatment centres and community mental health facilities, as well as providing advocacy and support for many consumers, families, carers and staff, both individually and systemically.

The improved issues tracking and following up of issues raised with the Local Health Networks (LHNs) that I reported on last year has again been successful and seen prompt responsiveness from the LHNs. Issues raised at visits by CVs have been followed up and delivered positive outcomes for consumers and this continues to be a highlight for our team. In the past year 108 issues were raised in reports that required follow up with mental health services management with 100 (92%) 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 also been significant. The office has responded to 100 calls of concern covering a vast range of issues. While not always able to deliver on the expectations of those seeking support with orders or discharge, they have in most cases, expressed appreciation that an external agency outside the treatment system is aware of their situation. Further, they have been appreciative that we have listened to them, presented their concerns to the treatment team and ensured they are aware of their rights and options available.

One particular family provided feedback to the CVS regarding the role we played which was very rewarding to receive – *'Thank you for the email and all your assistance, as well as the various follow up that you are doing on our behalf. The service that you provide is invaluable and has allowed us as a family to cope better with what has been an emotional and stressful situation'*.

We continue to undertake requested visits to facilities where concerns were raised, either at scheduled visits or by the department, family, friends or others. For these unannounced visits, we draw on the skills of CVs who have specialist backgrounds and professional qualifications in investigative processes and interviewing techniques. This was particularly useful in the recent intensive monitoring of the Inpatient Rehabilitation Service that CVS has been involved in, which is discussed further in section 2.4.2.

Following the release of the ICAC Oakden report in 2018 and recommendations 6 and 7 relating to the CVS, we have worked closely with the Office of the Chief Psychiatrist (OCP) to address the recommendations. In response to recommendation 6, we have increased the number of unannounced visits undertaken to mental health facilities each month, which has been generally well received by staff in the units who understand and welcome the variation of visits.

In response to recommendation 7 regarding qualifications and skills for CVs, the Minister appointed Julian Gardner AM to conduct a review of this aspect of the CVS. For full transparency and quality improvement, I requested that the scope of this review be widened to look at all aspects of the SA CVS, including our issues tracking and follow up processes. Mr Gardner conducted his review in early 2019 and met with myself and the CVS mental health coordinator, a group of CVs and attended a scheduled CVS mental health visit, which included a new orientee CV. This process was very transparent and consultative, and I would like to thank both the OCP and Mr Gardner for their work in this process. Whilst the final report has not yet been released by the Minister for Health and Wellbeing, I am confident that the findings will show what a great scheme we have built and provide suggestions for ongoing improvement of the scheme.

The CVS has continued to be involved in various committees and submissions following on from the consequences of the Oakden Older Persons Mental Health Service and ICAC report, and one of the most important outcomes in the past year was the establishment of the Royal Commission into Aged Care Quality and Safety on 8 October 2018. The CVS provided a submission to the Royal Commission and looks forward to the release of the interim and final report by Commissioners Tracey and Briggs in the coming year. Whilst this will primarily affect the Aged Care sector, it is hoped there are recommendations that have a positive effect for the Older Person's Mental Health Services that the CVS visits in SA.

This reporting period also saw the release of the interim report of the Community Affairs Senate Enquiry into Effectiveness of the Aged Care Quality Assessment and accreditation framework, which looked at the Oakden example and CVS involvement in this. The interim report provides a very good context of the CVS visits to Oakden over the years and highlights the various issues that CVS had identified and raised with many levels of management within the service and NALHN. In particular, it highlighted in greater detail the issues the CVS reported since 2011 in regards to Oakden and the poor standard of care and facilities and the support of the Spriggs family.

1.3 Recognition of Community Visitors

A highlight this year was receiving the news that our nomination for 'The Premier's Certificate of Recognition for Outstanding Volunteer Service' had been successful. The Premier's Certificate of Recognition acknowledges accomplishments, reinforces shared goals and is a sign of appreciation for volunteers across South Australia. It also assists us to highlight the great work that our volunteers do day in, day out.

Selection for the certificates is based on volunteers meeting one or more of the following criteria:

- » Made significant contribution to the community and/or organisation.
- » Provided ongoing commitment and dedication to volunteering.
- » Demonstrated leadership in their volunteer role.
- » Promoted volunteerism within the community.

I was extremely proud to receive this Certificate on behalf of our team of dedicated Community Visitors, and as I said to our Community Visitors, the Award is for them collectively and individually.

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

2. Functions of the Community Visitor Scheme

2.1 The purpose & objectives

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

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

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

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

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

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

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

2.2 Conducting Monthly Visits and Inspections

The *Mental Health Act 2009* mandates that each approved treatment centre and authorised community mental health facility will have a visit and inspection by two or more Community Visitors at least once in every 2 month period.

In the 2018-2019 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 | » Northgate House |
| » 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 |

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

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

- » Whyalla Hospital and Health Service;

- » Riverland Regional Health
- » Mount Gambier and Districts Health Service

The gazetted Authorised Community Mental Health Facilities visited by the CVS in 2018-2019 financial year were:

- | | |
|--|--|
| » Ashton House | » Northern Community Mental Health Service |
| » Eastern Community Mental Health Service | » Southern Intermediate Care Centre |
| » Elpida House | » Trevor Parry Centre |
| » Marion Community Mental Health Service | » Western Intermediate Care Centre |
| » North East Community Mental Health Service | » Wondakka Community Rehabilitation Centre |

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

In response to the release of the ICAC Oakden report in 2018 and recommendation 6 regarding the PCV's power to undertake unannounced visits, since October 2018 the CVS has been undertaking approx. 50% of scheduled visits as unannounced. The Community Mental Health Services have been excluded from this for the meantime while the CVS visits are well established in these centres.

Further to the bi-monthly 'scheduled' visits as described above, the CVS also conducts 'requested' visits. As the name suggests, these visits occur when a client, carer, guardian, relative, friend, or any person or organisation who is providing support to a client, makes a request for a visit by a Community Visitor. If a request is made to a manager of, or a person in a position of authority at a treatment centre or community mental health facility, that person must advise the CVS office of the request within two working days.

Visitors refer to a prompt sheet (Appendix 3) during their visits and inspections and this gives guidance under seven main headings as to which elements they should review and consider as part of the visit. Post visits, the CVs complete an online report that again contains a variety of predetermined questions under a range of headings that also give focus to the reporting of visits. Section 3 of this report provides a summary of the outcomes and themes emanating from the visit reports.

2.3 Recruitment and training of CVs

The recruitment and retention of CVs remains an ongoing challenge and a regular highlight. I remain impressed by the calibre of our CVs. Whilst there are no formal qualifications required for the role, applicants must be:

- » over 18 years of age
- » not working full-time
- » willing to undergo DHS screening, such as disability and child-related screening
- » able to access a computer and mobile phone.

and demonstrate:

- » good communication skills
- » a desire to help individuals through advocacy
- » dedication to improving services.

People with lived experience and from culturally and linguistically diverse backgrounds and Aboriginal heritage are encouraged to apply.

Suitable applicants undertake a comprehensive training program including orientation visits to facilities to gain the relevant knowledge and understanding to effectively undertake the role.

Our current CVs have impressive and diverse backgrounds and skills as well as passion.

It is pleasing that the CVs themselves have personally and professionally gained experience and value from the role. This was articulated perfectly in the email below which was received from one of our CVs who sadly has decided not to seek reappointment, due to personal reasons:

"Today I undertook my last visit of my 3 year appointment.

I want to acknowledge it has been an absolute privilege to be a part of this scheme. I have partnered with some of the most diverse, talented and committed people I have ever met and been supported by a team that goes so much more beyond professional. That is a given, however the collaboration and accessibility has made the role not just an experience but has validated the worth of the scheme and its objectives.

I hope to have contributed in some small way and have always been encouraged by seeing, sometimes very small but practical outcomes for clients and occasionally being a part of hopefully addressing much larger systemic issues.

I wish you all the very best for the future and hope there will be an outcome more appropriate in the role of CVS into the Disability NGO areas."

More details on the recruitment and training of CVs can be found in section 4 – Workforce.

2.4 Advocacy

2.4.1 Individual advocacy

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

During 2018-19, the CVS received approximately 100 requests for advocacy from clients, family members, carers and staff members. Some examples of the advocacy undertaken by the CVS office include:

- » A consumer in James Nash House sought advocacy from the CVS to support their application for NALHN grant funding to establish a Tai Chi program for clients, which was successful, and this program has since commenced at the benefit of many clients in JNH. We received an email below from the parents of this consumer providing some feedback after the initial Tai Chi class, which was fantastic to receive.

'Dear Maurice

You may remember that some time ago you supported an application for a grant for a Tai Chi class at JNH. The first class was held at JNH today and 20 people attended the class including four members of staff.

The vast majority were from KOB not Birdwood but hopefully in the future their maybe more. Particularly if it becomes more regular from the dual diagnosis patients who XX believes could do with more exercise.

Without your support I do not believe this would have happened.

Many thanks'

- » A number of concerned family members have contacted CVS over the past year regarding issues with the treatment and care of a loved one in a mental health facility. In the units where a Carer Consultant is employed, the CVS has requested the involvement and support of a Carer Consultant, which assisted in positive resolutions of the families' concerns and also provided important additional lived experience support for the family members.

2.4.2 Systematic advocacy

During this period, the CVS has continued to lobby for systemic change that would deliver improved outcomes for service consumers. Some of the CVS's key focuses during 2018-19:

Inpatient Rehabilitation Service

During CVS visits to the Inpatient Rehabilitation Service (IRS) unit at the Glenside Campus, various issues have been noted and raised with CALHN and the Office of the Chief Psychiatrist. These included reports regarding staff culture, poor communication with consumers, smoking related issues and high incidents of violence and aggression. Following a range

of reports and indicators, in March 2019 CALHN commissioned an independent review of the service which found a number of concerning aspects and resulted in 30 recommendations for the service. These included aspects that the CVS had reported on during visits to IRS, as well as clinical aspects relating to the Model of Care of the unit and the lack of contemporary care being provided to consumers.

Following the public release of the independent review and recommendations in May, the PCV was invited to be on the Intensive Monitoring and Inpatient Rehabilitation Governance Steering Committee, looking at the implementation of all recommendations. The PCV also suggested that CVS could undertake intensive monitoring through increased visits to IRS, which CALHN were very agreeable to commencing straight away, which we commend. The CVS commenced additional visits to IRS with a core group of experienced CVs, initially starting with 2 per week, gradually reducing to fortnightly at the time of writing this report. It is anticipated the additional visits to IRS outside of the regular scheduled visits will continue until the end of the year. Whilst many of the recommendations made will take time to implement including a significant culture change for staff, it has been pleasing to see some quick improvements with a good leadership team.

Forensic Mental Health Services

In my 2017-18 Annual Report, I discussed the issues facing the mental health system in relation to forensic mental health services and the impact this was having on bed block in the secure Psychiatric Intensive Care Units (PICUs) and clients waiting in EDs for a number of days for a secure bed to become available. Whilst there have been some improvements in aspects of forensic mental health care, unfortunately the CVS continued to be made aware of the lengthy restraint of forensic and corrections clients in EDs and other consequent impacts on mental health units that are not suitable to treat these clients.

This topic continued to be a regular item of discussion with most LHNs who are expressing their concern at the impact the lack of secure beds at James Nash House is having on their acute mental health units, particularly the PICUs. Whilst the implementation of the 2017 Review of Forensic Mental Health Services has been slower than hoped, I understand there have been some improvements made through the court diversion program, resulting in less admissions to acute mental health facilities.

The CVS continues to advocate for appropriate mental health services based within the correctional and prison system. In March this year, the PCV wrote to David Brown, CE of Department of Correctional Services (DCS) about the need for mental health assessment units to be established within the prisons as is the case in other jurisdictions. Mr Brown indicated that DCS are open to the provision of assessment and treatment units being located in custodial settings however, this would require appropriate funding to be made available. CVS will continue to persevere through the appropriate channels.

Other issues relating to forensic mental health services are explored further in section 3.3.

24-hour ED target breaches

In my previous annual report I reported on the anecdotal evidence that CVs were hearing from staff in the mental health units that they were being fined \$1000 each time a mental health consumer spent more than 24 hours in ED and the National Emergency Access Target (NEAT) was breached. This was then having a flow on affect on the mental health units who were feeling as though they needed to discharge consumers early to make a bed available for the consumer coming from ED. In March 2019, I wrote to the CEOs of each LHN in an attempt to clarify the policy regarding fining the mental health units or hospital if a bed was not found within 24 hours. We also asked where the money was being taken from, whether it was from the mental health unit directly or the hospital more broadly?

The general response from LHNs was that there was not a policy in place to impose fines on the mental health units for each breach of the 24-hour target and no money had been taken from the mental health unit or hospitals budget. One LHN did believe there was an intention for SA Health to be fining the LHN for the ED target breaches, including the 4-hour target for all other patient groups, and had therefore been allocating money from the hospital's budget to a holding budget for the fines, however at the time of writing they had not yet had any money collected.

Pressure on discharge

As reported in last years Annual Report, the CVS was becoming increasingly concerned with the information and anecdotal comments regarding a perceived pressure on psychiatrists and treating teams to discharge patients early, to enable greater bed flow. Unfortunately, this has continued to be raised with CVS and in particular, the PCV has received information from two psychiatrists regarding significant clinical concerns for their former patients, in both acute and community mental health settings. Disturbingly, they have alleged that there has been a number instances where patients

have been discharged from community mental health services and clozapine clinics without the direction or confirmation of their treating psychiatrist.

The CVS has taken these allegations very seriously and has relayed a significant number of emails and documents to the Minister and the Chief Psychiatrist and his office as many of the allegations relate to clinical care.

2.5 Referring matters of concern

A key component of the role of the CVS is to refer matters of concern raised in visits reports to the appropriate agencies 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 (HCSCC), Public Advocate, Ombudsman etc.

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

As example:

- » 108 issues were raised in reports that required follow up with mental health services management with 100 (92%) being resolved during the reporting period.
- » concerns regarding the restraint of shackling of numerous forensic clients for a number of days in the RAH ED were referred to the Chief Psychiatrist and the Ombudsman's office, who conducted inspections and investigations in to the matters.
- » significant concerns regarding a prisoner in the correctional system not receiving appropriate mental health treatment were referred to Department of Corrections, Ombudsman's office and the Chief Psychiatrist. The Department of Corrections advised that they have undertaken a review of the concerns relating to the prisoner.
- » A complaint raised by an older person's mental health consumer relating to the way she was treated by her community mental health worker and then had SAPOL and SAAS arrive at her home to transport her to hospital was referred to the HCSCC to investigate.

2.6 Influence plans, policy and practice development

A significant and important role of the CVS is its contribution to planning, policy, strategy, reviews and investigations at both a commonwealth and state level. In addition, the CVS has an important role to play to ensure policy and clinical practice development is influenced by the experience of people with disability and their relative, guardian, carer, friend or supporter.

The PCV has been invited to attend committees and discussion panels and has been asked to contribute to an array of reviews, investigations, reports and discussion papers. Examples include:

- » ICAC Recommendations Implementation Working group
- » Inclusive Play Workgroup
- » Intensive Monitoring and Inpatient Rehabilitation Governance Steering Committee
- » Meetings with Mental Health Directors of NALHN, CALHN and SALHN
- » National Review of Community Visitor Schemes – Westwood Spice
- » NDIS Quality and Safeguard Commission meetings
- » NDIS Stakeholder Forum - Key Influencers and Industry Group
- » Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) – met with Deputy Commonwealth Ombudsman
- » Regular meetings with other Statutory officers such as the Public Advocate, Chief Psychiatrist, Mental Health

Commissioner and Health and Community Services Complaints Commissioner

- » Review of Mental Health Governance
- » Review of SA Community Visitor Scheme – Julian Gardner AM
- » Royal Commission into Aged Care Quality and Safety
- » SA representative on the Independent Advisory Committee of the National Disability Insurance Agency
- » SA Ambulance Services – Community Advisory Committee
- » SA Health - Oakden Oversight committee
- » SA NDIS Psychosocial Disability Transition Taskforce
- » Senate inquiry interim report – ‘Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices and ensuring proper clinical and medical care standards are maintained and practised’
- » Statutory Authorities Group and Rights Protection Agencies meeting
- » Workshop for Royal Commission into Violence, Abuse, Neglect and Exploitation of people with Disabilities

3. Mental Health outcomes and themes

3.1 Visit statistics

The mental health visit and inspection reports (Appendix 4), completed by Community Visitors (CVs) after every visit, gave focus to five main domains:

Communication – client and staff interaction/respectful communication

Environment – suitability of facilities and their maintenance

Quality of client services and access

Safety and Rights – least restrictive practices, and

Treatment and Care planning

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

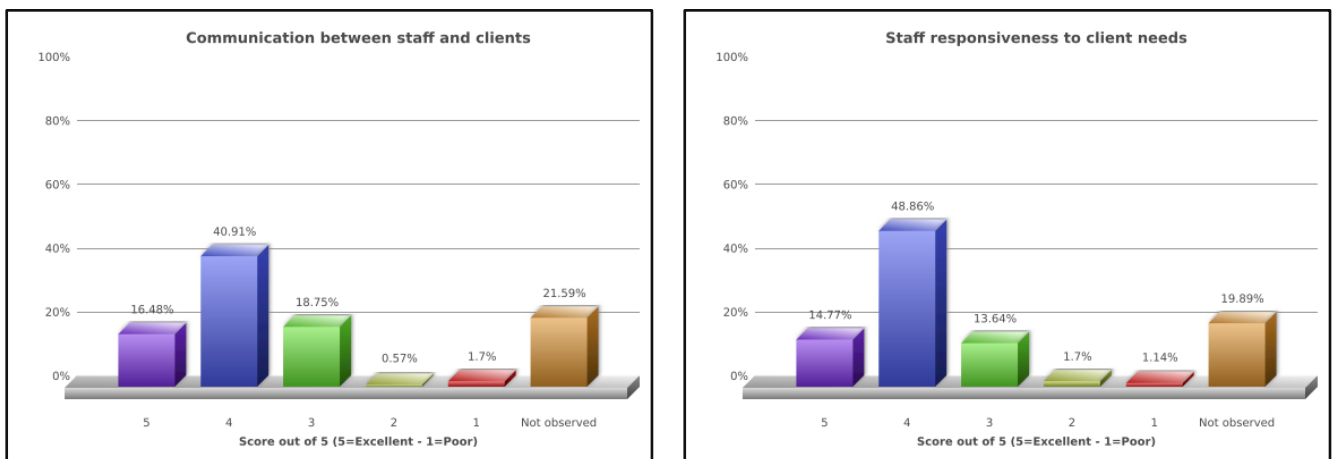
In the first three areas of the report, the CVs are requested to provide a rating out of five for the service against a range of questions related to that section.

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

3.2 Key Report findings

3.2.1 Communication – client and staff interaction/respectful communication

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



In addition to ratings CVs also provided comments where relevant.

Positive comments – 150 positive comments were made; examples as follows:

The two-way communication at the monthly residents meeting was open, respectful, encouraging and very positive. It can be seen during the meeting we attended that the staff and residents communicate positively. The residents' suggestion and feedback are responded well by the staff during the meeting.

Staff seemed to have a great relationship with the residents and asked a few if they would like to talk to us. We talked to XX who said that the relationship he has with the staff is really special and makes such a difference for him.

Warm, empathetic and genuine the Management and Staff have a demonstrable rapport with the residents; a rapport that is reflected in their participation rates and positive outlook.

There is a high degree of staff interaction throughout the day as required or sought. Every morning there is a 10am meeting of most clients and staff which overviews any issues, concerns or items to be considered. The format is relaxed and we were invited to sit in. A client helps guide the meeting under supervision following a 'protocol' type list which raises issues but sets programs and activities for the day. As there is a comparatively high turnover of clients this allows new admissions to become aware of the usual programs etc and to raise any topics clients want to raise. These covered everything from reminding clients to respect others privacy, organising the Sunday BBQ and individual queries with issues with their rooms, so very relaxed, safe. Another client takes 'minutes' so all involved appeared relaxed and involved in the process.

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

CVs were advised that in an issue regarding a client concern of their treatment, the client...did not have a great grasp of English. When a SACAT assessment was made he had no representation and his understanding of the process may have been limited and agreement given without full knowledge.

At the time of the inspection the relationship between staff and their clients was poor. There were staff members in the nurses' station very busy with what appeared to be administrative work. This lack of client-staff interaction was observed by both visitors and noted by the individuals we spoke with.

During our visit, a consumer was attempting to summons a staff member on the intercom, to no avail. XX intervened and assisted the consumer to obtain assistance. Whilst the matter was dealt with, it appears that, at least sometimes, the staff are under some pressure to provide responses to the consumers within a reasonable time.

One patient raised the issue of the torchlight that was used to make the hourly night-time observations. This was discussed with staff who advised that it is a necessary safety check but that they try to minimise patient disturbance and avoid shining the light into the face area.

Overall staff responsiveness and communication with clients scored well and many positive interactions were observed by CVs during visits. Of particular effectiveness were the units and facilities that held regular (daily/weekly) morning meetings with clients, providing a forum for communication between staff and clients and allowing clients' needs to be addressed in a positive way.

Another positive impact in improving the experience for clients in a number of EDs is the addition of dedicated 24/7 mental health nurse within the ED and another hospital trialling a dedicated social worker in the ED. The effectiveness of these additional roles in the ED environment was noted as *'having a very positive impact upon the care offered to new admissions, particularly when these admissions are out of office hours...We were told that these two innovations/appointments have improved the responsiveness significantly'*.

As was reported last year, the glass barrier around the nurse's stations in some units was again noted to cause frustration and distress for clients, with one particular visit report noting *'communication through the glass barrier covering the nurses station was limited. CVs observed one client becoming distressed, yelling and crying after being refused a cigarette. This client needed to raise her voice to be heard through the glass barrier, presumably increasing her level of frustration'*. This can also lead to unnecessary escalation of behaviour for clients which can then have other detrimental effects such as a code back, seclusion or medication needing to be used.

One particularly concerning instance was reported where *'the CVs spoke to one of the patients in XX who was 'scolded' by a nurse in a very loud voice and told he was "detained under the MH Act and risked losing any leave out of the unit due to being late returning". He indicated that he felt like a small child again but didn't want to complain as he thought this might result in a longer stay'*. This interaction may very well have had a detrimental effect on this client's recovery and would certainly have affected the therapeutic relationship going forward.

Another aspect limiting effective communication and responsiveness to clients is the need for timely interpreters where there is a language barrier. Whilst interpreters are used where they can, it is important that clients understand their rights and can participate in their treatment and care meaningfully, with the use of appropriate interpreters.

3.2.2 Environment – suitability of facilities and their maintenance

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

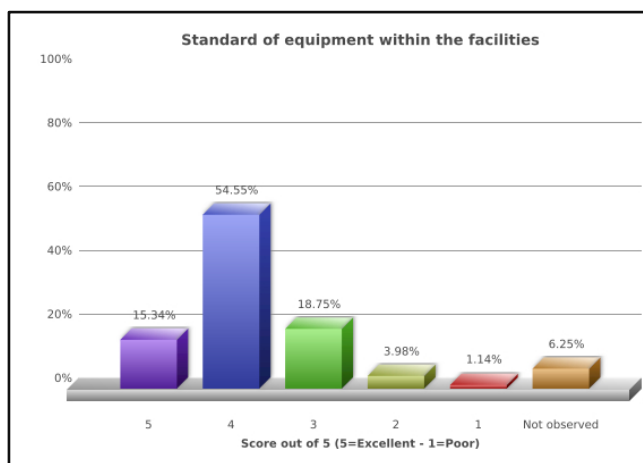
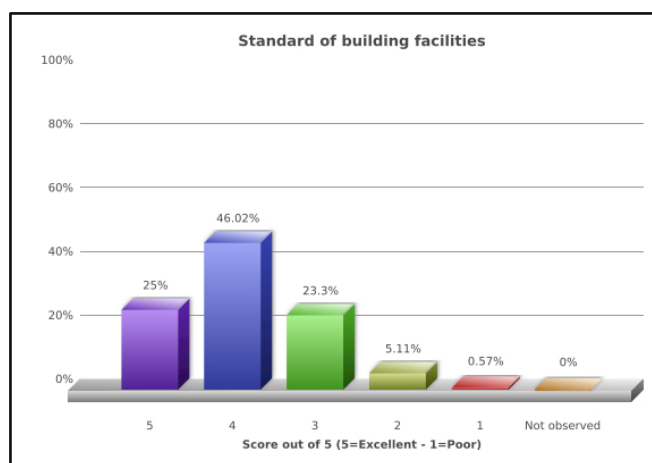
Building facilities, equipment and grounds

Overall the building facilities and grounds were rated as adequate and to a good standard, with the addition of two new short stay units assisting in improving the environment for those who would ordinarily be in an ED.

CVs also reported on positive improvements to the grounds and outdoor facilities of various units, including therapeutic gardens being established with the help of clients, planting new trees, herbs and vegetable gardens. The landscaping and garden work undertaken by clients in the Ken O'Brien Centre is of particular note and is a credit to both the dedicated clients and staff who undertook the design and installation work. It was noted that *'the kitchen garden is a source of much of the fresh fruit and vegetables used in their meal preparation'*.

While there are many great improvements occurring and fantastic newly purpose-built facilities, there are still some units where issues were raised in regards to the facilities, equipment and grounds. Common issues raised included lack of access to outdoor spaces, neglected and stark outdoor courtyards, shared rooms and bathrooms and litter of cigarette butts around the grounds, particularly around the entrance to the units.

The buildings at James Nash House was regularly commented on by CVs, with the stark custodial feel of the building in comparison to the Ken O'Brien Centre building next door. The environment was described as unsuitable for current therapeutic mental health care practice.



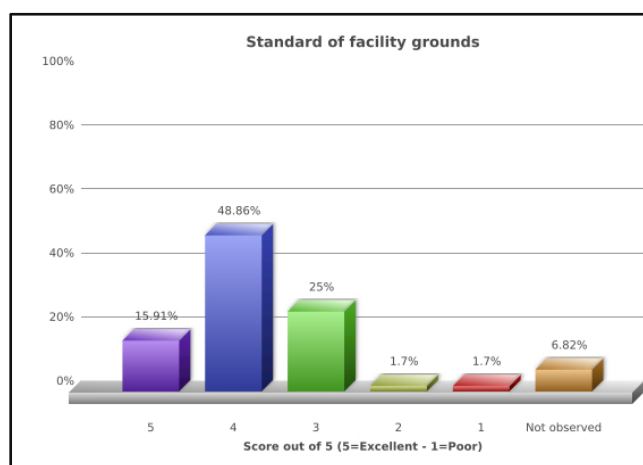
The following comments are from visit reports regarding standards of building facilities, grounds and equipment.

Positive comments – 219 positive comments were made; examples as follows:

The building facilities are of an exceptionally high standard, with spacious rooms (some with bariatric beds), lots of natural light and ample rooms dedicated to various activities (e.g. yoga/meditation, reading, table tennis etc.).

For the writer, this was the first visit to the Short Stay Unit. The facility is more relaxed, pleasant and quiet in comparison to the previous, noisy unit which had no natural light. The individual beds now have a floor-to-ceiling wall between them but still have only a curtain at the front to provide privacy. There is natural light and access to a courtyard outside.

All private rooms overlook the lovely outdoor areas & gardens which include extensive raised flower and herb beds for added sensory enjoyment.



The half-court basketball court, as suggested/requested by the residents, is now en train, and to be constructed in the coming months. The staff are delighted to have this underway, as it will provide a robust and appropriate sports facility for the residents to get some formal and informal exercise.

Issues – 82 issues of concerns were identified; examples as follows:

It was obvious that XX was cramped in and gives little opportunity for clients to spend time in privacy other than in their bedrooms

The standard of building facilities varies between departments and wards. The ED is adequate for its purpose however, given its limited space and lack of privacy and natural light, it is unsuitable for accommodating mental health patients for longer than 24 hours. The mental health wards are considerably better environments complete with courtyards, indoor and outdoor activity areas and spacious rooms - many with en suite bathrooms.

XX is one of the oldest buildings in the mental health services and some large infrastructure changes such as better bathrooms have not yet been funded. Obvious ligature points have been removed and lighting improved with use of downlights recessed in the ceilings. There are plans to put laminated photographs and other colourful works on the walls of the upstairs dormitory to make it seem less bare and institutional.

A problem raised by clients in the morning meeting and noticed by the CVs is the accumulation of cigarette butts outside the building. There is provision of ashtrays near the entrance. However, these are flimsy, damaged and often broken into from the street overnight. Compounding the issue, there is an outdoor area directly opposite the entrance which has concrete benches and becomes an immediate smoking zone even though there are large signs in this area that state 'No Smoking'. (on leaving we observed a smoker head straight to this area.) Because the ashtrays are flimsy they are easily broken open and we could see butts were simply blowing out into the ground. Unfortunately, this is the main entrance to what is otherwise an attractive, well maintained and well provisioned unit.

Privacy

Whilst the majority of visits recorded satisfactory privacy arrangements for clients, there were still examples noted where units do not provide adequate privacy. A common aspect of this was the need for additional interview or private rooms for clients and staff to have meetings or as a private space for clients when family are visiting. This was also identified in a number of EDs, where privacy is already limited.

One unit in particular is split over two levels and due to various aspects, clients must vacate their bedrooms during the day and spend their time in the common areas downstairs. Whilst this is accommodated for with various activities and programs, clients are not able to have their own privacy during these hours if they wish.

An aspect that was commented on by numerous clients was the disruption during the night when staff are undertaking regular observations of clients. Whilst the clients understood the reason and need for regular observations to be undertaken, many noted that they were awoken in the night by the torchlight.

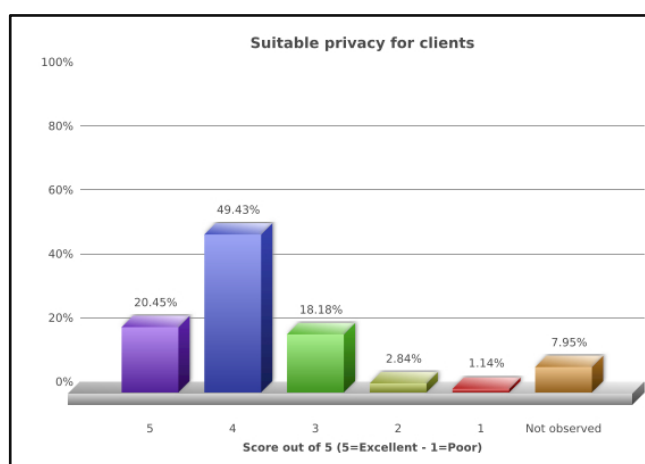
The following comments are from visit reports regarding suitable privacy for clients.

Positive comments – 79 positive comments were made; examples as follows:

Clients are very happy with their privacy being upheld.

All clients have separate bedrooms with ensuites.

Individual rooms with swipe card access as well as areas around the unit where the clients can withdraw are provided. Client feedback indicated the unit feels very safe and secure.



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

Staff commented that there is no interview room or private areas for staff and families to have quiet conversations with patients. Staff and family have to use the patients' bedrooms, which staff feel is an invasion of privacy.

There was discussion about the space available to consumers and the potential of overcrowding. XX can be noisy (and was unsettled at the time of the visit) and this can impact on consumers who need peace and quiet to enable them to recover.

A client identified the lack of privacy as being of concern, particularly with others passing his door (as part of his care, he must be in the line of sight at all times, and as a result, his door is always open). XX also alleged that he is 'exposed' when he uses the bathroom facility in his room.

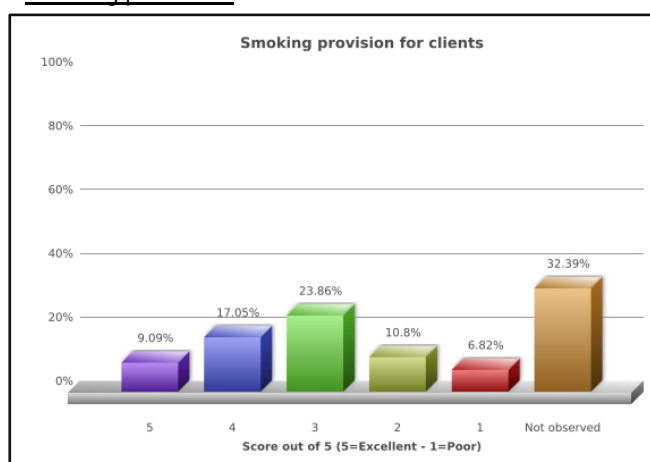
Bedrooms are inaccessible 10.30-2.30 due to cleaning upstairs, and bathrooms are shared. Significantly, the upstairs area is unavailable because of insufficient staff numbers to allow for supervision in the dormitory area.

Two clients mentioned that they are having difficult time to sleep at night because the staff checks on the clients often during their sleeping hours with flash lights. It was acknowledged that this monitoring can cause disturbance and be counterproductive.

3.2.3 Quality of client services and access

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

Smoking provisions



The issue of smoking again continues to be a significant issue and the implementation of the SA Health Smoke Free policy in mental health units was the subject of a recommendation by the independent review of Inpatient Rehabilitation Service at the Glenside Campus. Both staff and clients acknowledge the discrimination for those in the closed units who wish to smoke and the often challenging behaviour displayed due to not being able to smoke has a large impact on the number of code black incidents across the system.

It is also often reported that the Smoke Free policy is inconsistently implemented across facilities, causing confusion for consumers who spend time in different

facilities across SA. The CVS will await to hear if a resolution to the Smoke Free policy is found for the Glenside Campus, which we believe will have a positive effect for all.

The CVS continues to advocate for an exemption to the SA Health Smoke Free policy for those in closed mental health units who are unable to leave the hospital grounds.

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

Issues – examples as follows:

This matter is a source of challenges for staff/patient relations. Issuing of cigarettes is not a traditional nursing role but is one which takes up a good deal of time.

Whilst staff are very keen to encourage residents to quit smoking, (and do so at every juncture) the staff understand the difficulties and stresses in doing so for some of the residents. Smoking huts appear to work well in containing the smokers and these huts are used.

XX expressed concern that the consumers have to go outside for smoking. She said that this is extremely disruptive as most consumers smoke regularly. It is also unsafe for consumers to be out the front smoking for them and the community.

No smoking policy is a major issue in this facility, due to long admissions (no less than 3 months). That is very harsh for consumers and staff to implement it and causes many incidents and aggression. The staff need to escort the clients to smoke outside, it creates problems because often staff are unable to accompany clients every hour.

Smoking is a very challenging issue due to the no smoking policy and the demand of clients being specially in the closed ward, this can cause aggressive reactions. In the open ward, clients are legally allowed to smoke in the streets. That can expose them to drug dealers, compromising safety and care. The ward closes its doors at 8 pm and clients can sometimes demand to go out before bedtime.

Recommendation

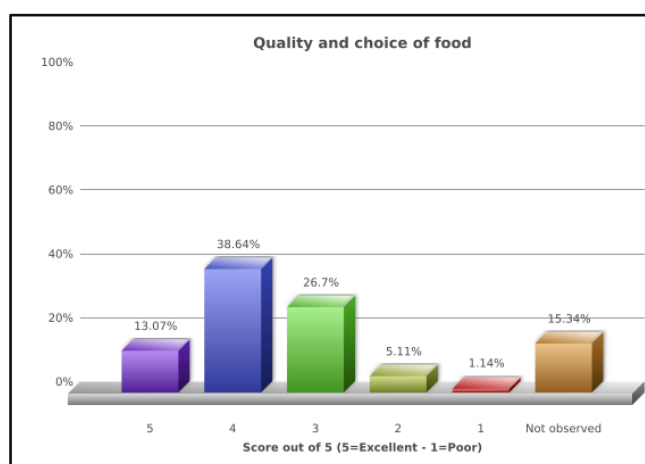
1. That SA Health review the SA Health Smoke-Free policy and make exemptions for mental health consumers in closed wards.

Quality and choice of food

As has been reported in previous years, quality and choice of food is an important contributor to wellbeing for those in mental health facilities and evidence shows that good nutrition has positive impacts on good mental health. In the past year, the CVS has seen an improvement in the quality and choice of meals, particularly for the mental health units in the larger hospitals. Examples of facilities where clients are involved in meal planning and preparation was positively reported on, giving clients greater choice and control and practicing skills that will assist in rehabilitation and recovery. Easy access to fresh fruit and snacks is another aspect of good practice that was appreciated by clients.

However, for the clients in the long stay facilities, such as James Nash House, meals and food continues to be a source of angst and unhappiness.

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



Positive comments – 92 positive comments were made; examples as follows:

A number of clients spoken to during our visit confirmed that the quality and choice of food available to them was very good. There was fresh fruit available in bowls on the tables and also the equipment to make toast and drinks in open wards.

At the monthly meeting, for those who don't want to cook for themselves, staff encouraged residents to use a series of daily 3 course meals (cooked lunches) that can be purchased each weekday. The menu varies each day and includes soup, dessert and a main such as schnitzels, pasta, etc. Cooking classes are run regularly for the residents, and we were invited to join a bbq lunch that was being provided for staff and residents on the day of our visit.

Clients have access to the spacious and well-equipped kitchen at all hours except at night, when they can use the pod kitchenettes. They take part in deciding the menu and in shopping and cooking.

The clients regularly engage in cooking for each other in the facility kitchen or on the BBQ. In general conversation with a number of the clients together in the pergola area, they were unanimous in agreeing that the variety and quality of food provided was good.

Issues – 31 issues of concerns were identified; examples as follows:

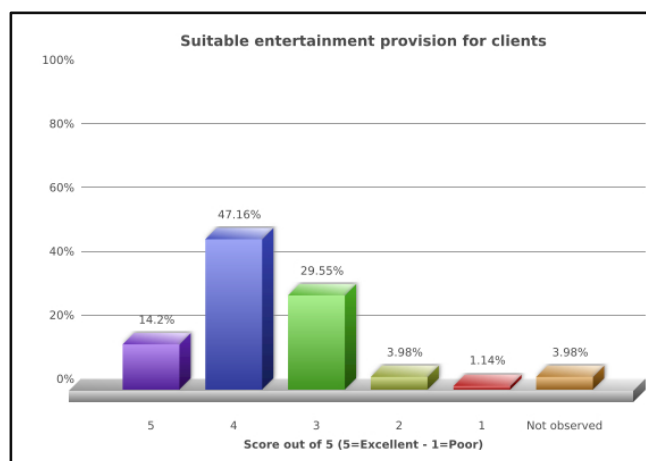
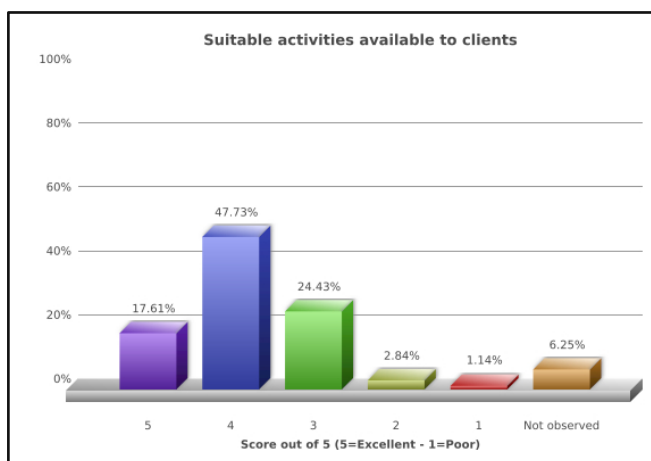
The CVS talked to a consumer who communicated to us that she would like the kitchen to be open longer and more often.

Standard and variety of food is still an issue. The menu is still repeating every week. This is fine for short stays in hospital, but the same food for each day of the week over months and years can become monotonous.

There is a new computerised food order system was introduced and it is mentioned that the staff and clients are still trying to adjust to this new method of ordering food. It requires the clients to be available when the staff is on the ward with the computer. In two cases, clients were out etc and so staff have to make choices for them.

Activities and entertainment

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



A well-structured and delivered activity and entertainment program for clients is essential to promoting good mental wellbeing, developing skills to assist in recovery and breaking the boredom that a hospital environment can ensue. It is particularly important for clients in the closed units or who are not able to leave the ward, as just providing a television for entertainment is not good enough.

Several good examples of structured activity programs have been highlighted during CVS visits, including involving artists in residence, gardening, cooking classes and yoga sessions. In particular the art programs run in some units have led to clients displaying their artwork at various exhibitions, which is a fantastic achievement. Another great achievement was the successful application for NALHN innovation grant funding by a client at James Nash House to establish a Tai Chi program for clients. The first class had an attendance of 20 people including four members of staff, providing not only great benefits for the physical and mental wellbeing of the clients but helping to build relationships between clients and staff.

Unfortunately, we continue to hear of the impact vacant positions such as activity coordinators and occupational therapists has on the provision of meaningful activities, where often these roles are not backfilled when needed or not available over weekends. It was pleasing to hear that at least two units were adjusting their staffing to include allied health and activities staff over the weekends, which can often be a time of boredom for clients on the ward. As one client described it, 'mental illness doesn't suddenly change over the weekend so why should there be any less activities and staff here on a weekend'.

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

Positive comments – 223 positive comments were made; examples as follows:

A broad scope of activities are offered each day. These include a cooking class, a coffee group, a walking group, money matters class, and numerous others.

A Day Program is prepared weekly. Activities include Loss-&-Grief, relaxation, wellness, ACT, craft, cooking (including an outside BBQ), presentations, sensory group, movie night, quiet room, veggie gardening, excursions to the local pool and gym, walks, etc. The facility has an exercise bike, table tennis, and exercise ball.

A full range of well-planned and appropriate activities and self-improvement activities is scheduled for each morning and afternoon, with some also run on weekends. Staff were keen to inject a sense of fun and humour into some of the drier topics such as budgeting.

There is a wide and varied range of activities available to clients at the facility and elsewhere. Staff assist clients to achieve set objectives and goals from well-constructed person centred and practical plans that are designed to help them transition to independent living arrangements.

There is a quality art studio with materials and a kiln. Clay work is a popular sensory activity. The music room is also well equipped with instruments, CDs and space for groups of clients to listen, play or relax. The art and music therapists work with individuals or groups. These forms of therapy are optional and open to anyone, and staff from all disciplines join in.

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

XX provides very little in the way of activities and the lack of this was the basis for a complaint from one resident.

Clients mentioned that they have participated in some activities previously such as cooking, but since Easter the activities became less. The Occupational Therapist (OT) is on leave and he or she is not replaced. Also, there is no OT aid.

Consumer in the SSU complained of lack of activities. Nursing staff confirmed this is an issue and noted this was worse on weekends. There was an activity being held during the visit but the consumer advised nothing had been offered the day before.

For those not permitted off of the ward, little is made available to clients, other than a television behind a plastic panel. On the other hand, excellent music and other facilities are provided at the shared facilities for those voluntary clients who have access to other locations on the overall campus.

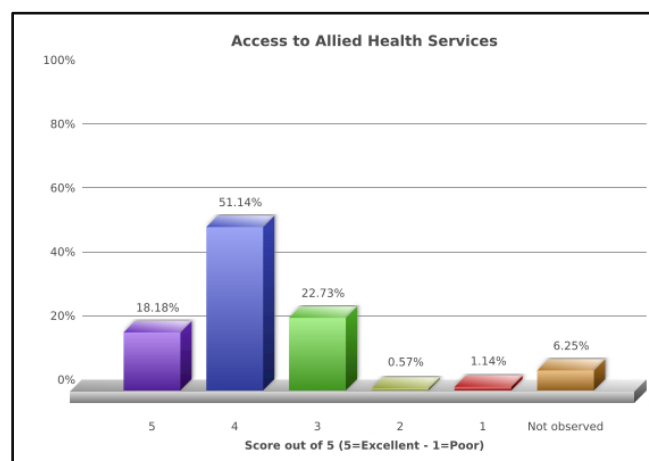
Opportunities to access the campus' music, art and craft facilities are limited due to funding and restructuring of areas/departments.

One consumer mentioned disappointment that a group that she found helpful was not always run on the days when it was scheduled.

Access to Allied Health Services

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

As noted above, the lack of backfilling allied health staff and availability on weekends continues to be raised with CVs. For the units that do not have allied health services based within the unit, the wait times for these services can be lengthy. With the accommodation shortages being faced in the community and a lack of suitable housing options, we have heard many Social Workers are relying on assistance from their colleagues in addressing client's needs in these areas, and their presence in the mental health units are essential.



The roles of Consumer and Carer Consultants continue to play such an important and empowering role in the mental health units and it has been pleasing to hear of several facilities recruiting additional staff in these roles.

As previously reported, the trial of a Social Work position based in the ED for mental health patients has had great successes and the CVS advocates for this position to continue.

Positive comments – 81 positive comments were made in this reporting period, examples as follows:

CVs were informed that funding had been improved to employ one full-time Social Worker who would be based within allied health and come down to work in ED as needed to link clients to services such as Housing SA.

Every patient has their own allied health professionals, such as Social Worker and Psychologist. There is a strong focus on bio-social-psycho education and support.

Regularly serviced by Physio, Social worker, OT, Dieticians. One visitor to the ward mentioned that the assistance by a social worker with a relative when in the community had proven invaluable.

Seemed to be a good range available, and specific mention was made of the value of a peer specialist worker in recent times. There is also an Aboriginal Liaison Officer.

Issues – 18 issues of concerns were identified; examples as follows:

CVs received information that the availability of an Occupational Therapist (needed for sensory modulation) and Physiotherapy are very limited in Ward XX. There is also no Dietitian. Seemingly selection processes and placement processes that commenced...have stalled for one reason or another.

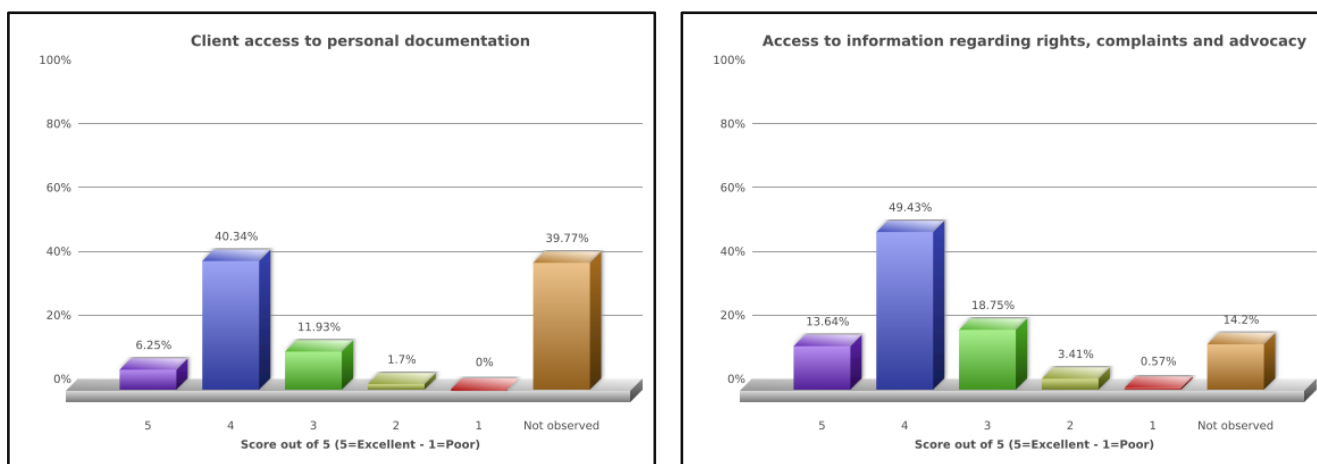
Positions are not backfilled when staff go on leave.

The absence of onsite Drug and Alcohol Services, and indeed of adequate community-based help for those issues, continues to be a major problem due to the high prevalence of methamphetamine use and its very destructive consequences.

This was expressed to us as an ongoing issue. The units seem to still be overpopulated and they find it hard to have these other services assist them, the staff stated that "it is even hard to get a doctor here sometimes". Visiting the SSU the CVs were informed that the staff find it very frustrating that Disability SA does not see clients anymore when they are in mental health units.

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

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



Overall, mental health services rated well in regard to access to information including client rights and advocacy, and CVs were pleased to see the CVS was well promoted in the treatment centres, including the CVS visit notification posters on display in the common areas.

A number of facilities provide clients with a welcome pack or admission brochure containing information including their rights and advocacy information, and a number of units include a CVS brochure in these packs.

One area of information for clients that could be improved, relates to client's access to the NDIS. Numerous clients who were asked about this at CVS visits did not have an understanding of it and whether they may be eligible and/or how to apply. With the roll out of the psychosocial disability pathway over the last year, it is hoped the understanding and information provided to clients will increase and a greater number of clients may be able to access the scheme.

Positive comments – 83 positive comments were made; examples as follows:

A support plan is developed in consultation with each client on their third day of residence, and progress is evaluated in a meeting the day before they leave. Each client leaves with a written copy of this document which also details supports and appointments after discharge. Staff make one follow-up phone call during the week after discharge.

When clients arrive they are handed a book containing their rights and the rules of the ward. The latest survey showed some shortage regarding clients' access to their care plans. That been resolved by weekly (every Sunday) meetings organised and run by XX. They will do BBQ and then have a conversation about their care plan and its importance.

The staff welcome feedback and in addition to making themselves available to residents, staff also encouraged residents to use the suggestion box in the reception area, including those who may wish to do so anonymously. The reception area provides thorough information for the residents such as the citizen's rights to information, brochures and the board for community information and services.

There is a brochure rack in the ward. CV posters and brochures are part of the display. Posters advertising the CV visit were on display in several locations.

Issues – 17 issues of concerns were identified; examples as follows:

Files and individual service plans are all available and seem up to date. However, they seem to be very clinical in focus, with very little reference to home circumstances of the patients who are all from country areas. For many of them, a new file is started when they arrive, which raises questions about continuity of care.

Generally good, but not aware of NDIS, which may be very relevant for them in future.

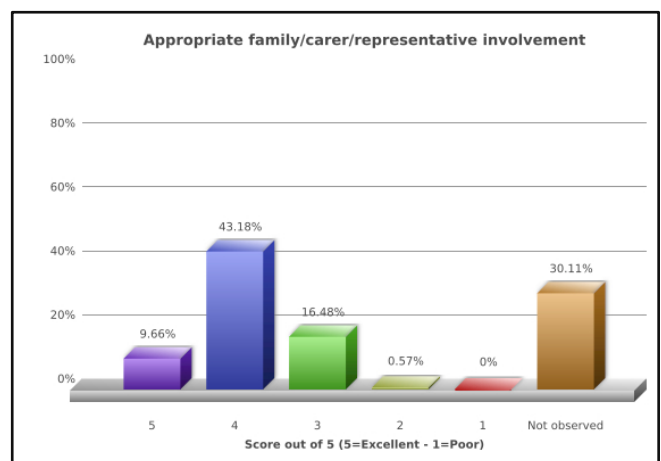
The client we spoke to knew of her rights from previous inpatient periods. However, she said that this time she did not receive any information about her personal safety. She also noted that after an "incident" involving a violent patient (and police in attendance) there was no debriefing by staff to other clients afterwards. She also commented that during the "incident", staff paid no attention to other clients, and she was left fearful for her safety.

Appropriate family/carer/representative involvement

The following chart provides data on CVs ratings of appropriate family/carer/representative involvement. There was a positive improvement in the rating of family involvement since last year's report and in the coming year the CVS would like to increase the participation of family and carers in CVS visits, given the important perspectives they may have about their loved ones treatment and care.

The role of Carer Consultant in the mental health units also assists in not only supporting the family and carers in their own experiences, but provides a conduit to greater involvement in their loved ones treatment and care.

A great example was of one facility looking at their staffing levels to ensure staff are available when family are visiting clients, which CVs noted 'they are currently doing surveys at the moment that are being put into a graph. This data is to let them see when family is visiting most so they can adjust their staffing at these times'.



Positive comments – 68 positive comments were made; examples as follows:

Care plans include the participation of significant others according to the individual wishes of each client and their family members and/or carers and/or representative.

CVs spoke with Carer Consultant who receives referrals from hospital doctors and tries to catch up with the families of patients when they visit. XX has worked in Ward XX for five to six years and has contact with every family of the elderly patients.

Families are actively encouraged to participate in the care and wellbeing of the consumers, using family conferences with staff and their doctors.

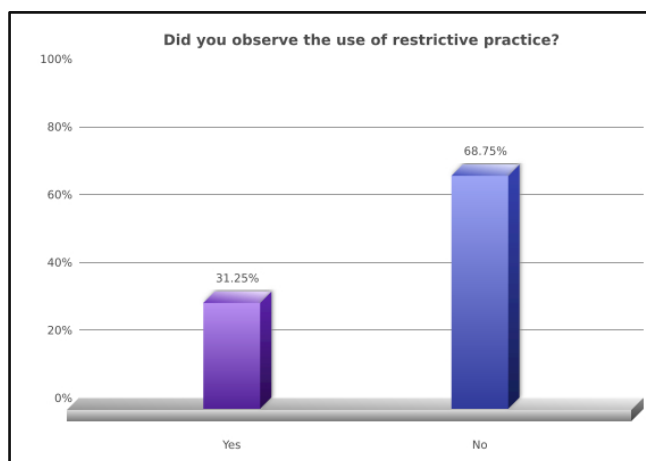
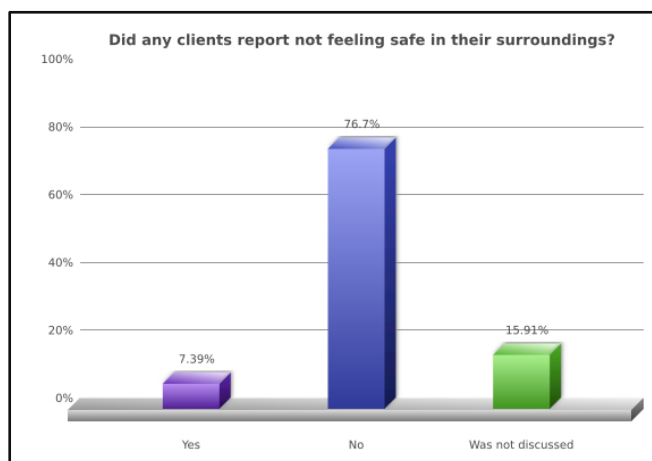
Issues – 4 issues of concerns were identified; examples as follows:

Clients reported no involvement of their families in the development of individual care plans.

We spoke about the challenges of liaising with families in rural areas during a Glenside stay, but it did appear to us that not a great deal of family involvement is happening.

3.2.4 Safety and Rights – least restrictive practices

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



The CVS continues to monitor personal safety at all visits drawing attention to situations and environments which could potentially expose individuals to risk. Interesting to note is a significant increase in the observation of restrictive practice by CVs, up by 15% on last year's report. It is not clear in which particular area of restrictive practice this is.

As reported last year, the use of handcuffs and shackles for forensic and corrections clients in ED was still prevalent over the past year. In addition to this, the shortage of forensic mental health beds has meant that forensic clients have been placed in acute mental health units, under the watch of security guards, often two security guards per client. The presence of security guards creates an intimidating environment and is not helpful for creating a therapeutic environment. Having said that, it has been pleasing to hear that there has been a move towards the reduction or removal of security guards in a number of facilities, replacing them with additional mental health trained staff or chaperones. This provides a greater opportunity for de-escalation techniques to be used before security intervene if a challenging situation arises.

The successes at Northgate House in terms of restrictive practice highlight the crucial role that culture plays in a safe and therapeutic environment, and the use of a values based recruitment process ensures that staff are suitable for the culture of the unit.

Positive comments – examples as follows:

A client who wanted to speak with CVs to praise the Centre and its staff, especially in comparison with other parts of the mental health system she has been using for the last 15 years, emphasised that being given greater independence has made her feel more in control; she has now accepted the need to keep up her medication, and is considering training to become a peer support worker in the future.

XX is very proud of the fact the facility has been free of all restraints for almost two years. Her ethos is that staff be carefully selected using a values-based interview process to ensure they are all a good fit for the culture she has developed. The right staff are committed to getting to know the patients and understanding their behaviour. In this way the environment can be altered to accommodate their needs rather than the other way around, using physical or chemical restraint.

The unit has been working to reduce the restrictive practices used. For example, there were no security guards in evidence at this unit during the visit. The Nurse Unit Manager (NUM) commented that the environment feels more therapeutic as a result.

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

During the day from 10.30 until 14.30 clients are downstairs and they are restricted from going upstairs to their rooms on the first floor. If they are particularly tired they can speak with a nurse and remain upstairs.

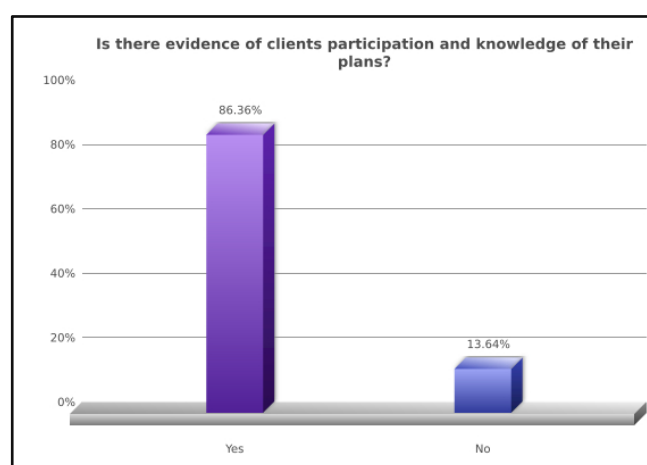
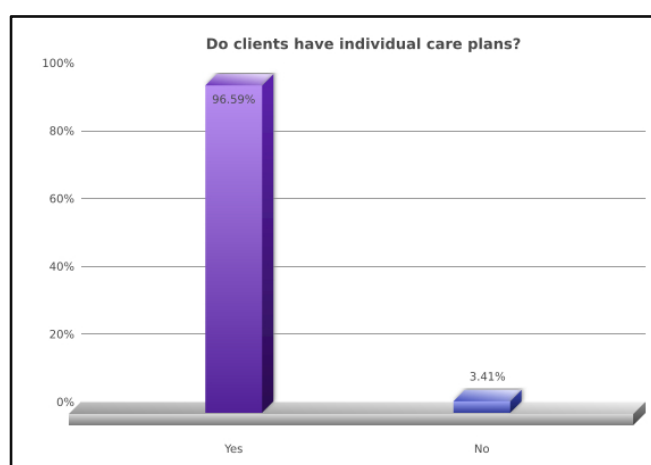
Staff made the observation that the two guards located at the front entrance of the facility are a form of 'restrictive practice', particularly since XX is an open ward. In addition, these guards do not maintain records of which patients/clients are exiting and re-entering the facility. The use of guards at the entrance is currently a necessity because of the range of patients (including forensic patients) who are being treated at the facility.

XX brought up the significant issue of having 'Inpatient Treatment Order (ITO)' patients in an open ward. XX made the observation that the safety of these patients is difficult to manage as they may leave the ward unnoticed and felt that the policy should be that the doors of the open ward should be locked and opened upon request as is the case between 8 pm and 8 am. XX felt that such a policy could eliminate contraband and minimise the risk of harm to unwell patients who may be determined to abscond.

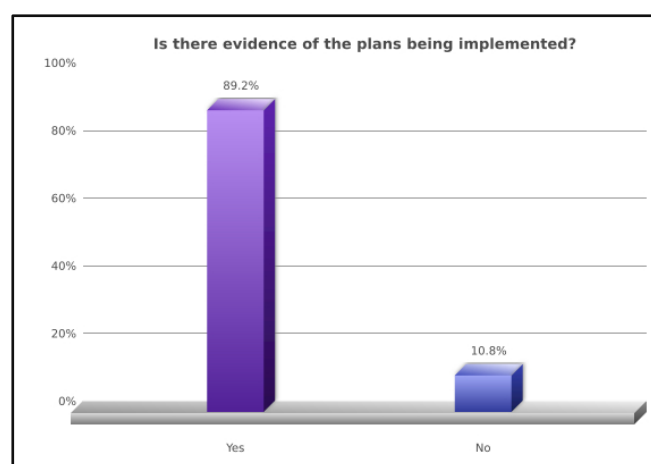
The increase in the number of forensic and section 269x clients at XX (due to lack of vacancies at James Nash) is creating a number of issues. The increase in security presence can raise anxiety in consumers and visitors and therefore detract from the maintenance of a therapeutic environment. One consumer (section 269x) will be at XX for the next 3 months under surveillance of two guards but he is no longer acutely unwell.

3.2.5 Treatment and care planning

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



It is pleasing to note that while CVs reported that 97% of visits indicated that clients have individual treatment and care plans, there was also a 10% increase in the reporting of evidence of plans being implemented and family or guardian involvement in the plans, since last year's annual report.



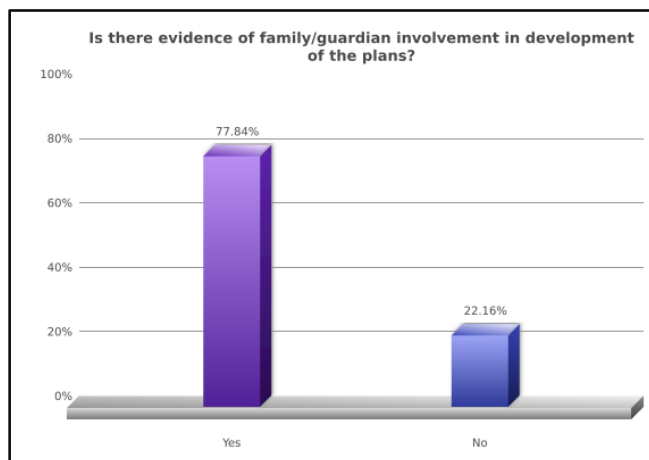
Whilst the high levels of development and implementation of treatment and care plans is pleasing, the CVS continues to hear of the lack of continuity between mental health settings, particularly in the ED, which is when a well-documented treatment and care plan could be very helpful. Treatment and care plans are an important document in giving the client some control over their life when they become unwell and provide an avenue to adhere to their wishes, documented at earlier times in their recovery journey. They also assist clients in not having to 're-tell' their story each time they are admitted to a new unit or reviewed by a new consultant.

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

Positive comments were made; examples as follows:

Care plans are initiated and reviewed at the centre. On day three of a client's stay a support plan is developed with the client to determine what goals the client has for their time at the centre. An evaluation meeting is held with the resident the day before discharge. Involvement of family in the development of the plans was brought up with a couple of residents and together with the presence of the carer consultant there is some evidence to indicate this is considered.

CVs viewed a Treatment Recovery Care Plan (TRCP). These plans contain client goals and outcomes, as well as discharge plans where appropriate. CVs spoke to the husband of a client...who was very happy with the facility and services and was aware of his wife's TRCP and has been involved in it.



We viewed a number of rehabilitation plans which set out goals as specified by clients. The template has been developed by the Centre to make the plan workable and useful. Upon exit, clients can obtain a summary version to take with them. New staff can easily understand these plans gaining a first overview of the clients' needs and goals.

Both clients were well informed about their personal care plans and showed clearly that they saw it as driven by their choices.

A client stated that he knew about his care plan and was actively involved in the plans for his upcoming return home. XX stated that in the Office of the Chief Psychiatrist's iPad survey, the XX is now consistently above 85% in every category including care plans where they were previously falling short

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

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

Some outcomes which are part of care plans are dependent on court orders and there was some frustration expressed by one or two consumers at the delays in this process.

With the substantial increase of admin tasks required of nursing staff, the development and progressing of care plans is not given the priority required.

3.3 Issues and Challenges impacting on Mental Health Services

3.3.1 Forensic Mental Health Services

An ongoing concern for forensic mental health consumers is the stigma caused by the process of applying for various stages of transition through their rehabilitation and recovery. For each stage of transition these consumers must go back before the courts to apply for a variation of their licence conditions and approval to transition back into the community, which means that it is a public hearing and is therefore often reported on in the media by court reporters. These media articles include consumers full names and often photos identifying them, as well as negative and stigmatising reports about them including the crimes they have been found not guilty of due to mental incompetence. The CVS is regularly being told of the negative impacts the media and their interactions have on their (and their families) life and prospects of successful rehabilitation.

These media articles and the negative reports have had impacts on consumers rehabilitation and integration in the community and we know of examples where media articles have negatively impacted client's ability to secure employment and housing. As the media articles include their full name, employers and landlords have been able to find these stigmatising articles easily via a quick internet search. The protection of clients' privacy in such cases would greatly assist their rehabilitation and their success in finding accommodation in the community. These media articles, reported on at each point of a person's transition back to the community, are also traumatising for the families and other victims of the crime.

The CVS believes that having a Mental Health Review Tribunal in SA (as is in the case in other jurisdictions) rather than going back to the courts, would make a significant difference to the rights of these consumers, as Tribunal hearings are not open to the media and not reported on.

The 2015 independent review of SA Forensic Mental Health Services (released in 2017) also included discussion around this topic and highlighted that:

Of the jurisdictions that legislate for review periods, all but the Northern Territory also have specialist mental health review tribunals established for the purpose of reviewing supervision orders (or equivalent), primarily in relation to placement and conditions of leave. Western Australia also has a dedicated mental health review board that considers leave applications for individuals detained under the Criminal Law (Mentally Impaired Accused) Act 1996 (WA).

It is likely that the inclusion of regular review periods, oversights by a specialist mental health review tribunal, would assist with the issues discussed above regarding the prolonged inappropriate detention of forensic patients in acute mental health units or in custody¹.

The review also made recommendation 4.8 - *Consider the establishment of a specialist mental health review tribunal that can oversight and review, in a cost effective and efficient manner, forensic patients.* In its response SA Health supported recommendation 4.8 and noted that SA Health will further consult with the Minister for Mental Health and Substance Abuse and the Attorney-General to determine the feasibility of recommendation 4.8². Whilst I have previously raised this issue with the Minister for Health and Wellbeing, I have not had any further update on the government's position and any further work that may have been undertaken. I have also raised the need for this Tribunal with the Chief Psychiatrist and the Mental Health Commissioner and understand they are also supportive.

Recommendation

2. That recommendation 4.8 of the Review of SA Forensic Mental Health Services - *Consider the establishment of a specialist mental health review tribunal that can oversight and review, in a cost effective and efficient manner, forensic patients* - is considered by Government as a matter of priority.

¹ Assoc Prof. Ed Heffernan, Ms. Bobbie Clugston, Dr. Steve Patchett, 2015, Review of the South Australian Forensic Mental Health Service, p.41.

² Department for Health and Ageing, 2017, SA Health Response to the Recommendations of the Forensic Mental Health Service Review, 2017, p.5.

3.3.2 NDIS psychosocial disability transition

The 2018/19 year saw the start of the NDIS psychosocial disability pathway and through CVS visits and representation on the SA NDIS psychosocial disability transition taskforce, some significant concerns relating to delays in consumers receiving NDIS packages and transitioning, and the unfortunate reduction of successful NGO psychosocial programs have emerged.

Whilst there are certainly some good success stories emerging with the implementation of the NDIS, a significant barrier over the last 12 months has been the delays in finalising consumers NDIS plans and packages, and the availability of appropriate accommodation and support providers and staff to implement the plans. This has been particularly evident for forensic mental health consumers and consumers with complex needs or behavioural challenges. The allocation of the 31 houses through the Specialist Disability Accommodation (SDA) funding to mental health consumers has been great to assist with the current accommodation shortages, however many consumers who have been allocated one of these houses at the beginning of 2019 are still awaiting finalisation of their NDIS plan and have not yet commenced transition. This is causing extreme frustration for many consumers who are concerned that they have a house sitting ready and they are not yet able to live in it due to delays with the NDIS processes.

There are significant issues concerning forensic mental health consumers and the conflict between the best practice in forensic mental health and requirements of court approved transition and the NDIA's procedures for plan approvals and client transition periods. As previously discussed, these consumers must go back to the courts to seek approval for changes to their licence conditions including for transition to community. For the courts to assess and approve this, they require detailed management plans, which the NDIA will not approve without a discharge date. The NDIA will also not make plans for community follow up earlier than 12 weeks from a discharge date, which makes it impossible in a forensic setting where the court system is involved.

One psychiatrist described the situation very well below:

It places the patient in a cruel Catch-22. NDIA will not commit to a management plan until there is a discharge date but there cannot be a discharge date until there is a management plan. The courts, who approve the discharge, will not allow a patient's discharge without knowing what the community follow up will be. The legislation says the court must consider "whether there are adequate resources available for the treatment and support of the defendant in the community" and that the safety of the public is the court's paramount consideration, i.e. the court cannot agree to a patient's discharge without knowing what the follow up will be, even if they understand, and are sympathetic to, the patient's circumstances.

Another important aspect for forensic consumers is a transition period consisting of gradual transition leave into the community, which is often stipulated by the courts. This period can often take many weeks or months and involve staff and accommodation from both the original forensic mental health service and the new service provider in the community. The NDIS does not fund supports for the transition period to the community, which causes great issues in enabling a successful transition for both the consumer and ultimately the courts who are providing the approval.

The current delays with this process for NDIS eligible consumers at James Nash House and Ashton House may mean that these consumers spend much more time in a forensic mental health facility than clinically required, causing a lack of flow for new consumers requiring a bed in these facilities, but also having a detrimental effect on an earlier transition and rehabilitation in the community.

Delays in NDIS plans being approved are also having an impact of the discharge of a number of long stay consumers in acute mental health units in various hospitals and community rehabilitation centres, who would otherwise be ready for discharge. Over the past year we have been contacted by numerous staff and families who are concerned for the rights of these consumers who are unnecessarily being held in a restrictive environment for many months and even years.

Some of the delays have been attributed to the NDIS requirement for independent assessments to be conducted (i.e. Occupational Therapy and Neuro-psychology), however there are limited resources and practitioners available in SA to undertake these and the wait times can cause significant time delays. This was commented on in a report by CVs who noted:

Whilst ward staff are aware of the needs of the clients, we were told of the following action by decision-makers apparently outside of the ward. After obtaining formal in-house professional OT advice for XX, the formal advice, has been overturned with separate subsequent advice being obtained from an outside / independent OT. The revised advice reportedly rejected all of the previous advice and made a separate set of recommendations regarding the care for this client. We were told that the subsequent finding recommended support be altered to only 2 hours or so each

day with the client. We understand that from the discussions that in the longer term under such a reduced care regime that the client may relapse back to his previous condition.

In the forensic mental health setting this is again a significant issue of concern, given the time delays but also that the independent assessments are not shared with the treating team and therefore are not considered in the report written by the treating psychiatrist for the court outlining the management plan.

Another aspect of the introduction of NDIS is the ceasing of funding from 30 June 2019 for a number of very successful community based psychosocial support programs including Partners in Recovery, Personal Helpers and Mentors and Day to Day Living. Many community mental health staff reported their concern about the changes to these programs and impact this would have on many of their clients who may not receive an NDIS plan for various reasons and would lose crucial psychosocial support.

CV's discussed the defunding of community-based psychosocial support services with the Social Worker and were advised that the defunding of Partners in Recovery (PIR) was a concern. Social Workers are currently referring to the GP Access program.

Whilst the 2018-19 Federal Budget announced funding for Continuity of Support for current clients of those programs who are found ineligible for supports under the NDIS, concerns were also raised for consumers who may not currently be in one of those programs but would have benefited from it in the future and will not have that option anymore. These programs were initially defunded with the anticipation that a large number of mental health consumers would be moving over to the NDIS, however this transition has not happened and there is concern expressed that a large number of consumers are now 'falling through the gaps'. These consumers were being supported by very experienced mental health workers employed by NGOs, and due to the funding ceasing, the NGOs have had to make many of these positions redundant. As at 31 May 2019, of the SA Health funded mental health clients, only 32% have been deemed eligible for the NDIS, with 24% having an approved NDIS plan³. A particular concern is the large number (46%) of consumers who have not engaged with the NDIS access process and may not be receiving services that they may be eligible for.

Recommendations

3. That SA Health invest in NDIS Psycho-Social support workers who can work with agencies and Community Mental Services and staff to assist individuals in pre-panning initiatives and liaising with the NDIA and Local Area Coordinators to enable as many clients as possible to obtain psycho-social support services through NDIS funding.
4. That SA Health, Forensic Mental Health Services and the Attorney General's Department work with the NDIA to resolve NDIA policy issues relating to delays in NDIS plans for forensic consumers.

3.3.3 Accommodation shortages

As was reported in last years annual report, SA continues to face an accommodation shortage for a vulnerable population group including mental health consumers. CVs at visits continue to hear about the difficulties facing mental health units in discharging consumers in a timely manner, where they are housing challenges. It is often reported that many consumers have been deemed ready for discharge by the treating teams however, are awaiting accommodation to be secured, meaning they spend more time than necessary in a more restrictive environment, i.e. an acute mental health unit.

Whilst we understand that it is an SA Health policy that consumers are not to be discharged to homelessness, we have again heard stories of consumers being discharged to caravan parks or turning up to the Hutt St Centre with only a bag of clothes in their hands. Also of concern regarding available accommodation is the advice that a number of SRFs are now only accepting clients that have an NDIS package, which limits the options for accommodation even further for many consumers. This leads to a concern that more and more consumers will need to reside in boarding or rooming houses, which are unregulated and could provide many risks to vulnerable consumers rights, safety and appropriate supports in their accommodation.

³ Summary of State Mental Health client transition – 31 May 2019, provided at SA NDIS Psychosocial Disability Transition Taskforce meeting, 20 June 2019.

The CVS continues to advocate for a state housing plan and was pleased to see the recent announcements of a Housing and Homelessness Strategy that is currently being developed by the South Australian Housing Authority to address the housing and homelessness system in South Australia over the next 10 years.

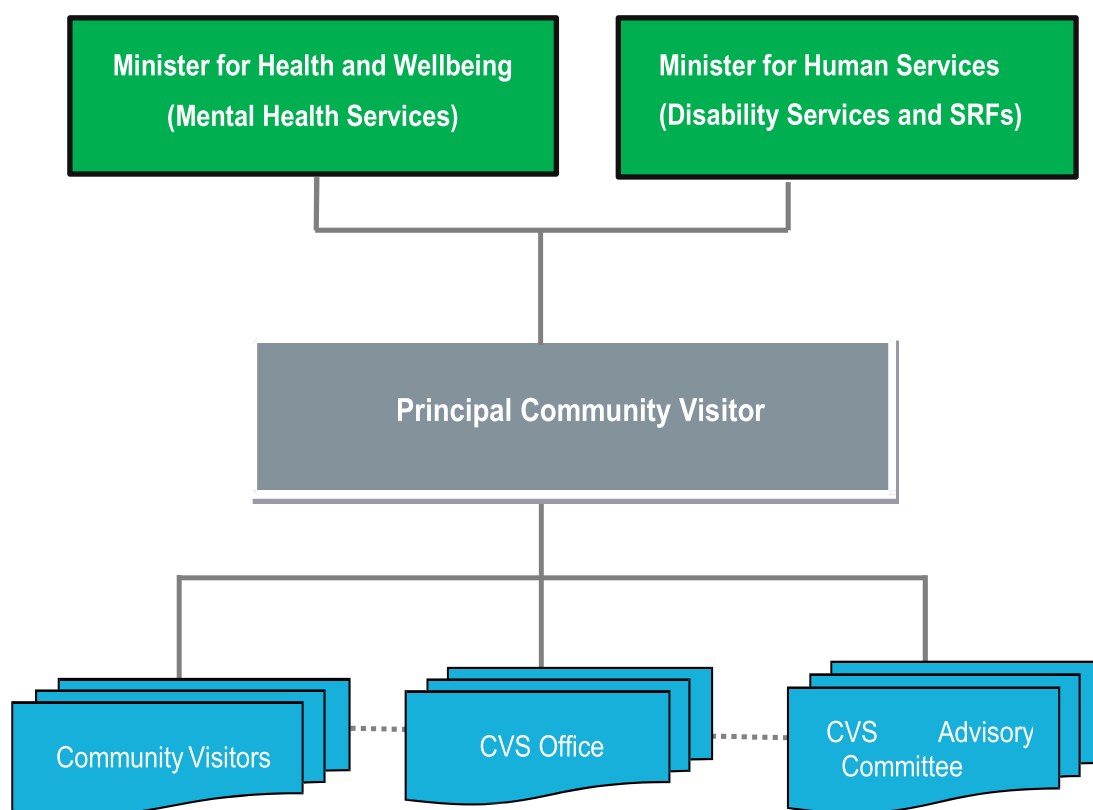
4. Workforce

4.1 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 Health and Wellbeing (Minister for Mental Health Services) on matters related to the Scheme's functions under the *Mental Health Act, 2009*; the Minister for Human Services (Minister for Disability Services) on matters related to the Scheme's functions under the Disability Services (Community Visitor Scheme) Regulations, 2013 and on matters relating to Supported Residential Facilities.

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

An Advisory Committee provides strategic advice and support to the PCV, monitors the key issues arising from the work of the CVS, and contributes to strategic networks and relationships.



The Community Visitor Scheme is auspiced by the Department for Human Services (DHS) for administrative purposes only.

4.2 Staff of the Community Visitor Scheme

Following is a list of paid staff members who worked either full or part time in the Community Visitor Scheme Office during the 2018-19 reporting period:

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

4.3 Advisory Committee

The members of the Advisory Committee during 2018-2019 were:

Ms Anne Burgess	Chairperson
Mr Maurice Corcoran AM	Principal Community Visitor
Dr Niki Vincent	Equal Opportunity Commissioner
Ms Anne Gale	Public Advocate
Dr Grant Davies	Health and Community Services Complaints Commissioner
Mr John Hermann	<i>proxy</i> for Health and Community Services Complaints Commissioner

Mental Health Representatives:

Dr John Brayley	Chief Psychiatrist and Director Mental Health Policy
Ms Lisa Huber	<i>proxy</i> for Chief Psychiatrist and Director Mental Health Policy
Mr Chris Burns	Mental Health Commissioner
Ms Carol Turnbull	Private Mental Health Services Representative
Mr David Saunders	<i>proxy</i> for Private Mental Health Services Representative
Ms Ellie Hodges	Consumer Representative
Ms Charmaine Gallagher	Carer Representative
Mr Tony Rankine	Community Visitor Representative (Mental Health)
Mr Kim Steinle	<i>proxy</i> for Community Visitor Representative (Mental Health)

Disability Representatives:

Dr David Caudrey	Disability Advocate
Ms Zofia Nowak	Director, NDIS Implementation, DHS
Professor Richard Bruggemann	Former Senior Practitioner

Ms Sandra Wallis / Ms Lorraine Marshall	Government Disability Accommodation Representative
Mr Peter Hoppo	Non-Government Disability Accommodation Representative
Ms Kris Maroney	Supported Residential Facilities Sector Representative
Ms Jayne Lehmann	Disability Carer Representative
Mr Jim Evans	Community Visitor Representative (Disability)
Ms Judy Harvey	<i>proxy</i> for Community Visitor Representative (Disability)

4.4 Community Visitors

The Community Visitors (CVs) have impressive backgrounds, skills and passion which have helped to deliver the Scheme's key outcomes of monthly visits and inspections and associated reports at a very high level.

Community Visitors are an integral and valued component of the Scheme and it is with great pleasure that we introduce two of our long-serving Community Visitors:

Lindy Thai – appointed 3/10/2013



I studied a Bachelor of Social Science (Human Services) at The University of South Australia.

The knowledge and skills developed in my studies, as well as insights from my work as a support worker, guide my practice in my role as a CV.

One of the most rewarding aspects of being a CV is seeing improvements in service provision at the sites visited, knowing that the reports written following the visits have contributed to bringing about positive change.

It is also a privilege to work alongside my fellow CV colleagues who I have learnt a lot from as well as formed friendships with.

Marianne Dahl – appointed 28/01/2014

Having studied Social Work back in the 80s, I undertook a variety of roles, mainly related to community development. This highlighted the serious inequalities faced by many groups within our society and the lack of understanding of many policy makers of the resulting impacts on people's daily lives. I have always had an acute sense of social justice and fairness. I also think that many community responses to marginalised groups are not always kind or fair.

Involvement with CVS has given me an opportunity to contribute to a client-centred evidence-based process which can influence positive change. This is such a privilege but is sometimes tough. Working with other like-minded people in the pursuit of systemic improvement makes CVS work not only satisfying but very enjoyable.

My small contribution will be my legacy.



It is also a pleasure to share some examples of the feedback provided from other CVs during the year.

"I am very proud to be a part of the CV scheme that supports both staff and clients in the disability and mental health sectors. Its presence is a sure sign of a healthy community."

[Community Visitor]

"The CVS staff are such a professional, helpful, warm and friendly group and headed up by a Principal who is a model of these attributes."

[Community Visitor]

"I continue to regard the CVS as the benchmark in "How to look after and retain volunteers" – you could put it into a manual and offer it to other government departments."

[Community Visitor]

Although it is always sad to see CVs leave the Scheme, it is also wonderful to see the opportunities which have opened up to them, demonstrated by three recent examples which are shared below.

"I would like to state that being given the opportunity to work as a volunteer in the role of Community Visitor with CVS has given me a true sense of pride and an invaluable experience. It created a stepping stone for much learning, experience, confidence and further employment."

Having the opportunity to meet and chat with and advocate for the vulnerable in our community has enriched my life in so many ways. As a person with lived experience myself it gave me a sense of worth and empowerment."

I loved the time and role and it really did give me such value and helped me in so many ways. I am grateful this service exists and thank the team and Maurice for the huge opportunity and honour of having worked in such a quality team and role."

[Resigning Community Visitor]

"I really can't speak highly enough the honour I feel for the opportunity to have been a Community Visitor with the Community Visitor Scheme."

I have sincerely enjoyed being part of the team, the friendships formed, the wonderful people I had the opportunity to meet from all walks of life, and the educational opportunities gained through the course of the work. Even today, first-hand knowledge acquired through the role assisted me as I was speaking with two carers from different families who currently have loved ones in the xxx Centre, one of whom was quite disappointed and thoroughly drained as she felt her daughters needs were not being met and the pressure for her to be discharged home when she is clearly still acutely unwell, requiring constant supervision."

I feel to a certain extent, once a Community Visitor, always a Community Visitor!"

[Resigning Community Visitor]

"I have enjoyed the contact I have had with you all and it truly was a privilege to be able to work towards the goals of the CVS with the team. It is pleasing to hear that the CVS role is valued highly by staff and management of facilities visited – and other related agencies serving clients of these facilities."

[Resigning Community Visitor]

Below is a list of all the Community Visitors who have contributed during the 2018-19 reporting period:

Adele Querzoli	John Leahy
Andrea Richardson	John Sheehan
Andrew Crowther	Judy Harvey
Angela Glenn	Kim Steinle
Angela Koutsidis	Lia Bibbo
Anna Segreto	Lindy Thai
Ayu Pamungkas	Maree Hollard
Brian Day	Marianne Dahl
Bryn Williams	Michele Slatter
Cathy Walsh	Nike Babalola
Cecil Camilleri	Nirvana Hurworth
Chan Panditharatne	Ron Oliver
David Meldrum	Sally Goode
Elle Churches	Sara Elfalal
Erika Davey	Sharon Hughes
Garry McDonald	Shipra Sareen
Gitta Siekmann	Sue Whittington
Helen Winefield	Sultana Razia
Ingrid Davies	Tony Rankine
Jacy Arthur	Von Cheng
Jane Meegan	Yingchao Han
Jenni Kendal	Yinzi He
Jim Evans	Maurice Corcoran (Principal Community Visitor)
Joanna Zhuang	

4.4.1 Community Visitor recruitment

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

Recruitment advertising for Community Visitors (CVs) is primarily facilitated through the Volunteering SA-NT website. However, the CVS has also used other career sites such as Seek Volunteer and Go Volunteer.

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

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

Two hundred and sixty-eight (268) Expressions of Interest were received during the reporting period, this represents a 27% increase on the previous year. Of these, sixty-six (66) applications were received (a 73% increase).

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 4.4.2)
- » undergo DHS screening checks and referee checks
- » undertake a minimum of two orientation visits with the PCV

Twenty-five (25) applicants proceeded to training after undergoing a successful interview (an increase of 56.25%).

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

Recommendations for appointment to the role of Community Visitor require Cabinet approval and endorsement by His Excellency, the Governor of South Australia. All appointments are then published in the Government Gazette.

Eleven (11) applicants were appointed in 2018-2019. Seven (7) did not proceed to appointment after training or orientation due to withdrawing (for a number of reasons, including securing full-time employment or personal / health reasons), or being unsuccessful after training / orientation. A further seven (7) are undertaking Orientation visits at the time of writing this report, with a view to being appointed if assessed as being suitable.

As reported in last year's Annual Report, the ICAC Commissioner, the Honorable Bruce Lander undertook an enquiry into Oakden which followed a report by the then Chief Psychiatrist. The Commissioner's report, 'Oakden: A Shameful Chapter in South Australia's History' contained a recommendation that a review of Community Visitors training and qualifications be carried out. As mentioned earlier in this report, an independent review has been undertaken by Julian Gardner AM who was the inaugural Public Advocate in Victoria and established their Community Visitor Scheme. The review has been completed but as a result of the uncertainty about the outcome of the review, the Minister for Health and Wellbeing requested that appointments to the role of CV will be for a one year term (rather than three years) until further notice.

4.4.2 Initial and ongoing support and training for Community Visitors

Initial training and orientation

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

- » **Module One:** Introduction, Overview and History of the Community Visitor Scheme
- » **Module Two:** Role, Function 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, Gender Safety, Restrictive Practices & Disability and its impact
- » **Module Ten:** Cultural Competencies, and
- » **Module Eleven:** Values Testing for Disability and Mental Health.

Sessions were held in August and November 2018 and February and May 2019. Twenty-five (25) participants attended training sessions, which is an increase of 56.25% on the previous year. In addition, two new staff members also attended the training as part of their induction.

On completion of the program, attendees are asked to complete a 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.

Participant use of the online survey tool was high and it provided a clear means of being able to collect and analyse participant feedback.

One hundred percent (100%) of respondents either strongly agreed or agreed to the following six (6) statements for six (6) of the ten assessed Modules:

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

The results for the remaining four (4) modules were that 95% of respondents strongly agreed or agreed. The remaining 5% selected "neither agree nor disagree".

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

Following are comments from the four workshops held during this reporting period:

- » **Module One:** Introduction, Overview and History of the Community Visitor Scheme
 - *I felt I gained a good understanding of the background, purpose and basic structure of the Community Visitor Scheme.*
 - *A good overview of the scheme.*
 - *Scenarios provide good examples when dealing with complex issues.*
- » **Module Two:** Role, Function and Scope of the Community Visitor Scheme
 - *Information provided in the manual backs up the presentation and will be a very useful resource for the future.*
 - *In this module, I gained a good understanding of the role of a Community Visitor, limitations of the role and responsibilities as a Statutory Officer.*

» **Module Three: CVS Visits and Inspections**

- *While the presentation and the manual provide a considerable amount of information it also made me realise that there is much more still to be learned through participation in the visits with the PCV and other CVs.*
- *The experienced Community Visitors that presented this module gave a great overview of the facilities and services that Community Visitors inspect and the scope and purpose of visits and inspections. I also gained a good understanding of the reporting requirements and how to deal with issues of concern.*
- *Current Visitor presentation was interesting and engaging.*

» **Module Four: Practical Matters for Community Visitors**

- *In this module I gained a good understanding of Community Visitor's reporting relationship with the Principal Community Visitor, reimbursement entitlements, support mechanism and volunteer rights.*
- *Information was well covered and provided reassurance that any support that was required would be provided.*

» **Module Five: Lived Experience**

- *Good to hear from someone who has lived experience.*
- *I gained an understanding of some of the experiences of individuals using mental health facilities and living in disability homes and their families, including stigmatisation, grief, the strengths based partnership model of care and consumer rights.*
- *Good to challenge perceptions.*

» **Module Six: Mental Health**

- *A good overview of relevant sections of the Act.*
- *Gained a basic understanding of mental disorders, the Mental Health Act and individual and consumer rights.*

» **Module Seven: Communication Strategies**

- *An important topic with many different facets which was well covered. The manual will provide a useful resource.*
- *I gained a good understanding of the variety of communication needs of service users and strategies for effective communication.*
- *Many ideas and pointers of appropriate communication with the examples that were discussed.*

» **Module Eight: Disability**

- *Presentation was excellent and clearly demonstrated some of the values and attitudes we don't always realise that we have. Again it was good to be able to meet and discuss some of these issues with a person who has lived experience.*
- *In this module I gained a clear understanding of disability and associated myths and stereotypes, as well as the history of disability and disability legislation.*
- *A good interactive session I won't forget quickly!*

» **Module Nine: Dual Disability, Gender Safety, Restrictive Practices & Disability and its impact**

- *The presenter was extremely knowledgeable about the topic which was excellent.*
- *In this module I gained a good understanding of the impact of disability on individuals and families, gender safety and restrictive practices.*
- *Good to hear about what a restrictive practice is.*

» **Module Eleven: Values Testing for Disability and Mental Health.**

- *The questionnaire was very useful and did challenge your values. It was good to discuss with other participants and re-evaluate your own ideas.*

- *Again, I have learned new things and ways to practice my future CV role and tasks.*

In addition to rating each module, the attendees are encouraged to provide some written feedback. Following are comments from the four workshops held during this reporting period:

- » *Well-structured and managed training which covered very relevant topics.*
- » *I thoroughly enjoyed the training and left feeling confident to begin working as a Community Visitor. I am eager to apply all that I learnt in the training and am looking forward to learning more along the way.*
- » *A lot of information was presented in a clear and engaging manner. This made the volume of information much easier to process whereas at other courses one may have tuned out after some time.*
- » *Was lovely to hear first-hand experience for both those with lived experience and those who are current visitors. Everyone was very nice and easy to approach. It was lovely meeting all the people in the office too.*
- » *The folder presentation and resources included are brilliant. Although so much information was presented over the 2 days it was easy to follow. Discussing real life scenarios and thought provoking discussions are personally my favourite way of learning so I really appreciated those discussions. It was a pleasant learning environment.*
- » *I strongly agree that the course was delivered by well-informed speakers to a very high standard, and I'm certain that every participant will come away more confident and effective in the scope of the CV role.*
- » *All up very comprehensive training thanks.*
- » *I learnt an incredible amount over the course of the two days! Maurice, Margie, Marianne, Bryn, Nick, Trevor and Richard were fantastic speakers and very knowledgeable about anything CVS, as well as bringing their personal experiences to the group which was very insightful. Leanne, Kate, Micah and Nicole were very helpful in explaining how the system works and offering tips and advice to us. Rondelle did an amazing job of making sure the two days ran smoothly and I really appreciated all the work that went into the training days. Even the food and drinks were excellent. A big thank you to everyone involved. The rest of the trainees were lovely people too!*
- » *My feedback re the training is entirely positive. I would like to thank and commend you and the CVS team for the thoroughness with which you addressed all of the modules. To Leanne, John, Micah, Nicole & Kate - thank you for the invaluable input; I appreciate the effort Maurice made in popping by to introduce himself. To the guest presenters - Margie, Trevor, Michelle, Sharon and Richard - for the challenges, inspiration and wealth of insight - I feel the foundation has been well laid in providing we novice 'Community Visitors' a useful perspective/toolkit to commence our roles. Thank you Rondelle for your adept management of our training.*

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-eight (38) orientation visits were completed with the PCV (an increase of 35% on the previous year).

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*.

From the twenty-five (25) participants attending the 2 day training, seven (28%) have not progressed through to appointment, providing confirmation that the current recruitment process and training program is thorough and robust in matching appropriate applicants to the role.

Ongoing training and support

Professional development needs are assessed and workshops are developed to ensure that CVs have the necessary skills and knowledge to effectively complete visits and inspections.

Community Visitors have access to ongoing training and professional development and were offered a number of external training opportunities, including:

- » Intellectual disability – e-learning
- » The Voices of Autism – Torrens University
- » Manual Handling
- » Disability Awareness Training – online course
- » LGBTIQ - Sexual Diversity - Southern Volunteering
- » TheMHS (The Mental Health Services Learning Network) Conference – Adelaide
- » Self-care for Mental Health professionals - webinar by Mental Health Professionals Network (MHPN)
- » NDIS Quality & Safeguarding for Operational Managers
- » Mental Health Advocacy and Leadership Training - Health Consumers Alliance
- » Behaviour Support, Compliance & Public Advocacy under the NDIS
- » Mental Health First Aid
- » Provide First Aid
- » NDIS Defensible Documentation

Appointed Community Visitors are also invited to attend the 'Introduction to the Mental Health Act and basic Communication Strategies in Mental Health' and / or 'Restrictive Practices' sessions of the training, as a refresher.

The CVS sponsored six (6) CVs to attend the TheMHS Learning Network 2018 Annual Conference which was held in Adelaide. The Mental Health Services Learning Network is an international learning network for improving mental health services in Australia and New Zealand. TheMHS Learning Network events bring together people from across Australia and New Zealand to stimulate debates that challenge the boundaries of present knowledge and ideas about mental health care and mental health systems.

Four (4) CVs participated in the National Volunteer Week parade, along with the Principal Community Visitor and staff from the CVS Office.



Annual development reviews are conducted with the PCV to provide a formal avenue for feedback and development discussions. Twenty-six (26) 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 43 active CVs, with 16 being reappointed for a second term of 1 year. A further sixteen CVs have resigned due to gaining work and/or health conditions (a 77% increase on the previous year).

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. A wide array of guest speakers have also been welcomed this year:

- » August 2018 – Hon. Michelle Lensink MLC, Minister for Human Services, guest speaker
- » October 2018 – Hon. Stephen Wade MLC, Minister for Health and Wellbeing, guest speaker
- » December 2018 – Caroline, who lives in supported disability accommodation and has previously had a visit from the CVS, came along to share her experiences of the visit with the group
- » April 2019 – Commissioner Chris Burns, South Australian Mental Health Commissioner, guest speaker
- » June 2019 – representatives from The NDIS Quality and Safeguards Commission

There were 72 attendances by CVs across the 5 'get togethers'. Notes from the August, October, December, April and June meetings have been included in bi-monthly newsletters, which are an important way of passing on relevant information to regional CVs.

These forums have encouraged a cohesive team approach, provided opportunity for shared learning among peers and been highly valued by the CVs with positive feedback being received, such as:

This was my first get together and I found it very useful getting to know other CV's and hearing their views.

Great job yesterday, thank you and to all others involved! As always, the day went smoothly; most professional.

I thought that there was some great information & discussion; really got a lot out of it.

A 'Reflective Practice' session is offered to CVs prior to 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.

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.

In early 2019, a 'Members Only' section was added to the CVS website which is another communication strategy for keeping in touch with CVs. Newsletters, policies and key documents are regularly uploaded to the site for ease of access and use by CVs.

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

4.4.3 Recruitment strategies external to CVS

Attendance at relevant networking, policy and strategic meetings have occurred with the Recruitment and Training Officer attending three Central Volunteer Managers and one Public Service Volunteer Policy meeting, in addition to an information session regarding the new Free Volunteer Screening Checks.

In addition, CVs are encouraged to talk about their role within their networks to encourage others to take an interest in the Scheme.

5. Conclusion

The past twelve months reporting period has again proved to be a very successful year for the scheme with the continued increase in visits conducted and the further establishment of visits to mental health community settings.

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

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

The CVS has commented on the introduction of the NDIS and whilst there have certainly been positive stories and outcomes for many consumers, a number of significant issues still remain whilst the NDIS becomes well established. The significant concerns outlined in this report relate to the delays in plans and packages being finalised, reduction of community based psychosocial support programs and in particular the impact for forensic mental health consumers who are eligible for NDIS support.

At this time last year, we were just coming to terms with the recommendations made by the Independent Commissioner Against Corruption (ICAC) in his report on Oakden and some of the key questions the Commissioner had of the CVS, especially in relation to our rates of unannounced visits and the training and qualifications of our CVs. These were important questions to ask and the independent review of the CVS was also very important as a means to respond to these questions and provide objective advice back to the Minister about the scheme and its overall performance.

Again, I would like to acknowledge the very open and transparent process that has been undertaken to address, consider and respond to the recommendations made by the ICAC. The OCP that has led this work have been exceptionally open and genuinely consulted us throughout this process and have been respectful of our independent, statutory role and function. Likewise, Julian Gardner AM was very clear and open with us on the review process and consultation opportunities, he kept us informed throughout the review and shared copies of his draft report and key findings. Mr Gardner has had many years of experience in the human rights field and had an outstanding way with words that captured complex key findings but in simple language.

This resulted in us trusting and valuing this opportunity to have independent scrutiny of what we do as a scheme and actually expanding the independent review into our processes for recording, referring and monitoring of issues identified by our visits and/or complaints that individuals and their families have disclosed to us about services. As a direct result of this and our own continuous improvement strategies, I can genuinely and confidently state that we now have a far better internal system that is efficient and effective for being accountable and responsive to our safeguarding role and our functions and powers described under the *Mental Health Act 2009, Part 8, Division 2 – Community Visitor Scheme*.

The review was a positive outcome from the ICAC recommendation 7 and the process of the review allowed us to look closely at all aspects of the scheme including recruitment and training of CVs, visit processes and our issues tracking and follow up. The independent reviewer found that: *"The process for resolving issues applied by the CVS is methodical, timely, has appropriate steps for the escalation of serious or urgent matters and ensures that the appropriate persons do provide a response"*. I am confident that the final review report will showcase the strengths of the SA CVS and I look forward to the release of the report in the near future.

I believe that the mental health sector as a whole has reflected on Oakden and the findings of both the initial investigation report by the previous Chief Psychiatrist and the ICAC report, and is far more conscious of their governance responsibilities. LHN responses to the CVS visit reports has improved considerably. Their individual and collective responses to these reports and the way in which they now use this feedback as part of their quality assurance and continuous improvement strategies, is great to see.

I would also like to reiterate the relationship between the CVS and the OCP, which has continued to strengthen and the responsive approach to concerns raised by the CVS to the OCP has been important. The collaboration and referrals between the CVS visits and reports and those of the OCP has significantly improved and there is recognition of their

similarities and differences. The reviewer confirmed that the CVS apply 'community standards', sometimes described as *"would I be happy with the care and treatment I observe if it were for my family member and are said to provide an early warning system for the Minister"*.

The reviewer also found that *"it is not the CVS role to conduct clinical reviews and assessments of a facility or of the treatment provided. That is the role of the Chief Psychiatrist. The clinical nature of inspections conducted by the OCP differs from but complements those by the CVS. The effectiveness of the combination of inspections is ensured by the positive level of co-operation and collaboration between the two agencies which was evident. I am satisfied that the combination of CVS and OCP inspections is sufficiently comprehensive"*. The CVS has benefitted from both the independent review, greater awareness across the sector in relation to our role and function and improved collaboration with the OCP.

In terms of the disability visitation and significant reduction of scope of the CVS within the disability and SRF sectors, I believe it is important to place on the record that all other States that have visitor schemes in place, found either a legislative or regulatory remedy to enable their schemes to continue to visit their respective NGOs and SRFs. It's not just the SA CVS and our NGOs who wanted the scheme to continue, the SRF Association, National Disability Services (the peak body for NGOs) and the NDIS Quality and Safeguards commission all expressed views about the importance of the CVS continuing, especially during this early stage of the NDIS implementation.

Although our current model of the Community Visitor Scheme has only been in place since July 2011, many of the visitor schemes were first initiated over a hundred and fifty years ago in various forms including South Australia's, where 'appointed Visitor' records to the old asylums go back 172 years.

Comprehensive research into the first mental health asylums in South Australia by Susan Piddock, (Department of Archaeology, Flinders University, Adelaide, South Australia "The history of lunatic asylums") identified some of the earliest records and reports of 'appointed visitors' back in 1847. *"A report of 1856 indicates that the first asylum had only five rooms but does not indicate their purposes (Bostock 1968: 154). It seems likely that these were primarily used by the inmates (sic) as the Visitors, who had been appointed in March 1847 to inspect the asylum, had noted the absence of accommodation for the keeper and his family (S.A. Visitors report 14/9/1847)"*. Another significant appointment was Mary Lee (Suffragette, Secretary and Leader of Women's Suffrage League of SA 1888-1895) who was appointed as the first female official Visitor to the Lunatic Asylums in 1896 and served in that role until 1908.

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

5.1 Future steps of the South Australia Community Visitor Scheme

In April 2019, the CVS held a strategic planning day and from this process, the team established the following priority areas for 2019-20 across all sectors. Progress against these issues and their strategies are presented at CVS Strategic Advisory Committee meetings as required. The larger task of developing a work plan is on hold until work is completed on our extension to visit those under guardianship.

Priority Areas – All Sectors
<ul style="list-style-type: none">• Complete an assessment into the effectiveness and structure of visits
<ul style="list-style-type: none">• Have sufficient number of Community Visitors to meet legislative requirements to cover all sectors
<ul style="list-style-type: none">• Monitor and report on hospital discharges to all those providing accommodation services
<ul style="list-style-type: none">• Systemic issues and appropriate approaches across sectors are identified
<ul style="list-style-type: none">• A visitation service is provided to the disability sector, SRF's and DOP
<ul style="list-style-type: none">• Continuously improve systems and processes for effective and efficient information flow across CVS
Mental Health
<ul style="list-style-type: none">• Forensic patients and DCS clients receive improved access to mental health services
<ul style="list-style-type: none">• Psychosocial supports for NDIS clients are transitioned appropriately
Disability
<ul style="list-style-type: none">• Specialist services under the NDIS are retained
<ul style="list-style-type: none">• Policies and procedures for supporting Disability Clients during hospital admissions are developed by LHN's
<ul style="list-style-type: none">• Accommodation and support is available for clients with complex needs and challenging behaviours
SRFs and Day Option Programs
<ul style="list-style-type: none">• Clients living in SRFs are supported to live independently
<ul style="list-style-type: none">• Residents of Rooming Houses have access to the CVS
<ul style="list-style-type: none">• Day Option Programs are visited

5.2 Recommendations

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

1. That SA Health review the SA Health Smoke-Free policy and make exemptions for mental health consumers in closed wards.
2. That recommendation 4.8 of the Review of SA Forensic Mental Health Services - *Consider the establishment of a specialist mental health review tribunal that can oversight and review, in a cost effective and efficient manner, forensic patients* - is considered by Government as a matter of priority.
3. That SA Health invest in NDIS Psycho-Social support workers who can work with agencies and Community Mental Services and staff to assist individuals in pre-panning initiatives and liaising with the NDIA and Local Area Coordinators to enable as many clients as possible to obtain psycho-social support services through NDIS funding.
4. That SA Health, Forensic Mental Health Services and the Attorney General's Department work with the NDIA to resolve NDIA policy issues relating to delays in NDIS plans for forensic consumers.

6. Acronyms

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

Acronym	Definition (cont)
NEAT	National Emergency Access Target
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
NUM	Nurse Unit Manager
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
OOPMHS	Oakden Older Persons Mental Health Service
PCV	Principal Community Visitor
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
SDA	Specialist Disability Accommodation
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
VSA&NT	Volunteering South Australia and Northern Territory

7. Appendices

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

Division 2—Community visitor scheme

50—Community visitors

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

51—Community visitors' functions and powers

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

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

51A—Delegation by Principal Community Visitor

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

52—Visits to and inspections of treatment centres

- (1) Subject to subsection (2), each treatment centre—
 - (a) must be visited and inspected at least once in every 2-month period by 2 or more community visitors; and
 - (b) may be visited at any time by 2 or more community visitors.
- (2) The Principal Community Visitor may, at any time, visit a treatment centre alone.
- (3) On a visit to a treatment centre under this section, a community visitor must—
 - (a) so far as practicable, inspect all parts of the centre used for or relevant to the care, treatment or control of patients; and
 - (b) so far as practicable, make any necessary inquiries about the care, treatment and control of each inpatient; and
 - (c) take any other action required under the regulations.
- (4) After any visit to a treatment centre, the community visitors must (unless 1 of them is the Principal Community Visitor) report to the Principal Community Visitor about the visit in accordance with the requirements of the Principal Community Visitor.
- (5) A visit may be made with or without previous notice and at any time of the day or night, and be of such length, as the community visitors think appropriate.

- (6) A visit may be made at the request of a patient or a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act.

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

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

53—Requests to see community visitors

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

54—Reports by Principal Community Visitor

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

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

Treatment Centre	Units Visited
Adelaide Clinic	Parks Torrens
Flinders Medical Centre	Margaret Tobin Centre – Ward 5H, 5J & 5K Ward 4G Ward 18V Emergency Department and Short Stay Unit
Glenside Campus	Rural and Remote - Country Mental Health beds Inpatient Rehabilitation Services Helen Mayo House - Women's and Children's beds Eastern Acute Eastern Psychiatric Intensive Care Unit (PICU) Jamie Larcombe Centre
James Nash House	Birdwood Aldgate Clare Ken O'Brien Centre – East & West
Lyell McEwin Health Service	Ward 1G Ward 1H – Older Persons Mental Health beds Mental Health Assessment Unit Emergency Department
Modbury Public Hospital	Woodleigh House Emergency Department
Mount Gambier and Districts Health Service	Integrated Mental Health Unit Emergency Department
Noarlunga Health Service	Morier Ward Emergency Department
Northgate House	Beachside Woodlands
Riverland General Hospital	Integrated Mental Health Unit Emergency Department
Royal Adelaide Hospital	Psychiatric Intensive Care Unit (PICU) Ward 2G Emergency Department Short Stay Unit
The Queen Elizabeth Hospital	Cramond Unit Emergency Department & Short Stay Unit South East (SE) Ward – Older Persons Mental Health beds
Whyalla Hospital	Integrated Mental Health Unit Emergency Department
Women's and Children's Hospital	Boylan Ward Adolescent Ward Emergency Department

Appendix 3: Visit and Inspection Prompt (Mental Health)

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

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

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

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

Appendix 4: Visit Report – blank form

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

REPORT TYPE	
Select report type	Mental Health CVS - Scheduled Visit and Inspection Report to Principal Community Visitor
ABOUT THE SITE	
(MH) Ward/Unit	
ABOUT THE VISIT	
Date of Visit	
Details of any Senior Staff spoken to during the visit (Name and Position):	
ABOUT THE VISITOR(S)	
Community Visitor (writer)	
Community Visitor (contributor)	
Community Visitor (other) - Details of any other community visitors present during the visit	
ENVIRONMENT AND SERVICES	
Communication (5 = Excellent – 1 = Poor, Not Observed)	
Communication between staff and clients	
Staff responsiveness to client needs	

Quality of Site (5 = Excellent – 1 = Poor, Not Observed)	
Standard of building facilities	
Standard of equipment within the facilities	
Standard of facility grounds	
Appropriate emergency procedures	
Suitable privacy for clients	
Quality of Services (5 = Excellent – 1 = Poor, Not Observed)	
Suitable client transport	
Smoking provision for clients	
Quality and choice of food	
Suitable activities available to clients	
Suitable entertainment provision for clients	
(CMH) Suitable referrals to other support services/activities	
(CMH) Suitable referrals to support rehabilitation in the community	
Access to Allied Health Services	
Rights and Responsibilities (5 = Excellent – 1 = Poor, Not Observed)	
Client access to personal documentation	
Access to information regarding rights, complaints and advocacy	

Appropriate family/carer/representative involvement	
Adequate opportunity to access day leave/holidays	
Rights	
Did any clients report not feeling safe in their surroundings?	
Did you observe the use of restrictive practice?	
If yes, did you enquire as to why restrictive practice was utilised?	
Additional comments regarding the rights of clients	
Individual Care Plans	
Do clients have individual care plans?	
How frequently are the plans reviewed?	
Is there evidence of clients participation and knowledge of their plans?	
(MH) Is there evidence of family/guardian involvement in development of the plans?	
(MH) Is there evidence of the plans being implemented?	
(MH) Do the plans appear to match the expectations and capacity of the clients?	
Additional comments regarding Individual Care Plans	
FINAL COMMENTS	
Please provide any additional comments and/or a short overview regarding this visit	

Please outline any issues for CVS office attention	
Please confirm that both Community Visitors have agreed to the content of this report	

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

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

PC013 Statutory Reporting Requirement	
Employment opportunity programs	Refer to the Department of Human Services Annual Report 2018-19
Agency performance management and development systems	Refer to the Department of Human Services Annual Report 2018-19
Work health, safety and return to work programs of the agency and their effectiveness	Refer to the Department of Human Services Annual Report 2018-19
Work health and safety and return to work performance	Refer to the Department of Human Services Annual Report 2018-19
Fraud detected CVS	Number of instances - 0
Strategies implemented to control and prevent fraud	Budget and Finances of the CVS is managed by DHS. CVS complies with all departmental, Treasury and audit frameworks. Refer to the Department of Human Services Annual Report 2018-19
Whistleblowers' disclosure	Refer to the Department of Human Services Annual Report 2018-19
Executive employment in the agency	Refer to the Department of Human Services Annual Report 2018-19
Summary of complaints by subject (table)	Refer to the Department of Human Services Annual Report 2018-19
Complaint outcomes (table)	Refer to the Department of Human Services Annual Report 2018-19