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### **Review of the Community Visitors Scheme**

As requested, I submit for your attention my report on a review of aspects of the Community Visitors Scheme in South Australia.

A handwritten signature in black ink, appearing to read 'Julian Gardner', followed by a horizontal line extending to the right.

Julian Gardner AM  
Date 8 March 2019

## Executive Summary

This review follows recommendations made by the South Australian Independent Commissioner Against Corruption in his report dated 28 February 2018, entitled “Oakden: A Shameful Chapter in South Australia’s History”.

The Commissioner recommended that a review be undertaken of the training and qualifications required for community visitors under the Community Visitors Scheme (CVS). The terms of reference for this review (see Appendix 1) were expanded to include an assessment of the processes used by the CVS to conduct inspections and resolve any issues identified by it as well as an assessment of whether the combination of inspections by community visitors and the Office of the Chief Psychiatrist (OCP) are sufficiently comprehensive

This review covers only those aspects of the CVS that come under the Mental Health Act (SA) 2009.

Community visitors are volunteers appointed by the Governor. Their functions are to conduct visits to and inspections of treatment centres and authorised community mental health facilities; to refer matters of concern; and to act as advocates for patients. It is also one of the functions of the Chief Psychiatrist to inspect these facilities.

While the functions of community visitors are clearly stated in the Act, it does not define the nature of their role. The latter is critical given that any consideration of the qualification and training requirements of community visitors must relate to the nature of their role and to the functions that they are required to perform.

Community visitor schemes in South Australia and in other Australian jurisdictions were established to assist in discharging the duty of the state to protect vulnerable citizens. Mental illness can adversely impact on a person’s cognitive and emotional capacity, making them less able to protect themselves and therefore more vulnerable to abuse and neglect. Some patients also experience significant restrictions on their human rights by being made subject to involuntary treatment and detention. Not only does this increase their vulnerability but it imposes an obligation on the state to ensure that their rights are respected and that their treatment is appropriate to their needs.

It is the role of community visitors to provide an independent, external oversight of the facilities in which these patients are treated. They have no powers to direct action but do report directly to the Minister and to Parliament. They are said to provide an early warning system for the Minister. It is not their role to conduct clinical reviews and assessments of a facility or of the treatment provided. That is the role of the Chief Psychiatrist. They apply community values sometimes described as assessing “whether I would be happy with this care and treatment for my family member” as well as monitoring compliance with the legislation and with any applicable standards of care.

Since the delivery of the Commissioner’s report improvements have been made in the practices and procedures of the CVS and in the OCP, including in the conduct of

unannounced inspections. The CVS procedures for recording and following up matters of concern have been enhanced and it is reported by the Principal Community Visitor that the responsiveness of responsible authorities with whom those concerns are raised is much improved.

I have examined the inspection protocols, the processes and the reports used in the CVS and find that they are appropriate to the role. The protocols and their documentation are complete and appropriate. They provide as much guidance as possible to enable issues to be identified and reported upon.

While there are some drawbacks in the use of unannounced visits, I am of the view that a mixture of announced and unannounced visits should be maintained.

The process for resolving issues applied by the CVS is methodical, timely, has appropriate steps for the escalation of serious or urgent matters and ensures that the appropriate persons do provide a response.

The clinical nature of inspections conducted by the OCP differs from but complements those by the CVS. The effectiveness of the combination of inspections is ensured by the positive level of co-operation and collaboration between the two agencies which was evident. I am satisfied that the combination of CVS and OCP inspections is sufficiently comprehensive.

While community visitors do concern themselves with aspects of clinical operations, they are quite able to do so without there being a requirement for specific qualifications. I do not recommend any change to the current qualification requirements of the CVS in order to appropriately discharge of the roles of the community visitors.

An extension of this recommendation is a specific finding in response to the Commissioner's recommendation that there are no current functions of community visitors that should be discharged by persons with specialist mental health qualifications.

The suggestion that community visitors should be trained in mental health care raises the question "to what level?" It does not need to be to a level that would enable them to provide mental health care nor to a level at which they could undertake accreditation assessments or reviews of clinical governance. Such is not their role. Community visitors should be and are already trained in mental health care to the extent necessary for their role. The training covers a broad understanding of mental illness, its impact on their role and on the relevant provisions of the MHA.

There are, however, opportunities for improvement in expanding the training in mental health care. Community visitors form views about the level of care and treatment and whether it meets the standards that should be reasonably expected in current practice. There is an absence of documentation and clarity about what those standards are and the potential for assessments to be subjective and inconsistent.

Therefore, it is recommended that community visitors should also have training in the standards of treatment and care that they should expect to observe in their visits.

There would be benefits, too, in increasing the level of ongoing training in mental health care. Mindful of the budgetary restraints on the CVS, I also recommend that the Principal Community Visitor explore the opportunities for the cost-effective use of digital training material that can be accessed by community visitors online at times of their convenience. Interviews or presentations by experts could be video recorded at minimal cost. In addition, the availability of pre-existing video material should be explored. Such ongoing training would enhance the training already provided.

### **Extract of findings**

Since the delivery of the ICAC Report positive changes have been made in the processes of the CVS and the OCP together with improved responsiveness of agencies responsible for responding to concerns raised by community visitors.

The inspection protocols and processes and the reports used in the CVS are appropriate.

The process for resolving issues applied by the CVS is methodical, timely, has appropriate steps for the escalation of serious or urgent matters and ensures that the appropriate persons do provide a response.

The combination of CVS and OCP inspections is sufficiently comprehensive.

No change is required to the current qualification requirements of community visitors in order to appropriately discharge their role.

There are no current functions of community visitors that should be discharged by persons with specialist mental health qualifications.

Community visitors are already trained in mental health care to the extent necessary for their role save that it is recommended that additional training be provided in the standards of treatment and care that they should reasonably expect to observe in contemporary practice.

Opportunities should be explored for the cost-effective use of digital training material to be provided on-line to community visitors.

### **Background**

This review, which is made at the request of the South Australian Chief Psychiatrist Dr John Brayley on behalf of the Minister for Health and Wellbeing, follows recommendations made by the South Australian Independent Commissioner Against Corruption, the Hon Bruce Lander QC, in a report dated 28 February 2018, entitled "Oakden: A Shameful Chapter in South Australia's History" (the ICAC Report).

The ICAC Report related to his investigation into the Oakden Older Persons' Mental Health Service (Oakden) which was also the subject of a report dated 10 April 2017 by the then

Chief Psychiatrist entitled “The Review of the Oakden Older Persons’ Mental Health Service”.

The State Government accepted in full all 13 recommendations contained in the ICAC report. Recommendation 7 was that a review be undertaken of the training and qualifications for community visitors (CVs) under the Community Visitors Scheme (CVS). The full Terms of Reference for this review are set out in Appendix 1.

The South Australian CVS is established under s 50 of the *Mental Health Act (SA) 2009* (MHA). It creates the position of Principal Community Visitor (PCV) and provides for such number of positions of community visitors as the Governor considers necessary for the proper performance of the community visitors’ functions. The visitors hold independent statutory appointments that are made by the Governor. They are volunteers who are reimbursed for any reasonable expenses incurred in their role such as travel and car-parking, they also receive an honorarium.

The purpose of the CVS in relation to functions under the MHA is stated in the PCV’s Annual Report 2017/18 as being “to further protect the rights of people with a mental illness who are admitted to mental health care units and limited treatment centres...” p 7.

Their functions as they relate to mental health facilities are set out in s 51 (1) of the MHA are to conduct visits and inspections; to refer matters of concern; and to act as advocates. The text of the relevant part of the Act is set out in Appendix 2.

The CVS also has functions in relation to Disability Services and Supported Residential Facilities that are outside the scope of this review.

The efficacy of the performance of the CVS in relation to mental health services was the subject of findings of the ICAC Report.

It stated at p 194:

However, it cannot be disputed that the CVS did not lead to identify most of the issues at Oakden, at least until Mrs Spriggs met with Mr Corcoran in June 2016. There are a number of possible reasons for this, including that the community visitors were not trained or qualified in a way which would have enabled them to identify such issues.

As a consequence, the Commissioner made recommendations which are contained in points 4, 5 and 6 of the terms of reference for this review. They relate to the requirements for the qualifications and the training of community visitors. They reflect the view formed by the Commissioner that had the qualifications and training of community visitors been different the deficiencies in the operations of Oakden would have been revealed and reported upon earlier.

The Commissioner’s findings in turn raise the question of what is the nature of the role of a CV and whether that role is appropriate. Any consideration of the qualification and training

requirements of CVs must relate to the nature of their role and to the functions that they are required to perform.

### **The nature of the role of CVs**

The first of the CVs' functions under the MHA is to "conduct visits ... and inspections". The CVS Training Manual in Module 2 on page 11 expands on this as follows: "They (CVs) undertake independent inspections or checks on services to ensure clients are being treated with dignity and respect and those services are responsive and appropriate to client needs and clients have been provided with information about their care and support".

Under the MHA CVs are also required to advocate for patients on matters "relating to the care, treatment or control of patients".

However, an examination of the functions of CVs under the MHA does not adequately address the question of the nature of the CVs' role. Without a clear understanding of the role it is not possible to answer questions about the nature of training required, or the qualifications required or how the CVS role fits with that of the Office of the Chief Psychiatrist (OCP).

It has been accepted for centuries that the state has a responsibility to protect those of its citizens who are vulnerable. This duty to protect particularly arises because of infancy or the lack of cognitive capacity. Hence there developed the inherent *parens patriae* jurisdiction of superior courts that can be exercised today.

Mental health facilities care for and in some cases confine vulnerable citizens. There are those who, while voluntarily in a facility, may, because of their mental illness, lack their usual cognitive and emotional capacities to protect themselves from neglect, harm or mistreatment. It is the role of CVs to monitor, on behalf of the state, the care of patients to ensure that they are treated humanely and professionally and that they are protected from abuse, harm or neglect and that their rights are respected.

Arguably an even more important rationale for the establishment of the CVS is that mental health facilities contain people who are held there against their will. This extreme intrusion upon the human rights of an individual is justified by the need to discharge the duty of the state to protect those citizens who lack capacity as a result of their mental illness and who are therefore vulnerable and less able to protect themselves. The restriction of an individual's human rights in some cases is justified by the need to protect the public from those who, because of their mental illness, may present a risk of harm to others.

Human rights may be restricted but only to the minimum degree necessary and proportionate. It is the role of CVs to provide an external, independent monitoring of mental health facilities to ensure that vulnerable people are treated with respect, that any restriction on their human rights is as minimal as necessary and that their care is of the highest reasonable standard.

This role is discharged in two distinct ways. The first is that of inspection and the second is that of advocacy. The latter role in the CVS is limited in its scope but nevertheless invaluable. It means that a vulnerable person is able to talk in confidence to someone who has an official position but, of critical importance, is independent of the facility in which they are held. Not only can that person receive some reassurance and comfort from contact with an independent person but also it is possible for CVs to follow up and resolve matters that are troubling the person.

It is important to note that the office of the PCV receives a significant number of calls from patients the outcome of which may be the provision of brief advocacy services or the making of a special visit to the facility. These visits are a function of the advocacy role rather than that of inspection.

A reading of the ICAC report suggests that the emphasis of its recommendations in relation to the CVS was on the inspection role to the exclusion of the advocacy role. It is important to accurately understand the full scope of the role when considering the requirements for training and for qualifications and in considering the complementarity of the role with that of the OCP.

In some respects CVs do inspect matters in common with those that are the concern of the Chief Psychiatrist. CVs do monitor compliance with patients' rights under the MHA as well as any standards set by legislation or by instrumentalities of the state. However, their inspection role is not one akin to that which occurs during the process of accreditation nor to one of that is part of clinical governance. Both of these require high level technical or clinical knowledge.

They apply "community standards", sometimes described as "would I be happy with the care and treatment I observe if it were for my family member?". Their role is quite distinct from that of clinical oversight. Similar schemes in Australia have been described as being the "eyes and ears of the Minister" and as providing an early warning system for the Minister. This is evidenced by the fact that they do not have any power to direct change but do have power to report to the state through the responsible Minister and to Parliament.

The fact that CVs are independent of and external to the mental health system is critical. CVs are members of the community who are required to ensure that the duties of the state are discharged and its responsibilities met in the care of vulnerable people.

### **TOR 1. The statutory role of the South Australian CVS and how it compares with similar programs in other Australian jurisdictions.**

The potential benefit of comparing the South Australian CVS with similar programs in other Australian jurisdictions is to determine whether there are any aspects relating to qualifications, training and processes in other schemes that differ from the SA scheme and which, if reflected in the CVS, could be of benefit.

While on their face the schemes in the various States and territories have much in common, there are, in fact, major differences. The most significant of these is that only the Victorian

and SA schemes are staffed by volunteers. Visitors in the other jurisdictions are remunerated. This difference inevitably makes a comparison of the qualification requirements and training practices less than useful.

The range of facilities visited by the various Australian schemes varies. The South Australian scheme is responsible for visiting not only mental health facilities but also disability facilities and Supported Residential Facilities. This is also the case in Victoria.

In WA the Mental Health Advocacy Service deals only with mental health services and is markedly different from the others in that it is an advocacy service rather than an inspection service. Advocates, among other functions are required to contact or visit every person made involuntary within certain timeframes. Advocates also provide representation and support at tribunal hearings. In NSW Official Visitors are concerned only with mental health services as are Official Visitors in Tasmania.

In Queensland Community Visitors also have a specific function in relation to children and young people.

The various schemes have co-operated in the preparation of a large and comprehensive spreadsheet that sets out the major features of each scheme in a comparative table. I have examined the most recent version which is dated June 2017 and have had discussions with representatives of each of the schemes other than in Queensland and the NT.

Given the existence of the spreadsheet, and as advised by the Chief Psychiatrist, it is not necessary for this report to include a detailed comparison of the schemes other than to refer to them in discussion of the central issues of qualifications and training.

**TOR 2. How the South Australian CVS role is currently met, including:**

- **The inspections protocols in place and reports used**
- **The process of identifying and resolving issues.**

The CVS has two documented protocols: a Visit Inspection Protocol and a Visit and Inspection Prompt. The latter draws upon the National Standards for Mental Health 2010 and is designed to draw the attention of visitors to the matters that they should consider in their visits. In addition, there are two Visit Report Forms. They list matters to be reported upon after every visit under the headings of Environment and Services with sub-headings for Communication; Quality of Site; Quality of Services; Rights and Responsibilities; and Rights.

One of the forms, both of which are completed on-line, is for planned visits and one for visits that are requested by or on behalf of a patient. The latter type of visit is part of the advocacy role of the CVS.

Prior to each visit each CV receives by email a brief note regarding the site(s) to be visited and the contact persons in those sites and a copy of the last report made following a visit to that site. The last of these enables a follow up, if necessary, of any outstanding issues and is designed to ensure that attention is given to specific matters.

It is a requirement under the MHA for visits to be conducted by two visitors (except in cases where a visit is requested by or on behalf of a patient or is conducted by the PCV). Apart from enabling more contacts with patients, this has obvious advantages of increasing the observations made and of moderating the application of standards. In the WA scheme where visits are made by only one person it was reported that some visitors feel isolated in their visiting.

In addition, it is the practice of the CVS to rotate CVs among the facilities visited and to vary the combination of the pairs of CVs. This is designed to avoid the potential for CVs to become too close or too familiar with the facility and its personnel, thereby raising the risk of loss of objectivity and willingness to be critical. In Tasmania the rotation is very structured whereas in WA the scheme's manager commented that she saw a need to introduce this practice.

A critical change in the practice of inspections has occurred since the publication of the ICAC Report. At p 17 of that report the Commissioner stated:

I have considered the position of the Principal Community Visitor and made some observations about his powers to make unannounced visits to facilities such as Oakden. The Community Visitor Scheme for which he is responsible did not make any unannounced visits to the Oakden Facility prior to the commissioning of the Chief Psychiatrist and the review team to prepare the Oakden Report.

Whereas previously almost all visits were scheduled in advance and the times known to the facility, since October 2018 at least 50% of visits by the CVS are unannounced. The implication in the Commissioner's comment is that a facility, knowing when an inspection is due, will be able to present in a way that is more favourable than the norm. In practice the PCV reports that there are some drawbacks to unannounced visits in that patients cannot be advised in advance that there will be an opportunity to speak to an independent person thereby reducing the incidence of discussions with patients. It is also less likely that consumer and carer consultants will be available. There is no reported difference in the number or range of issues identified on unannounced visits when compared to those that are announced in advance.

Despite this, I am of the view that a mixture of announced and unannounced visits should be maintained.

I did not ascertain any processes in place in other jurisdictions that could be adopted for the betterment of the CVS.

In my view the processes in place to meet the CVS role are appropriate. The protocols and their documentation are complete and appropriate. They provide as much guidance as possible to enable issues to be identified and reported upon.

The second aspect under this term of reference is the process for resolving issues. It has many layers as described below.

One of the concerns identified by the PCV following the Oakden Report was the lack of a timely, or of any, response to issues raised by him with the responsible authorities. A process has been put in place to address this.

Any issues suitable to be raised at the time of the visit are raised with senior staff of the facility. At the same time any outstanding issues from a previous visit are followed up and any concerns about obstacles to the inspection are raised.

If serious issues are identified CVs are required to call the CVS office immediately. Issues identified at the visit are reported in the written Visit Report Form. These are all entered into a Tracking Register which records details of the issue, the actions taken, and the time for follow up.

All issues raised in Visit Report Forms are “triaged” in the CVS office. Any serious or urgent matters are brought to the attention of the PCV. A decision is then made as to whether it needs to be raised immediately with the Local Health Network, the Chief Psychiatrist or the Minister.

All outstanding issues are reported monthly to the Director of Operations and/or Clinical Director of each Local Health Network. A response is requested in two weeks. Importantly, monitoring and updating of the Tracking Register ensures that outstanding responses are pursued. All visit reports are forwarded monthly to the Directors and also to the Unit managers.

A useful example of the effectiveness of this process for resolving issues was that in relation to the concerns raised by CVs in mid 2018 about the mix of clinical and mental health wards in Ward 4GP at the Flinders Medical Centre. Within a week of the visit the PCV emailed the Chief Psychiatrist detailing concerns. The Chief psychiatrist conducted an inspection six days later and finalised a written report three days after that.

In addition to these measures for raising and resolving issues of concern, a timetable of regular meetings has been established. The PCV meets:

- Quarterly with the Director of Operations in each of the five Local Health Networks.
- Every two months with the Chief Psychiatrist, and
- Every two to three months with the Minister.

The CVS Advisory Committee meets every two months. Included in the papers for its meetings is a copy of the Issues Register.

To ensure that the PCV can identify when and with whom issues were raised he has, since the ICAC Report, introduced more formal processes for agendas and records of meetings.

The PCV reported that since the ICAC Report, the responsiveness by those to whom issues referred by him has markedly improved and is very satisfactory.

In my view the process for resolving issues is methodical, timely, has appropriate steps for escalation of serious or urgent matters and ensures that the appropriate persons do provide a response.

**TOR 3. Whether the combination of CVS and Office of the Chief Psychiatrist (OCP) inspections is sufficiently comprehensive.**

The office of Chief Psychiatrist is created by s 89 of the MHA. The functions are contained in s 90 of the MHA. One of those functions is to “advise the Minister on issues relating to mental health and to report to the Minister any matters of concern relating to the care or treatment of patients”: s 90(1)(d). The Chief Psychiatrist has authority to inspect the premises and operations of any “incorporated hospital”; may enter at any time; and may require the production of documents or records: s 90 (4) and (5).

It is the practice of the Chief Psychiatrist to carry out both unannounced and scheduled inspections. The ICAC report was critical of the then practices of the OCP, observing that “the statutory powers...were not exercised to the extent that they could have been” (p 193). Since the release of that report the Chief Psychiatrist has implemented a more intensive program of inspections with a particular focus on those that are unannounced.

The Chief Psychiatrist Inspections Policy Guideline 2019 lists three types of inspections. They are:

- Standard inspection
- Comprehensive inspection
- New Unit inspection.

The Inspection Policy states that inspections are carried out by teams:

Inspection teams will be composed of individuals who will bring different skills, knowledge and perspectives, depending on the type and scope of the inspection. Each inspection team is led by a member of the Office of the Chief Psychiatrist. The size of an inspection team will depend on the type and scope of the inspection.

Inspections are usually carried out by the Chief Psychiatrist together with someone from his office who has expertise in the governance of safety and quality. This person is normally a mental health professional. A roster of other clinicians who can conduct inspections is in place. A number of mental health staff across the Local Health Networks have been trained in investigation procedures including the collection of evidence and administrative law, and further training to enhance capacity is being conducted. There are plans to include persons with a consumer or carer background in the inspection team. It will be interesting to observe the effect of this proposal if implemented to determine if it complements or duplicates the role of the CVS.

Inspections may occur when a matter of concern has been raised with the Chief Psychiatrist. Otherwise, the focus of inspections is upon the model of care, critical safety issues, the data on reviews of critical incidents and how findings have been implemented, the adequacy of physical amenities (such as ligature points) and matters of compliance with the MHA.

These foci are primarily technical in nature. However, there are aspects of OCP inspections that do overlap with those of CVS. For example, both the CVS and the OCP inspections do address aspects of quality and safety such as care plans and the availability of therapeutic activities. CVS will raise concerns about safety, including ligature points, and will assess the general atmosphere of the facility and the degree to which it is welcoming.

The complementary nature of the two inspections is seen in the practice of the Chief Psychiatrist to obtain the reports made by the CVS on a facility before conducting an inspection of it. The example given above about the inspection carried out and the report prepared regarding Ward 4GP of the Flinders Medical Centre following a matter being raised by the PCV with the Chief Psychiatrist is also instructive. It illustrates the difference in the two roles but at the same time it illustrates the effectiveness of the combination, especially given the efficiency of the PCV in referring issues and following them up and the responsiveness of the OCP. The importance of the relationship is recognised in the holding of meetings between the PCV and the Chief Psychiatrist every two months.

In discussions with representatives of schemes in other jurisdictions it was a common view that the community visitor schemes rely on the complementary inspections by the Chief Psychiatrist.

It has already been noted that critical to the effectiveness of the CVS is that fact that CVS are independent of and external to the mental health system. The OCP is not. There is essential value in the combination of the two.

There is no doubt that the two inspections have different functions. The clinical nature of the inspections by the OCP complements that of the CVS. It can be said to be made more efficient and effective by having the CVS identify issues that need the attention of the OCP and causing it to conduct an inspection.

The complementary nature of the two schemes does, however, need to be made effective by good co-operation and collaboration. In my view this exists in South Australia.

I am satisfied that the combination of CVS and OCP inspections is sufficiently comprehensive.

#### **TOR 4. The qualification requirements for the CVS and whether they are appropriate to the role.**

As stated above, the skills and qualifications needed to perform any role are determined by the nature of that role and the tasks to be performed. Therefore, the discussion above of the nature of the role of CVS in carrying out their functions as set out in the MHA is critical to defining the skills and qualifications that are required.

There are no formal qualifications specified as being required for the role of a visitor in the CVS. The absence of any requirement for formal qualifications and, to a large extent, the drafting of the selection criteria is in common with most of the other Australian schemes.

The only schemes requiring formal qualifications are those of NSW, the ACT and the NT. In NSW in each panel of two Official Visitors one must be medical practitioner or a suitably qualified clinical person. The Principal Official Visitor in NSW noted that the Chief Psychiatrist does not have the same inspection role as exists in other jurisdictions. This may explain why it is considered necessary to have one of the two visitors conducting a visit described as a “clinical visitor”.

In the NT panels consist of three people. Two of these must be medical or legal practitioners. The 2017 spreadsheet entry for the NT noted that there are difficulties recruiting. In the ACT an Official Visitor in the mental health stream must be either a legal practitioner of five years standing; or a medical practitioner, or a person nominated by a body representing consumers of mental health services, or a person with experience and skill in the care of persons with a mental disorder or mental illness. The Public Trustee and Guardian advised that at present there are no Official Visitors with a clinical background.

The selection criteria for the CVs in South Australia are as follows:

#### Personal Abilities/Aptitudes/Skills

An interest in and commitment to the rights of people with a mental illness or a disability

Excellent communication and interpersonal skills

Skills and abilities to undertake visits and inspections

The ability to prepare and provide written reports

The ability to provide support and act as an advocate for patients/residents to promote the proper resolution of issues relating to their care and treatment, including issues raised by families or associates

The ability to refer matters of concern to the appropriate persons or organisations

The ability to empathise with people from different backgrounds, including those from other cultures, socio-economic groups and religion

The ability to work collaboratively with other Community Visitors, staff, service providers and others, to contribute to the work of the CVS.

#### Experience

Experience in working in a volunteering role

#### Knowledge

Knowledge of the various communication mechanisms required when liaising with a diverse audience

Knowledge of disability sector

Knowledge of mental health sector.

In addition, the CVS website states that applicants must be:

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

People with lived experience and from culturally and linguistically diverse backgrounds and Aboriginal heritage are encouraged to apply. The PCV advised that of the present CVs some 80% have lived experience of their own or as a carer or as a family member. While this does not amount to a formal qualification it is relevant to having an understanding of mental health or disability and potentially some understanding of the system.

There is one aspect of the CVS operations that is markedly different from the schemes in other Australian jurisdictions and which is relevant to the selection of visitors in ensuring their competence and suitability. It is the fact that training occurs **before** a recommendation is made for appointment. After short-listing a prospective visitor is required to:

- Attend an interview

- Participate in a two-day workshop

- Undertake a minimum of two orientation visits to facilities with the PCV and to prepare a written report after their second visit

- Participate in a final interview with the PCV and recruitment officer.

In other jurisdictions the selection process is the more usual process of interview, referee checks and any necessary police checks. The advantage of the CVS process is that there is ample opportunity to assess suitability during the two-day training and in practice with observations that can be made while visiting, including the capacity for report writing. These steps provide an opportunity to test the meeting of the selection criteria including knowledge of the mental health system. It is very much easier to exclude applicants from appointment than it is to dismiss visitors after appointment.

The advocacy function requires skills in listening, communicating and analysing and a capacity for practical follow up. To pursue a person's complaint about the hearing of their appeal or the level of their medication does not require legal or clinical knowledge and training but rather a capacity to collect information and know where and with whom to pursue the complaints.

If the inspection function were that of a clinical inspection then the requirement for clinical expertise would be necessary. However, it is not of that character. In fact, comments were made by several of the people consulted that there are some potential disadvantages of having visitors with, say, a mental health nursing background. There is a risk that a patient may not see them as independent of the system. There is the risk that they may be sympathetic to the pressures upon nurses and therefore make allowances that a lay person would not. The Principal Official Visitor in NSW, where one of the two members of a visiting panel is a "clinical visitor", commented that she would be concerned if both members of a panel were clinical visitors. She expressed the view that the combination was necessary to ensure that community standards as well as the principles in the legislation were applied.

Those interviewed in other jurisdictions shared the view that having visitors with mental health qualifications was not necessary to improve effectiveness. The WA program manager reported that problems had arisen with advocates who were clinical psychologists.

However, it should be noted that the WA scheme is an advocacy program and the issue related to the model of advocacy sought to be applied there.

As stated already it is not the function of a CV to conduct an inspection that evaluates the clinical practices of a facility. Such a role would require qualifications in mental health care. Their role does require high level communication and interpersonal skills; advocacy, negotiation and investigative skills; report writing skills; analytical skills; and high standards of ethics, integrity and commitment to promoting human rights. These requirements are reflected in the current selection criteria.

In my view the current qualification requirements of the CVS are appropriate to the discharge of the role of the CVs.

**TOR 5. The training requirement for CVs and, in particular whether they should be trained in mental health care.**

The present training provided by the CVS commences with a two-day course. The headings of the contents of this course are as follows:

1. Community Visitor Scheme – Introduction, Overview and History
2. Role, Function and Scope of the CVS
3. CVS Visits and Inspections
4. Practical Matters for Community Visitors
5. Lived Experiences
6. Mental Health
7. Communication Strategies
8. Disability
9. Dual Disability, Gender Safety and Restrictive Practices
10. Cultural Competencies
11. Values
12. Policies/Procedures/Guidelines
13. Resources

The Mental Health module includes:

Mental Health Act 2009

What is mental illness? and

Classifications of mental disorders.

The course is followed by supervised visits before appointment. After appointment occasional training sessions are provided and there are bi-monthly meetings of CVs where interactive, 'reflective practice' sessions occur. An example given by the PCV of additional training was that of a session on treatment and care plans. The initial training is comprehensive, covering matters such as the legislation, the role of other agencies, communication strategies, report writing etc.

The training includes sessions presented by a person with lived experience and by the Senior Training Nurse from the OCP. It covers a description of the most common forms of mental

illness, especially those likely to be encountered and practical matters such as the purpose and content of treatment and care plans. Discussions with CVs did not identify any areas that they felt in retrospect had not been included.

The content of any training for a specific role must be directly related to the nature of that role. The recommendation of the Commissioner raises the question of whether CVs should be trained in mental health care. This in turn invites the question: “to what extent?” Clearly it is not necessary to a CV’s role for them to be trained to the level at which they are capable of providing mental health care. Nor is it necessary for CVs to be trained to the level required to conduct a clinical review of the service. They do, however, need a broad understanding the most common types of mental illness, of symptoms and how the symptoms of illness may impact on interactions between visitors and patients. They also need to understand the ways in which communication with patients can be made the most effective. Training in the provisions of the MHA as they relate to involuntary treatment and the rights of patients under the MHA is also necessary. Such matters are currently provided in the training.

In conducting a visit CVs need to be able to process what they observe through the lens of an appropriate standard. What have been described as “community standards” are adequate to assess a wide range of matters. These include, for example, access to rights information, access to rights of review, cleanliness, some aspects of safety, capacity to communicate with family, ease of communication with staff, quality of food and the like. A patient’s understanding of their care plan or the degree of input into it can be ascertained by skilful communication.

However, a question raised by the Commissioner’s recommendation is whether CVs have sufficient knowledge of what should be expected in an appropriate level of care. What, for example, should a patient expect in terms of frequency and ease of contact with a consultant psychiatrist, to what extent should the nursing staff have specialist qualifications, what facilities should be available for providing different levels of sensory stimulation, what non-pharmacological therapies should be provided and so on. In essence there is a need to know what, by reference to current best clinical practice, should be the expected standards of care and treatment.

Reference to the National Standards for Mental Health Services 2010 and especially Standard 10.5 concerning Delivery of Care gives some guidance, although the broadness of the provisions does not directly lead to an understanding of what should be expected in practice. The guiding principles in s 7 of the MHA are very broad and the only specific South Australian standards that have been issued relate to specifics such restraint, seclusion and ECT.

There is a need for training that would enable CVs to understand what is the reasonable standard of care and treatment that should be provided in a mental health facility. The Chief Psychiatrist has indicated his willingness to assist in such training. It is a matter that should be considered by the PCV and discussed with the Chief Psychiatrist.

Given the complementarity of the inspections by the OCP and the CVS, the training for CVs should also include information about the role of the OCP and how that is discharged in practice. Since the delivery of the ICAC Report the present Chief Psychiatrist has put into practice a different and more proactive regime of inspections. CVs would benefit from an understanding of the OCP's role and current practices.

While the number of psychogeriatric patients being visited is small in number, consideration should be given to specialist instruction for visits to those facilities. There can be unique challenges in communicating with patients suffering from dementia. There can be unique behavioural problems and risks of assault. It may be difficult to assess whether patients are naturally resting or sleeping a lot or are over-medicated. There is a greater likelihood of patients being socially isolated.

The adequacy of resources available to the PCV for training is beyond the scope of this review. There may be cost effective ways in which ongoing training can be provided. It is recommended that consideration be given to the use of digital resources in providing ongoing training. For example, it may be possible to source suitable videos on topics about specific types of mental illness or current practices in treatment and care. In addition, videos could be made of presentations by experts in aspects of mental health care or of the role and practice of the OCP. While webinars may require resources beyond that of the CVS budget, simple videos of interviews or presentations could be produced at a minimal cost. These training resources could be made available on CVS website or forwarded by email and could be accessed by CVs at times of their convenience. It would also be possible to require CVs to report on their access to these resources as part of their annual performance reviews.

My discussion with a group of CVs suggested that the use of a workshop to discuss ideas for training, both in terms of method, such as the use of more adult learning principles, and in terms of content, could be productive and is worth consideration.

In summary CVs should be and are already trained in mental health care to the extent necessary for their role as far as having a broad understanding of mental illness, its impact on their role and on the relevant provisions of the MHA. It is recommended that they should also have training in the standards of treatment and care that they should expect to observe in their visits. Consideration should be given to the use of digital material that can be accessed by CVs online at times of their convenience.

**TOR 6. Whether some of the current CV's functions should be discharged by persons with specialist qualifications in mental health.**

It is not a function of the CVs to monitor and review the clinical operations of the facilities that they visit. That is a function of the Chief Psychiatrist. They are not, for example, required to review the model of care or the adequacy of the system for reviewing critical incidents or the adequacy and basis for reaching a diagnosis nor to review medications that are prescribed. These are functions that would require specialist qualifications in mental health.

This is not to say that CVs in the performance of their functions will and should consider matters that can be said to be within the compass of clinical operations. Elements of care that may be considered by CVs could include, for example, the rates of the use of seclusion, the opportunity for patients to have input into their care plans, the provision of activities, whether the facility has a welcoming atmosphere, whether the staff are accessible and some aspects of safety. Observing and reporting on such matters does not in my view require specialist mental health qualifications. For example, it is not the role of a CV to be critical of the use of seclusion per se. However, they may note that the rate of use of seclusion has noticeably changed or that it is outside expected standards. To report and raise concerns about such matters requires some knowledge of the system and good observational skills but does not require clinical expertise. That is the requirement of those to whom the CVs' concerns are reported.

A CV may observe that a person appears to be, say, overly lethargic or incoherent in speech, and as a consequence ask about their condition and whether it is related to medication. To do so, however, is not to perform the same function as a review of medication. A patient may complain to a CV about their perceptions of the nature or the effects of medication and a CV may report their concerns to staff. However, this response does not require the CV to make any judgement about the medication. It does not require specialist qualifications in mental health.

There are questions of standards of care and treatment that should be the subject of inspections by CVs. However, as illustrated above, a person who meets the eligibility requirements for a CV is well able to address those questions. To some extent this ability could be said to come with experience and learning in the role. The practice of combining an experienced CV with a less experienced person on a visiting panel recognises and addresses this possibility.

I do not find that there any of the CVs' current functions should be discharged by persons with specialist mental health qualifications.

## **Appendix 1.**

### **Terms of Reference**

#### **Review of the South Australian Community Visitors Scheme**

##### ***Background***

The Independent Commissioner Against Corruption (ICAC), The Hon. Bruce Lander QC, announced an investigation into possible maladministration at the Oakden Older Persons Mental Health Service on 25 May 2017. The Commissioner handed down his report into the Oakden Older Persons Mental Health Facility on 28 February 2018.

The State Government accepted in full all 13 recommendations contained in the ICAC report on the Oakden Older Persons Mental Health Service and provided a response to the ICAC Report on 1 March 2018 South Australian Government Response to the Independent Commissioner Against Corruption's Report 'Oakden: A Shameful Chapter in South Australia's History'.

In accordance with the ICAC report the provider is required to specifically consider the following recommendation within the context of their review:

**Recommendation 7** - The Minister for Mental Health and Substance Abuse (the Minister) cause a review to be conducted of the community visitor scheme (CVS) to determine whether the CVS should be amended to:

- require community visitors be trained in mental health care;
- require community visitors to possess certain qualifications in mental health care; and
- provide that some of the community visitors' current functions be discharged by persons with specialist qualifications in mental health

### ***Consultant Requirements***

Undertake a review and make recommendations in relation to:

1. the statutory role of the South Australian Community Visitors Scheme and how it compares with similar programs in other Australian jurisdictions
2. how that role is currently met, including:
  - o the inspection protocols in place and reports used
  - o the process for identifying and resolving issues
3. whether the combination of CVS and Office of the Chief Psychiatrist (OCP) inspections is sufficiently comprehensive
4. the qualification requirements for CVs and whether they are appropriate to the role
5. the training requirements for CVs and, in particular whether they should be trained in mental health care
6. whether some of the CV's current functions should be discharged by persons with specialist qualifications in mental health.

Note: (1) (2) and (3) are additional to the Commissioner's Recommendation 7 requirements (4) (5) and (6)), but represent useful contextual information.

## **Appendix 2.**

### **The Mental Health Act (SA) 2009**

#### **Section 51 Community Visitors' functions and powers**

(1) Community visitors have the following functions:

(a) to conduct visits to and inspections of treatment centres as required or authorised under this Division;

(ab) to conduct visits to and inspections of authorised community mental health facilities as required or authorised under this Division;

(b) to refer matters of concern relating to the organisation or delivery of mental health services in South Australia or the care, treatment or control of patients to the Minister, the Chief Psychiatrist or any other appropriate person or body;

(c) to act as advocates for patients to promote the proper resolution of issues relating to the care, treatment or control of patients, including issues raised by a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act;

(d) any other functions assigned to community visitors by this Act or any other Act.

Section 51 (2) sets out the functions of the Principal Community Visitor.

The Principal Community Visitor has the following additional functions:

(a) to oversee and coordinate the performance of the community visitors' functions;

(b) to advise and assist other community visitors in the performance of their functions, including the reference of matters of concern to the Minister, the Chief Psychiatrist or any other appropriate person or body;

(c) to report to the Minister, as directed by the Minister, about the performance of the community visitors' functions;

(d) any other functions assigned to the Principal Community Visitor by this Act or any other Act.

Section 52—Visits to and inspections of treatment centres

(1) Subject to subsection (2), each treatment centre—

(a) must be visited and inspected at least once in every 2 month period by 2 or more community visitors; and

(b) may be visited at any time by 2 or more community visitors.

(2) The Principal Community Visitor may, at any time, visit a treatment centre alone.

(3) On a visit to a treatment centre under this section, a community visitor must—

(a) so far as practicable, inspect all parts of the centre used for or relevant to the care, treatment or control of patients; and

(b) so far as practicable, make any necessary inquiries about the care, treatment and control of each inpatient; and

(c) take any other action required under the regulations.

(4) After any visit to a treatment centre, the community visitors must (unless 1 of them is the Principal Community Visitor) report to the Principal Community Visitor about the visit in accordance with the requirements of the Principal Community Visitor.

(5) A visit may be made with or without previous notice and at any time of the day or night, and be of such length, as the community visitors think appropriate.

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

Section 52A has provisions similar to those in s 52 regarding visits to community mental health facilities. It came into effect from June 2017.

### **Appendix 3.**

#### **Persons consulted as part of this review**

Maurice Corcoran AM, Principal Community Visitor, SA  
Kate Thomas, Mental Health Co-ordinator, CVS, SA

Helen Winefield, Community Visitor, SA  
Bryn Williams, Community Visitor, SA  
Michelle Slatter, Community Visitor, SA  
Marianne Dahl, Community Visitor, SA  
Tony Rankine, Community Visitor, SA  
Jim Evans, Community Visitor, SA  
Sharon Hughes, Community Visitor, SA  
Greg Fulton, Prospective Community Visitor, SA

Dr John Brayley, Chief Psychiatrist, SA  
Ben Sunstrom, Office of the Chief Psychiatrist, SA  
Dr Michael Page, Psychiatrist and Unit Head, Ward 18V  
Paula Rae, Nurse Unit Manager, Ward 18V, Flinders Hospital  
Colleen Pearce, Public Advocate, Victoria  
Leonie Swift, Manager Community Visitor Program, Victoria

Brendan Marsh, training manager, Community Visitors program, Victoria  
Anne Gale, Public Advocate, SA  
Andrew Taylor, Public Trustee and Guardian, ACT  
Trish Mackey, Deputy Public Advocate, Human Rights Commission, ACT  
Shannon Pickles, Official Visitor, ACT  
Donna Ayriss, Manager Mental Health Advocacy Service, WA  
Phil Donnelly, Manager, Official Visitors, Tasmania  
Karen Lenihan, Principal Community Visitor, NSW  
Jae Radican, Program Manager, NSW