

SOUTH AUSTRALIAN  
COMMUNITY VISITOR SCHEME  
MENTAL HEALTH SERVICES



PRINCIPAL COMMUNITY VISITOR

**Annual Report**  
2013/2014

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

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

**FOR FURTHER INFORMATION:**

Community Visitor Scheme  
GPO Box 292  
Adelaide SA 5000

Phone 1800 606 302  
Fax 08 7424 7239  
Email [cvs@sa.gov.au](mailto:cvs@sa.gov.au)  
Web [www.sa.gov.au/CVS](http://www.sa.gov.au/CVS)

ABN: 97 643 356 590 ISBN: 978-1-74243-720-0 ISSN 2201-6614 (Print) ISSN 2202-6614 (Online)

The information in this publication or components of it can be provided in an alternative format on request.  
Please contact 1800 606 302.



**South Australian  
Community Visitor Scheme**

Level 3, 182 Victoria Square  
ADELAIDE SA 5000

GPO Box 292  
Adelaide SA 5001

Tel: 1800 606 302  
Fax: 08 7424 7239

Email: [cvs@sa.gov.au](mailto:cvs@sa.gov.au)  
[www.sa.gov.au/cvs](http://www.sa.gov.au/cvs)

Hon. Jack Snelling, MP  
Minister for Mental Health and Substance Abuse  
Minister for Health and Ageing

Dear Minister

In accordance with Division 2, section 54 of the *Mental Health Act 2009* (the Act), it gives me great pleasure to submit to you the Annual Report of the Principal Community Visitor 2013-2014 for presentation to Parliament.

This report provides an account of the work of the South Australian Community Visitor Scheme during the financial year ending 30 June 2014, in compliance with the Act and the Department of Premier and Cabinet Circular (PCO13) on Annual Reporting Requirements.

Yours sincerely

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

**Maurice Corcoran AM**  
Principal Community Visitor

30 September 2014

## CONTENTS

<b>1. INTRODUCTION</b>	<b>1</b>
1.1 A message from the Principal Community Visitor	1
1.2 The context of mental health	2
1.3 Data caveat	3
1.4 Annual reporting requirements	3
<b>2. EXECUTIVE SUMMARY</b>	<b>5</b>
<b>3. SUPPORTING LEGISLATION AND POLICY</b>	<b>6</b>
3.1 United Nations Convention on the Rights of People with Disabilities	6
3.2 National legislation and policies	6
3.3 South Australian legislation and policies	12
<b>4. STRATEGIC PARTNERSHIPS</b>	<b>14</b>
4.1 Minister for Mental Health and Substance Abuse	14
4.2 SA Health Chief Executive and Deputy Chief Executive, System Performance	14
4.3 Executive Director of Mental Health and Chief Psychiatrist	14
4.4 Staff of approved treatment centres and emergency departments	14
4.5 The Community Visitor Scheme Advisory Committee	15
4.6 Health and Community Services Complaints Commissioner and the Public Advocate	15
<b>5. FUNCTIONS OF THE COMMUNITY VISITOR SCHEME</b>	<b>17</b>
5.1 Community Visitor functions	17
5.2 Monthly visits and inspections	18
5.3 Requested visits	20
5.4 Advocacy	20
5.5 Disability and supported accommodation facilities	23
<b>6. REPORT OUTCOMES AND THEMES</b>	<b>24</b>
6.1 Summary of reporting outcomes	24
6.2 Delay in admission and treatment	30
6.3 Treatment and care plans	35
6.4 Clients with intellectual disability, brain injury or autism in acute mental health units and forensic care	39
6.5 Gender safety	43
6.6 Activities and stimulation in treatment centres	46
6.7 Sigma for forensic patients transitioning to the community	51
6.8 Impact of SA Health no smoking policy	53
6.9 Menu options	58
6.10 Evidence of good practice	60

<b>7. WORKFORCE</b> .....	<b>62</b>
7.1 Governance of the Community Visitor Scheme.....	62
7.2 Staff of the Community Visitor Scheme.....	62
7.3 Advisory Committee .....	63
7.4 Community Visitor recruitment .....	64
7.5 Initial and ongoing support and training for Community Visitors .....	64
7.6 Volunteer contribution .....	65
<b>8. CONCLUSION</b> .....	<b>67</b>
8.1 Next steps .....	67
8.2 Recommendations .....	68
<b>9. REFERENCES</b> .....	<b>70</b>
9.1 Community Visitor Scheme .....	70
9.2 External references .....	70
<b>10. APPENDICES</b> .....	<b>71</b>
Appendix 1: Visit and Inspection Prompt (Mental Health) .....	71
Appendix 2: Issues Classification Scheme.....	72



**Water Lily** by Angelina Hogan, Consumer

*Drifting on water, the lily makes me feel relaxed and peaceful. I chose the colours as they are warm and calming.*

## 1. INTRODUCTION

### 1.1 A message from the Principal Community Visitor

It is with enormous pleasure that I present this report, which represents the work of the South Australian Community Visitor Scheme (CVS) for the third full year of operation.

I begin my message by acknowledging and thanking our Community Visitors, who have made an exceptional contribution to the CVS throughout this third year. Our Community Visitors have an extensive range of experience, skills and abilities that they bring to the role (See Section 7.6 *Volunteer Contribution*). We have been very fortunate to attract and retain people of this quality to the CVS.

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

Our Community Visitors have collectively volunteered 1167 hours of their time in visiting, inspecting and reporting during this past 12 months – an outstanding contribution to mental health services in South Australia. Together, we have improved the quality of our visit reports and the manner in which we have captured the issues and data that informs this report.

I would like to acknowledge the CVS Advisory Committee members for their contribution made to the strategic direction of the CVS over this past year. In late 2013, the Committee expanded to include representatives from the Disability sector to support the CVS expansion into Disability Accommodation and Supported Residential Facilities.

These committee meetings have provided us with a forum for well-informed discussion about a range of issues that are identified through visits, the rights of individuals and the obligations of providers.

I would particularly like to acknowledge and thank a number of the committee members who I have also met with individually to work through specific issues: Anne Burgess, Committee Chairperson; Peter Tyllis, Chief Psychiatrist; John Brayley, Public Advocate; and Steve Tully, Health and Community Services Complaints Commissioner.

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

I also take this opportunity to acknowledge many of the staff in treatment centres and emergency departments who have given their time to provide Community Visitors with briefings during visits and shared their concerns about the wellbeing and treatment of patients. I remain incredibly impressed with many staff throughout the sector that are committed to improving the service journey for their patients and have been willing to educate and share their concerns when the system is having a detrimental effect on patient's wellbeing.

To the various staff who have had the opportunity to work in the CVS office in this reporting year and who have maintained and supported the scheme to enable Community Visitors and myself to undertake our respective roles, thank you.

**Maurice Corcoran AM**

## 1. INTRODUCTION

### 1.2 The context of mental health

Mental illness has a profound impact on many Australians and their families. The *National Survey of Mental Health and Wellbeing 2007*<sup>1</sup> found that one in five Australian adults experience some form of mental illness in any year, and one in four may experience more than one mental disorder. Almost half of the Australian population (45.5%) will experience mental illness at some point in their lifetime<sup>2</sup>.

Stigmatic attitudes around mental illness can interfere with the dignity of those with mental illness and their ability to be included and to participate in their communities<sup>2</sup>. The majority of individuals experiencing mental health problems have also been discriminated against on the basis of their mental illness and there has been a general lack of acceptance or inclusion from the community.

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

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

All States and Territories in Australia promote a recovery framework and in 2013, the Australian Government released a *national framework for recovery oriented mental health services - Policy and Theory*<sup>3</sup>. The framework has been developed to assist mental health settings to align practice with recovery principles and encourage a review of the skill mix of the mental health service workforce. The value of lived experience will be heightened in services as a result of this framework to enhance the use of “experts by experience”.

South Australia is well positioned to facilitate the new national framework since we have a well-established lived experience workforce of both consumer and carer workers who are well imbedded into the acute inpatient mental health service provision. The ultimate goal of the national framework for recovery is to improve the quality of life for people experiencing mental health issues.

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

---

<sup>1</sup> *National Survey of Mental Health and Wellbeing: Summary of Results* - Australian Bureau of Statistics

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

<sup>3</sup> *A national framework for recovery oriented mental health services Policy and Theory Commonwealth of Australia 2013* – Australian Health Ministers Advisory Council – National Mental Health Strategy



### 1.3 Data caveat

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

Where possible explanatory narrative has been added but nevertheless, interpretation must be informed by context.

### 1.4 Annual reporting requirements

The 2013 Annual Reporting Requirements of the South Australian Department of the Premier and Cabinet outlines the requirements for the content of South Australian government annual reports, within the statutory obligations of any relevant Acts.

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

Accordingly, information regarding the finances, service agreements and workforce of the Mental Health CVS are contained in the Department for Health and Ageing Annual Report 2013-14.

## Sometimes I look around me

by Tony Mons, Consumer

Sometimes I look around me  
And my observations are profound,  
There are those who go about life smiling  
And those that beg on the ground.

Can you help me kind sir  
With loose change for a cup of tea?  
Can you stop for just a second,  
Just to speak to me?

I haven't been this way for all my life  
I'm a product of circumstance.  
I was married for close to thirty years  
And my wife and I would dance.

Sheila died of cancer  
I remember her so dear,  
She brightened up my darkest moods  
With a sprinkling of cheer.

She cooked and cleaned  
Doted over me with a minimal of fuss,  
And now it seems society  
Could not give a tinker's cuss.

I've been around for many a year  
And fought in Vietnam,  
T'was then I took to alcohol  
And my depression it began.

People they just look down on me  
As if I were a bum,  
But I was once a proud father  
With three daughters and a son.

The family they deserted me  
When my problems were too hard to handle,  
Sheila she illuminated my life  
In the darkness herself a candle.

## 2. EXECUTIVE SUMMARY

A highlight during this reporting period has been the ongoing recruitment and retention of exceptionally qualified and experienced Community Visitors (CVs). The CVs have impressive backgrounds, skills and passion that have helped to deliver our key outcomes of monthly inspections and associated reports at a very high level. With the expansion into disability sector, the demand for CVs has increased and targeted recruitment campaigns are in place to increase our workforce.

Visits are planned and negotiated to ensure that CVs are familiar with the units and their staff. This has helped to build trust with both patients and key staff, especially in long-stay units.

The CVS has continued to develop a comprehensive means of processing information and issues that are identified during visits to facilitate timely follow up and data analysis. Issues of significance or issues identified as systematic are documented on an Issues Register for further research and action. The Issues Register is tabled at the CVS Advisory Committee where there have been robust and well-informed discussions about how best to advance these issues. This has influenced the many successful outcomes that the CVS has already achieved.

Visit reports are provided back to the Mental Health Executive Director's on a monthly basis seeking action on outstanding issues and where appropriate highlighting good practices to ensure staff are acknowledged. Copies of these reports are also provided to treatment centre staff.

Over this third year, there were 510 individual issues/comments reported by CVs, compared to 420 in the 2012-13 reporting period and 146 in 2011-12. Of the total 510 reported comments it is pleasing to note that 166 were reports that highlighted innovative and very positive actions that have taken place in units for which we have been able to commend staff/units.

There are a number of units who are really focussed on a range of continuous improvement strategies in a concerted effort to achieve best practice. These same units are eager to hear back from CVs and use their reports in a constructive manner.

The CVS has received a range of comments from providers about the value of the Scheme and how important it is to have an independent 'watch-dog' who provides reports back to the service.

Examples of responses include:

*It is a delight to have you visiting the wards and talking with staff and patients so informatively and with such evident concern for the welfare, we appreciate your reports and the feedback they provide us.*

*Thank you for your recent report and the acknowledgement of one of our staff who dealt with a difficult situation in a calm and professional manner. I will ensure he is acknowledged and recognised through formal correspondence.*

*Thanks again for another set of informative reports. We all appreciate confirmation of what is happening well and very valuable to pick up the insights of where we can improve. The CVS is a very valuable tool for service improvement. Thanks for your time and that of the visitors.*

*I have also had time to have a look at this report and again there are issues which are helpful to be raised by your team, as they are long standing issues for us.*

*Thanks a lot for this report which is very helpful in raising points so clearly.*

*Thank you for the recent report, I will ensure the team and informed of your positive feedback.*

*This is fabulous feedback and it is always appreciated.*

*Thanks for the opportunity to read the visit report for December, is it possible that we can discuss as it appears that comments attributed to me have been taken out of context. (Note: in this instance, the report was discussed and revised after consultation with CVs)*

### 3. SUPPORTING LEGISLATION AND POLICY

#### 3.1 United Nations Convention on the Rights of People with Disabilities

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

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

Under the UNCRPWD, discrimination on the basis of disability 'means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

It includes all forms of discrimination. The Convention aims to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

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

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

#### 3.2 National legislation and policies

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

The National Mental Health Strategy was first endorsed in 1992 by the Australian Health Ministers' Conference as a framework to guide mental health reform. The National Mental Health Strategy aims to:

- Promote the mental health of the Australian community ;
- Where possible, prevent the development of mental disorder;
- Reduce the impact of mental disorders on individuals, families and the community; and
- Assure the rights of people with mental illness.

The strategy includes:

- the *National mental health policy*
- the *National mental health plan*
- the *Mental health statement of rights and responsibilities*
- the Australian health care agreements

The National Mental Health Strategy has been reaffirmed by Health Ministers a number of times, most recently, in 2008 and the *Fourth National Mental Health Plan* (the Fourth Plan) which was released in November 2009. The Fourth Plan states that people with mental health problems and mental illness have rights and responsibilities to be informed about and involved in decisions about their own individual treatment and this is in line with recovery oriented practice. Mental health legislation should include recognition of these rights and the conditions that apply when decision-making is delegated.

#### **National Standards for Mental Health**

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

The Standards focus on:

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

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

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

### 3. SUPPORTING LEGISLATION AND POLICY

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

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

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

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

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

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

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

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

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

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

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

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

- (1.16) The MHS upholds the right of the consumer to express compliments, complaints and grievances regarding their care and to have them addressed by the MHS.
- (1.17) The MHS upholds the right of the consumer, wherever possible, to access a staff member of their own gender.

#### **National Health Reform Agreement**

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

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

#### **National Partnership Agreement on Improving Public Hospital Services**

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

### 3. SUPPORTING LEGISLATION AND POLICY

#### **National Mental Health Commission**

In the 2011–12 Federal Budget, \$32 million was allocated to establish a National Mental Health Commission (NMHC), which commenced operation in January 2012. The main function of the NMHC is to monitor, assess and report on how the mental health system is performing and its impact on consumer and carer outcomes. The NMHC produces an annual National Report Card on Mental Health and Suicide Prevention.

The first Report Card<sup>4</sup> from the National Mental Health Commission developed ten recommendations to achieve their vision for a contributing life for people with mental health difficulties and their families:

1. Nothing About Us Without Us, there must be a regular independent survey of experiences and access to all mental health services
2. Increase access to timely and appropriate mental health services and support from 6-8 percent to 12 percent of the Australian population
3. Reduce the use of involuntary practices and work to eliminate seclusion and restraint
4. All governments must set targets and work together to reduce early death and improve the physical health of people with mental illness
5. Include the mental health of Aboriginal and Torres Strait Islander peoples in closing the gap targets to reduce early deaths and improve wellbeing
6. There must be the same national commitment to safety and quality care for mental health services as there is for general health services
7. Invest in healthy families and communities to increase resilience and reduce the longer term needs for crisis services
8. Increase the level of participation of people with mental health difficulties in employment in Australia to match International levels
9. No one should be discharged from hospitals, custodial care, mental health or drug and alcohol related treatment services into homelessness, there must be increased access to stable and safe places to live.
10. Prevent and reduce suicides, and support those who attempt suicide through timely local responses and reporting.

---

<sup>4</sup> National Mental Health Commission, 2012: *A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention*, Sydney: NMHC



The second Report Card<sup>5</sup> continues the NMHC's commitment for change, building upon the foundations and whole of life scope established in the first Report Card and added an additional eight recommendations:

11. People with co-existing mental health difficulties and substance use problems must be offered appropriate and closely coordinated assessment, response and follow-up for their problems.
12. National, systematic and adequately funded early intervention approaches must remain. This must be accompanied by robust evaluation to support investment decisions, with a focus on implementation, outcomes and accountability.
13. A National Mental Health Peer Workforce Development Framework must be created and implemented in all treatment and support settings. Progress must be measured against a national target for the employment and development of the peer workforce.
14. A practical guide for the inclusion of families and support people in services must be developed and implemented, and this must include consideration of the services and supports that they need to be sustained in their role.
15. The Commission calls for the implementation and ongoing evaluation of a sustained, multi-faceted national strategy for reducing discrimination.
16. All Australians need access to alternative (and innovative) pathways through school, tertiary and vocational education and training.
17. Where people with mental health difficulties, their families and supporters come into contact with the justice system and forensic services, practices which promote a rights and recovery focus and which will reduce recidivism must be supported and expanded.
18. Governments must sign up to national targets to reduce suicide and suicide attempts and make a plan to reach them. These targets must be based on detailed modelling.

---

<sup>5</sup> National Mental Health Commission, 2013: *A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention*. Sydney: NMHC

### 3. SUPPORTING LEGISLATION AND POLICY

#### 3.3 South Australian legislation and policies

##### The South Australian Strategic Plan

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

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

**Target 23: Social Participation** – assist people to deal with all forms of illness and to live a satisfying life where they can contribute to their community

**Target 24: Volunteering** – Maintain a high level of formal and informal volunteering in South Australia at 70% participation or higher

**Target 30: Boards and Committees** – Increase the number of women on all State Government boards and committees to 50% on average by 2014

**Target 31: Chairs of boards and committees** – Increase the number of women chairing State Government boards and committees to 50% by 2014

**Target 86:** to improve **psychological wellbeing** in South Australia

##### South Australia's Mental Health and Wellbeing Policy

The *South Australia's Mental Health and Wellbeing Policy* (2009-2014) sets out a number of key policy directions aimed at improving South Australia's mental health care system and supporting the recovery process for everyone who experiences mental ill-health. The policy builds on the strategic reforms and developments outlined in *Stepping Up: A Social Inclusion Plan for Mental Health Reform* (2007-2012) and the *Review of Community Mental Health Services in South Australia* (2008).

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

##### The Mental Health Act 2009

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

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

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

##### Review of the Mental Health Act 2009

During 2013-14, the Office of the Chief Psychiatrist undertook a *Review of the Mental Health Act 2009*. The Review provides an account of matters that came to light in the first four years of operation of the Act and issues raised in the course of public submissions and focused consultations. The Review was tabled in Parliament on 1 July 2014 and released for a 4 week public consultation period.

Of particular relevance are the following recommended changes to CVS:

1. Community-based services and facilities should be included in the scope of the Community Visitor Scheme through the regulations.
2. The term of appointment to the Principal Community Visitor position should be 5 years.
3. The contents of the Annual Report of the Principal Community Visitor should be described in more detail.
4. The Principal Community Visitor should have the capacity to conduct visits and inspections of facilities alone.

#### **Advanced Care Directives**

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

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

Standard 2 - Partnering with Consumers and

Standard 9 - Recognising and responding to clinical deterioration in acute health care.

#### **Volunteering Strategy for South Australia**

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

The strategy provides a vision and action plan for volunteering in South Australia for the next six years, its aim being to ensure that the number of volunteers continues to grow, despite pressure from changing norms such as increasing urbanisation, evolving technology, complex legislation, access to insurance cover, volunteer rights, and recruitment and recognition.

## **4. STRATEGIC PARTNERSHIPS**

### **4.1 Minister for Mental Health and Substance Abuse**

In accordance with Part 8, Division 2 of the Act, the PCV is required to report to the Minister for Mental Health and Substance Abuse on the functions of the Community Visitors. The PCV has met with the Minister on a three monthly basis during the 2013-14 period. The meetings have enabled the PCV to discuss issues of concern, provide regular updates on key matters, and discuss reports and observations by Community Visitors. The PCV has also communicated to the Minister's office between meetings when and if issues or concerns arise.

### **4.2 SA Health Chief Executive and Deputy Chief Executive, System Performance**

The PCV has met with the SA Health Chief Executive and Deputy Chief Executive, System Performance on a three monthly basis during the 2013-14 reporting period. This has proven to be a valuable opportunity to discuss issues of concern or highlights from visits. The Chief Executive and Deputy Chief Executive have been very supportive and have been able facilitate solutions and agreements at times when there appeared to be blocks.

### **4.3 Executive Director of Mental Health and Chief Psychiatrist**

Throughout the year the PCV has met with the Executive Director Mental Health and Substance Abuse and the Chief Psychiatrist on a bi-monthly basis. This has proven to be a valuable opportunity to discuss issues of concern or highlights from visits.

The Act identifies the Chief Psychiatrist as a key person to refer matters of concern to and in this context, the PCV has often referred matters of significant clinical importance with the Chief Psychiatrist. In South Australia the Chief Psychiatrist also has responsibility for state wide mental health policy.

### **4.4 Staff of approved treatment centres and emergency departments**

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

Upon arrival to a treatment centre or ED, Community Visitors report to the senior staff member on duty and receive a briefing on the current patient group and any issues of concern. Staff are able to advise the Community Visitors of specific patients that may have expressed a wish to speak to them, or whether there are any patients who may be agitated or very unwell at the time and therefore may be unsettling to have a 'stranger' approach them. Community Visitors also report back to the senior staff member at the end of the visit to discuss any issues and/or report any constructive feedback. CVS relies on senior staff within all units to actively engage with Community Visitors and promote the Scheme within their service.

There have been some great examples of partnership between some staff within units where it is clear there is great motivation to ensure that the rights of patients are upheld and that the recovery model is promoted.

During 2013-14 there has also been improved reporting to treatment centres staff and executive management following each visit. Every month the Mental Health Coordinator provides a copy of the visit reports to Mental Health Executive Directors outlining the issues raised and recommended action. This opportunity is also taken to highlight good practice occurring within units. A summary of this correspondence is also provided to unit staff for their information. Regular reporting has improved the relationship between CVS and staff/management resulting in the prompt resolution of issues.

### 4.5 The Community Visitor Scheme Advisory Committee

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

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

An important function of the Advisory Committee is to discuss the *CVS Issues Register*, which documents a range of significant issues that have been reported through Community Visitor reports from both scheduled and requested visits. Some are issues that have been determined to be systemic and others are of a serious nature requiring action.

The Committee is chaired by Anne Burgess who brings extensive skills and experience to the role and we are privileged to have her. Anne was formerly the Equal Opportunity Commissioner and has a strong background in equal opportunity, planning, strategy and problem solving from her years at senior levels within the areas of health, mental health and equal opportunity.

The Terms of Reference for the Advisory Committee are available on the CVS webpage [www.sa.gov.au/CVS](http://www.sa.gov.au/CVS)

### 4.6 The Public Advocate and Health and Community Services Complaints Commissioner

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



**Peril in the Night** by Mr Justin Hack, Consumer  
*I picked this picture due to the curved perspective, creating a dramatic effect. The man in the painting is being chased by his demon.*

## 5. FUNCTIONS OF THE COMMUNITY VISITOR SCHEME

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

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

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

### 5.1 Community Visitor functions

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

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

The PCV has the following additional functions:

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

## 5. FUNCTIONS OF THE COMMUNITY VISITOR SCHEME

### 5.2 Monthly visits and inspections

The Act mandates that each approved treatment centre will have a visit and inspection by two or more Community Visitors once a month.

There are 12 facilities within South Australia that are gazetted as approved treatment centres for the purposes of administering the Act. They are:

1. Adelaide Clinic
2. Flinders Medical Centre
3. Glenside Campus
4. James Nash House
5. Lyell McEwin Health Service
6. Modbury Public Hospital
7. Noarlunga Health Services
8. Oakden Services for Older People
9. Repatriation General Hospital
10. Royal Adelaide Hospital
11. The Queen Elizabeth Hospital
12. Women's and Children's Hospital

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

- Whyalla Hospital and Health Service (opened April 2014)
- Riverland Regional Health Service (opened June 2014)
- Mount Gambier and Districts Health Service (under development)
- Port Lincoln Health Service (under development)

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

Each treatment centre has a number of units within them as seen in Figure 5.2.1



## 5. FUNCTIONS OF THE COMMUNITY VISITOR SCHEME

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

Treatment Centre	Units visited
Adelaide Clinic	Parks Torrens
Flinders Medical Centre	Margaret Tobin Centre – Ward 5J Margaret Tobin Centre – Ward 5H Margaret Tobin Centre – Ward 5K Ward 4G Emergency Department
Glenside Campus	Rural and Remote - <i>Country Mental Health beds</i> Rehabilitation Services Helen Mayo House - <i>Women's and Children's beds</i> Eastern Acute - <i>formerly Cedars North West</i> Eastern Psychiatric Intensive Care Unit (PICU) – <i>Cedars PICU</i> Grove Closed - <i>Forensic beds</i>
James Nash House	Birdwood Aldgate Clare
Lyell McEwin Health Service	Ward 1G Ward 1H Emergency Department
Modbury Public Hospital	Woodleigh House Emergency Department
Noarlunga Health Service	Morier Ward Emergency Department
Oakden Services for Older People	Clements Makk McLeay
Repatriation General Hospital	Ward 18 Ward 17
Royal Adelaide Hospital	Ward C3 Emergency Department
The Queen Elizabeth	Cramond Clinic Emergency Department South East (SE) Ward
Women's and Children's Hospital	Boylan ward Adolescent ward Emergency Department
Whyalla Hospital	Integrated Mental Health Unit Emergency Department
Riverland General Hospital	Integrated Mental Health Unit Emergency Department

## 5. FUNCTIONS OF THE COMMUNITY VISITOR SCHEME

### 5.3 Requested visits

As part of the CVS mandate, requests can be made for a Community Visitor to visit individuals. One or more Community Visitor may respond to a requested visit from a patient who is currently being treated within a treatment centre or emergency department. A request to see a Community Visitor can be made by the patient, family member, staff, friend or other supporter contacting the CVS office directly.

If a patient requests a visit from a Community Visitor through a treatment centre staff member, the Act requires the staff member to notify the CVS office within two business days of the request being made to them.

There were 79 requests for advocacy/visit during the 2013-14 reporting period, of which 44 requests came directly from patients within emergency departments and treatment centres and 21 were from family members or carers. There were 10 requested visits from staff in treatment centres and 4 from other statutory bodies such as Health and Community Services Complaints Commissioner (HCSCC) or Office of Public Advocate (OPA).

### 5.4 Advocacy

#### Individual Advocacy

Below are some examples of the individual advocacy requests that the Principal Community Visitor (PCV) responds to – note: CVS is not a complaints resolution body or investigation unit.

- Community Visitors met with XXX who felt strongly that placement in the facility was not appropriate and wanted to leave. Community Visitors and others supported XXX through multiple appeals with the Guardianship Board over an 18 month period. XXX has now been moved to community accommodation and is very happy with the outcome.
- In order for XXX to transition from forensic care an independent psychiatric assessment was required. Initially the Social Worker assisted XXX to apply to the Legal Services Commission (LSC) for funding however this was denied.

Community Visitors were involved in supporting XXX through appeals to the Guardianship board and wrote a submission to the LSC, who then approved the funding for an independent assessment. As an outcome of the assessment, XXX has been given approval to be transitioned from forensic care and accommodation arrangements are being considered.

- Community Visitors supported XXX through a complaint to the Human Rights Commission and attended a conciliation hearing (along with Public Advocate and XXX's lawyer) with the Department of Corrections, facilitated through the Commission. Unfortunately, conciliation was not reached and the case has now progressed to the Federal Court for which we have been given prior notice requesting CVS involvement.
- An issue was raised where XXX had had a very disruptive incident with SAPol/Correctional Services. Details CVS sought from Snr staff are outlined below. The matter was also referred to the Public Advocate:

On 6 June SAPOL contacted the inpatient unit (IPU) advising that they wanted to take XXX to the city watch-house to apply five pending charges and bail conditions, following which XXX would return to the IPU. Senior staff suggested this would be better suited to a more controlled and planned approach and SAPOL agreed, providing that the risks of absconding were reduced, and 1:1 specialising was initiated.

SAPOL attended the ward on 10 June 2014 and XXX was arrested and charged with endanger life/threat to kill and arson. Once the charges were laid XXX was encouraged to accept legal representation and was provided with the contact details of Legal Aid and the Aboriginal Rights Movement by the Aboriginal mental health liaison coordinator. However, the offer was declined. XXX was, at the time, subject to an Inpatient Treatment Order (ITO), and because of this the social worker was looking into

## 5. FUNCTIONS OF THE COMMUNITY VISITOR SCHEME

how legal representation could be provided against XXX's wishes whilst under the Mental Health Act. The staff were concerned that without knowing when the hearing would be, XXX may be disadvantaged with regard to access to representation at short notice.

The charges were heard in the Magistrate's Court and a warrant of remand was issued on 11 June 2014 in XXX's absence. SAPOL had previously been asked to notify the IPU once a date was set, and staff documented that SAPOL had indicated that the Magistrate would come to the IPU for the hearing. Unfortunately, this did not occur and the hearing proceeded on 11 June and a warrant was issued. Staff from the Department of Correctional Services took over the guarding of XXX from SAPOL and made the decision to transfer XXX to a more secure environment.

On 11 June, XXX's ITO was revoked by the on-call consultant (no longer experiencing psychosis and had settled over the weekend) and XXX was taken into custody. This became a forensic matter and despite the IPU staff requesting that the transfer occur the next morning, Corrections insisted on executing the warrant to ensure that XXX was in a secure location. XXX was taken late at night and after she had been settled for the evening.

As it is quite rare for the IPU to manage such a complex forensic issue, staff identified that clarification is required for staff about the impact (if any) a Mental Health Act Order has on a person's right to refuse or accept legal representation.

### Systematic Advocacy

CVS is also involved in a level of systematic advocacy and during 2013-14, CVS was particularly involved with:

- **Stigma of public reporting of forensic patients transferring to the community:** Recent media articles have been stigmatising and unfair and have a detrimental effect on the patients and their families. CVS reported the cases to stigma watch and continues to advocate for change in this area (Refer to Section 6.7).
- **Treatment for patients with Borderline Personality Disorder (BPD):** CVS was contacted by a group of carers who raised issues regarding the lack of treatment options for people with BPD. CVS also received requests for a visit from people that were being turned away from the Emergency Department and had nowhere else to go.

The PCV met with the support group 'Sanctuary' and agreed to facilitate a meeting with the Health and Community Services Complaints Commissioner in order to refer the matter to them for follow up.

The following comments were received from the carers:

*We are immensely grateful to you for your role in enabling this to happen: you visited Sanctuary (support group) and listened to our stories; you provided us with the forum which allowed our message to reach the Health and Community Services Complaints Commissioner (HCSCC); and you continued as a part of the team which kept the pressure on. This milestone would almost certainly not have been reached without your and HCSCC support. Thank you so much for all that you do for those with mental illness and those who care for them.*

- **Length of stay for mental health patients in Emergency Departments (EDs):** CVS continues to monitor the length of stay and provide support to patients/families affected by the delays (Refer to Section 6.2).

The below summary was received from a mother regarding her daughter's circumstances and care leading up to admission to a mental health bed:

Sunday 25th May 2014: Her daughter showed all the early warning signs and the following morning said 'I think I need to go to XX (Inpatient Unit)'. Her mother took her to the local Community Mental Health Centre who tried to get her into Intermediate

## 5. FUNCTIONS OF THE COMMUNITY VISITOR SCHEME

Care Centre (ICC) however there were no beds available. She was deteriorating and her treating psychiatrist arrived and told her to go to ED and they would ring ahead.

In ED, her daughter was medically tested and put into a cubicle. She was getting more distressed and wanted to see a psychiatrist and get to the inpatient unit, but they were told there were no beds available across the system. She was a voluntary patient and was allowed out for a cigarette. Afterwards they went back to the cubicle out the back of ED. She lay down again and was sweating and very red in the face. They took her blood pressure again and said her heart was erratic so she was taken off for an ECG. A little while after she came back and started banging her head against the cubicle partition. A nurse came running in and said if she did that again she would be restrained. (She was shackled for nearly 3 days in ED on her last admission 6 years ago – and the experience frightened her). She settled down again and was crying.

Then she wanted to go out for a cigarette again so her mother took her to the fence and she had one and lit up another. Her mother went to the café to get a magazine and when she returned her daughter had gone. As she turned the corner there was a crowd of people gathered around and her daughter was in the middle banging her head against a brick wall. Two security guards grabbed her under each arm.

She was taken to a room with carpeted dirty walls, kicked skirting boards and stable doors. She was on a barouche and restrained at wrists and ankles and a security guard at the door. She was very subdued and had been injected in her leg. She had a big lump on the side of her head and clutched in her hand was a pamphlet, her Treatment Order, as she was now a detained patient.

She was reviewed by a neurologist/neurosurgeon who asked for the restraints to be removed while she was sedated and both he and her mother were there. In addition, a pharmacist visited to discuss her medication. However, there was still no sign of any psychiatrist until around 4:30pm who advised there was a backlog of bed availability and for the time being she would be kept in ED.

Day 2: She had been shifted to cubicle 10 and did not have restraints on. She did stink as she had wet herself and still had the same clothes on. She wouldn't shower and still had not eaten or drank anything. Apparently, she had pulled 2 drips out earlier on. She kept asking for cigarettes and the nurse gave her a plastic inhaler.

Now there are 7 mental health patients in the "mini" psych ward within ED. There is a security guard to 2 patients.

Day 3: She is still in ED, and seemed slightly improved and a bit more in reality, but very frustrated and bored. She just sits there all day with nothing to do. She is not eating again and asking about cigarettes constantly.

Late afternoon on Day 4 she was moved to the Inpatient Unit. She wanted to get treatment and had gone there voluntarily but her only option was through the ED and waiting in an unsuitable environment for 4 days under an ITO.

Six years ago, in April 2008, she was shackled by the wrists and ankles for nearly two days in the Emergency Department. She has had schizophrenia for 19 years, is not a violent person or a drug taker and has had other admissions before but prior to 2008, she has never been restrained – had previously been admitted to a psychiatric ward almost immediately. She was shackled because she asked to have a cigarette and was refused so she pushed the security guard and tried to go out.

While in the ED (3 days) she was not given her medication and became more psychotic and very distressed. A security guard was at the end of her bed and three others at the end of the other 4 patients near her. She thought she was in jail, so this added to the delusion. She also wanted to go to the toilet and a bedpan was rammed under her with all shackles on. Because of this traumatic experience she was in hospital for nearly 6mths, she had to have 12 sessions of ECT, for the first time and her medication was trebled.

## 5. FUNCTIONS OF THE COMMUNITY VISITOR SCHEME

The amount of medication has caused her to get Metabolic Syndrome, resulting in heart problems, obesity, mind blanks, incontinence, blood spotting and erratic, menstrual cycles. She has just been diagnosed with diabetes and is at risk of seizures.

### 5.5 Disability and supported accommodation facilities

Over the past 20 years there has been an increasing effort to shift the focus and intervention model of disability from that of a medical model to the 'social construct' of disability. An approach that sees disability as just part of the diversity of the population that moves from 'special' and segregated to normalisation and inclusion principles and strategies that integrates and empowers individuals with a disability through better access and inclusion and is based on formal rights and a value to the community rather than a deficit.

On 31 May 2012, the South Australian Government announced through the State Budget commitment of \$2.3 million over four years for the establishment of a disability CVS. The disability CVS provide people living in state-funded disability accommodation services or Supported Residential Facilities a visiting, advocacy and inspection service in order to protect their rights and wellbeing.

The disability CVS cover a potential target population of approximately 2,500 individuals. This is based on 682 people in disability institutions, 1,040 in group homes and the current Supported Residential Facilities population of approximately 830 people.



**Simpson Desert Oasis** by Jason Cutler, Consumer

## 6. REPORT OUTCOMES AND THEMES

### 6.1 Summary of reporting outcomes

Community Visitors prepare written reports after each scheduled and requested visit. This information informs the content of feedback to treatment centre staff, senior management and the Office of the Chief Psychiatrist.

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

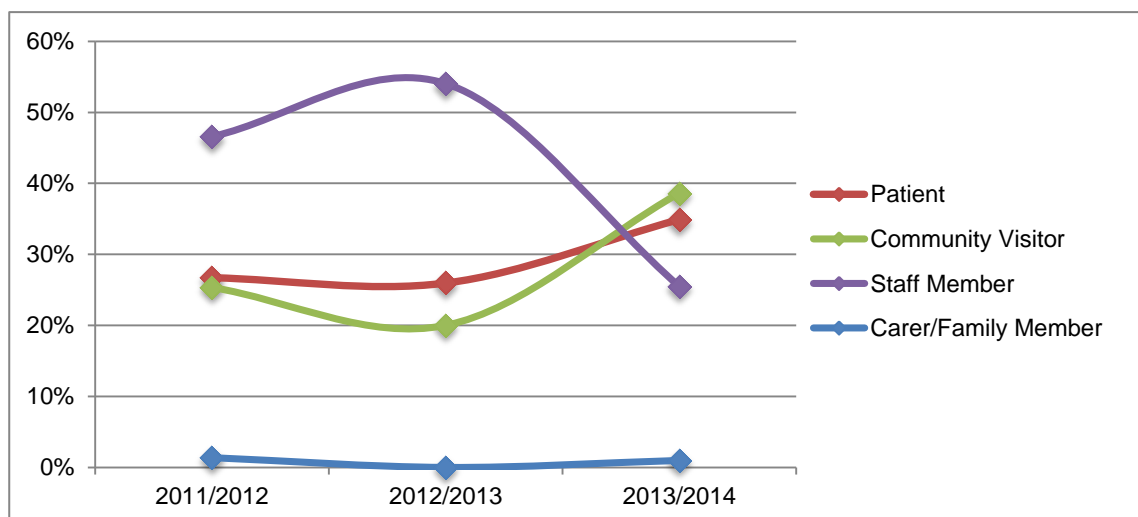
Data acquisition from the Community Visitor reports to the PCV throughout the 2013-14 period has demonstrated a number of trends that are further explored through this section.

The table 6.1.1 and figure 6.1.1 below relate to the number of issues/positive comments raised by patients and families, Community Visitors and staff in the previous reporting periods.

Of the total 510 reported comments during 2013-14, it is pleasing to note that 166 (30%) were reports that highlighted innovative and positive actions that have taken place in units for which we have been able to commend staff/units.

	2011-12 Total	2012-13 Total	2013-14 Total	2013-14 (Issues)	2013-14 (Positive)
<b>Patient</b>	39	109	178	124	54
<b>Community Visitor</b>	37	84	197	118	79
<b>Staff Member</b>	68	227	130	98	32
<b>Carer/family/other</b>	2	0	5	4	1
<b>TOTAL</b>	<b>146</b>	<b>420</b>	<b>510</b>	<b>344</b>	<b>166</b>

**Table 6.1.1 the actual number of issues/positive comments raised during visits and by whom**



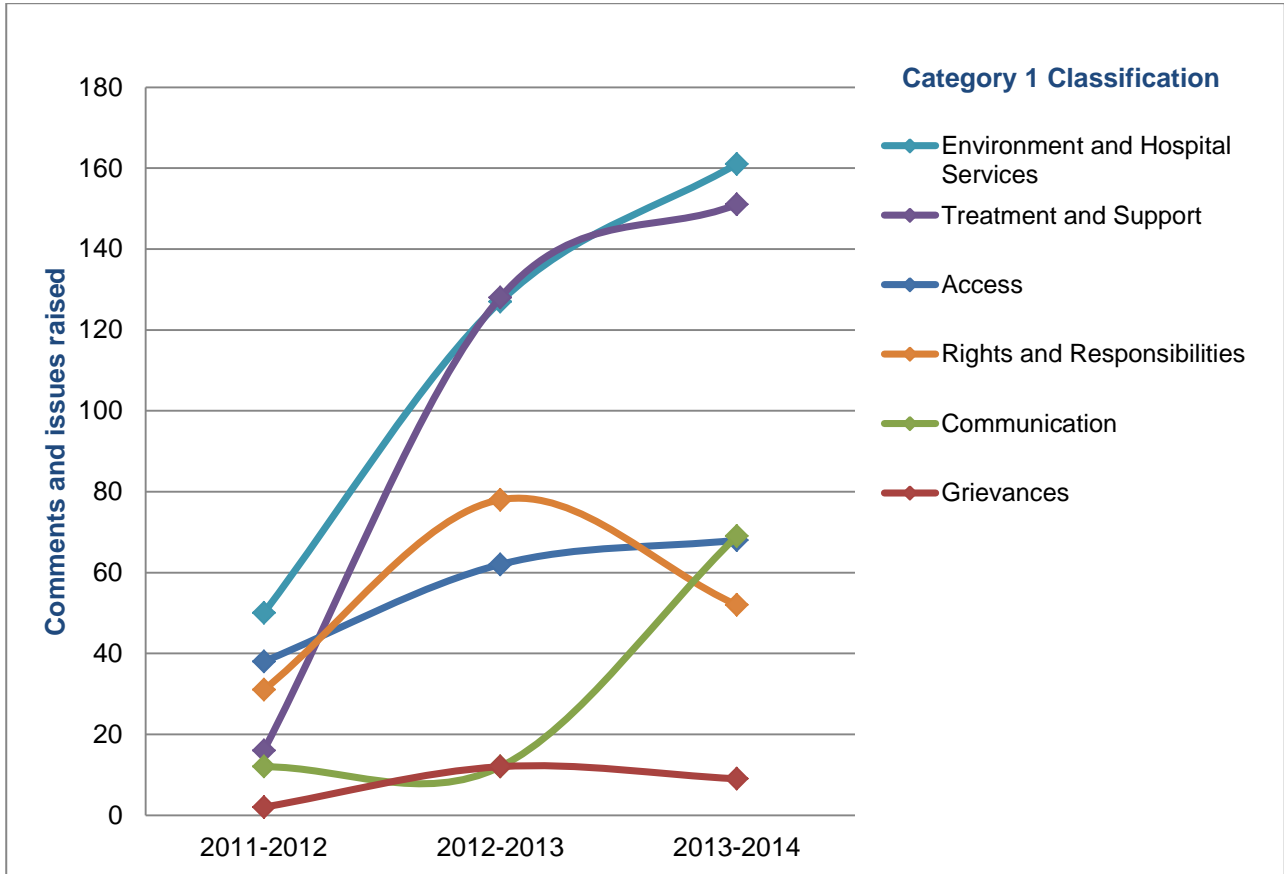
**Figure 6.1.1 the total issues/comments reported by whom as a percentage of the total comments for each reporting period**

It is pleasing to note that the comments raised by patients have increased over the reporting periods. However, a noted area for improvement is to increase the number of issues raised by carers/family members. In this context it should be noted that Community Visitors only inspect each unit once a month and family members/carers may not be present. CVS continues to work with Carer Consultants and other staff to ensure families/carers are aware of the role of Community Visitors.

**Reporting classification**

Issues identified within written reports are assessed by staff within the CVS office and a two level issues classification scheme [Appendix 2] is used to categorise issues that are raised.

Figure 6.1.2 shows that the Level 1 categories most commonly reported during 2013-14 were *Environment and Hospital Services*, *Treatment and Support*, *Access* and *Communication*.

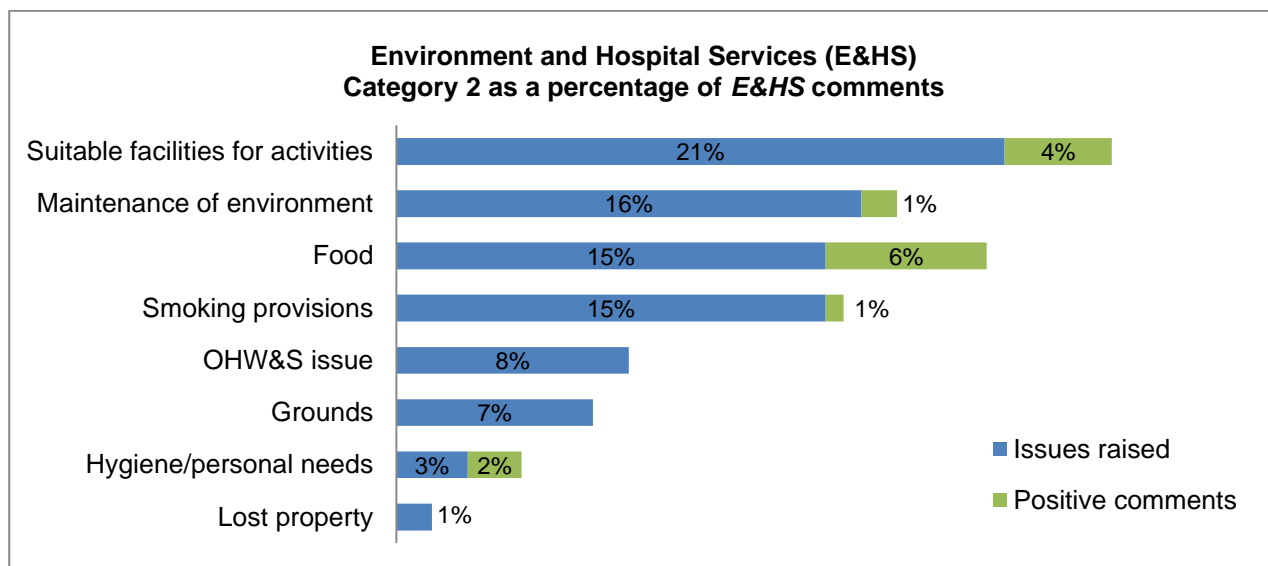


**Figure 6.1.2 – Comparison of issues/comments by Category 1 for the 2011-12, 2012-13 and 2013-14 reporting periods**

## 6. REPORTING OUTCOMES AND THEMES

The most reported Level 1 category was **Environment and Hospital Services**. Figure 6.1.3 below shows the Level 2 categories most commonly reported within Environment and Hospital Services were *Suitable facilities for activities*, *Maintenance of environment*, *Food* and *Smoking provision*.

**Environment and Hospital Services – 161 total (138 issues raised, 21 positive comments)**



**Figure 6.1.3 - Level 2 categories for Environment and Hospital Services 2013-14**

*Suitable facilities for activities* related to lack of space to run groups and access to appropriate facilities i.e. gyms, activity rooms/areas etc (See Section 6.6).

*Maintenance of environment* and *Grounds* issues were primarily relating to old and out-dated buildings in need of repair as well as issues related to new mental health facilities, particularly issues with facility design. Some of these issues were also related to OHS&W of patients such as lack of shade in outside areas, lack of appropriate window shades, plumbing issues etc.

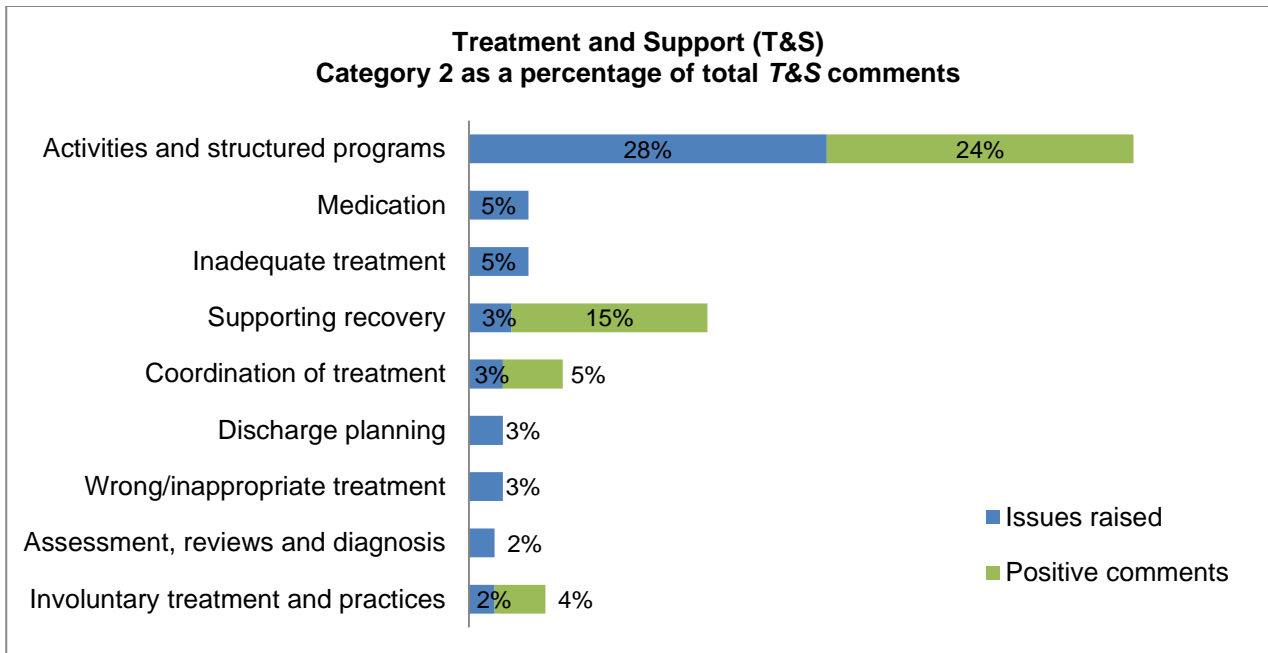
Issues relating to *Food* were mainly raised by patients regarding the quality of the food, inadequate portion size and limited menu options (particularly for long stay wards) (See Section 6.9).

Issues relating to *Smoking provisions*, specifically for patients in closed wards, were raised through staff, patients and CV observation. It is also concerning that patients will leave the safe and supportive environment of the open wards to go to the site boundaries to smoke where they have been subject to assaults and other personal safety issues (See Section 6.8).



Issues relating to **Treatment and Support** were mostly relating to *Lack of activities and structured programs* as seen below in Figure 6.1.4 (See Section 6.6).

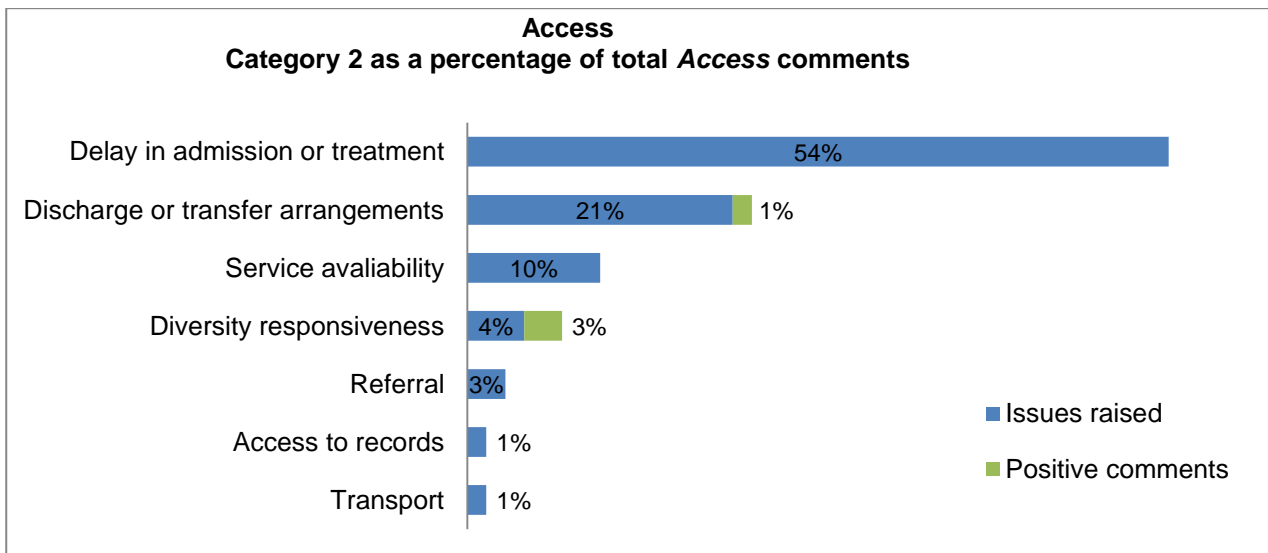
**Treatment and Support – 151 total (79 issues raised, 72 positive comments)**



**Figure 6.1.4 - Level 2 categories for Treatment and Support 2013-14**

Issues relating to **Access** were primarily relating to *Delay in admission or treatment, Discharge or transfer arrangements* and other *Service availability* as seen below in Figure 6.1.5

**Access – 68 total (65 issues raised, 3 positive comments)**



**Figure 6.1.5 - Level 2 categories for Access 2013-14**

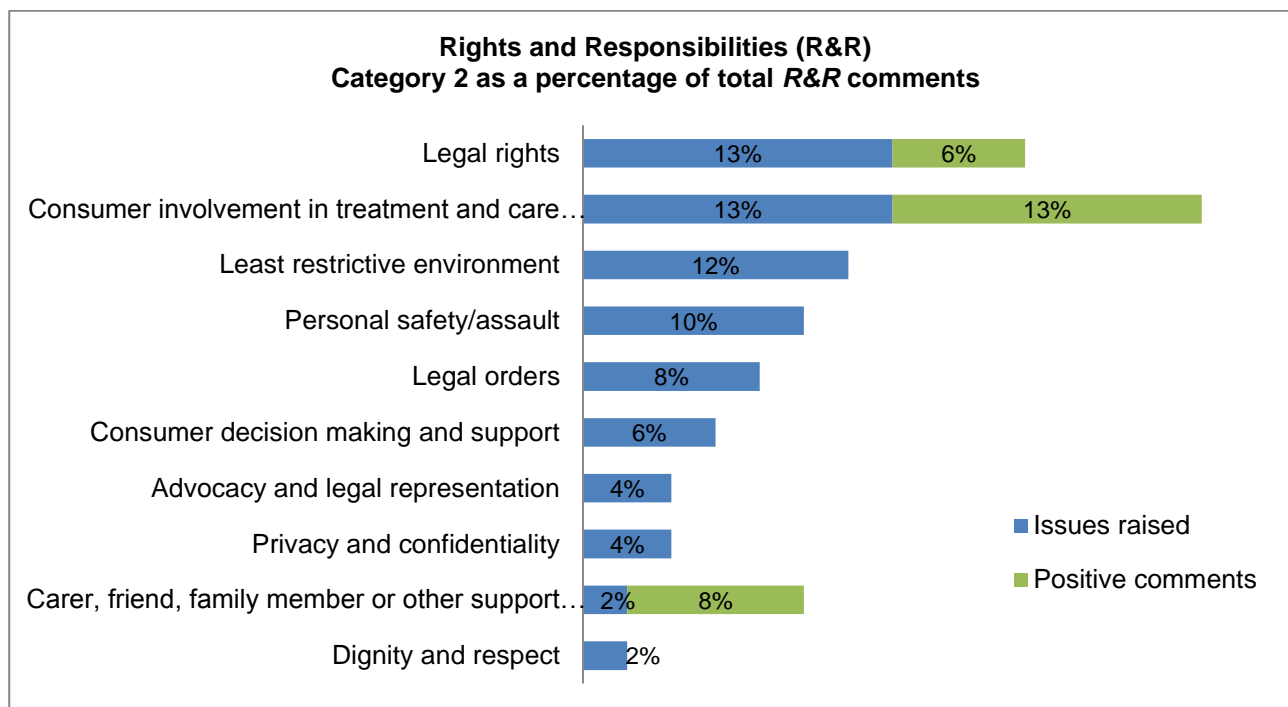
*Delay in admission and treatment* is largely impacted by lengthy waits in emergency departments (EDs) due to a lack of beds to transfer patients to for mental health treatment. CVS was contacted by patients and families/carers because people had been waiting in ED's from 2-6 days for an acute mental health or intensive care bed (See Section 6.2).

*Discharge or transfer arrangements* was impacted by a lack of appropriate accommodation options to discharge to, especially for people with homelessness.

## 6. REPORTING OUTCOMES AND THEMES

Issues relating to **Rights and Responsibilities** were mostly relating to *Legal Rights*, *Consumer involvement in treatment and care planning* and *Least restrictive environment* as seen below in Figure 6.1.6

**Rights and Responsibilities – 52 total (38 issues raised, 14 positive comments)**



**Figure 6.1.6 - Level 2 categories for Rights and Responsibilities 2013-14**

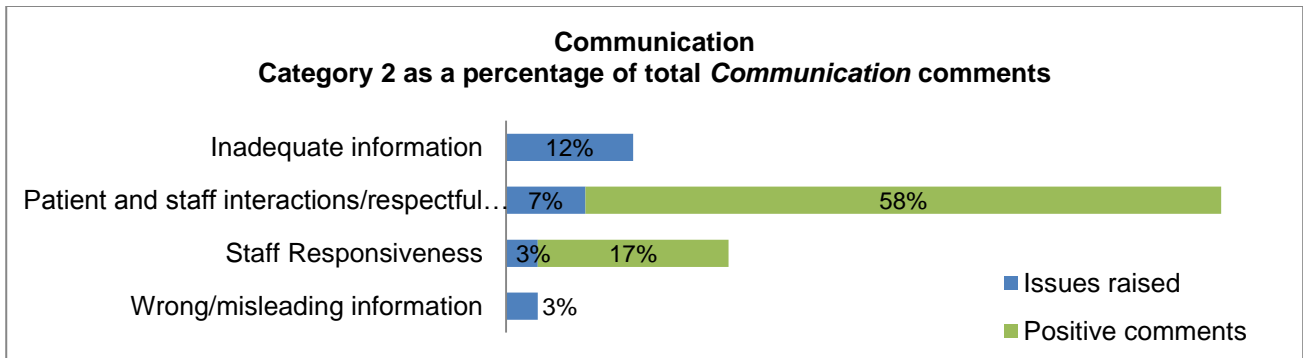
*Legal Rights* related to patients not understanding their rights to appeal and other rights while on an Inpatient Treatment Order.

*Consumer involvement in treatment and care planning* was closely linked with *Consumer decision making and support* and related to their involvement with their individual Care Plans. There was a particular focus during May and June 2014 visits to check the status of patient Care Plans as we have done in previous years (See Section 6.3).

*Least restrictive environment* related to a few incidents of seclusion that were reported to CVs, but significantly less than previous years. This category also included reports from patients of feeling 'hemmed in' and unable to go outside, particularly relating to long stay in Emergency Departments and where security guards are positioned at the end of their beds.

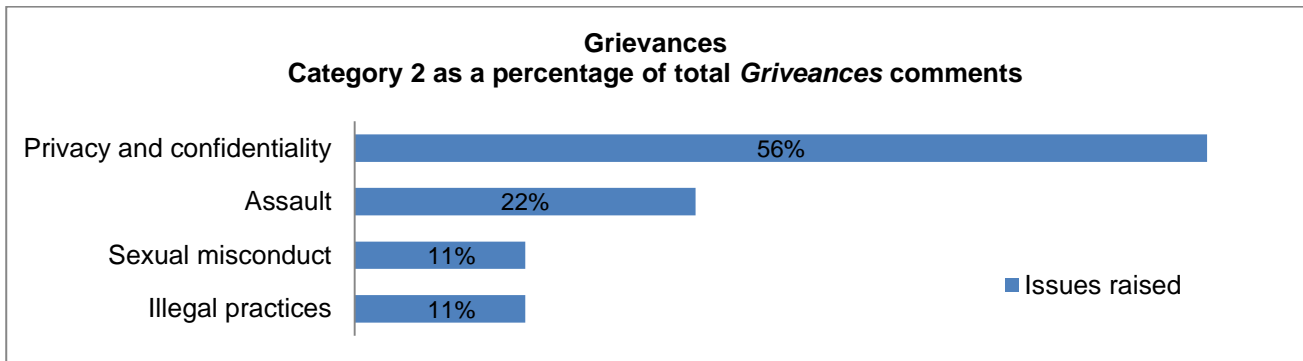
Comments relating to **Communication** were primarily positive comments and observations of respectful interaction between patients and staff as seen below in Figure 6.1.7 (See Section 6.10).

**Communication – 69 total (11 issues raised, 40 positive comments)**



**Figure 6.1.7 - Level 2 categories for Communication 2013-14**

**Grievances – 9 total (9 issues raised, 0 positive comments)**



**Figure 6.1.6 - Level 2 categories for Grievances 2013-14**

**Issues to be expanded further fall into the following categories:**

*1. Compromising clinical care or safety*

- 6.2 Delay in Admission and treatment
- 6.3 Treatment and Care plans
- 6.4 Clients with intellectual disability, brain injury or autism in acute mental health units and forensic care.
- 6.5 Gender safety

*2. Service improvement*

- 6.6 Activities and stimulation in treatment centres
- 6.7 Stigma for forensic patients transitioning to community
- 6.8 Impact of SA Health no smoking policy
- 6.9 Menu options
- 6.10 Evidence of good practice

## 6. REPORTING OUTCOMES AND THEMES

### 6.2 Delay in admission and treatment

Delay in admission and treatment is largely impacted by lengthy waits in emergency departments (EDs) due to a lack of available mental health beds to transfer patients for treatment.

During the 2012-13 reporting period and in consultation with the CVS Advisory Committee, this issue was added to the Issues Register as it was causing significant distress to patients and staff. During 2013-14 this issue has become more apparent through CV reports, requests for advocacy and monitoring of the ED Dashboard. The Dashboard is an on-line tool that shows how many patients are waiting to be assessed, awaiting a bed and it also identifies those who are presenting for mental health reasons in each ED.

Patients are experiencing lengthy waits in EDs for a mental health bed and at times there has been up to 28 patients in our EDs who have been there for more than 8 hours including some who were there between 2-7 days. The implications on both patients and staff alike have been evident through the reports by Community Visitors. In addition, there are issues regarding the inappropriateness of an ED environment for an acutely unwell mental health patient and the risk of increased physical and chemical restraint to manage patients in a high stimulus environment.

Staff have also reported that there has been no lull in demand since February 2014, as would usually be the case. The stress this places on staff is immense and as a result, the appropriate care of patients could be at greater risk.

#### Report results and comments

On average, there were over 5 individual reports of accessibility issues each month, with many of those reports of patients staying in ED for 4-5 days and up to 7.5 days. Below are some of the comments that CVs reported:

*A patient was waiting in the ED near renovations which was extremely noisy, but was the only ED bed available at the time. The patient was distressed about her room and was assured that she would be found a bed in a mental health facility as soon as one become available. (18/07/13)*

*One patient was well known to staff and was extremely agitated about having to stay in ED. (11/10/13)*

*The numbers of requests in Mental Health services have increased enormously in the last month and bed numbers are unable to keep up with this demand. Smoking still an issue that affects patients when there is a long period of waiting for MH beds to become available and increase the chance of aggression. (03/12/13)*

*CV's met with a patient who had been in the ED for two days under an ITO awaiting a bed. She was more than happy to talk about her experience (she had been in and out of hospital over the last few weeks including being medivaced from Pt Lincoln Hospital). She had positive things to say about the staff and her care and treatment although she felt the lengthy wait in the ED environment was not conducive to her recovery. She also had a security guard seated outside her cubicle, did not have access to her phone and was frustrated by the no smoking policy. (09/12/13)*

*Issues raised regarding poor referrals/transfer arrangements from ED not in the best interest of the patient. (10/01/14)*

*Delay in assessment by psychiatrist, patient unable to move to private services. (24/02/14)*

*Issues with access to beds for older people. (7/02/14) (24/02/14)*

*All cubicles in ED were full and some patients were being treated in the walkways. There were 6-8 patients in the ED waiting room. (12/03/14)*

*As continually reported each month, there continues to be extensive waits for admission to a bed in a mental health unit. The ED target of 4 hours from presentation to assessment and decision to admit or discharge is met quite consistently but from there the "blockage" of finding a bed is a*

*serious ongoing issue with patients waiting in the ED for days. The hospital was recently at 196% capacity. (20/03/14)*

*CVs met with a patient who had been in the ED for 5 days - she stated that she "knew what she was getting in to" when she presented but felt safer with people around her. (21/03/14)*

*On several occasions the overflow of detained mental health patients were placed in a 4 bed bay in an empty surgical ward – according to staff this presented serious safety issues as the bay is not designed for mental health patients and has many ligature points, medical tubing and other implements that could cause harm to self or others.*

*A woman suffering from severe post-natal depression who was very paranoid having to remain in ED for 4 days, then in the temporary ward for 5.5 days while waiting for a bed. Another example was a female patient who was in a psychotic state deteriorating in the ward for 8 days. She ended up being discharged from there and never made it to the mental health ward.*

*The temporary ward was described by staff as a 'disaster waiting to happen'.*

*There had been 12 detained patients in the ED at one time (11/04/14)*

*A patient spoke to CVs – she had been in the ED for 4 days and said it was taking too long to get help. (14/04/14)*

*XX had been waiting for a bed for 4 days and was told that there still would not be a bed available today. XX stated that he just wanted to be in a better environment than the ED. (05/05/14)*

*There were 17 mental health patients in the Emergency Department of which four had been waiting for a bed in an acute mental health facility for four days or more. The PECU had been full including additional patients accommodated only in chairs. There was a high presence of Security guards in the department.*

*CV's met with a young man and his father that had requested a visit. He had been in ED for 4 days on ITO - experiencing paranoia and psychosis. This was his second episode and admission, the first having been only a month or two earlier. He was in a small cell-like windowless room and his father had a mattress on the floor.*

*There was a security guard seated outside his room. Concerns were raised regarding inappropriate discussion of security guards - "you should see the nut cases we deal with" and referring to patients as "crazies". (13/05/14)*

*Staff expressed concerns about the lack of beds, increased lengths of stays and the poor environment for mental health patients and their genuine concern for the patients' wellbeing. CV's met with a patient flown from Naracoorte at 3am the week before and had now been in the ED for 6 days. She was extremely frustrated and agitated as she had twice been told that a bed was available for her and both times the transfer did not go ahead. She did not have any complaints about the staff or her treatment but felt it would have been much better and more therapeutic for her to remain in Naracoorte where she could see her husband and four children. (13/05/14)*

*CVs spoke to a patient who had been in ED for 4 days – she described her experience as very difficult. It was noisy, she had little sleep, she had not seen daylight for days and she felt her condition was deteriorating. She questioned why in home support was unable to be provided instead of inpatient treatment. (14/05/14)*

*The patient had been in the ED for 5 days – he had psychotic tendencies and we were advised that he can be verbally abusive. However, during our visit he was distressed & teary but remained controlled. He was tired but was finding it difficult to sleep. (23/06/14)*

*The lengths of stay of mental health patients in the ED impacts significantly on the ED. Staff expressed that it is therapeutically inappropriate for mental health patients in crisis to be located in the ED, both for the patients & other patients in the ED as the mental health patients are visible & in rooms of heavy staff & patient traffic. (18/06/14)*

*5 forensic clients in the PICU unit which again has an impact on the number of beds available for people in need of intensive psychiatric care. (17/06/14)*

## 6. REPORTING OUTCOMES AND THEMES

*Significant security presence in the ED to manage patients. (29/01/14)*

*The problem of discharge to the community for those patients currently in the closed ward. Some long-stay patients have both mental and physical health issues. It is difficult to find an appropriate community setting which would accept their management. (27/03/14)*

*Staff raised concerns about the issue of homelessness resulting in the admission of patients. Patients do not necessarily have mental health problems however, their situations lead to thoughts of suicide/self harm. The admission of homeless patients into the ED is a recurrent issue. At the time of our visit there were 3 homeless patients occupying beds in the ED. 6-9 beds in the ED are used for mental health patients. (30/05/14)*

*One long-term female patient has been in the inpatient unit since November last year due to waiting on accommodation. (21/03/14)*

*Long stay patients are still an issue here while they are waiting for accommodation (some patients waiting since January). The shortage of long stay accommodation causes beds to be taken by patients that don't necessarily need high level care, so therefore any new patient that does need high level care are having to wait in ED or are being transferred to facilities further away from their support network. (16/05/14)*

*Issues obtaining accommodation for patients. Due to bed shortages, patients are being moved or discharged earlier than they really should be which sometimes affects their successful recovery back in the community. (31/01/14)*

*Shortage of long term suitable accommodation within the community. There remains within a group of people who are long term patients and for whom there is no immediate alternative accommodation. This group of people have been in the unit for over 6 months and are effectively taking beds and services that could be directed towards other rehab patients. (19/06/14)*

### **Discussion**

The Community Visitors through their monthly visits to all metropolitan EDs over the past three years have established some very important working relationships with a range ED specialists and mental health nurses who work in these incredibly busy environments. In doing so, there has been a growing appreciation of the great work they do in quite stressful and demanding roles and on occasion the Principal Community Visitor has felt a genuine obligation to escalate this issue to the senior mental health officers in South Australia. On such occasions, it was obvious that the system was under enormous pressure and while our concerns were primarily for the patients in a system near crisis, it also recognised the extreme pressures on staff.

We were also aware that there seemed to be a correlation between length of stays in EDs and the increased likelihood of patients being restrained either physically or chemically. Senior staff acknowledge this, especially if the patient is a smoker.

There have been a number of initiatives that various units and staff have been undertaking to improve their practice and efficiency that should be acknowledged. In June 2014, the Crisis Respite Service was established to assist with hospital avoidance, however it is difficult to ascertain its efficacy at this early stage.

In 2013, the Department for Health and Ageing commissioned Ernst and Young to conduct a Review of the South Australian Stepped system of mental health care and its capacity to respond to emergency demand. In July 2013<sup>6</sup>, a report outlining the review findings and recommendations were published (the Review). Of particular relevance were the following recommendations:

*Recommendation 2: Develop a new function in the ED delivered by mental health nurse practitioners to optimise timely admission/discharges to the acute care pathway and medical/nursing delegations. This recommendation along with other measures outlined in recommendation 7, 8 and 9 should also reduce seclusion and restraint.*

*Recommendation 7: Develop and apply a consistent ED/MH team set of triage criteria and protocols.*

*Recommendation 8: Design and implement a system within ED to alert MH teams of repeat patients so they can be more actively managed to reduce incidents of ED contact in the future. This system should include the development of procedures to support the escalation of a case review for known patients representing multiple times.*

*Recommendation 9: Establish an ED/MH team liaison meeting with a Terms of Reference to monitor the advancement of practice development, practice change and outcome monitoring.*

### **Least restrictive environment**

During 2013-14, some specific incidents of seclusion and restraint were reported to CVs, however it was not particularly focused on during visits, as was the case in 2012-13. There were also reports of patients feeling 'hemmed in' and unable to go outside, particularly relating to long stay in Emergency Departments.

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

There is little evidence to support the therapeutic value of restrictive practices. There is potential for risk of physical or psychological harm to patients and staff, as well as increasing the risk of an adverse event occurring.

CVS has continued to monitor the policy and practice response from the department of Correctional Services to the Ombudsman's report (as per the 2012-13 PCV Annual Report recommendations).

The issues raised with CVS over the previous reporting periods have strongly suggested that the longer a person is in an ED waiting for a mental health bed the more likelihood of distress and agitation for the patient, and the use of seclusion, physical and chemical restraints. These issues are in addition to the negative impact this has on their recovery process.

---

<sup>6</sup> Ernst and Young - *Review of the South Australian stepped system of mental health care and its capacity to respond to emergency demand*, July 2013. Department for Health and Ageing South Australia

## 6. REPORTING OUTCOMES AND THEMES

### **Discharge and accommodation arrangements**

Closely linked with the issue of delay in admission and treatment is the difficulties with discharge and the lack of appropriate accommodation options to discharge to, especially for people who are homeless. It is not uncommon for patients to be staying in an acute mental health beds for very long periods, as there are no suitable accommodation options for them to be discharged to.

### **Recommendations**

1. That the Community Visitor Scheme continue to independently monitor the length of stays of mental health patients in emergency departments to ascertain whether there is improvement or otherwise.
2. That the Community Visitor Scheme monitors the intervention initiatives to address repeat presenters and encourage hospital avoidance.
3. That the Community Visitor Scheme monitors the use of nurse practitioners in EDs as per the Review recommendation two.
4. That the Community Visitor Scheme continues to monitor the incidence of seclusion and restraints and the use of the seclusion register.
5. That the Community Visitor Scheme continues to monitor the policy and practice response from the department of Correctional Services to the Ombudsman's report.



### 6.3 Treatment and care plans

The reporting of *Consumer involvement in treatment and care planning* was closely linked with *Consumer decision making and support* and related directly to active involvement with their individual Treatment and Care Plans.

The Act and National Standards for Mental Health Services 2010 (the Standards) stipulate a number of standards/requirements that relate to treatment and care in general and Treatment Plans in particular.

Standard 1 stipulates that the rights and responsibilities of people affected by mental health problems are upheld by the mental health service (MHS) and are documented, displayed and promoted through all phases of care.

Standard 1.10 in particular relates to the right for patients to be involved in their treatment and care: *The MHS upholds the right of the consumer to be involved in all aspects of their treatment care and recovery planning.*

Standard 6 stipulates that patients have a right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery.

Standard 6.7 in particular relates to the requirement for patients to be at the centre of their treatment and care and states: *Consumers are partners in the management of all aspects of their treatment, care and recovery planning*

Standard 10 relates to delivery of care and supporting recovery and stipulates that:

*10.1.4 The MHS encourages and supports the self-determination and autonomy of consumers and carers*

*10.1.6 The MHS provides education that supports consumer and carer participation in goal setting, treatment, care and recovery planning, including the development of advance directives.*

*10.4.8 There is a current individual interdisciplinary treatment, care and recovery plan, which is developed in consultation with and regularly reviewed with the consumer and with the consumers' informed consent, their carer(s) and the treatment, care and recovery plan is available to both of them*

*10.5.11 the treatment and support provided by the MHS is developed and evaluated collaboratively with the consumer and their carer(s). This is documented in the current individual treatment care and recovery plan.*

The SA Mental Health Care Plan tool has been carefully developed to ensure that all issues that impact on mental health (not just medication and risk management) are addressed and is focussed on recognising early warning signs, planning for relapse and ensuring a focus on strengths and goals. The aim of a consistent format was to assist services to ensure they are operating from a recovery oriented service provisional framework.

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

## 6. REPORTING OUTCOMES AND THEMES

### Report results and comments

In March 2014, the Community Visitors specifically focussed on Care and Treatment Plans during visits. The findings showed a few units that had recovery-focussed Treatment and Care Plans or made an attempt to ensure a consumer centred approach. However, the majority of care plans were out of date, without patient involvement or very clinical focussed assessments. In many cases, patients were not aware of what their Treatment and Care plan was, although in some instances it was evident that care and treatment had been discussed with them but it had not been framed as being within their Care Plan. Below are some of the comments that CVs reported:

*CV's asked a male patient if he has had his Treatment Plan discussed with him, he said that he has and also mentioned that the staff are overloaded with work and don't have a lot of time to sit and talk with patients.*

*CVs were impressed by the efforts of staff to fully involve families and address concerns, the thoroughness with which each patients situation is discussed and the way solutions were canvassed by the team. CVs asked about care plans in the unit and staff said a hardcopy of the care plan was given to each patient when they were well enough to understand what a care plan was. Nursing staff helped the patient to fill-in their care plan if they needed assistance. The care plan is comprehensive.*

*Where possible, Care Plans are undertaken with patients at the time of admission, if the patient is well enough, or as soon as his/her medical condition has stabilized. There are regular Consumer Progress Reviews involving patients, family/carers and the team, where goal setting is encouraged and supported; particularly when leading up to discharge.*

*In most instances, Care Plans are developed prior to admission – for known community clients, a Care Plan will be made with the client's active involvement and will incorporate medical management, the wishes of the client, involvement of relatives/carer etc. Sometimes these plans may need to be reviewed because of changed circumstances, but staff take into consideration the wishes of the client when he/she was well. For those clients who are not case managed in the community, a Care Plan will be established within 24 hours of admission, when the client meets with the Consultant/Registrar.*

*Care plans are given to patients on admission for review or development if they are a new patient. All care plans are reviewed over the course of the admission. Care plans are recorded on CBIS (Electronic patient record), a copy is given to patient to sign off once completed and this info then is put on CBIS.*

*Little information had been written in care plans. Most care plans were out-dated by 12-18 months.*

*Full care plans are written up within 2 months of admission. Patients are unable to give input due to their mental health illnesses, but family are invited to give input. Patients are consulted about changes to their medication. After the initial care plans is written, care plans are then reviewed every 4 months. If there is a change in patient behaviour then their care plan is re-done. Care plans are very detailed and include several assessments.*

*CVs spoke to several patients and where appropriate, asked about their experience and involvement in treatment and care planning. Patients consistently identified 'good' care as being: when staff are understanding, patient, give time to talk things through with them, listen to their concerns and experiences, and take them seriously. They appreciate discussion and information about what is being planned for them and what they can expect. These ongoing discussions seem important, regardless of whether information has been given in written form.*

*The unit have developed a Wellness Plan for patients, 'My mental health care plan'. It is an excellent patient centred document and canvasses all aspects of patient needs and preferences in relation to their care. When patients are able to, they can fill this in with assistance from someone in the treating team if they require it. The key issue in relation to this document is who reads it and who is aware of key features of it.*

*When a nurse comes on duty, it is likely that information will be gained in the speediest way e.g.in*

*handover meetings, on the journey board and by looking at risk evaluations in case notes. It is also quite probable that treating doctors have not read the patient's own mental health plan.*

*If this patient plan does not occupy a front and central place in care and treatment planning, it is understandable that some staff and patients don't use and regard it as an ongoing priority. Yet it is one way in which the patient voice could be heard and incorporated in all aspects of care.*

*The case notes that we read of one patient, revealed extensive professional information i.e. information to be shared and interpreted between professionals. In such a document there seems no space for consumer voice. Perhaps this is appropriate for purpose – yet it leaves the question open of how and where the patient actively contributes to their care and treatment plan in an ongoing way.*

*A patient indicated that he was unaware of his Treatment and Care Plans and what they might include specifically in relation to reducing restrictions on his movements and transition or discharge planning. His file indicated that his plan was 6mths out of date. When discussed with staff they advised that he had only been on the unit for 2 days and staff were still observing and getting to know him. There had been a recent plan put on CBIS but not printed for his file due to demands on administrative time. There were reassurances that within a short period of settling time it would be reviewed again given his new accommodation. It was also noted the patient was hard to engage and there had been attempts previously to engage him in the care planning but he had refused to participate.*

## **Discussion**

The Community Visitor Scheme believes that Treatment and Care Plans within closed units are just as important as in emergency departments, open units and in the community. Any treating team in any unit should benefit from referring to the patient's Care and Treatment Plan because if it has been completed as it should be, it will have vital information such as:

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

If any clinician decides not to refer to an individual's Care and Treatment Plans, they risk not being properly informed about the individual they are treating and possibly failing in their duty of care.

There has been considerable work and information developed to promote and highlight the need for Care and Treatment Plans as described in Part 6 of the *Mental Health Act 2009* (s39-41). There should be no excuse for clinicians and units not referring to these important documents and updating them whenever treatment is altered.

Although patients in closed units may be seen to be "too unwell to even attempt care planning", there should be concerted efforts made to consult with them at a basic level. They have a legislative right to be treated respectfully and with dignity and therefore to be consulted throughout their treatment especially when other basic rights and freedoms have been taken away.

It is important to note that leadership from within the units has a huge impact on changing the practices or ways in which staff engage with patients. One of the Clinical Service Consultants highlighted to CVs that they had implemented a process for staff to review all treatment plans in common areas with the patient as opposed to completing the documentation tasks from within the nurses' station. Leadership within units is very important to ensure that care plans are being implemented in consultation with patients and/or family members and the above is an example of good practice that could be promoted to all units.

The use and effectiveness of treatment and care plans is a significant issue which CVS will continue to monitor and report to the Office of the Chief Psychiatrist.

## 6. REPORTING OUTCOMES AND THEMES

### Recommendations

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



**The Hidden Shed** by Deane Staples, Consumer

*My inspiration for this work was that it was familiar to me, as I had drawn a similar picture in the past.*

#### 6.4 Clients with intellectual disability, brain injury or autism in acute mental health units and forensic care

The issue of clients with dual diagnosis of intellectual disability and/or acquired brain injury with mental illness is regularly raised during visits. CVs met with and observed a number of these clients who were and continue to be placed in forensic care at James Nash House (JNH) where it is generally acknowledged, that staff are not equipped or trained to provide the level of care required.

It was further acknowledged that this client group is extremely vulnerable in this setting and quite often the victim of assaults but as a 'forensic client' under Section 269C of the Criminal Law Consolidation Act 1935 (CLCA), they become the responsibility of the Minister for Mental Health and Substance Abuse.

Considerable research has been undertaken on this issue with State Government reports prepared such as the *Gaps in Secure Services Brief* (SA Health, February 2012) and *Forensic Disability: The Tip of another Iceberg* (Exceptional Needs Unit, September 2011). It recognised that both correctional and forensic services are ill equipped to adequately cater for the specific needs of those with mental health and intellectual disability, brain injury or autism.

There appeared to be very little action or progress on this issue during 2012-2013 and as a result, the PCV initiated a series of meetings with the Executive Director of Disability SA, Director of JNH, Mental Health General Manager of Northern Adelaide Local Health Network, and the Public Advocate.

These meetings developed and agreed to a number of options to try to address the above issues of concern:

- A discreet specialised disability team to work within existing secure units;
- A specific ten bed unit (maybe at JNH) for clients with an intellectual disability and/or acquired brain injury; and
- A one person at a time approach where individual client profiles are created one at a time, the profiles collated and a service response developed.

The three options were further developed by the Department of Communities and Social Inclusion, costings prepared, and relevant Ministers briefed; however further progress has not been evident.

While it is appreciated that we live in challenging times of fiscal restraint, the costs associated with flow-on effects into the intensive care units and emergency departments of hospitals is significant and needs to be recognised.

The PCV has raised on many occasions that if we fail to provide a service response to this specific, vulnerable client group, a serious or critical incident is likely to occur and questions will be asked as to why intervention did not happen.

#### Understanding the nature of Forensic Care

It is important to understand what a forensic client is within mental health services and how that is determined. Section 269C of the Criminal Law Consolidation Act 1935 (CLCA) provides that a person is mentally incompetent to commit an offence if, at the time of the offence, the person was suffering a mental impairment and in consequence of that mental impairment the defendant:

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

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

## 6. REPORTING OUTCOMES AND THEMES

In summary, the criteria is whether *as a result of that condition at the time of the offence*, the defendant did not know the nature and quality of the conduct, did not know the conduct was wrong, or was unable to control the conduct. This could be as a result of a person having an intellectual disability, brain injury or because they are experiencing a psychosis or delusions as part of their mental illness.

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

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

In South Australia, forensic care is provided at JNH where there are 30 beds and another 10 bed ward at Glenside Campus, Grove Closed. Approximately 25% of all forensic beds or placements are taken up by individuals with a disability. We were also informed by the Director of JNH that 7 out of the 17 on a waiting list to get forensic care place are also individuals with a disability and they are currently in the prison system.

There is also now a step down facility, Ashton House located near JNH that has 4 two bedroom units and two single room units. This takes the total forensic beds available to 50 and a new extension to JNH will result in a further 10 more beds being available – 60 in total.

### Report results and comments

During the course of visits and inspections over the last 3 years, numerous examples have been highlighted in relation to people with co-morbid disabilities and the inappropriateness of mental health services as they currently stand to adequately meet the needs of this group.

Below are some examples of comments raised during the 2013-14 reporting period regarding the inappropriateness of current services and challenges faced in relation to this client group:

*There is an expressed and acknowledged concern regarding the inappropriate placement of people with intellectual disability within the ward. Of considerable concern to the staff and the CVS was the placement of a female within the ward through the court system. She was the only female in an all-male and at times volatile environment placing her in a highly vulnerable position. She herself was confused and anxious at her placement and future planning. (24/09/13)*

*Again we were reminded of how difficult it is to cater adequately for the many patients who have an intellectual and/or other disability. Staff feel sure that this is a situation that is likely to result in a serious incident (22/10/13)*

*We talked about the lack of services for those who have a dual disability. It can be very stressful and frustrating for both the patient and family. (22/11/13)*

*There was a client who has previously been through the ward who has an intellectual disability and was admitted to the ward with minimal information from Corrections and there is difficulty in obtaining background information from Disability Services (28/11/13)*

*There were a high number of residents (in JNH) with intellectual disability (19/12/13)*

*CVs met with young man, D who had an intellectual disability and who was in one of the lounge areas with the door locked for his safety. He was copying words down and had very basic language skills. He appeared to be very eager to make friends and would be very vulnerable. One of the other male nurses who has a background in intellectual disability and who previously worked at Strathmont Centre informed us that the intellectual disability training has been completed and 12 staff had done this course. (24/03/14)*

*CVs had in depth talk with XXX who has been at JNH for 12 months, in solitary confinement because of unpredictable behaviour and aggressive interaction with other clients - said he does not like the other clients. Has assaulted nurses and broken the hand of a staff member. His behaviour deteriorates when left without contact for any length of time. Because of staff demands, it is hard to give XXX the attention he desires. As a result of his behaviour it has been impossible to find other suitable accommodation away from JNH. Another staff member suggested it would be advantageous for XXX to be visited by a disability support person on a regular basis for one on one interaction. Because of XXX's love of music, SAFM and Nova, CVs suggested involvement with the disability radio station RPH. A restraining order was being processed against XXX but has been dismissed. He was previously housed at Pennington but transferred because of violent behaviour.*

*XXX's bedroom is very sparsely furnished for his own protection; he has broken the windows on several occasions. The wall had many Achievement Certificates and Staff said that whenever XXX does as asked a certificate is printed to give encouragement.*

*There was one other client confined and restricted because of his threats to kill. (29/05/14)*

*There were 5 forensic clients (out of 10 beds) in PICU (Psychiatric Intensive Care Unit) which do not need intensive care. This has a big impact on the number of beds available for people in need of intensive psychiatric care. (17/06/14)*

### **Discussion**

CVS believes that the number of forensic beds available does not meet the current demand and when there are clients with intellectual disability, brain injury or autism utilising these beds, this puts further pressure on the system. This is evidenced by the fact that on our visits and inspections of our Psychiatric Intensive Care Units (PICUs) at Glenside and Margaret Tobin Centre, we discover that on regular occasions, up to 50% (9 out of 18) of the beds are taken up by forensic patients who are only there as the facilities are considered secure facilities.

When all the beds at JNH are full, forensic patients are frequently placed in PICU beds as they are the only other units that are considered secure by the Department of Corrections. However, the patients do not require intensive mental health treatment and this leads to a flow-on situation where extremely unwell mental health patients in need of psychiatric intensive care spend extended periods (up to 7 days) in EDs waiting to get a bed in a PICU.

It is acknowledged that staff skill level and a comprehensive understanding of the behaviours of this client group is essential to appropriate care. Twelve staff from JNH recently undertook a disability certificate course, which will assist in developing this understanding however, ongoing investment is required to build and strengthen staff skills.

The Gaps in Secure Services brief (SA Health, February 2012) recognised that both correctional and forensic services are ill equipped to adequately cater for the specific needs of those with mental health and intellectual disability, brain injury or autism. There was agreement to review the report and recommendations from the Gaps in Secure Services brief and to review the current needs of clients with disabilities within JNH and from that analysis, determine what service responses are required.

CVS reviewed the brief and has met with many clients over the past two reporting periods. The PCV wrote in the previous reporting period to the Minister for Disabilities and the Executive Director of Disability Services expressing concerns specifically about the number of assaults that involved this client group and also raised the issue that many end up in acute mental health units for long periods of time as a result of breaching license conditions with relatively minor misdemeanours. There was agreement to review the report and recommendations.

JNH is designed and staffed for people with mental health issues and the staff and the service does not have the expertise required to adequately treat and care for people with other disabilities. Some of these clients with intellectual disability and autism have extremely challenging behaviours and detention in secure environments such as JNH can be detrimental to their well-being. JNH

## 6. REPORTING OUTCOMES AND THEMES

acknowledge that the vast majority of assaults involve these clients, as either victims or instigators due to poor impulse control.

There have been statements made that with the additional 10-bed extension being built at JNH, there may be genuine means of separating some of the more vulnerable clients such as those with an intellectual disability and women. As the Public Advocate and others have stated on several occasions, there is ample evidence to substantiate the establishment of a discreet, specialised unit that caters for the needs of forensic clients with disabilities other than mental health.

During CVS Visit and Inspections to disability accommodation facilities there have been multiple cases of residents with Intellectual Disability released on license into community services with support by a NGO to live in the community (often under strict license conditions).

By way of example, CVs met with a young man with an intellectual disability and particularly challenging behaviours who had been released into the community with license conditions. Staff had developed a consistent response to bad behaviour, which had significantly abated his offending behaviour, violence and other challenging behaviours. Staff were working to develop his awareness of the consequence of his actions and ensured very strict adherence to the plan to maximise the benefit. Boundaries were applied that he could feel comfortable in, and it was evident that his situation had dramatically improved and there were indications that improvements would continue. This young man would otherwise have ended up in the prison or JNH system but instead was living in the community with supports to help prevent him reoffending.

### Recommendations

9. That the three options for responding to forensic clients with disabilities continue to receive serious consideration by the departments that have shared responsibility for this outcome.
10. That staff working in forensic care facilities have in-service training on working with clients who have dual disabilities, intellectual disabilities and those with brain injury and autism.
11. That individual case planning occur with all clients with disabilities who are currently within the forensic care services and corrections so that a collated profile of need is identified.



## 6.5 Gender safety

The issue of gender safety and gender informed service provision emerges as an issue, particularly the potential risk to female or vulnerable patients within closed ward environments. There is a need to ensure there are adequate strategies established to protect vulnerable patients. Important social factors contributing to mental illness include violence against women, perpetrated against them both as children and adults.

The National Standards for Mental Health Services 2010 (the Standards) stipulate that services promote optimal safety and wellbeing and ensure that patients are protected from abuse, exploitation, discrimination, coercion, harassment and neglect. Implementing gender safety measures and gender informed practice will assist government mental health services to meet these Standards and enhance the human rights of patients.

In May 2013, The Victorian Mental Illness Awareness Council (VMIAC) released a report '*Zero tolerance for sexual assault – a safe admission for women*' that examined closely the sexual harassment and sexual assault of female in-patients in Victorian psychiatric wards. This 12 month project included literature research, survey development and administration, focus groups, individual consultations, data analysis and Advisory Committee participation across the year. Data was gathered from nine Area Mental Health Services (AMHS) across the State, providing a snapshot of current Victorian psychiatric admission experiences for women<sup>7</sup>.

The data analysis that resulted from this work demonstrated that 85% of females felt unsafe during hospitalisation, 67% reported experiencing sexual or other forms of harassment during hospitalisation and almost half (45%) of respondents had experienced sexual assault during an in-patient admission. The report also found that of the 61% who reported the assault to nurses only 18% indicated that nurses were 'slightly helpful' and 82 % indicated that nurses were 'not at all helpful'.

Outcomes such as these should not be acceptable in this day and age and all mental health services, including those in South Australia, should be striving for a zero tolerance to sexual assault. The Office of the Chief Psychiatrist is developing gender safety guidelines to inform better practice in South Australia.

Staff and patients have raised concerns with Community Visitors about males and females being in Units together and the risk of abuse taking place. Community Visitors have been monitoring such things as the room allocation and the practices that are in place to safeguard against abuse and assault of patients. Anecdotally, we have heard of females and males being abused in mixed wards and a range of staff and patients have supported the idea of single gender wards or specific areas within wards that are for women only. Various units and staff have tried a range of strategies to minimize risks e.g. males located in bedrooms in one corridor and females in another. The design of some units makes this difficult.

### Report results and comments

*CVS visitors met with several patients and heard about case histories and care plans in the review meeting. There was a social worker from Families SA also present at the review meeting to discuss the needs and challenges of a particular patient. What becomes increasingly clear from these experiences is the complexity of patient's needs. Their mental health is so closely intertwined with psycho/social issues, and these often include, abuse, neglect, family violence, sexual abuse, poverty, drug and alcohol misuse as well as physical health issues. (19/09/13)*

---

<sup>7</sup> *Zero tolerance for sexual assault – a safe admission for women.* (2013) The Victorian Mental Illness Awareness Council (VMIAC)

## 6. REPORTING OUTCOMES AND THEMES

*A patient spent time with CV concerned that her room had a window that was potentially accessible at night and she was concerned that her husband would break in and harm her. She also reported that she had been raped while an inpatient and on further discussion was happy for it to be brought to the attention of the team leader. It must be said that it was difficult to ascertain how much her psychosis was affecting her recall but the matters were discussed with staff. The staff member was unaware of her concerns about the room allocation and would try to ensure that she is moved to one of the more "internal rooms" nearer the nurses station. In relation to the rape allegations he was concerned having not heard about it before and would follow up immediately with her and her doctor. (09/12/13)*

*A patient raised the issue of gender safety suggesting the segregation of male and female patients. He has observed a fair amount of sexual harassment between males and females and reported that it can become uncomfortable for some patients. (21/03/14)*

*There were a number of issues that had occurred in the old unit around gender safety. Often, women were unsafe in their bedrooms and in shared bathrooms. We felt that both of these problems were solved in the new building. Not only do patients have a private bathroom - but also a bracelet that swipes access to their bedroom which no other patient can use. (17/04/14)*

*A patient reported feeling unsafe in the unit particularly as one of the patients had repeated and very angry episodes where he needed to be isolated. She felt very threatened and at risk during these episodes and at times she felt that he was between her and the nurses station. She expressed to the CV's and her nurse that she would like a safe "women only" space. (17/06/14)*

### Discussion

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

It is suggested that within each unit, appropriately trained individuals take a lead on gender safety and meet regularly with counterparts from other units across mental health services to help drive continuous improvement in this area.

CVS will continue to raise the issue of gender safety and highlight good practice where relevant. It is essential that we share with other units what is possible when services are responsive to the needs of patients in acute mental health facilities.

The Community Visitor Scheme believes that it is essential that all existing and new psychiatric inpatient facilities be assessed in order to provide significant areas of gender segregation and ensure safety and privacy for vulnerable patients. It is also hoped that service wide education programs regarding gender sensitivity, gender safety and trauma informed care for all clinical staff in inpatient psychiatric facilities would do a great deal to enhance the human rights of service users.

Victoria has developed a number of audit tools for policy; observational and interview schedules; assessment of past trauma; and measures to increase clinician's competence with regard to disclosures of abuse<sup>8</sup>. The development of similar tools for South Australia will help to ensure that gender safety, gender informed care and trauma informed care frameworks are systemically encouraged across mental health services.

---

<sup>8</sup> Service guidelines on gender sensitivity and safety Promoting a holistic approach to wellbeing Published by the Mental Health, Drugs and Regions Division, Victorian Government, State of Victoria, Department of Health, 2011

### Recommendations

12. That the South Australian Office of Chief Psychiatrist continue its work into gender safety and issues Gender Safety Guidelines that incorporate practical audit or survey tools and checklists for Units together with a range of strategies to implement with associated timeframes.
13. That a zero tolerance for sexual assault approach be adopted and promoted across all services and which recognises that a range of vulnerable patients have been traumatised by previous assaults.
14. That all units and services acknowledge trauma informed care approaches and incorporate it into all aspects of care and treatment.

## 6. REPORTING OUTCOMES AND THEMES

### 6.6 Activities and stimulation in treatment centres

Standard six of the National Mental Health Standards states that, *Consumers have the right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery.* Standard 6.10 states, *Consumers have a right to choose from an available range of treatment and support programs appropriate to their needs.*

More specifically standard 10.1.3 stipulates that: *the Mental Health Service (MHS) provides education that supports consumer participation in goal setting, treatment, care and recovery planning, including the development of advance directives.*

The issue of lack of activities and stimulation within treatment centres has been an ongoing issue identified during the course of Community Visitor Scheme inspections in mental health units.

The following criteria are articulated in the National Mental Health Standards in relation to treatment and support and more specifically, in relation to self-care activities, which on some units, actually forms the basis of their therapeutic groups, activities and structured programs.

**10.5.13** *The MHS supports and / or provides information regarding self-care programs that can enable the consumer to develop or re-develop the competence to meet their everyday living needs.*

**10.5.14** *The setting for the learning or the re-learning of self-care activities is the most familiar and / or the most appropriate for the skills acquired.*

**10.5.15** *Information on self-care programs or interventions is provided to consumers and their carer(s) in a way that is understandable to them.*

Boredom and difficulty in securing time to talk to staff have been consistently reported by patients.

#### Report results and comments

The Community Visitors found that 22% of the issues raised and reported related to a lack of activities in treatment centres or lack of suitable facilities for activities. It was very frequently reported from patients that they were bored, there was a lack of activities or 'not much to do'.

*There were very little activities occurring again, patients mainly sat in the lounge chairs in front of TVs and were not engaged in activities (26/09/13)*

*Patients were requesting more flexible opening hours for the art and craft facilities, gym and relaxing room. Also requesting activities on weekends (14/10/13)*

*Patients agreed about the importance of activities and groups in their recovery, they wished there were more to do. (15/10/13)*

*Gym was the only offered activity program (17/10/13)*

*Limited physical activities and very little planned activities occur on the ward (3/12/13)*

*Staff commented on the lack of resources for activities. Good staff do what they can but lack the confidence in running groups. (1/12/13)*

*Patients suggested short courses/education be offered especially while in the long stay wards (19/12/13)*

*A female patient requested exercise equipment and more variety of activities especially for men (29/01/14)*

*Activities and structured programs required. May be planned but not always achieved. Activities need to be appropriate (21/02/14)*

*There are two separate but related functions that should be carefully examined. One is the daily range of planned activities (physical, educational, work and therapeutic) that are actually planned. These should be clearly established for each ward and schedules available to enable review of (a) the appropriateness of the activities and (b) the extent to which these are being achieved. (24/03/14)*

*It was felt more emphasis could be placed on physical activity / fitness plans. As an observation which CVs shared there seemed little opportunity for exercise for patients in these wards and a real need for someone to come in and provide classes. (24/03/14)*

*There had apparently been "no one to open the Gym" and CVs wondered about the possibility of contacting TAFE to ask if there are volunteers who are studying fitness and who are adequately trained who could be approached to supervise gym sessions when the Activities Coordinator is unavailable, or on a more regular basis. (26/04/14)*

*Boredom for patients is an issue as they only have minimal activities to do - colouring-in, crafts or watching TV and playing table tennis. (23/04/14)*

*CVs were provided with a folder outlining the activities offered and the results of a patient survey. These documents discuss various groups which have been offered with varying degrees of success although it must be said that we have not observed much of these activities on our visits. (14/05/14)*

*Recommendation that staff assess the communal movie content to ensure this is beneficial to recovery. This arose when we observed a patient watching a movie – the plot of which was set in a mental health facility and contained scenes of drug use, violence and suicide (Girl Interrupted Rating: MA). The other movie going in another common area was also a very violent movie and although there were others sitting in this area doing other things such as colouring in, the noise of the TV was across this entire area and it was difficult to have conversations over the noise. Discussion occurred with staff who advised nothing above M rated movies were allowed (13/06/14)*

*There are very little resources for the unit for any activities, once a week a BBQ is provided that provides only a small serving of food due to limited funding. (19/06/14)*

### **Evidence of better practice**

There were some units that had been identified as being effective in developing a range of activities and structure into their recovery programs, even where dedicated resources are not available; it was more about how staff work and participate in structured group activities.

One specific unit has been regularly reported by a range of Community Visitors as being very effective at seeing the relationship between activities and structured programs and care planning. They had developed wellness folders that were linked to the therapeutic groups program run regularly by all staffing groups. Topics such as understanding anxiety or depression, developing strategies to cope and staying well, were run regularly.

This unit not only had a recovery-oriented therapeutic groups program but also ensured that patients had access to a number of physical activities and craft groups. Staff on this unit were also reported to have been effective in encouraging patients to attend the groups and assisted them to see the benefits of learning and exploring self-care related issues in a group context. This unit has also implemented diaries for all patients, orientation meetings for new patients, daily walks and gym sessions.

Another unit was actively involved in fundraising activities to enable the improvements to the activity room.

## 6. REPORTING OUTCOMES AND THEMES

Below, are a range of positive comments from reports on various units and, in general, they reflect a more positive 'feel' when patients are encouraged and involved in a range of structured activities. Encouragement is important as it is acknowledged that when patients are very unwell they can be difficult to engage, but encouraging them to be involved is beneficial to their recovery process.

*Patients look forward to regular 'fry ups' (BBQs) (7/11/13)*

*Staff and patients love the delta dog and new gym (18/11/13)*

*Patients in the unit really enjoyed hand massage and nail therapy sessions (7/02/14)*

*A holistic approach of care plan, activities, family and social support is undertaken. Staff have also been asked to nominate any interests/hobbies they may have that they could share with patients. (26/02/14)*

*The art/craft room is available to be used at any time; adjacent is a relaxation/common room with piano/small library/ironing board; just across the corridor is the laundry; outside is the clothes hoist; the chapel is open at 11.30 am; the gym is open from 2.30 pm to 3.30 pm (and other times on negotiation - depending on the availability of a staff member to supervise the participants); Wii Fit is available in the gym; and there is a relaxation room. (31/03/14)*

*The Activity Program that was started approximately two months ago is still going. It is not very structured, but there is involvement from interested patients and all staff. In addition, it gives a chance for patients to do something in a safe environment outside the ward. (17/04/14)*

*The activities schedule is updated monthly so that the programme changes from month-to-month. The May schedule for all units includes: bus trips, a main event, this month was the Port River Dolphin Cruise, movement to music, newspaper reading, cognitive stimulation sessions, sing-alongs, beauty and massage therapy, Tai Chi, pet therapy, movie days, men's group, and happy hour. In addition, the units celebrate special occasions such as Mother's Day, Anzac Day etc. (12/05/14)*

*There are a wide range of activities on offer, run by various members of the multidisciplinary team (occupational therapist, psychologist and social worker) and the activities nurse. There is a focus on both physical and emotional wellbeing: the psychologist runs a weekly group; the occupational therapist a sensory group; there is a gym group 5 x week; tai chi and yoga groups 1 x week. In addition, there are regular walks, visits to the café and op shop, art therapy, cooking and discharge planning groups. (15/05/14)*

*Activities include: relaxation groups and Tai Chi; gym and pool access with physio support; seniors' groups with specific therapeutic focuses such as addiction; commemoration services for ANZAC Day, Remembrance Day and also Christmas celebrations; and fun activities designed to improve cognition such as quizzes, word games and puzzles. A weekly schedule of activities is designed by a full time nurse therapist who aims for a balanced spread of activities across the week and who seeks continuous feedback to ensure that the activities meet the interests and capabilities of the patients. (15/05/14)*

*We noted that on the whiteboard where the day's events are listed, the temperatures for the day are also present. We thought this was a nice idea for patients who are unable to go outside. (20/5/14)*

*There is some concern about that the activity coordinator retiring in August, as she has been there for 7 years. At present, an activity plan is presented weekly to the head of the unit and staff. Activities include: morning meeting daily, wide range of craft, pottery, cooking, DVD's, special activities funded from the collection of cans and bottles in the unit. This includes (music, ice cream, BBQs). All of the activities are between 9:30am/4pm. There are also therapy groups, yoga, relaxation and mood management classes that are run by the psychologist. (20/05/14)*

## Discussion

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

As can be seen from the range of reported comments, there are varying levels of activities and structured programs across mental health units and services in South Australia. Some units have indicated that they need funding in order to develop a more extensive activities program while other units have developed quite extensive activities programs and said it is more about changing the way staff work - ensuring collaboration across disciplines, good leadership and commitment to structured activities as a means to focus on recovery. Some of the units have been able to engage non-government organisations to come in and facilitate activities and others have used volunteers and/or their lived experience staff.

In many units, they rely heavily on a dedicated Activity Officer but at least one of the units have placed the emphasis on all multidisciplinary staff being involved in the facilitated groups. The group activity topics are determined by the needs of the patients at the time and may need to have a focus on coping with depression or anxiety or some other area that is relevant to the current patient mix.

Examples of activities that are taking place in units include:

- Patient morning meetings to discuss activities for the day (some units do every day);
- Orientation group meetings for new patients;
- Facilitated group activities i.e. solving the newspaper word puzzles or group discussion on articles (some units do this each morning);
- Morning or afternoon walk (some do every day, others do occasionally);
- Art, craft and cooking activities (these happen a few times each week in some units);
- Gym sessions (some offer morning and afternoon sessions daily, others occasionally, others say equipment can't be used because staff aren't trained to use the equipment – despite the expenses purchasing the equipment);
- Relaxation and meditation classes/sessions; and
- Structured groups focussing on coping with anxiety, depression, stress, medications, care and treatment plans.

Forensic care units are particularly poor in this area where CVs consistently report on patients who are in the process of transitioning back into the community but may only get one hour of Occupational Therapy (OT) per week. Grove Closed had an OT assistant working with patients in meal preparation and cooking once per week, but this resource was lost.

From an analysis of all reports it is obvious that some units are doing really well while other units are struggling to provide any meaningful activities. Generally, the units who do not do this well are where staff largely stay in nurses stations with limited consumer engagement.

In units where patients are regularly reporting boredom, it is obvious during visits that there has been nothing planned or organised, or while activities are planned and/or displayed on a board there is no active encouragement and proposed sessions often do not eventuate.

## 6. REPORTING OUTCOMES AND THEMES

### Recommendations

15. That all mental health units be required to post their weekly activities and sessions on their respective notice boards, keep appropriate documentation of participation rates and report on structured activity plans to the Office of the Chief Psychiatrist.
16. That the Department consider establishing a group of appropriately trained volunteers that could visit treatment centres to facilitate activities or programs.
17. That an objective assessment of treatment centre activities and programs be undertaken as a means to highlight and promote good practice and explore the impact of the above on patients and their recovery.
18. That the Community Visitor Scheme continues to monitor the levels of activities offered to patients.



**Harmony** by Miranda, Consumer

*I selected this picture, as the dugong is a harmless cute creature of the sea, this makes me feel peaceful. The aqua paint I used is one of my favourite colours.*



## 6.7 Stigma for forensic patients transitioning to the community

During 2013-14, there were multiple incidents of public stigma/reporting against forensic patients transitioning back to the community, especially from wards at James Nash House. Some of the media headlines included:

*SA judge criticises laws on mentally ill offenders while preparing to release woman who killed mother*

*A mentally ill woman who murdered her mother has been granted the first stages of her release from a secure psychiatric facility*

*Mentally ill killer takes another step closer to freedom from secure facility*

*Mum, accused of murdering toddler daughter, released on bail*

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

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

### Practice in other jurisdictions

The following excerpt is from a New Zealand Law Commission Report *Mental Impairment Decision-Making and the Insanity Defence*<sup>9</sup>:

*Most jurisdictions require certain factors to be considered on a review of patient status. While the factors vary, in broad terms they tend to require the decision-maker to weigh the need for public protection against the right to liberty of the accused and his or her other needs, such as the need for care or treatment. Considerations typically include factors such as the nature of the person’s mental impairment or other condition or disability; whether the person is, or would if discharged be, likely to endanger another person or other persons generally; whether the person could be adequately controlled by less intrusive measures; and other relevant matters.*

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

A patient in similar circumstances in the UK would be subject to a court ordered hospital detention (s.37), and a restriction order (s.41) which limits the options for discharge and leave and is only applied if necessary to protect the public from serious harm. The route for discharge is mainly through a Mental Health Review Tribunal, the tribunal has to consider the same criteria for detention as a civil detention, i.e. a person can only be detained if it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section.

---

<sup>9</sup> *Mental Impairment Decision-Making and the Insanity Defence* (New Zealand Law Commission report ; 120) Section 13.17

## 6. REPORTING OUTCOMES AND THEMES

However a forensic patient in the UK, who is an ongoing risk to others, would not be discharged, any more than someone who is an ongoing risk can be discharged under current SA legislation where the court has to consider if there is a risk they may harm an individual or individuals generally.

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

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

Under the NSW Mental Health (Forensic Provisions) Act 1990, the Tribunal has a wide range of responsibilities, and can make orders in relation to the treatment, care, detention and release of forensic patients.

The Tribunal also reviews the cases of all forensic patients. The Tribunal's decisions can involve the consideration of quite complex issues, and can impact directly on people's lives, health and liberty. In making its decisions, the Tribunal seeks to balance several sets of often competing rights - the individual's right to liberty and safety and to freedom from unnecessary intervention, the individual's right to treatment, protection and care, and the right of the community to safety and protection. The Tribunal is not a public process so will avoid the media reporting.

### Recommendations

19. That the SA Government give consideration to establishing a dedicated Mental Health Review Panel. The panel will allow for appropriate assessment and balancing of often competing rights - the individual's right to liberty and safety and to freedom from unnecessary intervention, the individual's right to treatment, protection and care, and the right of the community to safety and protection.

### 6.8 Impact of SA Health no smoking policy

The issue of smoking and no-smoking policies within acute inpatient mental health and emergency settings arose again as a key issue in the 2013-14 reporting period. In particular, not being able to smoke in closed units and the inequity between the implementation of the no smoking policy in open units verses closed units, has to be raised yet again.

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

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

It is recognised that there are well documented higher rates of morbidity and mortality from smoking related illnesses for people with mental health issues than for the general population. A 2009 study sought to investigate the relationship between mental illness and smoking by conducting population-wide surveys. In both the US and Australia, adults with mental illness in the 12 months prior to the survey, smoked at almost twice the rate of adults without mental disorders. Female smokers had higher rates of mental disorders than male smokers, and younger smokers had considerably higher rates of mental disorders than older smokers.<sup>10</sup>

Many treatment centres have worked with patients in an effort to help them quit through education and alternatives such as nicotine replacement therapy, inhalers and lozenges. Units such as James Nash House are proud to say they have been smoke free for years and this is a long stay unit. Other acute units continue to have patients smoking in their respective courtyards or directly outside. CV reports also illustrate that there have been inconsistent approaches across units in compliance with the no smoking policy. This issue is particularly unfair for patients in many of the closed units who can smell others smoking in nearby open units.

#### Report results and comments

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

Below are comments from reports that illustrate that the no smoking policy is still a big issue for patients and staff in EDs and acute mental health units:

*Some patients were still smoking in the courtyards and cigarette butts still litter the courtyard areas directly outside the unit. Contrary to the Department's policy of a non-smoking environment within the boundaries of all health facilities, the issue remains unresolved and unfulfilled from a practical implementation position. (22/08/13)*

---

<sup>10</sup> Smoking and Mental illness: Results from Population surveys in Australia and the United States David Lawrence, Francis Mitrou and Stephen Zubrick. *Public Health* 2009, 9:285)

## 6. REPORTING OUTCOMES AND THEMES

*Smoking in the courtyards is still happening and cigarette butts still litter the courtyard areas directly outside the unit. (26/09/13)*

*One patient was standing by the door of the nurse station acting quite upset, due to smoke free policy she cannot go buy cigarette by herself or smoke outside by herself. When she needs to smoke she contacts her family or friends to buy her some. (03/10/13)*

*A patient in the ED was involuntary and had been restrained during the visit because she had become agitated about not being able to smoke. (11/10/13)*

*An involuntary patient left the hospital because he wanted a smoke (13/11/13)*

*Smoking still an issue in ED that affects patients, especially when they have a long wait for a bed – frequently become aggressive and security presence/restraint is required (03/12/13)*

*Patients regularly asking staff for cigarettes. Staff keep patients cigarettes at nursing station to help manage risk and amount of smokes consumed (14/12/13 – Open unit)*

*The CV's also met with a patient who had been in the ED for two days under an ITO awaiting a bed. She was more than happy to talk about her experience She had positive things to say about the staff and her care and treatment although she felt the lengthy wait in the ED environment was not conducive to her recovery. She also had a security guard seated outside her cubicle, did not have access to her phone and was frustrated by the no smoking policy. (09/12/13)*

*Some patients get really upset about not being able to have a smoke. If they don't like the inhaler, they are given tablets or a patch. (22/01/14)*

*CVs spoke to patient who raised concerns about his property and that he was most distressed that he was unable to smoke. We were able to clarify the whereabouts of his property but were unable to help with his desire to smoke. (28/02/14 – Closed unit)*

*Smoking was raised by patients who felt it was cruel at a time of great stress and was only given nicotine inhalers which he used but found them not very helpful. One patient said that he found it helpful to have a smoke when he felt agitated but felt deprived while in Closed Unit. (31/03/14 – Closed unit)*

*Staff commented that the no-smoking policy remains an issue and many times patient's behaviour escalates to aggression. They had a code black the previous night because of a patient wanting to smoke (10/04/14)*

*On a previous admission, the patient was told that he would be able to have a cigarette as soon as he was transferred to Glenside. On arrival at Glenside this was denied and a staff member became quite angry that he had been told this as apparently, this happens frequently and they have to deal with the frustration and anger from the patients when they arrive and are denied the opportunity to smoke. (13/05/14)*

*Smoking remains an issue in ED. No smoking leads to Code Blacks for many patients on ITO. (26/05/14)*

*A forensic patient was not permitted to leave the ward to smoke - the patient had told CVs that the judge said she was allowed to have cigarettes, so she was confused as to why she was not permitted to smoke by ward staff. The patient's nurse was going to arrange for the head of the department to come & speak to the patient about her medication & re-affirm the reason for her not being allowed to smoke. The patient had been given inhalers but was not impressed about it. (26/06/14)*

*A nurse advised that the previous day visitors had brought cigarettes & a lighter to patients. Security attendance was required because patients were smoking in the toilet & outside area. (20/06/14 - Closed ward)*

*A nurse expressed concern over the use Clozapine for patients who are smokers. He said that the level of Clozapine in the body is severely affected by the sudden cessation of smoking & may have negative effects on patients. He mentioned the death of a patient at Modbury Hospital a couple of years ago - the patient was a smoker being administered Clozapine. After his death, the Clozapine level in his body was extremely high. The patient had a seizure, which resulted in his death. It is very possible that the level of Clozapine in the body contributed to the fatality. It was this staff member's view that too many things, eg. cigarettes are taken away from patients when they are in a position where they have no personal intention of stopping. This causes withdrawal symptoms that staff then have to deal with in their care of patients. (20/06/14)*

*Two patients mentioned that if you are sharing a room with a smoker it can be uncomfortable. Also that the outside area is not suitable for non-smokers & that smokers also smoke in areas where they aren't permitted to, so non-smokers have few outside areas to enjoy. (23/06/14)*

*The importance of activity was discussed with the Social Worker, and she explained that it was not only important to prevent boredom – but also because boredom produces other problems such as, frustration, smoking, conflict and helplessness. (15/10/13)*

*Patient happy that no smoking policy has made him give up smoking. Doesn't want to move to open ward due to temptation to smoke again (22/11/13)*

### **Discussion**

Patients in closed or psychiatric intensive care units are arguably at the most stressed and confused point of their lives. Unwell patients have stated on a range of occasions that being forcibly prevented from having a cigarette is a denial of their basic human rights and unfair when other patients directly outside of their units are allowed to smoke in their open air courtyards.

Unfortunately, for those who are very unwell, closed/intensive care units are the only areas where it is enforced. The consequences of seclusion, increased medication or assaults do appear to be relatively more detrimental to recovery and treatment than allowing individuals to be able to continue smoking in a safe outdoor courtyard.

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

Noarlunga Health Service and specifically Morier Ward have re-opened a smoking courtyard near the ward which appears to be well received by both patients and staff. This decision was made following significant discussion with management on the risks associated with patients having to go to the hospital boundary for a smoke where they could not be observed. The hospital had to 'weigh up' the risks of patients being vulnerable to drugs, assault and other safety concerns where they could not be observed, verses allowing them to smoke in an enclosed and observable courtyard area. However, patients from the closed unit are still unable to have a cigarette despite having an open-air courtyard.

Margaret Tobin Centre also have a designated smoking area at the back of the Unit but it is very close to the courtyard in their closed unit and therefore patients in the closed unit can smell the smoke but are unable to have one. Closed units appear to be the only units where all smoking has been stopped and patients and many staff believe this situation is unfair.

It is acknowledged that all efforts should continue as part of the treatment plan, to assist patients to reduce tobacco use and in the long term, to work towards ceasing use altogether. However, the current situation is unfair and there is a need for serious consideration of this issue given the above consequences is surely more detrimental to mental health recovery and treatment.

## 6. REPORTING OUTCOMES AND THEMES

As reported last year, the Government of Western Australian, Department of Health has provided a partial exemption to their no-smoking policy for involuntary mental health patients for the same reasons mentioned above and in April 2013 issued Guidelines for Mental Health Services<sup>11</sup>.

The Guidelines are quite extensive and include details on:

- Criteria to apply for the partial exemption;
- Smoking area specifications;
- Occupational Safety and Health Issues that need to be considered including a risk assessment;
- Environmental Considerations;
- Developing site-specific instructions;
- Managing frequency of smoking;
- Supervision of smoking patients;
- Management of smoking materials;
- Assessment and management of smoking and they have developed a 'mental health smoking assessment checklist'

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

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

Given the importance that patients within closed units place on this matter and the number of times this has been raised with the CVs by both patients and staff, the PCV felt an obligation to seek legal advice about this matter. In doing so, it seems apparent that there may very well be grounds for an individual complaint under the *Disability Discrimination Act 1992* (DDA) arguing that the SA Health No Smoking Policy has a more detrimental effect on patients in closed units who have a smoking addiction.

It has become apparent more recently, that the SA Health Smoke-free Policy Directive actually has an exemption clause for crisis situations as below:

*SA Health entities recognise that discretion is required when enforcing the policy for patients and visitors in distress. If smoking takes place on SA Health premises by patients and visitors who are highly distressed, it is recommended that staff apply the policy in a flexible way that does not add further distress to the situation. Managers and staff are encouraged to discuss ways to address such situations appropriately.*

This clause will enable services to consider further options for the care and treatment of mental health patients in distress to consider the overall benefits verses detriment. However, staff within EDs say that this raises a further dilemma about how this is managed within the unit – i.e. if staff are required to escort patients outside for a cigarette it has a chain effect on services back in the ED. Further discussion and education for staff is required to adequately address this issue.

---

<sup>11</sup> Smoke Free WA Health System Policy: Partial exemption for involuntary mental health patients (ref:OD 0414/13) – Guidelines for Mental Health Services. Government of Western Australia, Department of Health.

## Recommendations

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

### He sits beneath the pepper tree

by Tony Mons, Consumer

He sits beneath the pepper tree, a cigarette he smokes  
He's laden with depressive thoughts, there's no humour in his jokes.

He smokes and smokes some more, head tilted to the ground,  
Will no-one here please spare the time? An answer could be found.

If only they would talk with me, does anyone really care  
To listen intently to my thoughts? Instead they stop and stare.

He sits beneath the pepper tree, peppered by depressive thoughts  
Of suicide and self-harm and in these thoughts, he's caught.

A gentle hand. a listening ear could assist in many ways  
But no-one seems to have the time for him - This happens every day.

Do you know what it's like to be lonely and sit here all alone?  
With no one to converse with as you shed a single tear?

And so I sit alone and smoke to much - You'll always find me here

*Note: This poem was written by Tony who has Bi Polar - he wrote this while in a closed Ward and gave it to Community Visitors. The pepper tree is located outside 1G, the Acute Mental Health Treatment Centre at Lyell McEwin Hospital where patients go to the hospital boundary if they want to have a cigarette.*

## 6. REPORTING OUTCOMES AND THEMES

### 6.9 Menu options

Issues relating to food were mainly raised by patients regarding the quality of the food, small portion size and limited menu options, particularly for long stay wards.

Health is fundamental to improving the physical health of people with mental illness and good nutrition is a vital part of life. Providing nutritious food is an important part of caring for people in mental health inpatient facilities that requires a collaborative approach from everyone involved in the recovery process. People with mental illness are at significantly higher risk from chronic disease, particularly cardiovascular disease, which results in a reduced life expectancy.

Knowledge of how the food we eat is associated with mood, behaviour, and cognition is fundamental to understanding how diet and mental health are intricately related.

#### Report results and comments

The following comments from Community Visitor reports highlight issues relating to food are primarily regarding a lack of variety, a lack of nutritional content, overcooked and distasteful food.

*Two patients told us about dreadful food that is transported from the RAH. They gave descriptions of watery pumpkin and cold broccoli. One patient said that she put mustard on her peas just to warm them up a bit. (25/07/13)*

*There have been complaints again today about the food as well as at last visit. The complaints are about the temperature, the wateriness, too much white bread and the general unappetizing quality of the food. (21/08/14)*

*Staff informed the visitors that the catering service changed in July 2013 and that patients don't like the food in relation to freshness, taste and choice and that after 2 weeks patients will get menu fatigue as it doesn't change. Also the presentation of meals is not inviting to eat and the nutrition is questionable. This matter has been raised before in relation to quality, nutrition and limited menu cycle but seems nothing has changed. (26/08/13)*

*A patient complained about not being able to have salad and take this to her room, though she did say that she was getting enough nutrition. (23/09/13)*

*A patient complained about the inadequacy of food at supper time. Biscuits are provided but he would prefer sandwiches. He has asked the staff but his request has not been able to be fulfilled. He is also concerned that there is little choice of sandwiches at lunchtime (24/09/13)*

*One patient again raised the issue of "stodgy" food, not dietary controlled, over-loaded with carbohydrates. She too asked for salads, vegetables and fruit. This seems to be a recurring issue. She suggested cooking lessons. (19/09/14)*

*CVs observed that dinners were being discarded by patients and looked unappetising (15/10/13)*

*In regards to the food supplied by the RAH, two mothers commented that the food was "really bad" and it would be better to have food supplied from Women's and Children's Hospital where they have "real food" and "fresh salads." One mother said "the food looks like slop" and they have the "same sandwiches for lunch" every day. (18/11/13)*

*Food looks unappetising. Vegetables are cooked for the same amount of time as the meat. The nutritionist tried hard to make changes but input was not incorporated into the main decision (18/12/13)*

*Patient on vegan diet didn't like food (23/12/13)*

*Poor quality of food and presentation of food from RAH continues to be a problem (10/01/14)*

*Patients commented about the poor quality of the food, they are able to cook their dinner if they choose but in many cases their illness does not allow them to do any task and they have to eat what is offered by the unit. A patient that has a vegetarian diet did not have this choice for 3 days*



*when was feeling unable to get out of bed. Some patients offer to write an email letter about the food issue to help with a positive outcome in this issue. (19/02/14)*

*There were some negative comments from a couple of patients about the food. The message generally in relation to this, is that some food is fine e.g. roasts and sandwiches. However, when the food is mixed, for example, a risotto or similar, it becomes a mess of indistinguishable ingredients "a dogs breakfast". There is perhaps an issue here of all ingredients sometimes inappropriately being microwaved for the same amount of time. A patient who was vegetarian thought that the variety for this cuisine was very limited - usually a slice. (14/04/14)*

*One patient made the suggestion that the ward have a 'take-away' meal one evening a week. He felt that this would give patients something to look forward to and would break the monotony of being on the ward. (22/05/14)*

For one particular unit the following positive feedback was received:

*Additions had been made to food since last visit. Sandwiches regularly available, 3 hot meals a week served, pizza and salad available, presentation of food improved and feedback had improved (20/12/13)*

*A patient expressed his approval of the Unit, the accommodation and meals provided and this was supported by others sitting around the table. (13/06/14)*

### **Discussion**

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

Food preparation through a group approach is seen as an activity that is valuable for patients as they have to work collaboratively, divide up the tasks and ultimately enjoy the outcome. When patients and staff are involved in exercises like this, it's similar to team building but also assists in building therapeutic relationships. Patients are able to develop personal competencies in independent living skills and also enjoy the experience. Unfortunately in some units, these group activities have ceased or are not held due to fiscal and resource restraints.

Reports of particularly unappetising and overcooked food was reported regularly for a few specific units and the CVS will be following up directly with the units concerned, however the overall menu provision is still a systematic issue needing to be addressed.

### **Recommendations**

22. An independent review of the menu provisions in mental health units be undertaken with a particular focus on the needs of long stay patients.
23. The menu offers variety and food choices that are healthy, appetising, appealing and take into account the length of stay.

## 6. REPORTING OUTCOMES AND THEMES

### 6.10 Evidence of good practice

During visits, patients have reflected back to CVs how a staff member had influenced their recovery by genuinely being interested and supporting their recovery. CVs also see evidence of good practice occurring and such instances are documented in the reports and reported back to senior staff to ensure the individuals are acknowledged.

#### Report results and comments

Below are comments from reports that illustrate the good practice CVs have observed:

*A patient commented that 'staff are lovely' and 'no complaints' (05/09/13)*

*We were very impressed and encouraged by XXX's practice and recovery based person centred care philosophy. He demonstrated a warm respectful way of interacting with patients and they clearly felt comfortable with him. We were also encouraged to hear that he was aware in detail, of patient care and treatment plans and he described the ways in which he implemented these. One example of his strategy was the way in which he tried to ensure that patients had at least one walk per day. Not only is the walk important, but also the therapeutic conversations he has during them. Again, it was a reminder to CVS that where staff attitudes are positive, non-judgemental and recovery based, in line with the Act, good outcomes can occur – and these are often evidenced in small steps and in small examples of insightful interaction. (30/09/13)*

*Staff members are constantly attending to patients' needs or forestalling potential problems. Community Visitors have been frequently impressed by the calm and gentle way nurses distract patients who are unsettled or agitated, and reorient them with patience and kindness. Some patients have the potential to lash out or to be violent, but nurses are skilled at both protecting themselves and other patients. (21/10/13)*

*It was clear in one conversation with a patient, that she was finding staff enormously helpful in her journey of recovery. (10/01/14)*

*CVs were impressed with a particular staff member who responded to everyone with full attention, friendliness and respect and consistently responded to their needs in ways that they appreciated. (22/01/14)*

*Leadership in this unit prioritise excellence of care in spite of obvious practical challenges (19/02/14)*

*It is very apparent that staff attend to patients as first priority (21/02/14)*

*The care and interaction provided by MH nurse on duty in Emergency Department was outstanding (24/02/14)*

*CVs were impressed by staff willingness to help and readily be of assistance to follow up concerns. Overall, CVs were very impressed with the pro-active and thoughtful responses by all staff that they came in contact with. (24/02/14)*

*During the time that XXX was speaking with us, he was also dealing with an incident of a patient (involuntary) who had 'gone missing'. We observed the protocols for this event-including police notification and discussion with other staff, being undertaken efficiently and calmly. (12/03/14)*

*Staff are consistently friendly, compassionate, respectful and helpful to patients. In spite of some very serious and challenging situations, staff are calm and encouraging. (17/04/14)*

*The fact that staff pay attention to the whole picture of a patient's life - not just the illness, is a testimony to their professionalism and to what can be achieved by creating an appropriately caring/learning environment. It is so encouraging to see the ways in which the team learns from each other as well as the patient, in arriving at the best strategies and options for care. A patient talked about how supportive the environment was and how it created a space in which you could start to understand what had happened to you (the mental health crisis) and how to go forward. (12/06/14)*

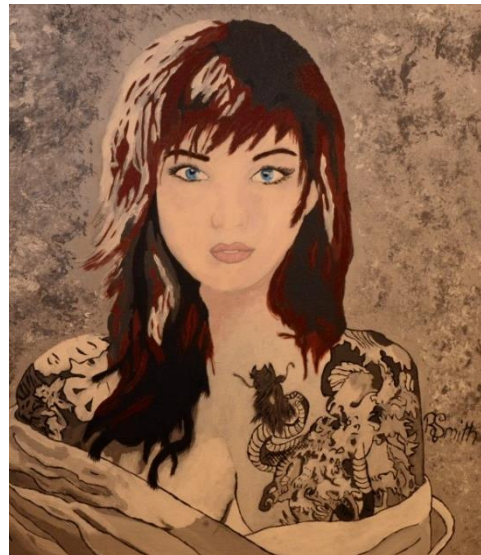
One nurse was about to begin a 'coffee and chat' session. He was planning to give people a page from a newspaper and try to facilitate some discussion. Team members have explained to us in the past, that it is sometimes very difficult to engage seriously unwell patients so we were pleased to see this attempt. (23/06/14)

**Consumer artwork**

We were very privileged to receive submissions from consumers of their artwork. They are excellent pieces as seen below and throughout this report and we would like to thank the contributors for generously allowing us to use their work.



**Spitfire** by Josh Griffins, Consumer  
*I like planes, in particular war planes as I like the colours, designs and the shape.*



**Tatts** by Rebecca Smith, Consumer  
*I chose to paint this picture I found as it looked challenging. Although the painting is mostly black and white, life is not necessarily so.*



**Sakura Canal** by Damon Pickett, Consumer  
*I chose my subject as it holds many elements within it that resonate with peacefulness and relaxation. The water, hills and morning sunrise combined with the beautifully contrasting Sakura tree granted me the feeling of timeless serenity*



**RIP Rab** by Penny Nolan, Consumer  
*This painting was a challenge for me, with the many colours and brush techniques used. It evokes memories of Rab, which I am painting for my close friend.*

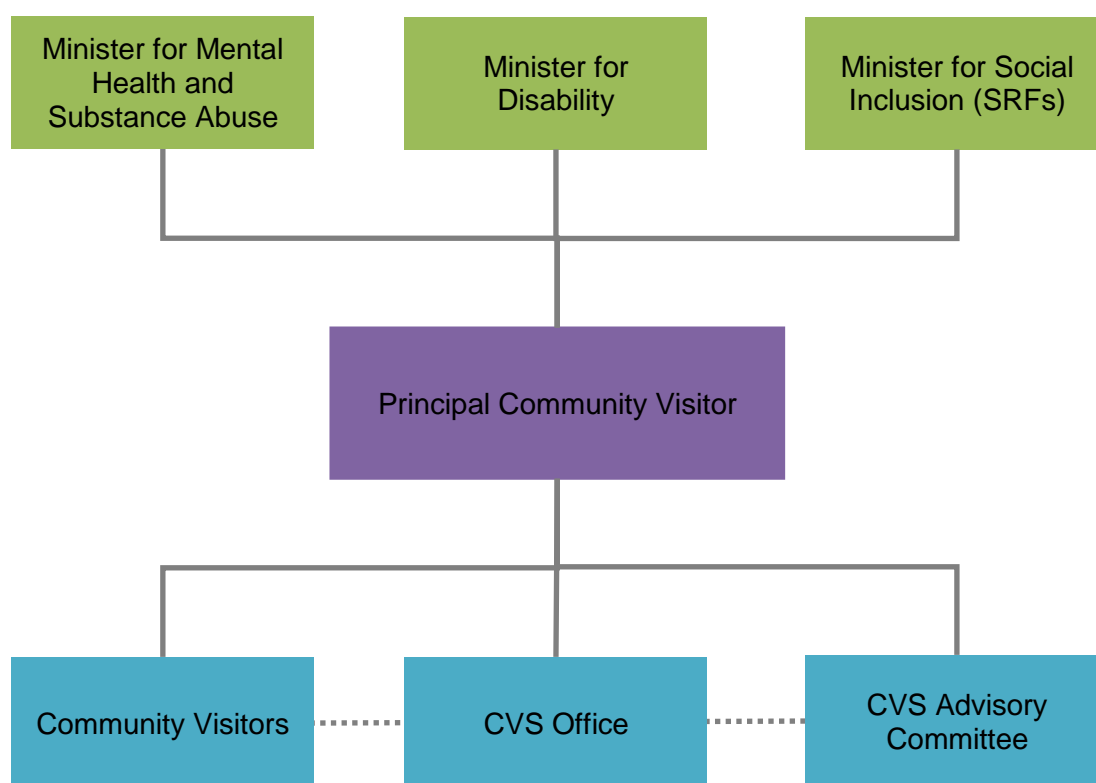
## 7. WORKFORCE

### 7.1 Governance of the Community Visitor Scheme

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

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

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



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

### 7.2 Staff of the Community Visitor Scheme

The following is a list of paid staff members who worked either full or part time in the Community Visitor Scheme office during the 2013-14 reporting period:

<b>Principal Community Visitor</b>	Mr Maurice Corcoran
<b>Mental Health CVS Coordinator</b>	Ms Charmaine Gallagher, Ms Sharon March and Ms Rebekah Mansfield
<b>Disability CVS Coordinator</b>	Ms Karen O'Keefe
<b>Administration Officer</b>	Mr Marc Williams

### 7.3 Advisory Committee

The members of the Advisory Committee during 2013-2014 were:

Ms Anne Burgess	Chairperson – CVS Advisory Committee
Mr Maurice Corcoran	Principal Community Visitor
Ms Anne Gale	Equal Opportunity Commissioner
Dr John Brayley	Public Advocate
Ms Sandy Edwards/Mr Steve Tully	Health and Community Services Complaints Commissioner
Dr Peter Tyllis	Chief Psychiatrist and Director Mental Health Policy
Ms Carol Turnbull	Private Mental Health Services Representative
Dr Jorg Strobel	Public Mental Health Services Representative
Ms Emma Willoughby	Consumer Representative
Ms Julia McMillan	Carer Representative
Ms Joan Cunningham	Community Visitor Representative
Mr Chris Firth	Community Visitor Representative (until December 2013)
Mr Barry Apsey	Community Visitor Representative (Proxy)

During 2013-14 the Committee was expanded to include representatives from the Disability Sector in line with the Community Visitor Scheme expansion into Disability Accommodation services and Supported Residential Facilities.

Mr Richard Bruggeman	Senior Practitioner
Ms Barbara Weis	Departmental Strategic/Policy Representative
Mr Tony Gillam	Government Disability Accommodation Representative
Ms Narelle Jeffery	Non-Government Disability Accommodation Representative
Mr Geoff O'Connell	Supported Residential Facilities Sector Representative
Ms Jayne Lehmann	Disability Carer Representative
Ms Ann Rymill	Disability Community Visitor Representative
Ms Marianne Dahl	Community Visitor Representative (Proxy)
(Vacant)	Disability Consumer Representative

Refer to Section 4.5 for more information

## 7. WORKFORCE

### 7.4 Community Visitor recruitment

The CVS is a member of Volunteering SA&NT Inc., 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 and media advertising.

People interested in applying to become a Community Visitor must be over 18 years of age and be willing to undertake a vulnerable persons screening check with DCSI. Before applying, interested people are encouraged to read the *Introduction to the Community Visitor Scheme* booklet, which outlines the attributes and level of commitment, required to undertake the role.

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

- attend an interview;
- participate in a two day workshop (see Section 7.5);
- undergo a screening check and referee checks; and
- undertake a minimum of two observation visits with the PCV.

If successful, the applicant is nominated for appointment and required to sign a *Conditions of Appointment* and a *Code of Conduct*. A cabinet submission is prepared recommending the appointment of the applicant to the role of Community Visitor and endorsed by His Excellency, the Governor of South Australia. Once appointed, Community Visitors are provided with photo identification.

### 7.5 Initial and ongoing support and training for Community Visitors

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 broken up over the two days with values, exercises, role plays and various guest presenters.

A minimum of two orientation 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.

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*.

Community Visitors have access to ongoing training and professional development opportunities through the SA Mental Health Training Centre (Department of Health and Ageing) and Volunteering SA. Community Visitors are encouraged to pursue these opportunities and discuss other interests with the PCV.

Annual development reviews are conducted with the PCV to provide a formal avenue for feedback and development discussions.

The PCV and CVS office staff are always available to answer any questions, provide further support and clarify procedures to all CVs.

In addition to interaction during visits, CVs meet on a three monthly basis to informally discuss their experiences during visits and provide group feedback for service improvement. Service updates and issues arising during visits regularly inform the discussion. This collaborative approach has been helpful in sharing dilemmas and issues so that all CVs can learn and develop better practice. These forums have encouraged a cohesive team approach, provided opportunity for shared learning among peers and been highly valued by the CVs.

The CVS Newsletter is distributed to the Community Visitors on a bi-monthly basis. This provides relevant updates on:

- CVS Issues Register
- Advisory Committee
- Recruitment
- Training opportunities
- Report writing requirements
- Stakeholder and service updates

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

The CVS is currently developing an online reporting tool. CVs provided input into the shaping of the reporting tool and were invited to attend a trial at the CVS office. On implementation, initial training and ongoing support will be provided by the CVS office.

### **7.6 Volunteer contribution**

The CVS currently supports 31 volunteers appointed to the role of Community Visitor. Each volunteer makes a significant contribution to the operation of the Scheme and to providing further protection to the rights of people experiencing mental illness who are receiving treatment and care within a treatment centre.

During 2013-14, a total of 1167 hours were spent by CVs carrying out monthly mental health visits. This includes time spent on visits, follow up and writing the report and equates to an average of 97 hours per month.

The skill set of Community Visitors is extremely high and very valued by the Scheme. In particular Community Visitors with personal lived experience or experience caring for vulnerable people are invaluable because of the empathy and understanding they can bring to the role. Where appropriate CVs have disclosed their own experience, which has been very empowering for patients and their families.

The profile of our CVs experience and professional training includes, but is not limited to: social workers, occupational therapists, nurses, psychologists, quality assurance and auditing professionals, school teachers, lecturers, tutors and principals, professional counsellors, barristers, journalists, policy officers, service executives and other managers; in addition to a number of our CVs currently studying and pursuing careers in these areas.

The CVS is privileged to have such experienced and committed volunteers that are dedicated to upholding the rights of vulnerable people and advocating for appropriate care and best practice to be provided.

## **Cultural Diversity**

by Tony Mons, Consumer

I look around the world today  
At all that I can see  
Australia we are the lucky land with  
Cultural Diversity

We're made of many races,  
creeds, colours, religion  
from the sun burnt land are we  
Australia we're the lucky land  
This land is girthed by sea  
With many foods, traditions to share  
Cultural Diversity

We came to this paled land of ours  
When I was only three  
I've 45 years to call my own  
And experience, so much for free  
The food, the customs and friendliness  
Cultural Diversity

And every day I feel oh so blessed by God  
I stand so tall and announce with dignity  
Australia I call my home  
Cultural Diversity



## 8. CONCLUSION

### 8.1 Next steps

#### Integrated Mental Health Units

The Act requires Community Visitors to visit and inspect both approved and *limited treatment centres*. Limited treatment centres or Integrated Mental Health Units are places determined by the Minister for Mental Health and Substance Abuse and are authorised under the Act to provide mental health treatment, care and rehabilitation for up to seven days.

Implementation of these new units are part of broader redevelopments occurring at the country hospital sites where they are located.

- The Whyalla Hospital (CVS visits commenced July 2014)
- The Berri Hospital (CVS visits commenced September 2014)
- The Mount Gambier Hospital (To open February 2015)

The CVS will be recruiting and supporting CVs within the local areas to provide visit and inspection services and advocate for patients receiving treatment within these centres.

#### Community Visitor workforce

The CVS has recently recruited a dedicated Recruitment and Training Officer to focus on building the volunteer workforce to approximately 120 visitors in order to meet the visit requirements for both mental health and disability sectors. This position will also be responsible for providing ongoing training for our appointed Community Visitors.



**Heath** by Jason Cutler, Consumer

## 8. CONCLUSION

### 8.2 Recommendations

This report discusses a range of significant issues that have emerged in section six of the report and attempts to arrive with a set of recommendations as a means of continuous improvement. These are recommendations from the Principal Community Visitor alone and do not necessarily represent views of the CVS Advisory Committee or the collective views of Community Visitors.

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

#### **Delay in Admission and Treatment**

1. That the Community Visitor Scheme continue to independently monitor the length of stays of mental health patients in emergency departments to ascertain whether there is improvement or otherwise.
2. That the Community Visitor Scheme monitors the intervention initiatives to address repeat presenters and encourage hospital avoidance.
3. That the Community Visitor Scheme monitors the use of nurse practitioners in EDs as per the Review recommendation two.
4. That the Community Visitor Scheme continues to monitor the incidence of seclusion and restraints and the use of the seclusion register.
5. That the Community Visitor Scheme continues to monitor the policy and practice response from the department of Correctional Services to the Ombudsman's report.

#### **Treatment and Care Plans**

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

#### **Clients with intellectual disability, brain injury or autism in acute mental health units and forensic care**

9. That the three options for responding to forensic clients with disabilities continue to receive serious consideration by the departments that have shared responsibility for this outcome.
10. That staff working in forensic care facilities have in-service training on working with clients who have dual disabilities, intellectual disabilities and those with brain injury and autism.
11. That individual case planning occur with all clients with disabilities who are currently within the forensic care services and corrections so that a collated profile of need is identified.

#### **Gender safety**

12. That the South Australian Office of Chief Psychiatrist continue its work into gender safety and issues Gender Safety Guidelines that incorporate practical audit or survey tools and checklists for Units together with a range of strategies to implement with associated timeframes.
13. That a zero tolerance for sexual assault approach be adopted and promoted across all services and which recognises that a range of vulnerable patients have been traumatised by previous assaults.
14. That all units and services acknowledge trauma informed care approaches and incorporate it into all aspects of care and treatment.

### **Activities and stimulation in treatment centres**

15. That all mental health units be required to post their weekly activities and sessions on their respective notice boards, keep appropriate documentation of participation rates and report on structured activity plans to the Office of the Chief Psychiatrist.
16. That the Department consider establishing a group of appropriately trained volunteers that could visit treatment centres to facilitate activities or programs.
17. That an objective assessment of treatment centre activities and programs be undertaken as a means to highlight and promote good practice and explore the impact of the above on patients and their recovery.
18. That the Community Visitor Scheme continues to monitor the levels of activities offered to patients.

### **Stigma for forensic patients transitioning to the community**

19. That the SA Government give consideration to establishing a dedicated Mental Health Review Panel. The panel will allow for appropriate assessment and balancing of often competing rights - the individual's right to liberty and safety and to freedom from unnecessary intervention, the individual's right to treatment, protection and care, and the right of the community to safety and protection.

### **Impact of SA Health no smoking policy**

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

### **Menu options**

22. An independent review of the menu provisions in mental health units be undertaken with a particular focus on the needs of long stay patients.
23. The menu offers variety and food choices that are healthy, appetising, appealing and take into account the length of stay.

## 9. REFERENCES

### 9.1 Community Visitor Scheme

The following documents can be found on the CVS website [www.sa.gov.au/cvs](http://www.sa.gov.au/cvs)

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

### 9.2 External references

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

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

*A national framework for recovery oriented mental health services Policy and Theory Commonwealth of Australia 2013* – Australian Health Ministers Advisory Council – National Mental Health Strategy

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

National Mental Health Commission, 2013: *A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention*. Sydney: NMHC

Ernst and Young - *Review of the South Australian stepped system of mental health care and its capacity to respond to emergency demand*, July 2013. Department for Health and Ageing South Australia

*Zero tolerance for sexual assault – a safe admission for women* (2013) The Victorian Mental Illness Awareness Council (VMIAC)

*Service guidelines on gender sensitivity and safety Promoting a holistic approach to wellbeing* Published by the Mental Health, Drugs and Regions Division, Victorian Government, State of Victoria, Department of Health, 2011

Garcia,I., Kennett,C., Quraishi,M., Durcan,G., (2005) *Acute care 2004: A National Survey of Adult Psychiatric Wards in England* - Sainsbury Centre for Mental Health

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

Smoking and Mental illness: Results from Population surveys in Australia and the United States David Lawrence, Francis Mitrou and Stephen Zubrick. Public Health 2009, 9:285

Smoke Free WA Health System Policy: Partial exemption for involuntary mental health patients (ref:OD 0414/13) – Guidelines for Mental Health Services. Government of Western Australia, Department of Health.

## 10. APPENDICIES

### Appendix 1: Visit and Inspection Prompt (Mental Health)

The Community Visitor Scheme provides an opportunity for Community Visitors to visit treatment centres to inspect premises and consult with patients, staff and relevant others to ensure that people with serious mental illness are receiving appropriate care and treatment.

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

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

## Appendix 2: Issues Classification Scheme

LEVEL ONE	LEVEL TWO
<b>Rights and Responsibilities</b>	Legal orders Legal rights Dignity and respect Consumer involvement in treatment and care planning Consumer decision making and support Carer, friend, family member or other support involvement Personal safety/assault Least restrictive environment Privacy and confidentiality Advocacy and legal representation
<b>Access</b>	Diversity responsiveness (interpreters, alternative languages and discrimination) Delay in admission or treatment Discharge or transfer arrangements Referral Refusal to admit or treat Service availability Transport Exit and re-entry Billing practices Information on costs Private/public election Access to records Private/public election
<b>Environment and Hospital Services</b>	Smoking provisions Lost property Food Hygiene/personal needs Grounds Suitable facilities for activities Maintenance of environment Information provision (e.g. brochures, info stands) OHW&S issues
<b>Treatment and Support</b>	Involuntary treatment and practices Assessment, reviews and Diagnosis Adverse outcome Coordination of treatment Activities and structured programs Inadequate treatment Medication Negligent treatment Rough/painful treatment Withdrawal/denial of treatment Supporting recovery Wrong/inappropriate treatment Discharge planning

<b>Grievances</b>	Inadequate/no response to complaint Reprisal/retaliation Inconsiderate service Privacy/confidentiality Accuracy/inadequacy of records Assault Competence Illegal practices Sexual misconduct
<b>Communication</b>	Staff responsiveness Patient/staff interactions/respectful communication Attitude Inadequate information Wrong/misleading information

# South Australian Community Visitor Scheme

GPO Box 292  
Adelaide SA 5000

**P** 1800 606 302

**F** 08 7424 7239

**E** [cvs@sa.gov.au](mailto:cvs@sa.gov.au)

**W** [www.sa.gov.au/CVS](http://www.sa.gov.au/CVS)



**Government  
of South Australia**