Annual Report

of the Chief Psychiatrist of South Australia

2019-20

Government of South Australia

SA Health

For more information

Office of the Chief Psychiatrist
Department for Health and Wellbeing
PO Box 287 Rundle Mall
Adelaide SA 5000
Telephone: 08 8226 1091
Facsimile: 08 8226 6235
healthocp@sa.gov.au

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Hon Stephen Wade MP
Minister for Health and Wellbeing

Dear Minister

In accordance with section 92 of the *Mental Health Act 2009*, I am pleased to submit the Annual Report of the Chief Psychiatrist for presentation to Parliament.

This report provides an account of the monitoring and administration of the *Mental Health Act 2009* and the activities of the Office of the Chief Psychiatrist for the financial year ending 30 June 2020, in compliance with the Department of Premier and Cabinet Circular on Annual Reporting requirements.

Yours sincerely

Dr John Brayley
Chief Psychiatrist

30 September 2020

Premier and Cabinet Circular 013 – Annual Reporting Requirements 2019-20

Requirement	Report Section
Strategic Focus	Chapter 1
Organisational Structure	Chapter 1
Changes to the Agency	As per DHW Annual Report 2019-20
Our Minister	The Hon Stephen Wade MP – Minister for Health and Wellbeing
Our Executive Team	Chapter 1
Legislation administered by the agency	*Mental Health Act 2009* *Criminal Law Consolidation Act 1935 (*delegated)
Agency contribution to whole of Government objectives	As per DHW Annual Report 2019-20
Agency specific objectives and performance	Chapters 2, 3, 4,5,6 and 7
Corporate performance summary	
Employment Opportunity Programs	As per DHW Annual Report 2019-20
Agency performance management and development systems	As per DHW Annual Report 2019-20
Work, health and safety and return to work performance	As per DHW Annual Report 2019-20
Workplace injury claims	As per DHW Annual Report 2019-20
Work health and safety regulations	As per DHW Annual Report 2019-20
Return to work costs	As per DHW Annual Report 2019-20
Executive Employment in the agency	As per DHW Annual Report 2019-20
Financial performance of the agency	As per DHW Annual Report 2019-20
Consultants	As per DHW Annual Report 2019-20
Contractors	As per DHW Annual Report 2019-20
Fraud detected in the agency (number of instances)	Nil
Strategies implemented to control and prevent fraud	As per DHW Annual Report 2019-20
Public Interest Disclosure	As per DHW Annual Report 2019-20
Public Complaints	Included in whole of SA Health (SLS) report

Mental Health Act 2009 – Annual Reporting Requirements

Requirement	Report Section
Section 92(1)(aa) in respect of the administrative functions conferred on the Chief Psychiatrist under this Act—information about how the Chief Psychiatrist has performed those functions	Chapter 2
Section 92(1)(a)(i) in respect of each level of community treatment order and inpatient treatment order—information about the number and duration of the orders made or in force during the preceding financial year	Chapter 4
Section 92(1)(b) in respect of the administration of Part 10 (Arrangements between South Australia and other jurisdictions)	Chapter 2

Foreword

The 19-20 year has been another significant year for the Office's oversight work in mental health in South Australia, across areas of statutory regulation, planning, policy development and safety and quality, with the addition of COVID-19 mental health work in the last quarter.

Our Office in conjunction with the Mental Health Commission had been asked to develop a Mental Health Services Plan for South Australia. This plan was accepted by Government, and became the State's Official Services Plan in November 2019. The document was developed following extensive consultation with the sector including people with lived experience, and contains a detailed analysis of our current system, and charts steps to be taken for a 5 year period. Some new initiatives are funded, but others which currently have in principle Government support, will require business cases over the course of the plan before they proceed.

The plan has many elements across all age groups that are grouped under the key goals of personalisation, integration and safety and quality. Illustrative examples of approaches in the plan include a modernised and expanded crisis response system for people in distress (covering telephone response, mobile response, crisis centres and beds), a safety and quality initiative to reduce preventable suicide deaths for people in our services, a new common intake point for youth services across State services and Commonwealth funded services, and new services for Older People.

At the same time work occurred in our Office to respond to the Oakden Report of the Independent Commissioner Against Corruption. This policy and response work has been on behalf of our Office, the Chief Executive of Health and the Minister. The recommendations from the Commissioner, and therefore our response, focuses on accountability and responsibility, and considers the governance of services, the enhanced regulation of mental health that is now in place post Oakden, and makes recommendations for future legislative change. This year has also been the first year of Board accountability for Local Health Networks, and it has been positive to see examples of Boards driving the vision for mental health in their services, or stepping up to address problems should they arise.

Information about our regulatory work is described in this report and the instances where our Office has used its gazettal powers, to place conditions on the operations of gazetted mental health services, are described. While we are proud of our regulatory work, and the analysis and consideration behind reports, it is important to note that the majority of problems we have highlighted have been brought to our attention by consumers and carers, frontline staff or executives of services. We have used our gazettal powers to draw a line in the sand to ensure that a problem is fixed, whether it be a building matter, or a clinical systems matter. While our intervention may be a catalyst, the success in addressing these issues rests with the services, and the lifting of conditions can be a good reason for local celebration, sometimes with a problem resolved that has been long standing.

During the year our Office also worked to convene a national work-group considering the process to review mental health standards. We have also looked at our own systems and how they might be improved. It is an irony that government and statutory Offices such as our own, that set and oversee standards, are generally not themselves subject to an accreditation regime – this is in contrast to the accreditation process that the health services we regulate regularly undergo. For this reason we have explored accreditation regimes that can cover the breadth of our Office's activities, and will commence the process in 20-21.

In March 2020 there was a dramatic pivot in our work towards COVID-19 mental health responses. Lines of effort were established to address the changes that were required to provide additional services, sustain existing functions, and have policies and services contingencies in place for inpatient, community team care, and non-government services. The Office developed a key liaison function with the COVID-19 Command Centre, and worked to support mental health care for people in quarantine.

I wish to thank our team in the Office for their extraordinary efforts this year across the range of work the Office covers. I also acknowledge the support of our key partners in undertaking this work, including people with lived experience, and those who work across the mental health and health sectors.

John Brayley
Chief Psychiatrist

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Acknowledgements

The Office of the Chief Psychiatrist is indebted to the contributors to this report without whom we would not be able to present this information. In particular, we thank the following for their assistance with data and analysis:

- Australian Bureau of Statistics.
- Data and Reporting Services, Commissioning and Performance, SA Department for Health and Wellbeing (DHW).

Data Caveat

This report contains an analysis and presentation of data regarding South Australian mental health service delivery during the ninth year of operation of the *Mental Health Act 2009*. The data has been obtained from various sources, which are not always directly comparable.

In some areas data is known to have quality issues and efforts will remain ongoing to improve the quality of this data. Care has been taken in the presentation, analysis and attribution of data so that the reader can more accurately interpret information that has been extracted from different datasets, services and time periods.

Chapter 1
Introduction

This chapter outlines the statutory role of the Chief Psychiatrist and the range of other roles and functions undertaken by the Office of the Chief Psychiatrist (OCP) during 2019-20. The *Mental Health Act 2009* (the Act) came into effect in 2010. It was reviewed in 2014 and subsequently amended in 2016 with these changes being proclaimed in June 2017.

1.1 Statutory Role and Function of the Chief Psychiatrist

The *Mental Health Act 2009* establishes the statutory position of the Chief Psychiatrist of South Australia (Section 89).

Section 90 of the Act outlines the functions of the Chief Psychiatrist.

90—Chief Psychiatrist's functions

(1) The Chief Psychiatrist has the following functions:

- (a) to promote continuous improvement in the organisation and delivery of mental health services in South Australia;
- (b) to monitor the treatment of voluntary inpatients and involuntary inpatients, and the use of restrictive practices in relation to such patients;
- (c) to monitor the administration of this Act and the standard of mental health care provided in South Australia;
- (d) 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;
- (e) any other functions assigned to the Chief Psychiatrist by this Act or any other Act or by the Minister.

(2) The Chief Psychiatrist may, issue standards that are to be observed in the care or treatment of patients.

(3) Any standards issued by the Chief Psychiatrist under this section will be—

- (a) binding on any hospital that is an incorporated hospital under the *Health Care Act 2008*; and
- (b) binding as a condition of the licence in force in respect of any private hospital premises under Part 10 of the *Health Care Act 2008*.

(4) The Chief Psychiatrist will—

- (a) have the authority to conduct inspections of the premises and operations of any hospital that is an incorporated hospital under the *Health Care Act 2008*; and
- (b) be taken to be an inspector under Part 10 of the *Health Care Act 2008*.

(5) For the purposes of subsection (4)(a), the Chief Psychiatrist may, at any reasonable time, enter the premises of an incorporated hospital and, while on the premises, may—

- (a) inspect the premises or any equipment or other thing on the premises; and
- (b) require any person to produce any documents or records; and
- (c) examine any documents or records and take extracts from, or make copies of, any of them.

Elsewhere in the Act additional functions are outlined to be undertaken by the Chief Psychiatrist. They are as follows:

- Acknowledge the receipt of forms for the making, and confirmation or revocation, of community treatment orders and inpatient treatment orders;
- Forward forms for the making, and confirmation or revocation, of community treatment orders and inpatient treatment orders to the South Australian Civil and Administrative Tribunal (SACAT);
- Ensure there is a mental health clinician with ongoing responsibility for the care, treatment and monitoring of a person subject to a treatment order;
- Determine a class of persons who are engaged in the care and treatment of patients as mental health clinician for the purposes of the Act;
- Determine a specified medical practitioner as an authorised medical practitioner for the purposes of the Act, and vary or revoke that determination;
- Determine a specified mental health professional as an authorised mental health professional for the purposes of the Act, and vary or revoke that determination;
- Receive communication via post from patients in treatment centres;
- Receive forms for the provision of emergency electro-convulsive therapy without the patient's consent;
- Receive matters referred by community visitors and the principal community visitor; and
- Request or approve actions by South Australian or interstate authorised officers or police officers for the administration of Part 10 cross-border arrangements.

Part 12, Division 2 Section 92 of the Act also establishes the requirement for the Chief Psychiatrist to present to the Minister an Annual Report before 30 September each year containing:

- In respect of the administrative functions conferred on the Chief Psychiatrist under this Act – information about how the Chief Psychiatrist has performed those functions;
- Community treatment orders and inpatient treatment orders in force during the preceding year;
- Demographics of the people subject to a treatment order during the preceding year; and
- Use of the cross-border arrangements of Part 10 of the Act.

1.2 Additional Roles and Functions of the Chief Psychiatrist

More broadly, the Chief Psychiatrist has a number of additional functions and roles within the Department for Health and Wellbeing, including:

- The development of a Mental Health Services Plan for South Australia (along with the SA Mental Health Commissioner) released in November 2019, and now currently being implemented;
- Development and implementation of the South Australian Suicide Prevention Plan, suicide prevention networks and suicide prevention community grants scheme. (These function remained with the Office of the Chief Psychiatrist in 19-20, however most have since transferred to Wellbeing SA in August 2020. The Office retains a clinical, professional and technical role in Suicide Prevention and will work closely with Wellbeing SA in 20-21 and beyond in this area) ;
- Provision of advice on Part 8(A) of the *Criminal Law Consolidation Act 1935* as it relates to mental health services and the responsibilities of the Minister for Health and Wellbeing;
- Development and implementation of Policy Directives and Policy Guidelines relating to the Act and mental health service provision;
- Oversight of mental health safety, quality and risk matters, and incidents;
- Oversight of mental health strategy and performance, and
- Represent South Australia at National Committees that relate to Mental Health Policy and its implementation and Mental Health Legislation, Safety and Quality

1.3 National Context

The Chief Psychiatrist is the jurisdictional representative for South Australia on national committees involved in mental health policy, legislation, safety and quality. During 2019-20 the Chief Psychiatrist is a member of the Mental Health Principal Committee (MHPC) and the Safety and Quality Partnership Standing Committee (a subcommittee of the MHPC).

The Mental Health Principal Committee was established as a sub-committee of the Australian Health Ministers' Advisory Council (AHMAC). In the first half of 2019-20 the Committee progressed with work on the following projects:

- Mutual recognition of mental health orders;
- The development of a National Digital Mental Health Policy Renewal
- National Mental Health Policy Renewal
- Continuation of the implementation of priorities in the 5th National Mental Health and Suicide Prevention Plan.

The Chief Psychiatrist was also the jurisdictional representative on the Mental Health Expert Advisory Group which was established under the Fifth National Mental Health Plan to advise AHMAC, through the MHPC on the implementation and of the Fifth Plan.

From March 2020 when COVID-19 was declared a pandemic the work of the Principal Committee shifted to providing input and advice on initiatives that could provide mental health support during the pandemic. The National Mental Health Pandemic Response Plan was developed by the National Mental Health Commission in April 2020 and was provided in draft form to the committee for their advice and input. The National Mental Health Pandemic Response Plan was formally released in May 2020. For further information on this and other national initiatives see **Chapter 5**

The Safety and Quality Partnership Standing Committee is a sub-committee of the Mental Health Principal Committee. In 2019-20 the Safety and Quality Partnership Standing Committee (SQPSC) which includes all Australian Chief Psychiatrists met three times. Subsequent to the declaration of COVID-19 as a pandemic a regular series of meetings between the jurisdictional Chief Psychiatrists has been established to discuss initiatives and issues that arise in the areas of mental health and safety and quality.

2019-2020 has seen significant changes to the operation of national committees with a number of changes to national processes currently being implemented following the establishment of National Cabinet. Mental health was a key focus at a national and state level with a number of initiatives introduced to prevent virus transmission but ensure access to health services and reduce the risk of emerging mental illness due to the personal, social and economic impact of COVID-19 on people's lives, and to respond to need as it emerged.

1.4 State Context

On 1 July 2020 the six regional Local Health Networks in country South Australia and the governing boards across each of the ten Local Health Networks commenced operation. The governing boards' functions include 'ensuring effective clinical and governance frameworks to support the maintenance and improvement of standards of patient care and services by the incorporated hospital and to approve those frameworks'.

The Mental Health Services Plan 2020-2025 was endorsed by government in October 2019 and released in November 2019. The Office of the Chief Psychiatrist will now move to overseeing the implementation of the plan over the next five years.

Impact of COVID-19

COVID-19 was declared by the World Health Organisation as a pandemic in March 2020. The early stages of the pandemic resulted in people across the state being required to stay at home and where possible move to working from home. This has impacted on the work of the Office of the Chief Psychiatrist the focus of the office moved to the planning and development of initiatives that could support the mental health of the community during the pandemic, support quarantine arrangements, contribute mental health expertise to the COVID command centre, and coordinate statewide policy and coordination related to the continuity of mental health services. This was while maintaining essential Office functions.

From May 2020 there was a return to a mix of policy and strategic work mixed with COVID-19 work which included the restarting of work including the implementation of the Mental Health Services Plan and training requirements under the *Mental Health Act 2009*. During the first wave of COVID-19 most of the Office worked remotely and then returned to a mixed model of working at home and in the office.

1.5 Mental Health Strategy Roles and Responsibilities

The statutory role of Chief Psychiatrist is combined with the Director of Mental Health Strategy within the Department for Health and Wellbeing and has been since early 2018. This creates a single point of mental health advice within SA Health.

The Chief Psychiatrist does not have an operational role. Within the Department commissioning of services and performance management is led by the Deputy Chief Executive Commissioning and Performance, and infrastructure is the responsibility of the Deputy Chief Executive of Corporate and System Support Services.

The Local Health Networks remained responsible for the day to day operations of mental health services. This included the management of all complaints and critical incidents; ensuring clinical service standards and National Health Care Standards for their services are met; and complying with local governance and state-wide mental health policies and guidelines.

1.6 The Office of the Chief Psychiatrist

During 2019-20 the Office of the Chief Psychiatrist carried out the roles and functions described in this report with a staff of 32.9 FTE funded through the Department for Health and Wellbeing and a staff of 6 FTE funded through the Central Adelaide Local Health Network. The CALHN employed staff have strategic and work reporting lines to the Chief Psychiatrist but have line management reporting within CALHN.

Executive Team – 2FTE Chief Psychiatrist Director Mental Health Planning Policy and Safety
Legislative and Policy Team – 4.6FTE ASO8 Manager, ASO7 Principal Policy Officer, ASO7 Principal Training Officer, ASO7 Accountability and Compliance Project Officer, ASO3 Order Compliance Officer.
Planning and Performance Team – 3.5FTE ASO8 Manager, ASO7 Principal Project Officer, ASO7 Planning Project Officer, ASO6 Senior Project Officer.

Resource Allocation Team – 2FTE ASO8 Manager, ASO-7 Principal Contracts Project Officer.
Consultants and Corporate Team – 7.2FTE ASO8 Principal Officer, ASO7 Principal Aboriginal Mental Health Officer, ASO6 Lived Experience Project Officer, ASO4/5 Carer Consultant, ASO 4/5 Consumer Consultant, ASO5 Ministerial and Project Officer, ASO4 Executive Project Support Officer, ASO3 Executive Assistant to the Chief Psychiatrist.
Suicide Prevention Team – 4FTE ASO8 Principal Suicide Prevention Officer, 3 ASO7 Suicide Prevention Officers – one permanent, two temporary.
Training Centre Team – 3FTE ASO8 Manager, AHP3 Training Officer, RN3 Training Officer.
Safety and Quality Team – 3FTE (employed by CALHN) ASO8 Manager, ASO7 Risk Manager, ASO2 Project Support Officer. **Permanent Staff – 2FTE (employed by OCP)** 2x RN3/AHP3/ASO7 Safety and Quality Project Officers (Safety monitoring, inspections, investigations) **Temporary staff – 2FTE (employed by OCP)** RN3/AHP3/ASO7 Safety and Quality Project Officers (Safety monitoring, inspections, investigations) ASO7 Inspection Project Officer (Safety data system establishment)
Information Management and Performance Monitoring Team – 3FTE (Statewide roles in strategy and reporting and employed by CALHN) CALHN: RN4 Manager, ASO7 Chief Reporting Officer, ASO7 Data Analyst.
Temporary Project Staff – 2.6FTE ASO8 Manager Older Persons Mental Health Reform Project, ASO4 Project Officer, Older Persons Mental Health Reform Project, ASO6 Aboriginal Mental Health Project Officer.

Chapter 2
Administration of the Mental Health Act 2009

One of the Chief Psychiatrist's primary functions is the monitoring of the administration of the *Mental Health Act 2009* (the Act). The Office of the Chief Psychiatrist undertakes a variety of tasks associated with ensuring the Act is applied consistently. The following chapter outlines the work undertaken in 2019-20.

During 2019-20 only one person was appointed by the Governor to the position of Chief Psychiatrist as per the *Mental Health Act 2009*.

Table 1 – Chief Psychiatrists

Name	Commenced	Ended
Dr John Brayley	7 May 2018	Appointed for a 5 year term

2.1 Advice

The Office of the Chief Psychiatrist received over 2000 telephone calls and emails requesting advice and support about the Act from consumers, carers, mental health services, general health services, Departmental branches, Government agencies and statutory offices.

2.2 Authorisations and Delegations

Authorisations

No authorisations were made by Directors of Treatment Centres during 2019-20.

Chief Psychiatrist Delegations

The Chief Psychiatrist can delegate powers and functions to a particular person or to a particular position in accordance with section 91 of the Act. During 2019-20 the following delegations were either made by the Chief Psychiatrist or were in place:

Table 2 – Chief Psychiatrist Delegations

Inspection powers. S 90(4), 90(5).		
OCP Staff	11/7/18 – 11/7/19; 24/4/19 – 31/11/19; 11/4/19-31/12/19; 03/06/19 – 30/12/19; 1/7/19 – 7/2/20; 3/6/19 – 31/12/19;3/6/19 – 31/12/19	
External Experts	Dr Peter Norrie (ACT)	4/1/20 – 31/3/20
	A/Prof Christopher Ryan (NSW)	11/10/19 – 31/12/19 & 24/2/20 – 30/6/20
	Dr Viki Pascu (WA)	22/7/19
	Dr Jane Casey (New Zealand)	13/10/19 – 15/10/19
	Ms Margaret Keville (SA)	3/6/19 – 31/12/19
Members of the Prescribed Treatment Panel (delegations to assist with investigations and	Dr Belinda Edwards	3/12/18 – 3/12/19 6/3/20 – 14/12/20
	Associate Professor Bernadette Richards	3/12/18 – 3/12/19 6/3/20 – 14/12/20
	Dr Cecil Camilleri	3/12/18 – 3/12/19

inspections)		6/3/20 – 14/12/20
	Ms Judy Smith	3/12/18 – 3/12/19 6/3/20 – 14/12/20
	Dr Shane Gill	3/12/18 – 3/12/19 6/3/20 – 14/12/20
	Ms Tara Simpson	3/12/18 – 3/12/19 6/3/20 – 14/3/20
	Dr Thomas Paterson	3/12/18 – 3/12/19 6/3/20 – 14/3/20
Operational powers and functions, such as ensuring every patient has a care coordinator. S 14, 19, 68(6), 69(2a), 70(4), 71(2a), 79(4), 81(3).		
Directors of Treatment Centres – To delegate operational powers to services where they can be carried out		Ongoing
Powers to chair the Prescribed Treatment Panel, take cross-border actions, gazette an Approved Treatment Centre, gazette an Authorised Community Mental Health Facility and to monitor the Act and mental health services. S 41(d) S 63(2), 66(2), 69(1), 69(2), 70(1), 90(1) 90(4) and 90(5) 96, 97A		
Dr Brian McKenny, Clinical Director, Mental Health, BHFLHN: Short-term Acting Chief Psychiatrist		4/7/19 – 20/7/19
Powers to monitor the Act and Mental Health Services. 90 (1) (a)		
Dr Duncan McKellar, Head of Unit, Older Persons Mental Health, NALHN: Acting Chief Psychiatrist for the purpose of taking part on the SALHN clinical Director selection panel		21/8/19 – 30/11/19
Powers to take cross-border actions, gazette an Approved Treatment Centre, gazette an Authorised Community Mental Health Facility and to monitor the Act and mental health services. S 63(2), 66(2), 69(1), 69(2), 70(1), 90(1) 90(4) and 90(5) 96, 97A		
Dr Mohammed Usman, Clinical Director, Child and Adolescent Mental Health, WCHN: Short Term Acting Chief Psychiatrist		4/10/19 – 10/10/19
Powers to monitor the Act and mental health services. 90(1) 90(4) and 90(5) 96, 97A		
Dr Duncan McKellar, Head of Unit, Older Persons Mental Health, NALHN. Any issues that arise during the period in relation to the Women's and Children's Health Network		4/10/19 – 10/10/19
Powers to chair the Prescribed Treatment Panel, take cross-border actions, gazette an Approved Treatment Centre, gazette an Authorised Community Mental Health Facility and to monitor the Act and mental health services. S 41(d) S 63(2), 66(2), 69(1), 69(2), 70(1), 90(1) 90(4) and 90(5) 96, 97A		
Dr Mohammed Usman, Clinical Director, Child and Adolescent Mental Health, WCHN: Short Term Acting Chief Psychiatrist		10/10/19 – 13/10/19
Powers to chair the Prescribed Treatment Panel, take cross-border actions, gazette an Approved Treatment Centre, gazette an Authorised Community Mental Health Facility and to monitor the Act and mental health services. S 41(d) S 63(2), 66(2), 69(1), 69(2), 70(1), 90(1) 90(4) and 90(5) 96, 97A		
Dr Mohammed Usman, Clinical Director, Child and Adolescent Mental Health, WCHN: Short Term Acting Chief Psychiatrist		14/10/19 – 20/10/19
Powers to chair the Prescribed Treatment Panel, take cross-border actions, gazette an Approved Treatment Centre, gazette an Authorised Community Mental Health Facility and to monitor the Act and mental health services. S 41(d) S 63(2), 66(2), 69(1), 69(2), 70(1), 90(1) 90(4) and 90(5) 96, 97A		
Dr Brian McKenny, Clinical Director, Mental Health, BHFLHN: Short-term Acting Chief Psychiatrist		16/1/20 – 19/1/20
Powers to chair the Prescribed Treatment Panel, take cross-border actions, gazette an Approved Treatment Centre, gazette an Authorised Community Mental Health Facility and to monitor the		

Act and mental health services. S 41(d) S 63(2), 66(2), 69(1), 69(2), 70(1), 90(1) 90(4) and 90(5) 96, 97A	
Dr Mohammed Usman, Clinical Director, Child and Adolescent Mental Health, WCHN: Short Term Acting Chief Psychiatrist	4/1/20 – 15/1/20

2.3 Community Visitors Scheme

The Community Visitor Scheme (CVS) is established under sections 50 to 54 of the Act. The purpose of the CVS is to be an independent statutory agency and to conduct visits and inspections of facilities that provide treatment and care to people with mental illness, to advocate for the proper resolution of issues and to refer matters of concern to the service, the Chief Psychiatrist or the Minister.

The Chief Psychiatrist corresponds and meets regularly with the Principal Community Visitor, in addition to considering urgent matters as they arise. The Office of the Chief Psychiatrist contributes to training and orientation sessions for Community Visitors on the Act.

In addition, the Community Visitor Scheme has worked in partnership with the Office of the Chief Psychiatrist, other Departmental branches and the Local Health Networks to review and implement the recommendations of the Oakden Report of the Independent Commissioner Against Corruption.

On 13 September 2019 Maurice Corcoran stepped down as the Principle Community Visitor. Maurice was appointed as the first Principal Community Visitor in 2011. Anne Gale was appointed as Acting Principle Community Visitor from 14 September 2019.

2.4 Cross-Border Arrangements

The Office of the Chief Psychiatrist provides advice and support to South Australian and interstate mental health services, consumers and families regarding the options available for treatment, transport and transfer of South Australians who are subject to the SA Act who are interstate and interstate people who are subject to interstate Acts who are in South Australia

During 2019-20 inquiries regarding 22 People were received pertaining to treatment, transport or transfer between South Australia and other jurisdictions. One international inquiry was received for available options for treatment, transport and transfer of people for or to overseas.

2.5 Education, Training and Support

The OCP provides education, training and support to health services, other government agencies and consumers and carers about the Act. This work is in addition to the broader mental health training and education provided by the SA Mental Health Training Centre. In 2019-20 education and training was provided about:

- *Mental Health Act 2009*;
- Authorised Mental Health Professional powers and functions;
- Authorised Officer powers and functions;
- Cross-border arrangements;
- Decision making capacity;
- The legal requirements for Documentation;
- ECT requirements of the Act;
- Forms;
- Guardianship and section 32 powers;
- Least restrictive practice;

- Making and confirming/revoking treatment orders;
- Mental Health and Emergency Services Memorandum of Understanding;
- Rights of consumers and carers;
- Safe searching techniques for Authorised Officers;
- Section 56 care and control;
- Statements of rights; and
- Treatment orders.

Education and training was provided to a broad range of partners and stakeholders. Education and training for hospitals was provided to mental health staff, emergency department staff and medical ward staff. Over 1213 people from the following agencies and groups were provided with education and training about the Act in 2019-20:

Berri Hospital ED and Community Mental Health Services, Ceduna Hospital, Club 84 -The Gully, Community Visitor Scheme, Correctional Services facilities-Adelaide Remand Centre, Yatala, & Mt Gambier, Country General Practitioners at Berri & Mt Gambier, Cowell/Cleve Hospital, Eastern(Tranmere) Community Mental Health Service, Flinders University, Flinders Medical Centre, Margaret Tobin Centre, Glenside Campus including Jamie Larcombe Centre, Headspace Adelaide, James Nash House, Home Support Services Fullarton, Hughes & Hawkins GP Clinics, Inner South (Marion) Community Mental Health Service, Karoonda & Lameroo Hospital, Lived Experience Group, Lyell McEwin Health Service ED & MH, Modbury Hospital, Mt Gambier Hospital, Noarlunga Health Service medical officers and clinicians, North Eastern (Modbury) Community Mental Health Service, Northern (Salisbury) Community Mental Health Service, Outer South (Noarlunga) Community Mental Health Service, Pinnaroo & Lameroo Hospital, Port Augusta Hospital, Pt Lincoln Hospital, Royal Flying Doctor Service, Port Lincoln Hospital, Quorn Hospital, Queen Elizabeth Hospital ED, Cramond Clinic & Ward SE Older Persons, QEH Medical Officers, Royal Adelaide Hospital, Royal Flying Doctor Service, Roxby Downs Hospital, Western (Woodville) Community Mental Health Service, Whyalla Hospital & Wudinna Hospital.

Of note eleven training session had to be cancelled due to safety requirements in relation to COVID-19.

2.6 Facilities

The Chief Psychiatrist can determine public incorporated hospitals and private licensed hospitals as approved treatment centres or limited treatment centres under sections 96 and 97 of the Act, and can determine public and private community health services as authorised community mental health facilities under section 97A of the Act. For a full listing of facilities see **Appendix One**

During 2019-20 the following determinations were made and published in the SA Government Gazette regarding facilities:

Approved Treatment Centres

Gazettal of New Services:

Adelaide Clinic, Ramsay Health

- NOTICE is hereby given of the variation of the previous determination, published in the Government Gazette on 30 May 2017, of the Adelaide Clinic, 33 Park Terrace, Gilberton, SA 5081 as an Approved Treatment Centre. The new Rose Ward at The Adelaide Clinic at 33 Park Terrace, Gilberton, SA 5081, will be included in the facility's determination as an Approved Treatment Centre. This variation commences 18 December 2019.

Limiting Conditions Placed on existing services:

Flinders Medical Centre, SALHN

- Flinders Medical Centre, Flinders Drive, Bedford Park, SA 5042, 21 November 2019 subject to new temporary conditions
    - May continue to admit patients subject to Inpatient Treatment Orders to the Margaret Tobin Centre Ward 5J Psychiatric Intensive Care Unit (PICU) subject to the following conditions:
        - The ward can admit patients who require short stay PICU care with an anticipated length of stay up to 5 days.
        - Patients who require longer admission, or are expected to require a longer admission, can only be admitted following an assessment of their needs against the physical condition and capability of the unit. This will be with the approval of the Clinical Director of the Mental Health Division of the Southern Adelaide Local Health Network, or the Head of Unit, Margaret Tobin Centre.
        - Patients who are either subject to an order under Part 8A of the Criminal Law Consolidation Act 1935, or are prisoners (persons committed to a correctional institution pursuant to an order of a court or a warrant of commitment) subject to an Inpatient Treatment Order, will only be admitted for PICU care by exception. This will be after an assessment of their needs against the physical condition and capability of the unit and with the approval of the Clinical Director of the Mental Health Division of the Southern Adelaide Local Health Network, or the Head of Unit, Margaret Tobin Centre.

James Nash House, NALHN

- James Nash House, 140 Hilltop Drive, Oakden, SA, 5086, 21 November 2019 subject to new temporary conditions
    - James Nash House may continue to admit acute and subacute patients, subject to Inpatient Treatment Orders or orders under Part 8A of the Criminal Law Consolidation Act 1935, to Aldgate and Birdwood wards, subject to the following conditions:
        - An assessment of patient needs against the physical condition and capability of the unit must occur before admission and, where admission proceeds, this assessment must inform the contents of the patient's treatment and care plan. Admissions will only be with the approval of the Clinical Director, Forensic Mental Health Service, Division of Mental Health, Northern Adelaide Local Health Network.
        - James Nash House must maintain a temporary risk management plan for both wards, which must be approved by the Chief Psychiatrist. The plan will address clinical care in the context of the physical condition of the wards and will remain in place until remedial works have occurred.

Royal Adelaide Hospital, CALHN

- Royal Adelaide Hospital, Port Road, Adelaide, SA, 5000, 25 June 2020 until 25 September 2020 subject to new temporary conditions
    - The Emergency Department may continue to operate as a Department providing emergency mental health care to voluntary and involuntary patients under the Mental Health Act 2009, providing that:
        - An intervention plan, approved by the Chief Psychiatrist, is in place to monitor and manage the quality and safety of care in the Department.

Limiting Conditions Revoked on an Existing Facility

Modbury Public Hospital, NALHN

- Modbury Public Hospital, 41-69 Smart Road, Modbury, SA, 5092, 21 November 2019, conditions previously gazetted are now revoked
    - The conditions gazetted on 3 January 2019 applying to the operation of Woodleigh House, Modbury Hospital, 41-69 Smart Road, Modbury SA 5092, are hereby revoked and Modbury Hospital can operate as an Approved Treatment Centre without conditions or limitations.

Authorised Community Mental Health Facility

The Borderline Personality Disorder Collaborative, BHFLHN

- BPD Collaborative will be an Authorised Community Mental Health Facility from 8 August 2019

Older Persons Mental Health Service – Southern Community Team – Springbank House, SALHN

- NOTICE is hereby given, in accordance with Section 97A of the Mental Health Act 2009, that the Chief Psychiatrist has determined from 23 March 2020 that: Building Block C of the Repatriation Health Precinct, 216 Daws Road, Daw Park SA 5054, will be an Authorised Community Mental Health Facility known as: Older Persons Mental Health Service – Southern Community Team – Springbank House.

Limited Treatment Centre

- There were no Limited Treatment Centres during 2019-20 and no determinations made.

2.7 Forms

The Chief Psychiatrist is responsible for drafting and publishing the forms required by the Act to undertake certain powers and functions. In 2019-20 there were 21 forms required to carry out and/or document certain powers and functions. No Act forms were created, varied or revoked during that time. For a list of the forms see **Appendix Two**.

All forms and determinations must be published on the internet and can be found here: https://www.chiefpsychiatrist.sa.gov.au

2.8 Legal Representation Scheme

The Act allows for a person, who is dissatisfied with a CTO or ITO made by a health professional, to request a review of that treatment order by SACAT.

Section 84 of the Act provides that a person who requests a review by SACAT of a treatment order made by a health professional is entitled to legal representation under a scheme established, and funded, by the Minister for Health and Wellbeing.

That Legal Representation Scheme is administered by the Legal Services Commission of South Australia under a Memorandum of Administrative Arrangement between the Minister for Health and Wellbeing, the Attorney-General, SACAT and the Legal Services Commission.

The SACAT Legal Representation Scheme figures for the 2019-2020 financial year as it relates to matters under the Mental Health Act only are as follows:

1. **Reviews appeals to SACAT regarding decisions by a treating psychiatrist/or treating team.**

- 310 total matters where legal presentation was provided for the 2019-2020 financial year consisting of:
    - 283 in regards to Level 2 ITOs
    - 11 in regards to Level 1 ITOs
    - 10 in regards to Level 1 CTOs
    - 6 in regards to Level 2 ITOs (being the second and subsequent Level 2 ITO)

2. **Internal Reviews appeals to SACAT in relation to decisions by SACAT in its original jurisdiction**

- 64 total matters where legal representation was provided for only in relation to disputes only under the Mental Health Act in the 2019-2020 financial year:
    - 49 in regards to Level 2 CTOs
    - 11 in regards to Level 3 ITOs
    - 4 in regards to ECT

2.9 Mental Health and Emergency Services Memorandum of Understanding 2010

The *Mental Health Act 2009* requires that a memorandum of understanding between relevant agencies be developed to describe the "exercise of powers relating to persons who have or appear to have mental illness and the provision of other assistance to enable or facilitate the medical examination or treatment of such persons." (section 59(1)).

Originally drafted in 2010, the Mental Health and Emergency Services Memorandum of Understanding (the MoU), has undergone a significant review process through 2019 -2020. The Review is overseen by the MoU Steering Committee (chaired by the Chief Psychiatrist) with representation from OCP, Mental Health, SAPOL, SAAS, RFDS, with plans to include Emergency Department and Consumer and Carer representatives in the latter half of 2020 (which has been subsequently implemented).

The MoU describes the collaborative intent and processes needed between relevant agencies to ensure that mental health consumers receive timely assessment and treatment in an appropriate setting. Sections 54A, 55, 56 and 57 of the *Mental Health Act 2009* are of particular relevance to the cooperation and function of partner agencies. The overarching premise of the MoU is that each individuals rights are protected at all times, and any intervention to provide assessment and treatment is undertaken with a least restrictive practice and trauma informed care approach, with a view to these activities being undertaken in a timely manner.

Review and re-drafting is in significant advancement and expected to be signed off by the Minister for Health and Wellbeing and the Minister for Police, Emergency Services and Correctional Services during 2020 -2021

2.10 Officers Authorised under the Act

The Chief Psychiatrist can determine individuals, or classes of professionals, to have specific powers and functions under the Act as an Authorised Officer, Authorised Mental Health Professional, Authorised Medical Practitioner or Mental Health Clinician under sections 3(1), 94, 93 and 3(1) respectively.

Authorised Officers

Authorised Officers are usually the first service providers to encounter a person when they may be mentally unwell and at risk, and have a number of powers and functions including taking a person into care and control, transporting a person, restraining a person (only if reasonably required), and searching a person and removing items if they pose a risk. All of these powers can only be used to facilitate the assessment and/or treatment of a person.

Subsection 3(1) of the Act defines authorised officers as mental health clinicians, SA Ambulance Service officers and Royal Flying Doctor Service medical practitioners and flight nurses. In addition, the Chief Psychiatrist can determine other classes of people as authorised officers through the SA Government Gazette.

During 2019-20 the following were gazetted in the SA Government Gazette as Authorised Officers:

- Nurse Practitioner – Drug and Alcohol Services, DASSA

For a full listing of authorised officers during 2019-20 see **Appendix Four**.

The OCP provides training and support to existing and new sites and services with authorised officers, considers applications for new classes and sites, manages the determinations through the SA Government Gazette and maintains records.

Authorised Mental Health Professionals

Authorised Mental Health Professionals (AMHPs) are a key component of the Act and the SA mental health system. AMHPs are senior mental health clinicians who must undertake additional training and continuing professional development to be able to carry out the role. In addition to being mental health clinicians and authorised officers, and having the attendant powers and functions of those positions, AMHPs can make level 1 Community Treatment Orders and level 1 Inpatient Treatment Orders to ensure people who are unwell get immediate access to the treatment and care they need. A treatment order made by an AMHP must be reviewed by a psychiatrist within 24 hours, or as soon as practicable.

During 2019-20, 22 senior mental health clinicians became AMHPs for the first time, 29 former AMHPs ceased their practice, 57 existing AMHPs had their determination renewed and 27 are not currently working in an AMHP role until their registrations have been renewed.

As of 30 June 2020 there were 184 registered AMHPs in South Australia,

The OCP provides training and support to existing and new AMHPs, considers applications for new AMHPs, manages the determinations through the SA Government Gazette and maintains records.

During 2019-20 the determination for 79 senior mental health clinicians as Authorised Mental Professionals were gazetted in the SA Government Gazette on the following dates:

- 4 July 2019, 25 July 2019, 8 August 2019, 29th August 2019, 12 September 2019, 26 Sept 2019, 31 October 2019, 14 November 2019, 12 December 2019, 19 December 2019, 12 March 2020, 2 April 2020, 28 May 2020, 25 June 202

Authorised Medical Practitioners

Authorised Medical Practitioners (AMPs) are an additional role created by the Act to allow appropriate medical practitioners who have significant psychiatric experience to carry out most of the powers and functions of psychiatrists, except those relating to prescribed psychiatric treatment. In practice this means that AMPs can review treatment orders made by other health professionals to confirm or revoke them, and can authorise medication and other treatment for patients they have assessed. AMPs are:

- Senior Psychiatric Registrars who have passed all of their examination requirements but have not as yet been fully accredited by the Royal Australian and New Zealand College of Psychiatrists and Australian Health Practitioner Regulation Agency, or
- Internationally trained psychiatrists who have qualifications that are not yet recognised in Australia.

An AMP candidate from either group must have undertaken specific AMP training from the South Australian Psychiatric Training Committee.

During 2019-20 there were 26 senior psychiatric trainees or overseas trained psychiatrists trained, nominated and subsequently determined as Authorised Medical Practitioners which were gazetted in the SA Government Gazette on the following dates:

- 5 July 2019, 12 September 2019, 24 September 2019, 12 December 2019, 12 March 2020, 19 March 2020, 26 March 2020, 9 April 2020 and 4 June 2020.

The OCP considers applications for new AMPs, manages the determinations through the SA Government Gazette and maintains records.

Mental Health Clinician

Mental Health Clinicians (MHCs), as determined by the Chief Psychiatrist in accordance with the Act, are tertiary qualified occupational therapists, psychiatrists, psychologists, registered nurses and social workers who are employed by a public or private mental health service. The Act provides MHCs with certain powers and functions, such as making a patient assistance request or a patient transport request, and also empowers them as Authorised Officers.

The Act's definition, and Chief Psychiatrist determination, of particular groups of health professionals as MHCs is only relevant to the use of the Act and has no impacts otherwise.

The OCP considers applications for new professions to be made MHCs, manages the determinations through the SA Government Gazette and maintains records.

During 2019-20 there were no determinations of individuals or classes of professionals as MHCs via the SA Government Gazette

2.11 Prescribed Psychiatric Treatment Panel

Establishment

The Prescribed Psychiatric Treatment Panel (the Panel) is established under Part 7 of the Act and has been recognised as a Government Committee through Cabinet. The Panel commenced operation in March 2018.

Functions of the Panel

The Panel is convened by the Chief Psychiatrist, to oversee complex Electro Convulsive Therapy (ECT) clinical matters and all applications for neurosurgery for mental illness. The Panel also has the capacity to seek the making of regulations to address new treatments as they emerge. It has been recommended that emerging treatments requiring regulation should be submitted to a Panel for consideration from an ethical, legal and medical perspective. The powers and functions for this oversight work are granted under sections 41C, 43 and 44 of the Act. In addition, Panel members are delegates under section 91 for the purpose of ECT suite inspections and ECT incident reviews. Under the ECT Standard, ECT facilities will be inspection every three years.

The Panel provides oversight of people receiving ECT by:

- Conducting a review of the progress of a patient who has, in the course of any 12 month period, received 3 or more courses of ECT treatment; and
- Conducting a review of the progress of a patient to whom, in the course of any 12 month period, 2 or more episodes of emergency ECT without consent have been administered.

Panel Membership

The Panel comprises Dr John Brayley, the Chief Psychiatrist, and 8 other members appointed by the Governor, comprising:

- Dr Cecil Camilleri – Consumer member
- Dr Terence Coyne – Neurosurgeon
- Dr Belinda Edwards – Senior Psychiatrist
- Dr Shane Gill – Senior Psychiatrist
- Dr Tom Paterson – Senior Psychiatrist
- A/Professor Bernadette Richards – Bioethicist
- Ms Tara Simpson – Legal practitioner
- Ms Judy Smith AM – Carer member

Panel Administration

The OCP administers the Panel through the provision of an Executive Officer, who manages day to day operations and the development and maintenance of processes, templates and systems.

In 2019-20, the OCP supported the Panel joining the secure video conference system, Digital Telehealth Network.

When a trigger number of ECT Consents or an emergency ECT treatment has been reached, the Panel requests a report by the treating psychiatrist, or may receive a report prepared by a treating psychiatrist on their own initiative. Once received, documentation relating to that case is considered by one psychiatry and one non-psychiatry Panel member, who present their detailed review of the

case to the entire Panel, which then makes observations, and recommendations if required, relating to the progress of the patient.

On occasion a systemic matter may arise and the Panel can follow up with the relevant hospital or agency, such as the Public Advocate or the South Australian Civil and Administrative Tribunal (SACAT). The Panel acknowledges the additional work needed by psychiatrists and ECT teams to comply with Act and Panel requirements. The Panel will continue to work towards improving and streamlining processes and welcomes feedback from consumers, carers, mental health services and practitioners, and partner agencies to do so. Consultation on a draft procedure for panel proceedings will be taking place in 2020-21.

Panel Proceedings

The Panel meets monthly apart from January, and was convened 11 times in 2019-20.

ECT Consent Progress Reviews

In accordance with subsection 41C(a), the Panel reviewed the progress of 35 patients who had three or more Form MHMHA-L ECT consents during 2019-20. The Panel deemed all cases and consents clinically appropriate and indicated. In three cases, the Panel made additional suggestions for consideration by the treating team. In addition the Panel regularly provides feedback and comment to practitioners, as part of the review process, and in a number of instances sought additional information.

Emergency ECT Progress Reviews

In accordance with subsection 41C(b), the Panel reviewed the progress of 17 patients who had two or more Form MHMHA-M emergency ECT episodes during 2019-20. The Panel deemed all cases as clinically appropriate and indicated. For three cases, the Panel wrote to SACAT to receive information on scheduling timeframes for hearings. The Panel also wrote to the Office of the Public Advocate to get information on the circumstances on a response for urgent request for assistance; it requested information on the circumstances of ECT patient discharge, and made an observation of timeliness of an Emergency ECT form signed, and treatment received.

Other Functions

The Chief Psychiatrist uses the expertise of the Panel to assist with other matters from time to time. In 2019-20 this other work comprised:

- a case review of an inpatient to determine if the standard of care and administration of ECT was reasonable and appropriate given their clinical condition and circumstances;
- reviewing incidents relating to ECT made into the SA Health Safety Learning System;
- inspecting an ECT Suite, under delegated inspection powers;
- releasing the Chief Psychiatrist ECT Standard and the ECT Policy Guideline;
- releasing an information sheet on the Effect of an Advance Care Directive that refuses ECT; and
- releasing an information sheet on Legal authority for the use of restrictive practice (force) to administer ECT treatment.

The need to clarify legal authority for restraint, and then inform the sector emerged from two earlier case reviews undertaken by panel members – cases that were identified by considering Safety Learning System reports. The need to re-communicate the binding status of Advance Care Directive refusal was identified in discussions emerging from ECT progress reviews (although there were no cases identified where advance care directives had not been followed).

Neurosurgery for Mental Illness

There were no cases requiring Panel consideration of an application for neurosurgery for mental illness in 2019-20.

Other Prescribed Psychiatric Treatment

There were no regulations relating to other prescribed psychiatric treatment considered during 2019-20.

2.12 South Australian Civil and Administrative Tribunal

The South Australian Civil and Administrative Tribunal (SACAT) is the independent statutory agency that makes and reviews matters relating to mental health treatment orders, guardianship and administration orders, advance care directives, and consent to medical treatment and palliative care. The Act allows a person who has been made subject to a treatment order to request a review of that order by SACAT.

The OCP and SACAT liaise regularly about matters that have come to the attention of either agency, particularly health professional practice and SACAT member practice that may impact on the health and safety of vulnerable people and on the capacity of mental health services and SACAT to carry out their role and functions.

2.13 Statements of Rights

The Chief Psychiatrist is responsible for drafting and publishing the statements of rights required by the Act under certain circumstances. In 2019-20 there were five statements of rights required by the Act. No statements of rights were created, varied or revoked during that time. For a list of the statements of rights see **Appendix Two.**

All statements of rights are available here:
https://www.chiefpsychiatrist.sa.gov.au

2.14 Treatment Order Compliance

The OCP provides systems, training and support to the LHNs to manage and improve Community Treatment Order and Inpatient Treatment Order compliance, to ensure that forms and processes are used in accordance with the Act. The management of treatment order compliance includes the entry of all orders into CBIS (as the statewide data system used to record treatment orders), the correction of errors or omissions at a local level, and a copy of all orders to be kept by the OCP.

During 2019-20 the OCP:

- Trained 17 new LHN compliance officers.
- Provided advice, support and problem-solving to the LHN compliance officers.
- Provided the treatment order compliance function for SACAT-made orders.

Table 3 – Level 1 Inpatient Treatment Order Compliance 2019-20 - Percentage

LHN	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Average Compliance
CALHN	99	100	100	96	97	97	97	97	97	94	95	95	97
BHFLHN	86	100	93	93	100	100	97	89	91	95	88	97	94
EFNLHN	100	100		100	100				100				100
FUNLHN	100	100	100	100	92	100	100	100	91		80	100	96
LCLHN	100	100	100	100	100	100	100	100	100	100	100	100	100
NALHN	100	100	99	99	99	100	96	95	99	96	98	95	98
RMCLHN	100	100	100	100	100	100	89	100	100	60	100	100	95
SALHN	80	86	79	77	80	75	77	71	60	69	73	72	75
WCHN	100	100	100	100	100	100	100	100	89	100	100	100	99
YNLHN					100							100	100

Chapter 3
Profile of People Accessing Mental Health Services

The South Australian Government's public mental health system provides services throughout the state to people who may need access, treatment and support. This chapter provides some detail about the demographic features of the people who accessed this care and support.

3.1 Demographics of People Accessing SA Mental Health Services

People who Accessed Community Mental Health Services

Gender

In 2019-20 as in previous years, the gender breakdown of people who access community mental health settings is consistent with the state population. However males are over-represented in those admitted to Community Rehabilitation Centres (CRCs) with the rate being close to twice the rate of females. This gender difference is replicated amongst all people on a Community Treatment Order (CTO) where males out number females by almost two to one. The gender ratio for people admitted to an Intermediate Care Centre (ICC) is slightly higher for females than males.

Table 4: Gender representation in community mental health settings

Gender	SA Pop	CMHS	ICC	CRC	All CTOs
Female	50.6	50.2	56.1	34.6	31.4
Male	49.4	49.5	43.5	65.4	68.6

Source: CBIS, HIP, ABS 3235.0 Population by Age and Sex, Regions of Australia.

Aboriginal and Torres Strait Islander (ATSI) Status

The latest ABS data estimates the number of Aboriginal and Torres Strait Islander People residing in South Australia as 45022. The data represents an underestimation of the true utilisation as some people do not identify their Aboriginal, Torres Strait Islander or other heritage when entering a service. With this caveat the data for 2019-20 shows the same pattern as previous years with ATSI people more likely than non-ATSI people to access services in all types of community mental health settings with the exception of Intermediate Care Centres.

Table 5: People who identified as ATSI who accessed community mental health settings

	SA Pop	ICC	CRC	CMHS	All CTOs
Number	45022	4	41	3294	212
Percentage	2.6	2.6	4.5	7.9	9.5

Source: CBIS, HIP, ABS 3238.0 Estimates and Projections, ATSI Australians 2016 to 2031.

Age

The age distribution of people who accessed community based mental health services is shown in **Table 6. Figure 1** shows the comparison of age breakdown of the South Australian population compared to those who access Community Mental Health Services. This shows the same general trend as in previous years. That is, for people from the age of 16 through to 44 there is a higher proportion in contact with mental health services than the general population, whilst in people aged 65 through to people over 85 the proportion is less than the general population. This trend is consistent with stage-of-life epidemiological data relating mental illness.

Table 6: Age in community mental health settings

Age Group	SA Pop		CMHS		ICC		CRC	
	No	%	No	%	No	%	No	%
0-15	330077	18.8	5560	13.2				
16-24	199750	11.4	7978	19.0	111	12.2	33	21.2
25-34	234886	13.4	7374	17.6	231	25.4	46	29.5
35-44	217793	12.4	6685	15.9	203	22.3	29	18.6
45-54	225436	12.8	5647	13.5	194	21.3	35	22.4
55-64	221686	12.6	3828	9.1	141	15.5	13	8.3
65-74	182453	10.4	2411	5.7	31	3.4		
75-84	101472	5.8	1483	3.5				
85+	45632	2.6	689	1.6				
Unknown			310	0.7				
Total		**100**	**41965**	**100.0**	**911**	**100**	**156**	**100**

Source: CBIS, HIP, ABS 3235.0 Population by Age and Sex, Regions of Australia

Figure 1: Age in community mental health services

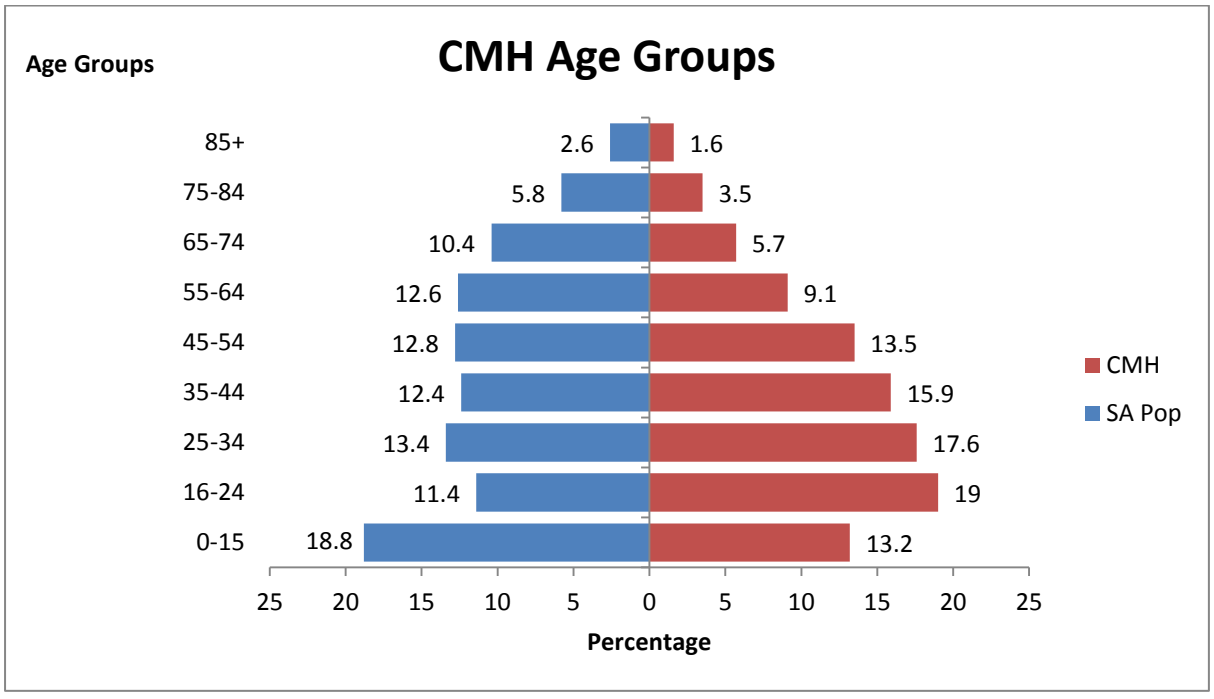
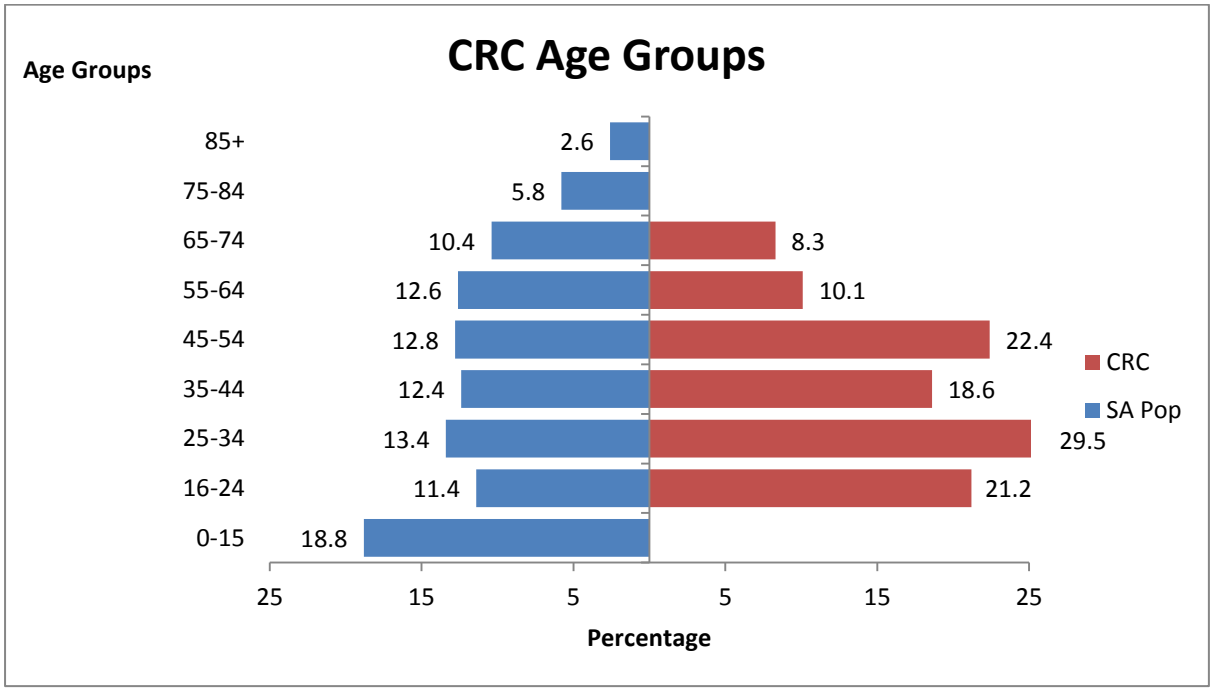
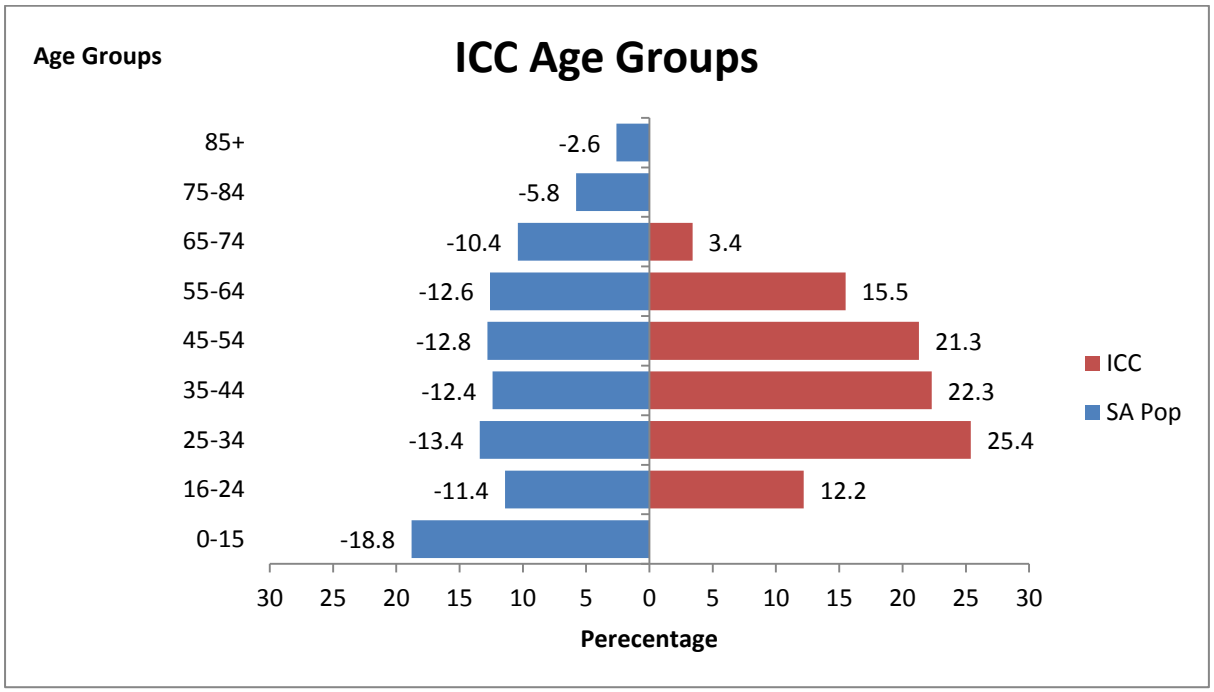


Figure 2 (next page) shows the age distribution of those people who accessed ICCs and CRCs. The figure shows that people who access a CRC are primarily aged between 16 and 54 with lower rates of access in proportion to the general population for those aged between 55-74 whilst those who accessed an ICC are primarily aged between 25 and 64.

Figure 2: Age in CRCs and ICCs





Cultural and Linguistically Diverse (CALD) Status

In South Australia, there were 249,804 people in 2019-20 who were born in a country in which English is not the Official Language. We have used this method to define the group who are CALD. We recognise this will include some people who speak English as a first language however this is unavoidable in predicting population rates of CALD status. As seen in **Table 7** In 2019-20 the number of CALD people on CTOs was slightly lower than the rate in the general population, however people from a CALD background had much lower rate of representation in ICCS and CMHS.

Table 7: CALD status in community mental health settings

	SA Pop	CRC	All CTOs	ICC	CMHS
Number	249804	14	298	70	2707
Percentage	14.2	9.0	13.3	7.7	6.5

Source: CBIS, HIP, ABS 2071.0 Census of Population and Housing: Reflecting Australia – Stories from the Census, 2016 – Culture Diversity

Place of Residence

The residential locality in South Australia, from which people access community mental health services, is displayed in **Table 8** and **Figure 3**. People from the Inner Rural area of South Australia were more highly represented in the people receiving a community mental health service when compared to their proportion of the population.

Figure 3: Community Mental Health Services Place of Residence

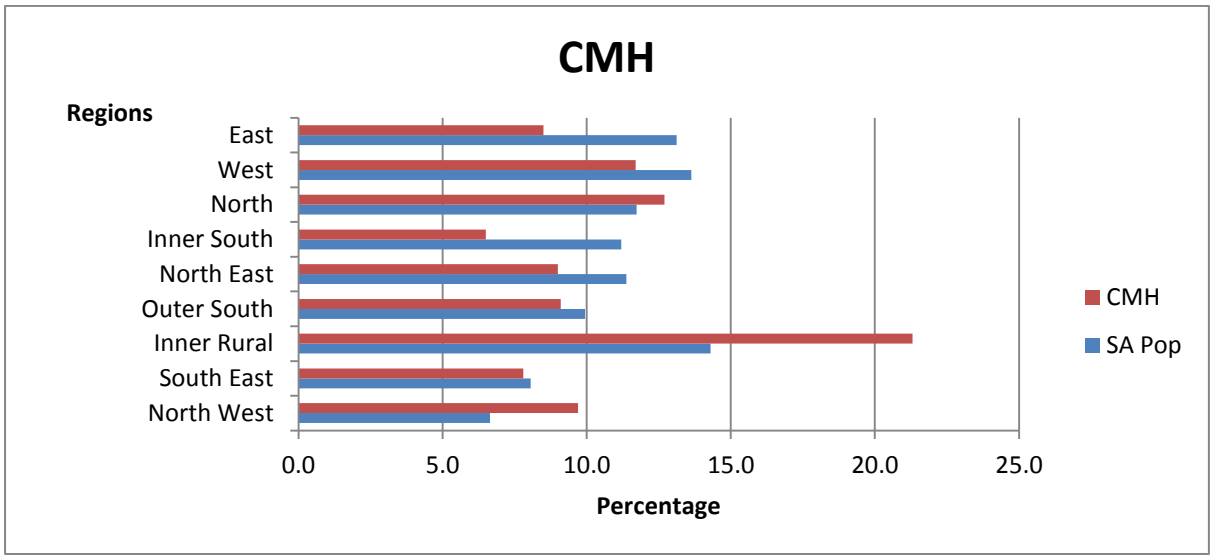


Table 8: South Australia population and community mental health services access by region.

Region	SA Population		CMHS	
	Number	Percent	Number	Percent
East	230838	13.1	3586	8.5
West	239807	13.6	4920	11.7
North	206420	11.7	5335	12.7
Inner South	197022	11.2	2734	6.5
North East	200124	11.4	3786	9.0
Outer South	174964	9.9	3839	9.1
Inner Rural	251446	14.3	8947	21.3
South East	141769	8.1	3260	7.8
North West	116795	6.6	4064	9.7
Interstate			360	0.9
Unknown			1134	2.7
Total	**1759184**	**100**	**41965**	**100.0**

Source: CBIS, HIP, ABS – 3235.0 Population by Age and Sex Regions of Australia

People who Accessed Inpatient Mental Health Services[1]

Gender

The proportions of women and men receiving the different types of inpatient services are consistent with previous years. The South Australia population and adult acute services have an almost even distribution between women and men. However, females are more prevalent in CAMHS acute and older acute services, with males more prevalent in PICU, forensic inpatient, and adult rehabilitation inpatient services.

Table 9: Gender representation in inpatient mental health settings

Gender	SA Pop	CAMHS acute	Adult acute	Older acute	PICU	Forensic inpatient	Adult Rehab	All ITOs
Female	50.6	65.1	48.2	63.4	30.2	13.4	38.2	43.4
Male	49.4	34.9	51.8	36.6	69.8	86.6	61.8	56.6

Source: CBIS, HIP

Aboriginal and Torres Strait Islander (ATSI) Status

Whilst ATSI peoples represent only 2.6% of the general SA population, they are over-represented in admission to all bed types, except older acute beds.

Table 10: ATSI in inpatient mental health settings

	SA Pop	CAMHS acute	Adult acute	Older acute	PICU	Forensic inpatient	Adult Rehab	All ITOs
Number	45022	47	661	0	52	28	4	829
Percentage	2.6	9.9	7.6	0	14.3	17.8	11.8	8.1

Source: CBIS, HIP

Age

In a pattern that is consistent with access to community mental health services, people aged between 16 and 54 access inpatient services at a rate that exceeds their proportion of the general population. Those aged 55 and over access services at lesser rates than their population proportion.

Table 11: Adult Acute, PICU and Forensic Inpatient

Age Group	SA Pop		CAMHS		Adult		Older		PICU		Adult Rehab		Forensic	
0-14	330077	18.8	83	17.0	67	0.8								
15-24	199750	11.4	393	83.0	1535	17.6			63	17.3	7	20.6	31	19.7
25-34	234886	13.4			2073	23.8			112	30.8	8	23.5	57	36.3
35-44	217793	12.4			1923	22.1			108	29.7	4	11.8	45	28.7
45-54	225436	12.8			1645	18.9	1	0.2	66	18.1	5	14.7	18	11.5
55-64	221686	12.6			1046	12.0	12	2.2	9	2.5	10	29.4	6	3.8
65-74	182453	10.4			267	3.1	272	49.8	6	1.6				
75-84	101472	5.8			115	1.3	199	36.4						
85+	45632	2.6			35	0.4	62	11.4						
Total	**1759184**	**100**	**476**	**100**	**8706**	**100**	**546**	**100**	**364**	**100**	**34**	**100**	**157**	**100**

Source: CBIS, HIP *Note the 0-14 admissions to Adult wards include infants admitted to Helen Mayo House

[1] Inpatient Mental Health Services are defined as overnight in a service in an approved or limited treatment centre.

Cultural and Linguistically Diverse (CALD) Status

People from CALD backgrounds are admitted to all inpatient beds at lower rates than their proportion in the general population with the exception of admissions to Older Acute beds.

Table 12: CALD status in mental health inpatient settings

	SA Pop	CAMHS acute	Adult acute	Older acute	PICU	Forensic inpatient	Adult Rehab	All ITOs
Number	249804	31	699	116	27	1	2	1065
Percentage	14.2	6.5	8.0	21.2	7.4	0.6	5.9	10.4

Source: CBIS, HIP, ABS

Place of Residence

The table below shows the mental health service catchments for inpatients. Indicative analysis would suggest that the proportion of adult acute inpatient service use is comparable to the populations in each service catchment. As children, youth and older people are distributed differently to adults within and across metropolitan and country areas, it is not possible to analyse the difference between total population and CAMHS and older acute services use by people in each catchment without additional data and further epidemiological examination.

Table 13: Inpatient Mental Health Services by region

Region	SA Pop		CAMHS Acute		Adult Acute		Older Acute		PICU		Forensic	
East	230838	13.1	41	8.6	1074	12.3	100	18.3	26	7.1	21	13.4
West	239807	13.6	69	14.5	1388	15.9	128	23.4	47	12.9	12	7.6
North	206420	11.7	67	14.1	891	10.2	50	9.2	72	19.8	6	3.8
Inner South	197022	11.2	45	9.5	954	11.0	56	10.3	38	10.4	9	5.7
North East	200124	11.4	48	10.1	867	10.0	54	9.9	53	14.6	61	38.9
Outer South	174964	9.9	64	13.4	960	11.0	50	9.2	68	18.7	10	6.4
Inner Rural	251446	14.3	99	20.8	1217	14.0	74	13.6	28	7.7	12	7.6
South East	141769	8.1	11	2.3	554	6.4	14	2.6	3	0.8	6	3.8
North West	116795	6.6	21	4.4	407	4.7	12	2.2	6	1.6	10	6.4
Interstate			11	2.1	391	4.5	8	1.5	19	5.2	10	6.4
Unknown					3	0.0			4	1.1		
Total	**1759184**	**100**	**476**	**100**	**8706**	**100.0**	**546**	**100.0**	**364**	**100.0**	**157**	**100.0**

Source: CBIS, HIP

3.2 Electroconvulsive Therapy

Prescribed psychiatric treatment is defined by the Act as Electroconvulsive Therapy (ECT), neurosurgery for mental illness or any other treatment declared by regulation to be a prescribed treatment. ECT is the only prescribed psychiatric treatment currently practiced in South Australia.

ECT is a specialised medical procedure where controlled seizures are induced under general anaesthesia. ECT is performed by a qualified multidisciplinary team that includes a psychiatrist and an anaesthetist. ECT is only used in specific circumstances, most commonly to treat major depression and sometimes other severe mental illness such as acute mania, catatonia and schizophrenia.

During 2019-20 ECT was administered in SA at five public hospitals: Flinders Medical Centre, Glenside Health Service, Lyell McEwin Health Service, and the Queen Elizabeth Hospital, and two private hospitals: the Adelaide Clinic and Fullarton Private Hospital. .

Electroconvulsive Therapy Service Use

The number of people who receive ECT, and the number of ECT treatments provided, has remained reasonably stable across public and private services, with temporary increases and decreases but no indication of sustained trends.

Table 14: ECT Use

Service Setting	2014-15				2015-16			
	People		Treatments		People		Treatments	
Public	369	67	4461	61.7	390	67.3	4546	55.7
Private	181	33	2769	38.3	191	32.7	3612	44.3
Total	**550**	**100**	**7230**	**100**	**581**	**100**	**8158**	**100**

Source: HIP, Ramsay Health

Service Setting	2016-17				2017-18			
	People		Treatment		People		Treatment	
Public	416	69.1	4750	62.8	367	66.6	3609	57.7
Private	186	30.9	2809	37.2	184	33.4	2649	42.3
Total	**602**	**100**	**7559**	**100**	**551**	**100**	**6258**	**100**

Source: HIP, Ramsay Health

Service Setting	2018-19				2019-20			
	People		Treatment		People		Treatment	
Public	366	69.4	3936	65.9	381	70.4	4388	68.3
Private	161	30.6	2037	34.1	160	29.8	2035	31.7
Total	**527**	**100**	**5973**	**100**	**541**	**100**	**6423**	**100**

The age profile of people receiving ECT is similar across public and private services, with the peak age being around 50, followed by older adults between 50 and 80, and then younger adults between 25 and 50. See **Table 15**.

Table 15: Age for ECT in public and private settings by no of people

Public			Private		
Age Group	People		Age Group	People	
	No	%		No	%
0-15	0	0	0-19	1	0.6
16-24	11	2.8	20-29	16	10.0
25-34	33	8.5	30-39	16	10.0
35-44	48	12.4	40-49	33	20.6
45-54	78	20.1	50-59	42	26.3
55-64	76	19.6	60-69	28	17.5
65-74	82	21.1	70-79	20	12.5
75-84	46	11.9	80-89	3	1.9
85+	14	3.6	90-99	1	0.6
Total	**388**	**100**		**160**	**100**

Source: HIP, Ramsay Health *Patients counted more than once if their birthday put them into a different age bracket during the year

The following tables provide demographic information on gender, Aboriginal and Torres Strait Islander, and CALD for the people who received ECT in a public setting.

Table 16 – Aboriginal and Torres Strait Islander – by no of people in public setting

	SA Pop	Received ECT
Number	45022	8
Percentage	2.6	2.1

Table 17 – Gender – by no of people in public setting

Gender	SA Pop	Received ECT
Female	50.6	60.9
Male	49.4	39.1

Table 18 – CALD – by no of people in public setting

	SA Pop	Received ECT
Number	249804	42
Percentage	14.2	11.0

All people receiving ECT in private services had a diagnosis of depression, with almost 65% of people receiving ECT in public services having a diagnosis of depression. See **Table 19**

Table 19: Diagnosis for people receiving ECT in public and private settings

Diagnosis	Public		Private	
	No	%	No	%
Depressive disorders	351	63.7	160	100
Schizoaffective disorders	66	12.0		
Bipolar disorders	65	11.8		
Other disorders	69	12.5		
Total	**551**	**100**		**100**

*Patients counted more than once if their principal diagnosis differed during the year

Of the 381 people who received ECT in public services in 2019-20, 20.8% received 1-6 treatments and 57.3% received 7-12 treatments, indicating that most people (78.1%) received 1-12 treatments, or one course of ECT, in line with best practice understandings of ECT treatment efficacy. Of the remaining people who received ECT, 12.6 % received 13-18 treatments and 5.5% received 19-24, indicating more persistent symptoms and a second course of ECT, and 3.8 % received over 24 treatments, representing people who receive ECT regularly throughout a year to maintain their health and wellbeing.

Table 20: Treatments per person – Public Services

Number of treatments	People	Percent
1-6	79	20.8
7-12	218	57.3
13-18	48	12.6
19-24	21	5.5
25+	14	3.8
Total	**381**	**100**

Source: HIP

3.3 Restrictive Practices

Reporting of Restrictive Practices

Restrictive practice consists of:

- Chemical restraint – the use of medication with the primary aim to restrict a person's freedom of movement.
- Mechanical restraint – the use of mechanical devices to restrict a person's freedom of movement.
- Physical restraint – the use of another person's hands or body to restrict a person's freedom of movement.
- Seclusion – the confinement of a person in a room from which free exit is prevented.

The Office of the Chief Psychiatrist has undertaken a number of activities to support best practice – which is to reduce and eliminate where possible the use of restraint and seclusion. This has included an ongoing trauma informed care strategy, supported by a community of practice led by Prof Nicholas Procter (Professor of Mental Health Nursing at University of South Australia) which seeks to prevent, where possible, the use of restrictive practices. The Office has also worked with LHNs to identify trends in local service data and see that they are responded to.

Statistics for restrictive practices are published nationally by the Australian Institute of Health and Welfare up until 18-19[2]. The data in this report will not seek to reproduce the national report with benchmarks from other states

In 2019-20 there was a further reduction in the use of mechanical restraint when compared to 2018-19, this continues the trend commenced in 2017-18. The use of seclusion has also reduced when compared to 2018-19 which had experienced an increase of 2.8% when compared to 2017-18.

Table 21: Restrictive Practice Event by Type

Type of Event	2015-16		2016-17		2017-18		2018-19		2019-20	
	No	%	No	%	No	%	No	%	No	%
Restraint – chemical	523	14.6	343	7.7	211	9.5	106	5.3	52	3.7
Restraint– mechanical	2057	57.2	2745	61.7	92	4.2	44	2.2	21	1.5
Restraint – physical	607	16.9	357	8.0	321	14.5	313	10.7	165	11.7
Seclusion	409	11.4	1002	22.5	1587	71.8	1623	81.7	1169	83.1
Total	**3597**	**100**	**4447**	**100**	**2211**	**100**	**1986**	**100**	**1407**	**100**

Source: SLS

[2] AIHW, Mental Health Services in Australia, updated 21 July 2020, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/restrictive-practices/restraint

Table 21b displays the use of different restrictive practice across the 5 LHNs.

Table 21b – Restrictive Practice Event Type by LHN

LHN / Event Type	Chemical		Mechanical		Physical		Seclusion	
	No	%	No	%	No	%	No	%
CALHN	9	17.3	8	38.1	61	37.0	419	35.8
NALHN	12	23.1	3	14.3	39	23.6	565	48.3
Regional LHNs	3	5.8	1	4.8	6	3.6	9	0.8
SALHN	24	46.1	9	42.8	57	34.6	100	8.6
WCHN	4	7.7	0	0	2	1.2	76	6.5
Total	**52**	**100**	**21**	**100**	**165**	**100**	**1169**	**100**

Source: SLS

Table 21c shows the total restrictive events in each LHN.

Table 21c – Total Events by LHN

LHN	Total	
	No	%
CALHN	497	35.4
NALHN	619	44.0
Regional LHNs	19	1.3
SALHN	190	13.5
WCHN	82	5.8
Total	**1407**	**100**

Source: SLS

Table 22 – Restrictive Practice by LHN and Service Type

LHN / Service	CAMHS		Adult		Older		Forensic	
	No	%	No	%	No	%	No	%
CALHN			492	63.5	5	33.3		
NALHN			81	10.4	4	26.7	534	100
Regional LHNs			19	2.4	0			
SALHN			184	23.7	6	40.0		
WCHN	82	100	0	0	0			
Total	**82**	**100**	**776**	**100**	**15**	**100**	**534**	**100**

Source: SLS *Note: Seclusion data now includes Forensic Services Lockdown incidents.

Table 23 – Restrictive Practice by LHN, People, Events, and Average per Person

LHN / People	People		Events		Average
	No	%	No	%	
CALHN	202	48.4	497	47.5	2
NALHN	89	21.3	257	24.6	3
Regional LHN	13	3.1	19	1.8	1
SALHN	77	18.5	190	18.3	2
WCHN	36	8.6	82	7.8	2
Total	**417**	**100**	**1045**	**100**	

Source: SLS

For the purpose of the above table the incidents of Forensic Services Lockdown have been removed from the table. During 2019-20 there were 362 Lockdown events recorded for Forensic Services.

The SLS system now includes robust recording of duration of restrictive practice events, with universal recording of minutes in SLS. This requirement was put in place in 18-19 and this process has continued to evolve throughout 19-20.

Work to reduce and eliminate where possible restrictive practices will continue to be pursued. It is expected that it should be possible to make further gains in mental health settings, in particular in the area of seclusion reduction.

It should be noted that this data does not include non-mental health settings, such as emergency departments and South Australian Ambulance Service (SAAS), which are recorded separately in SLS.

On 3 June 2109 a Chief Psychiatrist Memo was distributed to the leadership of the Local Health Networks and the Adelaide Clinic. The memo outlined the interim approval for the use of existing restraint devises as a last resort for people experiencing mental illness. The memo outlined the process for the approval of restraint devices that would be implemented during 2020-2021. The process and criteria for approving mechanical restraint devices currently in use and for new devices will include an assessment of the device, the level of staff training provided and the policies and procedures services have in place that limit their use, and guide their application. This approval process uses clinician and consumer and carer input into the approval system and is part of restraint and seclusion reduction work.

The criteria were informed by the state-wide review of mechanical restraint devices undertaken by a multidisciplinary team coordinated by the Office of the Chief Psychiatrist. Three workshops were held which included the South Australian Ambulance Service, Central Adelaide Local Health Network and the Women's and Children's Health Network. The workshops included people with lived experience, carers and consumer representatives. The learnings from the workshops and review of policies from other jurisdictions have been incorporated into the revised restraint and seclusion policy.

Chapter 4
Mental Health Act Treatment Orders

The following Chapter provides information on each type and level of treatment order. This includes demographic information and the number and duration of each type and level of order.

4.1 Treatment Orders

The Act establishes limited powers for health professionals and SACAT to make treatment orders, which allow for the lawful treatment of people against their will if their health and safety is at risk of harm because of their mental illness. There has been a steady increase in the use of compulsory orders in recent years and a concern that the use of such orders could be minimised.

It should be noted that the use of such powers should be limited to circumstances where there is no less restrictive means than an order of ensuring appropriate treatment of the person's illness. It is an object of the Act that people retain their freedom, rights, dignity and self-respect as far as is consistent with their protection, the protection of the public and the proper delivery of the services.

In 2019-20 there were 12453 treatment orders active. The first four years of the operation of the Act, from 2010-11 to 2013-14, saw the use of treatment orders remain consistently in the low 8000s. Since 2015-16 however, the use of treatment orders has increased, with the 12453 an increase of 40.4% compared to 2014-15

Table 24 - Total Number of Treatment Orders

	2014-15		2015-16		2016-17		2017-18		2018-19		2019-20	
CTO1	283	3.2	390	3.7	526	4.5	644	5.7	784	6.3	782	6.3
CTO2	1260	14.2	1314	12.6	1407	12.2	1417	12.5	1377	11.1	1452	11.7
All CTOs	1543	17.4	1704	16.3	1933	16.7	2061	18.2	2161	17.5	2234	17.9
ITO1	5373	60.6	6218	59.4	6794	58.7	6524	57.7	7270	58.7	7164	57.5
ITO2	1775	20.0	2331	22.3	2591	22.4	2600	23.0	2824	22.8	2895	23.2
ITO3	179	2.0	208	2.0	252	2.2	131	1.2	126	1.0	160	1.3
All ITOs	7327	82.6	8757	83.7	9637	83.3	9255	81.8	10220	82.5	10219	82.1
Total	**8870**	**100**	**10461**	**100**	**11570**	**100**	**11316**	**100**	**12381**	**100**	**12453**	**100**

Source: CBIS

The 12453 treatment orders in 2019-20 were made for 6171 individuals. Most people (78.2%) were subject to only 1 or 2 treatment orders, with the remaining 21.8 % being subject to 3 or more treatment orders.

Table 25 - Number of Orders per Person

Number of orders per person	Number of people	Percent
1	3155	51.1
2	1672	27.1
3	565	9.2
4	323	5.2
5	176	2.9
6	114	1.8
7	70	1.1
8	42	0.7
9	18	0.3
10	12	0.2
10+	24	0.4
Total	**6171**	**100**

Community Treatment Orders

A Community Treatment Order under the *Mental Health Act 2009* is an order that allows a person with a mental illness to receive compulsory, community-based treatment.

In South Australia there are two CTO types. A Level 1 Community Treatment Order can last for up to 42 days and can be made by an authorised mental health professional or medical practitioner. A CTO1 not made by a psychiatrist or authorised medical practitioner must be reviewed by a psychiatrist within 24 hours or as soon as practicable.

A Level 2 Community Treatment Order can last for up to 12 months (6 months if the person is aged less than 18 years) and can be made by the South Australian Administrative and Civil Tribunal on application by the Public Advocate, a medical practitioner, mental health clinician or other person with a proper interest in the welfare of the patient.

Demographics of People on Community Treatment Orders

Gender

Men are more likely to be subject to CTOs than women, with men making up 65.0% of the people subject to CTO1s and 70.5% of people subject to CTO2s.

Table 26 - Community Treatment Orders – Gender representation

Gender	SA Population		CTO1		CTO2	
Female	890398	50.6	274	35.0	428	29.5
Male	868786	49.4	508	65.0	1024	70.5
Total	**1759184**	**100**	**782**	**100**	**1452**	**100**

Source: CBIS

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander People make up 10.0 % of people subject to CTO1s and 9.2% of people subject to CTO2s, which is similar to the 7.9% percent of people receiving community mental health services who are ATSI people.

Table 27 - Community Treatment Orders – ATSI representation

	SA Population	CTO1	CTO2
Number	45022	78	134
Percent	2.6	10.0	9.2

Source: CBIS

Cultural and Linguistically Diverse (CALD)

Culturally and linguistically diverse people make up 14.3% of people subject to CTO1s and 12.8% of people subject to CTO2s, which is similar to the 14.2% of the SA population who are CALD.

Table 28 - Community Treatment Orders – CALD representation

	SA Population	CTO1	CTO2
Number	249804	112	186
Percent	14.2	14.3	12.8

Source: CBIS

Age

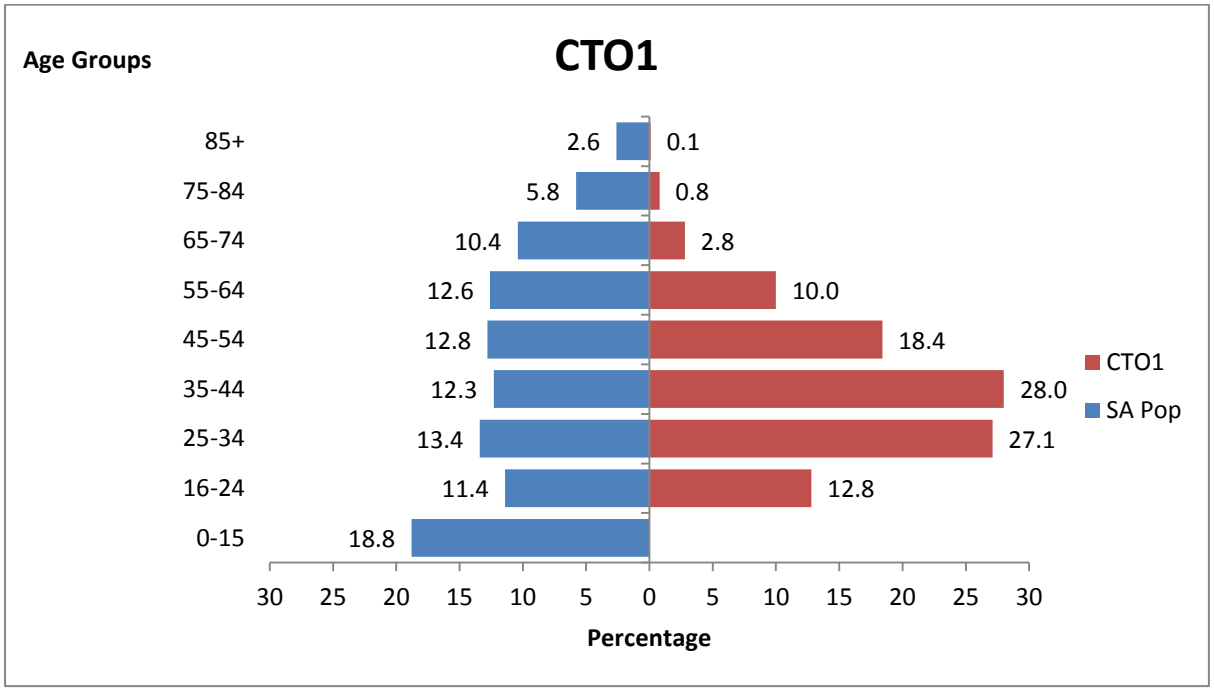
Most people subject to CTOs are aged between 25 and 54 (72.4%) and are represented in higher proportions than in the South Australian population.

Table 29 - Community Treatment Orders – Age representation

Age Group	SA Population		CTO1		CTO2	
	Number	Percent	Number	Percent	Number	Percent
0-15	330077	18.8	0	0	0	0
16-24	199750	11.4	100	12.8	120	8.3
25-34	234886	13.4	212	27.1	322	22.2
35-44	217793	12.4	219	28.0	410	28.2
45-54	225436	12.8	144	18.4	310	21.3
55-64	221686	12.6	78	10.0	190	13.1
65-74	182453	10.4	22	2.8	73	5.0
75-84	101472	5.8	6	0.8	25	1.7
85+	45632	2.6	1	0.1	2	0.1
Total	**1759184**	**100**	**782**	**100.0**	**1452**	**100**

Source: CBIS

Figure 4: Age Distribution for Community Treatment Orders



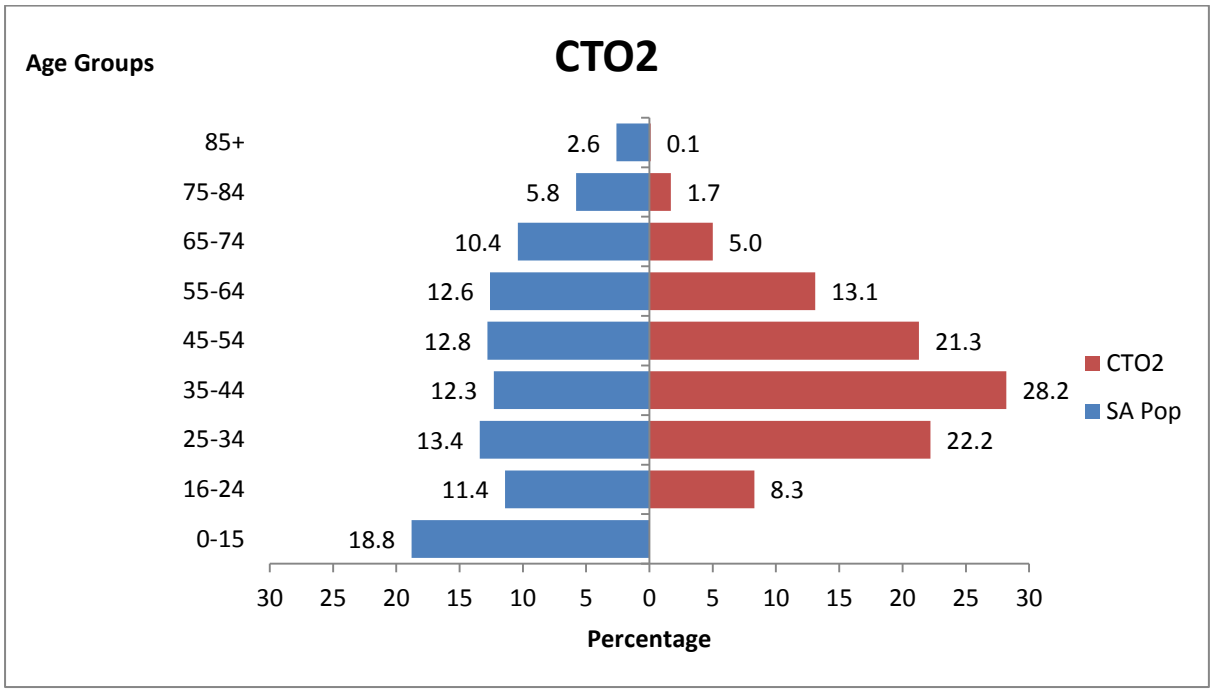


Table 30 - Community Treatment Orders – Place of Residence

Region	SA Population		CTO1		CTO2	
East	230838	13.1	117	15.0	282	19.4
West	239807	13.6	161	20.6	182	12.5
North	206420	11.7	67	8.6	205	14.1
Inner South	197022	11.2	73	9.3	110	7.6
North East	200124	11.4	109	13.9	200	13.8
Outer South	174964	9.9	87	11.1	124	8.5
Inner Rural	251446	14.3	72	9.2	168	11.6
South East	141769	8.1	24	3.1	65	4.5
North West	116795	6.6	39	5.0	60	4.1
Interstate			5	0.6	16	1.1
Unknown			28	3.6	40	2.8
Total	**1759184**	**100**	**782**	**100**	**1452**	**100**

Community Treatment Orders Numbers and Duration

Most CTO1s (91.9%) and CTO2s (95.2%) are made for their maximum duration, with only a very small proportion (1.4%) subsequently revoked earlier. **Tables 31 to 34** display the detail over the last 5 years, showing that while the numbers of CTO1s and CTO2s have increased since 2015-16.

Table 31 - Community Treatment Order – Level 1 – Expiry Period

Expiry Period	2014-15		2015-16		2016-17		2017-18		2018-19		2019-20	
Orders made	283	100	390	100	526	100	644	100	784	100	782	100
Expiry – maximum	263	92.9	356	91.3	498	94.7	508	78.9	725	92.5	719	91.9
Expiry – less than max	20	7.1	34	8.7	28	5.3	136	21.1	59	7.5	63	9.1

Source: CBIS

Table 32 - Community Treatment Order – Level 1 – Duration

Duration	2014-15		2015-16		2016-17		2017-18		2018-19		2019-20	
Orders made	283	100	390	100	526	100	644	100	784	100	782	100
Revoked at 24- hour review	7	2.4	18	4.6	4	0.8	13	2.0	10	1.3	18	2.3
Subsequently revoked	20	7.1	7	1.8	8	1.5	20	3.1	21	2.7	11	1.4
Went for intended duration	256	90.5	365	93.6	514	97.7	611	94.9	763	97.3	753	96.3

Source: CBIS

Table 33 - Community Treatment Order – Level 2 – Expiry Period

Expiry Period	2014-15		2015-16		2016-17		2017-18		2018-19		2019-20	
Orders made	1260	100	1314	100	1407	100	1417	100	1377	100	1452	100
Expiry – set for maximum	1149	91.2	1186	90.3	1293	91.9	1339	94.5	1325	96.2	1383	95.2
Expiry – set for less than max	111	8.8	128	9.7	114	8.1	78	5.5	52	3.8	69	4.8

Source: CBIS

Table 34 - Community Treatment Order – Level 2 – Duration

Duration	2014-15		2015-16		2016-17		2017-18		2018-19		2019-20	
Orders made	1260	100	1314	100	1407	100	1417		1377	100	1452	100
Subsequently revoked	9	0.7	17	1.3	17	1.2	10	0.7	8	0.6	6	0.4
Went for intended duration	1251	99.3	1297	98.7	1390	98.8	1407	99.3	1369	99.4	1446	99.6

Source: CBIS

Community Treatment Orders Level 1 and 2 – Multiple Orders

There were 782 CTO1s made for 696 people with 623 (89.5%) individuals having one CTO1, 60 (8.6%) having two and 13 (1.9%) having three or more.

There were 1452 CTO2s made for 1084 people with 726 (67.0%) individuals having one CTO2, 348 (32.1%) having two and 10 (0.9%) having three.

Inpatient Treatment Orders

An Inpatient Treatment Order under the *Mental Health Act 2009* is an order that allows a person to receive compulsory, inpatient treatment for a mental illness.

A Level 1 Inpatient Treatment Order can last for up to seven days and can be made by an authorised health professional or medical practitioner. All ITO1s must be reviewed within 24 hours, or as soon as practicable, by a psychiatrist or authorised medical practitioner, who cannot be the same clinician who made the order.

A Level 2 Inpatient Treatment Order can last for up to 42 days and can be made by a psychiatrist or authorised medical practitioner for a patient currently on an ITO1. A Level 2 Inpatient Treatment Order may, once only, be extended by a psychiatrist or authorised medical practitioner for a period up to 42 days from the day on which the order would, had it not been extended, have expired.

A Level 3 Inpatient Treatment Order can last for up to 12 months (six months for a person aged less than 18 years of age) and can be made by the South Australian Civil and Administrative Tribunal on application by a range of people including the Public Advocate, a mental health clinician or other person with a proper interest in the welfare of the patient.

Demographics of People on Inpatient Treatment Orders

Gender

Men make up a higher proportion of people subject to ITOs than women, making up 56.5% of ITO1s, 56.4% of ITO2s and 63.8% of ITO3s.

Table 35 - Inpatient Treatment Orders – Gender representation

Gender	SA Population		ITO1		ITO2		ITO3	
Female	890398	50.6	3117	43.5	1263	43.6	58	36.3
Male	868786	49.4	4047	56.5	1632	56.4	102	63.8
Total	**1759184**	**100**	**7164**	**100**	**2895**	**100**	**160**	**100**

Source: CBIS

Aboriginal and Torres Strait Islander (ATSI)

The proportion of ATSI people subject to ITOs is slightly higher, at 8.2% for ITO1s, 8.1% for ITO2s and lower at 5.6% for ITO3s, than their proportion in adult acute inpatients services of 7.6%.

Table 36 - Inpatient Treatment Orders – ATSI representation

	SA Population	ITO1	ITO2	ITO3
Number	45022	585	235	9
Percent	2.6	8.2	8.1	5.6

Source: CBIS

Cultural and Linguistically Diverse (CALD)

The proportion of CALD people subject to ITOs is moderately higher, at 9.5% for ITO1s, 12.6% for ITO2s and 13.8% for ITO3s, than their proportion in adult acute inpatient services of 8.0%.

Table 37 - Inpatient Treatment Orders – CALD representation

	SA Population	ITO1	ITO2	ITO3
Number	249804	679	364	22
Percent	14.2	9.5	12.6	13.8

Source: CBIS

Age

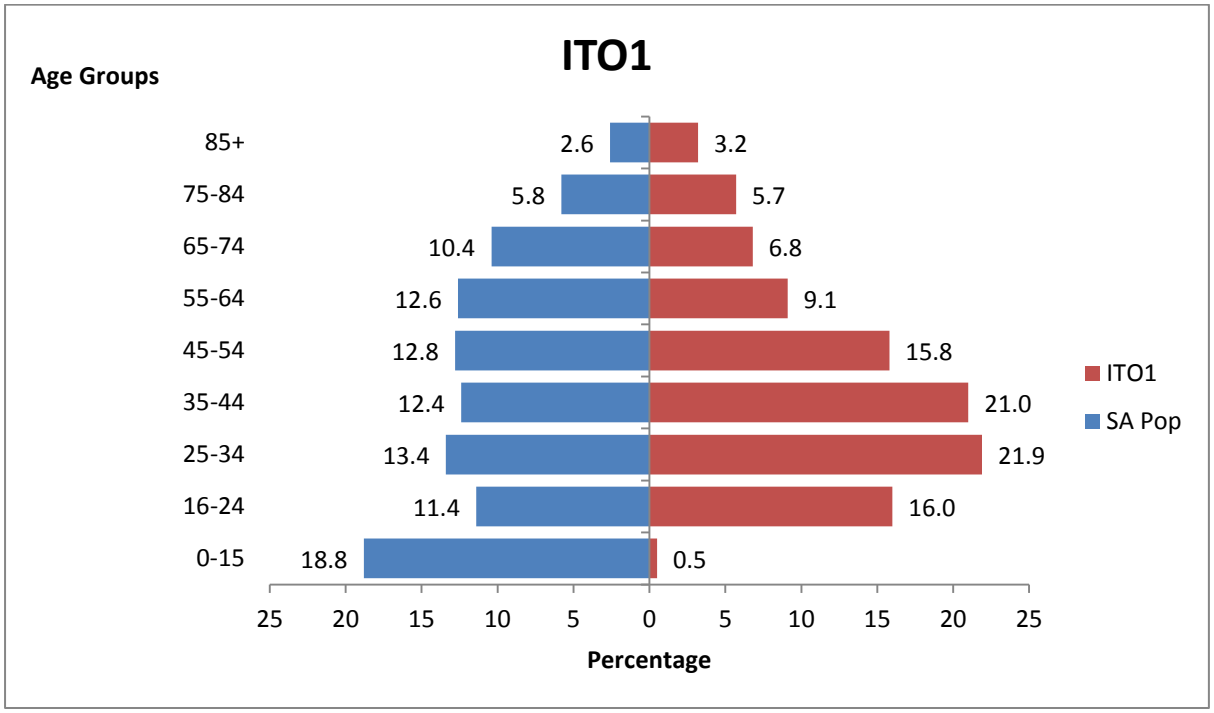
Most (greater than 55%) of the people subject to ITO1s, ITO2s and ITO3s are between 25-54 . See **Table 38** below or **Figure 5** over the page.

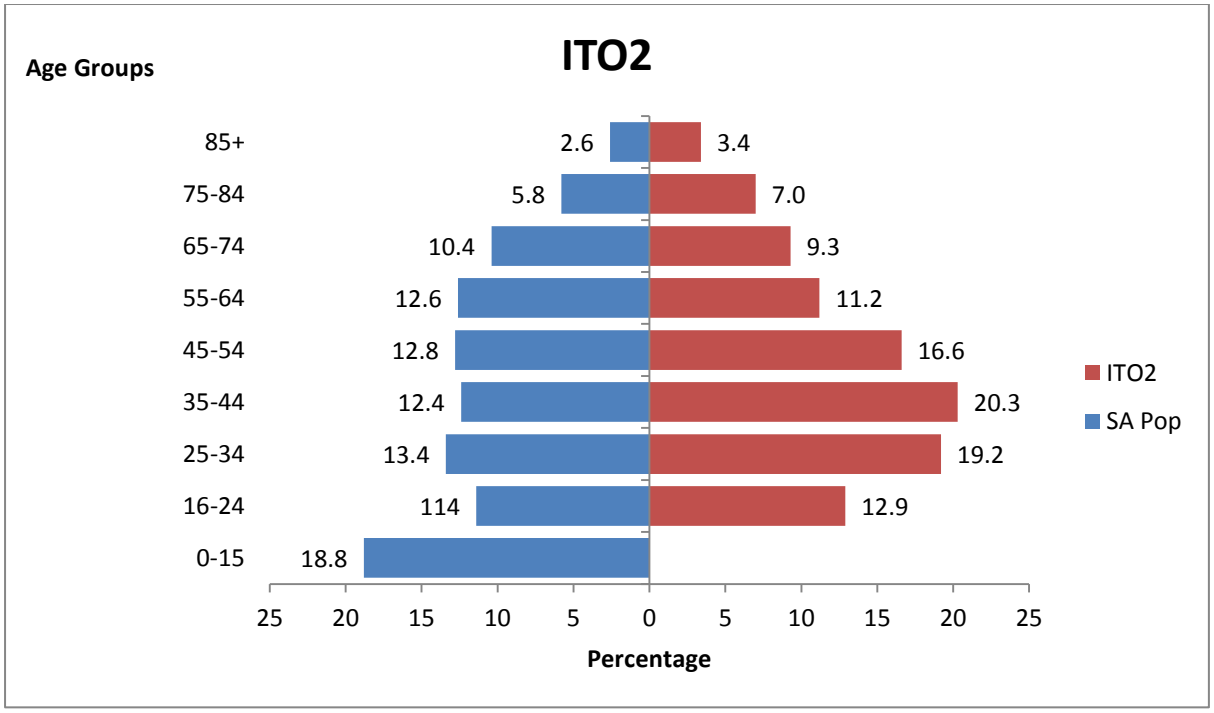
Table 38 - Inpatient Treatment Orders – Age representation

Age Group	SA Population		ITO1		ITO2		ITO3	
0-15	330077	18.8	38	0.5	1	0.0	0	0
16-24	199750	11.4	1146	16.0	373	12.9	21	13.1
25-34	234886	13.4	1569	21.9	556	19.2	34	21.3
35-44	217793	12.4	1501	21.0	589	20.3	26	16.3
45-54	225436	12.8	1131	15.8	482	16.6	17	10.6
55-64	221686	12.6	650	9.1	323	11.2	23	14.4
65-74	182453	10.4	487	6.8	270	9.3	20	12.5
75-84	101472	5.8	410	5.7	203	7.0	16	10.0
85+	45632	2.6	232	3.2	98	3.4	3	1.9
Total	**1759184**	**100**	**7164**	**100.0**	**2895**	**100.0**	**160**	**100**

Source: CBIS

Figure 5: Age Distribution for Inpatient Treatment Orders





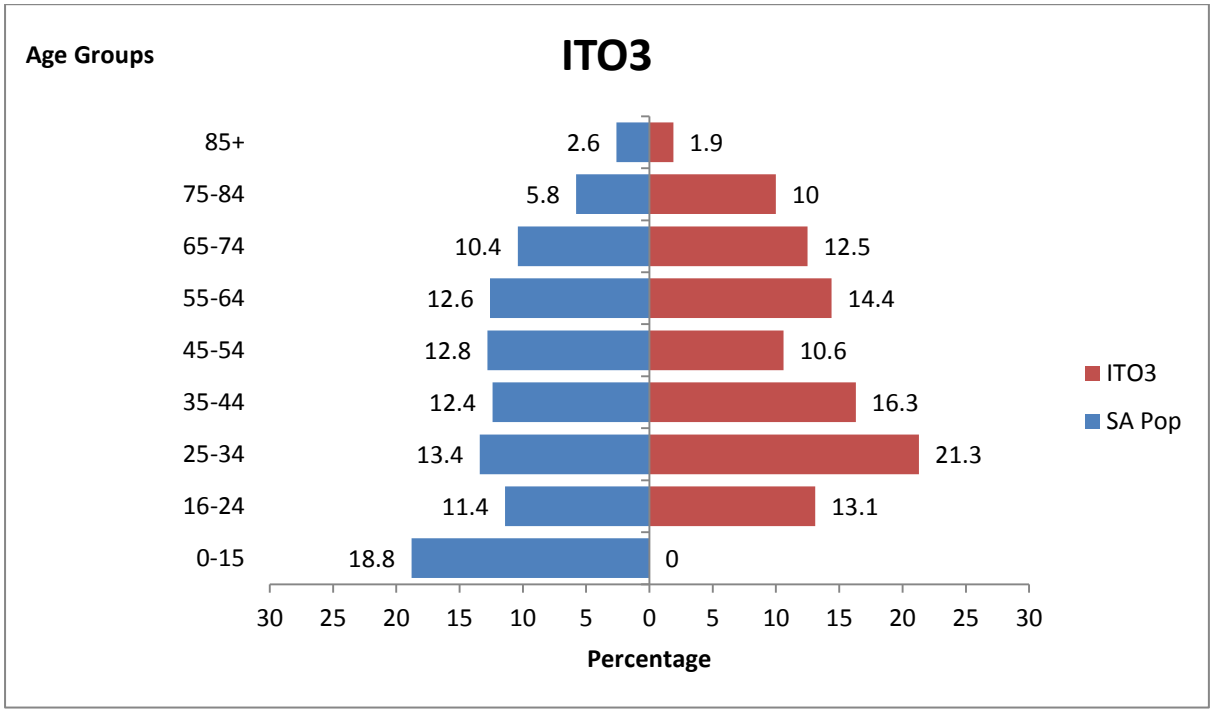


Table 39 - Inpatient Treatment Orders – Place of Residence

Region	SA Population		ITO1		ITO2		ITO3	
East	230838	13.1	933	13.02	409	14.1	43	26.9
West	239807	13.6	1148	16.02	536	18.5	30	18.8
North	206420	11.7	782	10.92	289	10.0	20	12.5
Inner South	197022	11.2	634	8.85	301	10.4	10	6.3
North East	200124	11.4	775	10.82	294	10.2	18	11.3
Outer South	174964	9.9	849	11.85	351	12.1	10	6.3
Inner Rural	251446	14.3	902	12.59	325	11.2	12	7.5
South East	141769	8.1	350	4.89	98	3.4	5	3.1
North West	116795	6.6	304	4.24	120	4.1	4	2.5
Interstate			86	1.20	41	1.4	2	1.3
Unknown			401	5.60	131	4.5	6	3.8
Total:	**1759184**	**100**	**7164**	**100**	**2895**	**100**	**160**	**100**

Source: CBIS

Inpatient Treatment Orders Level 1

ITO1 use has increased by 33.3% since 2014-15. Most ITO1s (81.4%) were made for the maximum duration of 7 days. Of the total 7164 ITO1s made, 23.8% were revoked by a psychiatrist at the 24-hour review stage and 15.2% were subsequently revoked, leaving 61.1% to continue for their full duration. See **Table 40** and **41** for details.

Table 40 - Inpatient Treatment Order – Level 1 – Expiry Period

Expiry Period	2014-15		2015-16		2016-17		2017-18		2018-19		2019-20	
Orders made	5373	100	6218	100	6794	100	6524	100	7270	100	7164	100
Expiry – set for maximum	5185	96.5	5836	93.9	5603	82.5	5298	81.2	5883	80.9	5832	81.4
Expiry – set less than max	188	3.5	382	6.1	1191	17.5	1226	18.8	1387	19.1	1332	18.6

Source: CBIS

Table 41 - Inpatient Treatment Order – Level 1 – Outcome

Outcome	2014-15		2015-16		2016-17		2017-18		2018-19		2019-20	
Orders made	5373	100	6218	100	6794	100	6524	100	7270	100	7164	100
Revoked at 24-hour review	1366	25.4	1202	19.3	1510	22.2	1466	22.5	1867	25.7	1702	23.8
Subsequently revoked	929	17.3	960	15.4	1103	16.2	1074	16.5	1217	16.7	1086	15.2
Went for intended duration	3079	57.3	4056	65.2	3167	46.6	5450	83.5	4186	57.6	4376	61.1

Source: CBIS

Inpatient Treatment Order Level 2

ITO2 use has increased by 63.1% since 2014-15. Most ITO2s (94.3%) were made for the maximum duration of 42 days. Of the total 2895 ITO2s made, 76.8% were subsequently revoked by a psychiatrist when the patient had recovered sufficiently for less restrictive treatment to be used. See **Table 42** and **43** for details.

Table 42 - Inpatient Treatment Order – Level 2 – Expiry Period

Expiry Period	2014-15		2015-16		2016-17		2017-18		2018-19		2019-20	
Orders made	1775	100	2331	100	2591	100	2600	100	2824	100	2895	100
Expiry – set for maximum	1665	93.2	2024	86.8	2235	86.3	2268	87.2	2633	93.2	2731	94.3
Expiry – set less than max	120	6.8	307	13.2	356	13.7	332	12.8	191	6.8	164	5.7

Source: CBIS

Table 43 - Inpatient Treatment Order – Level 2 – Outcomes

Outcomes	2014-15		2015-16		2016-17		2017-18		2018-19		2019-20	
Orders made	1775	100	2331	100	2591	100	2600	100	2824	100	2895	100
Revoked at 24- hour review	-	-	-	-	-	-	-	-	-	-	-	-
Subsequently revoked	1024	57.7	1517	65.1	1764	68.1	1772	68.2	2040	72.2	2223	76.8
Went for intended duration	751	42.3	814	34.9	827	31.9	828	31.8	784	27.8	672	23.2

Source : CBIS

Inpatient Treatment Order Level 3

Of the 160 ITO3s, 56.3% of ITO3s were made for the maximum duration of 12 months. Of the total 160 ITO3s made, 43.1% were subsequently revoked by SACAT when the patient had recovered sufficiently for a less restrictive treatment to be used or after a review requested by the patient or their family. See **Table 44** and **45** for details.

Table 44 - Inpatient Treatment Order – Level 3 – Expiry Period

Expiry Period	2014-15		2015-16		2016-17		2017-18		2018-19		2019-20	
Orders made	179	100	208	100	252	100	131	100	126	100	160	100
Expiry – set for maximum	38	21.2	43	20.7	68	27.0	54	41.2	69	54.8	90	56.3
Expiry – set less than max	141	78.8	165	79.3	184	73.0	77	58.8	57	45.2	70	43.8

Source: CBIS

Table 45 - Inpatient Treatment Order – Level 3 – Outcome

Outcome	2014-15		2015-16		2016-17		2017-18		2018-19		2019-20	
Orders made	179	100	208	100	252	100	131	100	126	100	160	100
Revoked at 24- hour review	-	-	-	-	-	-					-	-
Subsequently revoked	63	35.2	82	39.4	121	48.0	31	23.7	41	32.5	69	43.1
Went for intended duration	116	64.8	126	60.6	131	52.0	100	76.3	85	67.5	91	56.9

Source: CBIS

Inpatient Treatment Orders Level 1, 2 and 3 – Multiple Orders

There were 7164 ITO1s made for 5258 people with 4060 (77.2%) individuals having one ITO1, 782 (14.9%) having two, 259 (4.9%) having three, 89 (1.7%) having four, 37 (0.7%) having five, 12 (0.2%) having six, 11 (0.2%) having seven and 8 (0.2%) having eight or more.

There were 2895 ITO2s made for 2306 people with 1868 (81.0%) individuals having one ITO2, 338 (14.7%) having two, 69 (3.0%) having three, 19 (0.8%) having four, 6 (0.3 %) having five and 6 (0.3%) having six or more.

There were 160 ITO3s made for 122 people with 88 (72.1%) individuals having one ITO3, 30 (24.6%) having two and 4 (3.3 %) having three.

Reviews and Appeals

Information on the number of reviews undertaken by SACAT is reported in their annual report, which is available on their website at: http://www.sacat.sa.gov.au/resources-updates/annual-and-performance-reports

Chapter 5
Legislation and Policy

The OCP undertakes a number of other legislative and policy initiatives outside those required by the *Mental Health Act 2009.*

5.1 Criminal Law Consolidation Act 1935

Part 8A of the *Criminal Law Consolidation Act 1935* (CLCA) provides the legislative powers and functions relating to forensic mental health patients and forensic mental health orders.

Ministerial Directions

The Minister may place a person subject to detention under a Section 269V (2) using a Ministerial Direction. A Direction is most often used to transfer the custody, supervision and care of a forensic patient from a health facility to a prison, for a limited period of time. The power to make such a Direction was delegated to the Chief Psychiatrist and the Chief Executive SA Health during 2019-20 by the Minister noting that the Minister continues to retain this power to make a Ministerial Direction.

The OCP coordinates the making of Ministerial Directions with the Forensic Mental Health Service. Appropriate reviews of requests for Ministerial Directions are made to ensure placement in prison is appropriate for the person concerned and there is regular clinical review whilst a forensic patient is placed in prison.

In 2019-20, there were 60 separate Ministerial Directions in place for 26 individuals.

There has also been one application for international transfer under the *International Transfer of Prisoners Act 1997* (Cth). The Minister for Police, Emergency Services and Correctional Services delegated to the Minister for Health and Wellbeing pursuant to section 9 of the *Administrative Arrangements Act 1994*, his powers and functions under section 6 (1) of the *International Transfer of Prisoners (South Australia) Act 1998* insofar as those powers and functions may be exercised in relation to defendants committed to detention pursuant to Part 8A- Mental Impairment provisions of the CLCA. This delegation was published in the Government Gazette on 28 May 2020.

5.2 Independent Commissioner Against Corruption – Oakden Report

Following the former Chief Psychiatrist Dr Aaron Groves' Review of Oakden in April 2017, the Independent Commissioner Against Corruption conducted their own investigation and released the Oakden Report in February 2018. The ICAC Report built on the clinical and service focus of the Chief Psychiatrist Report with thirteen recommendations relating to statewide, systemic and governance matters.

The OCP was asked to lead and coordinate the response to the ICAC Report on behalf of the Department for Health and Wellbeing and delivered a Preliminary Report in December 2018, describing the work done to that point. In March 2019 the OCP commenced working on the Final Report, in collaboration with the Community Visitor Scheme, Departmental branches and the Local Health Networks. The Final Report was released in September 2020 and describes the ICAC

recommendations; matters reviewed, actions that have been completed and those still underway, and proposes some further actions for consideration.

5.3 Key National Initiatives

Vision 2030

The Commonwealth Government published Vision 2030, its blueprint for mental health in Australia covering research, prevention, early intervention, treatment, recovery and multi-sector approaches to psychosocial wellbeing. It involves working with states and territories as partners with the commonwealth, alongside a range of community stakeholders.

National Mental Health and Wellbeing Pandemic Response Plan

As a consequence of the pandemic and following the initial pandemic response that saw a number of initiatives such as the Medicare telehealth items among others introduced, a *National Mental Health and Wellbeing Pandemic Response Plan* was endorsed by the National Cabinet on 15 May 2020 with the following three core objectives, to:

- meet the mental health and wellbeing needs of all Australians to reduce the negative impacts of the pandemic in the short and long-term;
- outline core principles and priority areas to inform jurisdictions as they respond to the challenges of COVID-19; and
- define governance, coordination and implementation requirements.

This plan was developed due to awareness of the increased need for an expanded and coordinated mental health response to the impact of the COVID-19 pandemic on all Australians, including those with severe and complex mental illness. This response needed to reach across the federated model of mental health care. The Plan set out a series of actions for addressing the mental health and wellbeing needs of the Australian community during and in the recovery phases of the COVID-19 pandemic and was developed with input from States and Territories. South Australia, along with all other state and territory jurisdictions provided information about actions taken in response at the local jurisdictional level.

National Suicide Prevention

In July 2019, the Prime Minister announced that the Australian Government is working towards zero suicides in the community and appointed Ms Christine Morgan, Chief Executive Officer, National Mental Health Commission as the first National Suicide Prevention Adviser reporting to the Prime Minister. It was also announced that a Towards Zero approach would be adopted nationally and Ms Morgan would work with relevant Ministers to drive a whole-of-government approach to suicide prevention activities.

As one part of making suicide prevention a priority, all governments committed to drafting a new national suicide prevention strategy for Australia: the National Suicide Prevention Implementation Strategy which was drafted as one of the actions under the Fifth Plan. The Plan will be released in line with the first report of the National Suicide Prevention Adviser. This is planned to take place in the second half of 2020.

National Productivity Commission Report into Mental Health

The Chief Psychiatrist along with other officials of the Department for Health and Wellbeing met with the Productivity Commission to provide feedback on its draft report and recommendations. The final report was provided to the Commonwealth Government in June 2020 and its release is expected in the second half of 2020 once the Commonwealth Government's response to the report is published.

Commonwealth Mental Health Initiatives

The Commonwealth has commenced the implementation of three new mental health initiatives which aim to identify and address unmet mental health needs of Australians:

- Adult Mental Health Centres
- Community based residential eating disorder treatment centres
- National Perinatal Mental Health Check.

In the 2019-20 Budget, the Commonwealth Government announced $114.5 million for a trial of eight Adult Mental Health Centres, with one to be established in each state and territory. South Australia has commissioned the Urgent Mental Health Care Centre as part of this trial.

Fifth Plan implementation and Progress in South Australia

The State has reported on Fifth Plan progress in South Australia for the second time to the National Mental Health Commission which has responsibility for oversight of national progress. *The Mental Health Services Plan 2020-2025* was developed and constitutes the contribution to the implementation of the Fifth Plan in South Australia.

Digital Mental Health Framework Advisory Group

The Digital Mental Health Framework Advisory Group was established following the determination of its Terms of Reference, role and function, composition, timeframes and operational aspects of the advisory group to advise on Action 32 of the 5th National Mental Health and Suicide Prevention Plan, to develop a Digital Mental Health Framework.

Third edition of Information Priorities

MHISSC has finalised a third edition of the Information Priorities following extensive consultation with mental health sector stakeholders, jurisdictions and relevant AHMAC committees of which SA is a part. The 3rd edition of the Information Priorities identifies priority areas and strategies to guide mental health information development in Australia over the next ten years. It provides a long term vision for mental health information development which is personalised, comprehensive and connected. The third edition builds on previous National Mental Health Information Priorities documents and has been designed to be accessible to a general audience as well as technical specialists.

Development of Adelaide Metropolitan Joint Regional Mental Health and Suicide Prevention Plan

On 4 August 2017, the Council of Australian Governments (COAG) Health Council endorsed the *Fifth National Mental Health and Suicide Prevention Plan and Implementation Plan* (2017-22). Under Priority Area 1, Action 1.1, Primary Health Networks (PHNs) and Local Health Networks (LHNs) were directed to develop joint Regional Plans by mid-2020. Joint regional planning was proposed through the Fifth Plan as a key platform for mental health reform, and as a way of supporting integrated planning, commissioning and service delivery. Governments were required to also support LHNs and PHNs to develop and publicly release these joint plans. During 2019-2020, the Adelaide Primary Health Network and the four LHNs: Central Adelaide LHN, the Northern LHN, the Southern LHN and the Women's and Children's Health Network as well as the Office of the Chief Psychiatrist worked on the development of the Metropolitan Adelaide Regional Mental Health and Suicide Prevention Plan which is expected to be released in the second half of 2020.

5.4 Optional Protocol to the Convention against Torture

The Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) is an international agreement aimed at preventing torture and cruel, inhuman or degrading treatment or punishment. The objective of OPCAT is to prevent the mistreatment of people in detention.

The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) aims to improve how people's rights are protected when they are detained under any government law. It does this by providing for a rigorous process of independent inspections of all places of detention which includes mental health wards.

Under OPCAT, State Parties agree to establish an independent National Preventive Mechanism (NPM) to conduct inspections of all places of detention and closed environments.

The Australian Government (on behalf of all Australian states and territories) ratified OPCAT on 21 December 2017 and agreed to comply with this protocol lodging the instruments of ratification with the United Nations.

Earlier this year, the Subcommittee on Prevention of Torture (SPT) had planned to visit Australia and undertake visits to detention centres and other relevant places. All jurisdictions were advised and preparations for this visit were commenced through the provision of information as requested. This visit however was postponed due to COVID-19 and is proposed to occur.

5.5 Ligature Risk Management – Chief Psychiatrist Standard

The OCP consulted for and commenced the development of a new Chief Psychiatrist Standard relating to Ligature Risk Management, which was released on 5 September 2019

The Standard describes the requirement for ligature audits in both public and private residential and inpatient mental health units, as well as emergency departments and community mental health facilities. These units need to respond to and report on ligature risk, for the purpose of reducing that risk and leading to better outcomes for consumers and their families.

5.6 Restraint and Seclusion in Mental Health Services – Policy Suite

In 2019-20 the OCP commenced a review of the 2015 Restraint and Seclusion in Mental Health Services Policy Guideline, Chief Psychiatrist Standards and the Prevention Toolkit.

The review incorporated:

- Current interstate and international best practice.
- Feedback from consumers and carers, mental health service staff, emergency department staff, general health staff, lawyers and advocates, Principal Community Visitor, Public Advocate, Health and Community Services Complaints Commissioner, and other Government agencies and Departments.
- Findings of complaints, incidents and investigations.
- Findings of the Independent Commissioner Against Corruption.
- Findings of the Ombudsman and the Coroner.
- Observations of the Office of the Chief Psychiatrist.

- Relevant state and national standards, policies and plans.
- Use of restraint and seclusion in South Australian services.

The review of the policy documents found that the existing Guidelines were too long and too narrative, that all mandatory elements were not included in Chief Psychiatrist Standards, that the Toolkit required additional factsheets and instructions, and that updates to reflect contemporary and emerging best practice were required.

To this end, The Office of the Chief Psychiatrist is revising its restrictive practice policy documents and has developed a draft Restrictive Practice in Mental Health Services Chief Psychiatrist Standard, to replace the Restraint and Seclusion in Mental Health Services Policy Guideline (2015) .

The draft Restrictive Practice in Mental Health Services Chief Psychiatrist Standard was released in 2019. Consultation on the draft standard has occurred with LHNs and other stakeholder with their feedback currently being considered for amendments to the draft.

The final Standard is due for release in 2020-21, in conjunction with a revised Restrictive Practices Toolkit.

Chapter 6
Chief Psychiatrist Inspections and Investigations

The Chief Psychiatrist has powers of inspection under section 90(4) of the Act and is able to delegate these powers to individuals to assist with inspections and investigations; this is covered in more detail in **Chapter 3.**

During 2019-2020 the Office undertook some extensive investigation and inspection reports. While the inspections may be recorded against a single date, some of the more in depth reports required extensive data reviews, and technical analysis.

In March 2020 due to COVID-19 a number of planned inspections were cancelled and key clinical staff in our Safety and Quality team had significant roles in the SA Health and the OCP COVID-19 response, including establishing a key mental Health Liaison Officer Role in the SA COVID-19 Command Centre. Inspections re-commenced in June 2020. During this period work continued on key reports.

There have been legislative changes to enable virtual inspections to be undertaken where necessary to reduce the risks associated with COVID-19. These powers have not been formally used at this time of writing this report, although in June 2020 pre-meeting of an inspection team occurred for a hybrid: gazettal inspection of the to be completed Neuro-behavioural Unit at the Repat Health Precinct in July 2020 which involved local OCP staff attending in person and a psychogeriatrician from NSW and a dementia care expert from Victoria attending virtually.

Inspection Framework

Chief Psychiatrist Inspection Protocol
The Chief Psychiatrist Inspection Protocol was developed in February 2019 and refined during the following months to support the governance of inspection process and to detail roles and responsibilities of both the Office of the Chief Psychiatrist and the Local Health Networks. The Protocol describes how inspections are conducted, the criteria used, and the reporting and recommendation processes in place.

In preparation for an inspection, the inspection team reviews any complaints made, Safety and Learning System reports and Community Visitor reports that relate to the service being inspected. Once on site the inspection team will take notes, may take copies of documents available on site, review case notes and conduct interviews with staff and consumers. Other safety and quality documents and reviews may also be seen.

The Inspection Report constitutes a summary of the informing factors, observations, analysis and recommendations for a particular inspection. Once the initial draft is completed, it is provided to the health service responsible, for a review of any errors in fact. Services commonly provide an initial response to the inspection findings, although this is not formally required until the final report has been settled. Feedback from the service informs the final version of the Inspection Report, including mention of any responses from the services – the report is then formally submitted to the service responsible for action.

The service then provides a response outlining their plans for addressing the recommendations and timelines for doing so. The inspection team documents the recommendations, identified actions and timelines in a database, to enable follow up by the Chief Psychiatrist. The service and the inspection team may identify particular recommendations and actions that are within the scope of existing

safety and quality or service improvements systems and mechanisms, and may refer recommendations for attention through those systems and mechanisms.

Recording of Inspections on the Safety Learning System

During 2019-20, the Safety and Quality Team further refined a project to integrate management of inspections into the state-wide Safety Learning System (SLS). The Inspection module enables the OCP to record Inspection findings directly into the Inspection Module and produce standardised inspection reports which are provided to the service inspected and enables both the OCP and LHN to track recommendations.

New Unit Inspections

During 2019-20 the Chief Psychiatrist was requested to undertake an inspection at four new units to determine the suitability of the unit to be included in an Approved Treatment Centre or to become an Authorised Community Mental Health facility under the Act.

Ongoing meetings between the Office of the Chief Psychiatrist, Building Management, LHNs and where relevant, architects have occurred to ensure suggestions and recommended initiatives are considered early in the planning stage to circumvent last minute, and potentially costly, building alteration. The ongoing involvement of the OCP also contributes to the creation of a positive therapeutic environment

Table 46 – New Unit Inspection

Operator	Facility	Date of Inspection
Home Support Services	Mental Health Rapid Hospital Avoidance Program (operated between June 2019 and March 2020, supporting CALHN RAH – see note below)	23 Jul 2019
BHFLHN	Borderline Personality Disorder Collaborative Clinic	02 Aug 2019
Private	Rose Wards Adelaide Clinic	05 Dec 2019
WCHHN	Paediatric Emergency Department WCH (see note below)	20 Feb 2020
SALHN	Springbank House	02 Mar 2020

For two of the services, an inspection was undertaken but a formal gazettal notice was not published. For the WCHN ED, the new structure updated the existing ED, so a new gazettal notice was not required.

For the Mental Health Rapid Hospital Avoidance Program, the service was subject to a gazettal inspection. However because the service was entirely mobile seeing people in the community it did not meet the definition of an Authorised Community Mental Health Facility, which are understood to have consulting facilities on site. Nevertheless the same process was used for the service, and the staff base inspected. It is anticipated that when the Act is next subject to review a new category of Authorised Community Mental Health Service will be proposed.

The team has also reviewed the design of new facilities at the Lyell McEwin Hospital, however as this is early in the process it is not included above.

Unannounced Inspections

During 2019-20 there were 15 unannounced inspections. The inspections were undertaken with a focus on consumer care and *Mental Health Act 2009* compliance

Table 47 – Unannounced Inspections

Operator	Facility	Date of Inspection
NALHN	Tarnanthi Sub-acute unit	22 Jul 2019
BFLHN	Rural & Remote Inpatient Unit	30 Jul 2019
CALHN	Western Community Team	06 Aug 2019
CALHN	Ward 2G – Royal Adelaide Hospital	20 Aug 2019
SALHN	Noarlunga Emergency Department	24 Aug 2019
CALHN	Western Intermediate Care Centre	25 Sep 2019
SALHN	Jamie Larcombe Centre	23 Oct 2019
NALHN	Ward 1G – Lyell McEwin Hospital	05 Nov 2019
CALHN	Cramond (PICU)	26 Nov 2019
FUNLHN	Whyalla Inpatient Unit	02 Dec 2019
FUNLHN	Whyalla Emergency Department	02 Dec 2019
FUNLHN	Whyalla Community Mental Health Team	03 Dec 2019
FUNLHN	Whyalla Community Rehabilitation Service	03 Dec 2019
WCHN	Whyalla Child & Adolescent Mental Health Service	03 Dec 2019
CALHN	Emergency Department – Royal Adelaide Hospital	02 Jan 2020

Announced Inspection

During 2019-20 there were 9 announced inspections.

Table 48 – Announced Inspections

LHN	Facility	Date of Inspection
SALHN	Ward 5J (PICU), Flinders Medical Centre	22 Jul 2019
SALHN	Morier Ward, Noarlunga (revisit)	22 Aug 2019
SALHN	FMC MH units	24 Aug 2019
NALHN	Woodleigh House	28 Aug 2019
CALHN	Ward SE, Cramond & MH SSU - QEH	03 Sep 2019
NALHN	James Nash House	27 Sep 2019
Ramsay	ECT Unit Inspection – Adelaide Clinic	13 Nov 2019
NALHN	Modbury Woodleigh House	18 Nov 2019
CALHN	Ward SE – Queen Elizabeth Hospital	16 Jan 2020
SALHN	Ward 5J, Flinders Medical Centre	19 Jun 2020
CAHLN	Emergency Department (2F) Royal Adelaide Hospital	26 Jun 2020

In addition to the above Inspection staff working on the COVID-19 response, surveyed the Kahlyn Day (19 March 2020) Centre, and the Adelaide Clinic (23 March 2020) as potential sites for additional bed capacity during the first wave of the pandemic. The Kahlyn site was considered unsuitable for this purpose, but options at the Adelaide Clinic were identified. (The purpose of this arrangement was to enable COVID-19 negative patients to be transferred to beds should public bed capacity be

limited due to COVID-19 positive patients or the space requirements for people who required inpatient care, but also were in quarantine.)

In addition while not classified as inspections three meeting were held to consider the authorisation of restraint devices. These meeting were attended by clinicians and involved either presentations and/or discussion on restraint indications and procedures.

Table 49 – Restraint Device Meetings

Date	Location	Restraint Device Inspected
9 December 2019	RAH Emergency Department	Posy Device
10 December 2019	SAAS Rescue, Retrieval and Aviation Service Facility	Posy Net Device and Prototype net
4 February 2020	WCH Emergency Department	Posy Net Device

Issues Raised During Chief Psychiatrist Inspections

In 2019-20 the OCP undertook 31 inspections, with a number of recommendations made. Those recommendations can be categorised into themes, as displayed in the table 50 below. The themes in the table relate to where more than one recommendation was made that related to that theme. There were multiple occurrences of a single recommendation that was not able to be grouped into a single theme

Table 50 – Themes of Inspection Recommendations made in 2019-20

Recommendation Themes	Number	Percent of total
Ligature safety – including ligature audits	10	16
Door safety	14	23
Model of Care	5	8
Team Communication and systems	7	11
Automated External Defibrillator	2	3
Duress Alarm system	4	6
Consumer Engagement	4	6
Staff (including training/education)	5	8
Cultural Safety	2	3
Building Infrastructure	3	5
Consumer safety	4	6
Clinical Systems	3	5
MHA Consumer Rights	3	5

Example recommendations and example actions taken from the above themes are provided in the table below.

Table 51 – Examples of Findings and Recommendations and Actions

Therapeutic and safe environment
Recommendation A recommendation was made about a ligature risk at a specific, with reference to OCP safety advice. (Details of this risk are not described in this report, because it is still being managed in some other sites.)
Action: • The risk was removed and an alternative solution found.
Documentation of Mental Health Act Orders
Recommendation • A clear system is in place to demonstrate MHA orders and rights are provided to patients and carers.
Action: • The unit has now included MH Act leaflets in the 'welcome packs' provided to consumers and carers upon admission. All MH orders are documented within the Sunrise electronic records system.
Consumer and Carer Feedback
Recommendation • Actively utilise the YES (Your Experience of Services) and MH CES (Carers Experience of Services) surveys, and the Consumer Feedback module within Datix – these will provide the unit with more robust data/information regarding services and patient experience. These are in line with the Mental Health Services Plan; 2020-2025.
Action: • The YES and CES surveys were implemented in the unit within eight weeks of the inspection.

Inspections have been undertaken in health services to create equity in country and metropolitan services and using safety and quality information routinely collected to identify services for inspection. We have also had an interest in inspecting services operating with ageing infrastructure.

In some instances inspection outcomes led to the imposition of gazettal conditions. A list of gazettal conditions made in 19-20 is described earlier in this report.

Investigations

The Office of the Chief Psychiatrist undertook 4 investigations. The following criteria are used from the Office's Investigation Policy. The Chief Psychiatrist would investigate matters:

- Matters of a systemic nature that are related to the delivery of mental health care by the unit or team, or a service.
- Matters involving more than one practitioner or affecting multiple consumers would also be considered.
- Local resolution has not occurred, this may include a complaint has not been resolved by local investigation or could not reasonably be resolved by initiating such an investigation.
- The powers of the Chief Psychiatrist represent the most effective way of resolving the issue.

Mental Health Services investigation
A detailed but preliminary report for this investigation, of services within the Southern Adelaide Local Health Network, was completed. This matter will be discussed further in the 20-21 Annual Report.

A public statement, which has been prepared in the context of the confidentiality provisions of the ICAC Act (the matter was subject of a referral from the ICAC Commissioner) was prepared and released on 2 July 2020 and is available on the Chief Psychiatrist's website.

Prolonged mechanical restraint of a mental health consumer in an emergency department
The OCP undertook an investigation of a mental health consumer's care at the Royal Adelaide Hospital ED was initially commenced by an independent consultant delegated powers under the *Mental Health Act 2009* then followed up by further fact finding by this Office.

The investigation involved the prolonged restraint of a patient who is a prisoner who was also subject to a *Mental Health Act 2009* order.

The investigation report made 10 recommendations involving SA Health, DCS and the OCP in order to avoid similar circumstances in future. These recommendations included distinguishing health restraint from corrections restraint, the recording of corrections restraint under the SA Health Policy, avoidance of ED stays, clarifying relevant policies of accountability leadership reporting and responsibilities, exploration of the transfer of custody to Health from Corrections as can occur when people are brought in by police, and automatic referral to the aboriginal liaison service of any indigenous person subject to mechanical restraint.

These recommendations link with other Restraint and Seclusion work currently underway, and a new standard under development. This work is occurring and the recommendations and their response will be discussed in next year's Annual Report,

The consumer was also offered to be provided with a copy of the investigation report.

Investigation in to delays in Transfer of Care for Mental Health Consumers at South Australian Metropolitan Emergency Department
This investigation was undertaken in response to concerns expressed by South Australian Ambulance Service (SAAS) about increasing problems of mental health (MH) consumers experiencing a delayed transfer of care (TOC) in SA Emergency Departments (EDs), commonly referred to as "ramping". The investigators visited the Emergency Departments of the Royal Adelaide Hospital (RAH), Lyell McEwin Hospital (LMH) and Flinders Medical Centre (FMC). They interviewed representatives from SAAS, and from SA Emergency Departments and Mental Health services.

The investigators also examined data collected about delayed transfer of care and reviewed several policy documents from SA Health and the Australasian College of Emergency Medicine. The investigation met its terms of reference and provided comprehensive reporting which provides analysis and findings of:

- The frequency and duration of delayed TOC/external triaging/ramping of people with a mental illness across the system and at different hospitals;
- Handover of patient care processes in place at different sites
- Determining the effect delays in transfer of care have on consumers, family and staff;
- Compliance with the Mental Health Act (MHA) 2009, and relevant policies during periods of delayed transfer of care

The investigation provided a number of recommendations divided into immediate, urgent, short-term and longer-term recommendations to assist in the prevention of delays in the TOC, or if ramping occurs, strategies to mitigate the effects of these delays, including actions that could be taken by SAAS and receiving hospitals.

Whilst not all recommendations will apply to every emergency department, the report does provide a broad approach that will have relevance for all Local Health Networks. A draft copy was circulated to LHNs, and the report has just been finalised at the time of writing.

The Investigation report will be distributed to Local Health Networks.

An Individual Patient Care Investigation
An investigation into the clinical care and management of an inpatient was undertaken to determine if systemic or individual factors negatively impacted upon their care. The outcome of this investigation is not described as it would identify individuals.

Northern Adelaide Local Health Network – Oakden Follow Up
The Review into Oakden resulted in six recommendations, including its closure. Following consultation and assessment for all consumers of that facility all were transferred to other health care facilities. One of these facilities was Northgate.

An investigation was undertaken to assess the current circumstances and clinical outcomes of a sample of consumers who had resided at Oakden and transitioned to Northgate. The review considered medical records, comments and reports from the Office of the Public Advocate, the Coroner's Office, family members and Northgate House staff, for a total of eight consumers who had transferred from Oakden to Northgate.

The investigation found consumers of Northgate and their families have experienced a high quality of care, and subsequent quality of life (and care in death) that is well resourced, considerate of least restrictive means of care and individualised. The family members spoke highly of Northgate, including the model of care and staffing ratios, individualised care and facility design.

Other matters (not classified as an investigation).
In some instances detailed data analysis and cross correlation of data was undertaken by staff that has been investigatory in nature to support inspection or other quality improvement work but has not been a part of a formal investigation.

Chapter 7
Office of the Chief Psychiatrist

The Chief Psychiatrist has a range of functions that are outlined in Section 90 of *the Mental Health Act 2009*. This includes roles that relate to:

- Promoting continuous improvement in the organisation and delivery of mental health services in South Australia;
- Monitoring the use of restrictive practices; and
- Providing advice on issues relating to mental health.

The reporting requirements set down by the *Mental Health Act 2009* do not require information about these activities. However together they are the largest component of the workload of the Office that supports the Chief Psychiatrist. This chapter outlines some of the work undertaken by the OCP in 2019-20, much of which compliments the statutory role.

7.1 Aboriginal and Torres Strait Islander Mental Health

National, State and SA Health strategy and policy requires the mental health and wellbeing needs of Aboriginal and Torres Strait Islander People to be an integral component of service planning and delivery.

A designated Principal Aboriginal Mental Health Advisor role within the OCP continues to provide oversight and advice for implementing positive changes for mental health service provision to Aboriginal people at department, LHN and the non-Government sector, including:

- Coordination of 22 Aboriginal Mental Health First Aid (AMHFA) trainers to deliver training in South Australia. Training has been delivered to SA Health staff in metropolitan Adelaide and to non-government organisations, including Life without Barriers in the Riverland. Due to COVID-19 restrictions all scheduled training was placed on hold; however they are likely to resume during September 2020. In total 30 individuals have undertaken this training.
- Development of an Aboriginal specific mental health module to 4Mental Health Connecting with People (CwP) Suicide Prevention Training (clinicians only), based on the department's Aboriginal Mental Health Clinical Practice Guideline and Pathways – A culturally appropriate guide for working with Aboriginal mental health consumers
- Working with the Senior Program Manager Safety and Quality Team continues, to improve system data sets to better reflect Aboriginal data collection
- Work on developing five Aboriginal Suicide Prevention Networks with a further five Aboriginal Youth Suicide Prevention Networks in;
    - Point Pearce Aboriginal Community
    - Murray Bridge
    - Gerard Aboriginal Community, Riverland Region
    - Whyalla
    - Davenport Aboriginal Community, Port Augusta
- Concept development for a South Australian Aboriginal Mental Health and Wellbeing Centre of Excellence that can deliver a holistic, culturally-lead mental health and wellbeing service with a toward Zero Suicide approach in reducing Aboriginal suicides in SA.

An additional 12 months of Closing the Gap funding has been provided to the OCP for 2020-21 by the Aboriginal Health directorate, which will significantly bolster capacity in outcomes for the Aboriginal Mental Health programs of the OCP going forward.

Governance development

- In 2019-20, work was undertaken to commence the establishment of the Aboriginal Mental Health and Suicide Prevention Committee to have oversight in the way suicide prevention programs undertaken by the Office of the Chief Psychiatrist will support:
    - Finalising an Aboriginal Suicide Prevention and Wellbeing Plan
    - Development of the Aboriginal Suicide Prevention Networks (Adult & Youth)
    - Development of a South Australian Aboriginal Youth Council
    - Mental Health Aboriginal Workforce Pledge (Policy Development)
    - Development and delivery of key suicide prevention training to communities and others and in language (where possible)
    - Responsibility of the role of Media, including social media
    - Keep Them Here – the Aboriginal Metropolitan Suicide Prevention Network.

Other areas of contribution to Committees and planning included:

- Aboriginal Interagency Forum Group
- Mental Health Services Plan Project Group
- Towards Zero Suicide Project Committee
- NDIS Mental Health Working Group
- SA Health Senior Officers Group Aboriginal Health
- National Suicide Prevention Trial Evaluation Aboriginal and Torres Strait Islander Committee

Training and Education

- 60 Aboriginal health workers across the state have undertaken Connecting with Peoples' (CWP) Suicide Prevention Awareness, Suicide Response, Self-Harm Awareness and Response, Compassion at Work and Emotional Resilience training as part of Nunkuwarrin Yunti's Statewide Aboriginal Health Forum during November 2019 and March 2020.
- As part of the OCP's COVID-19 response to Aboriginal communities, CwP 4Mental Health Suicide Prevention training modules will be delivered to Aboriginal communities across the state to support mental health and wellbeing for members. This training is in partnership with Thirilli – Aboriginal Critical Response Team, OCP and the Aboriginal Mental Health Nurse Practitioner that will provide clinical support.
- Partnership with the Mental Health Training Centre to continue to oversee the delivery of Aboriginal Mental Health First Aid Training across SA and to utilise video resources to provide training via on-line during Covid-19.
- Commenced the work on the review of the Care on Country Training Framework. Review of the training framework designed to build community mental health literacy and capacity to support community members who are experiencing 'dis-ease' of mind, body or spirit and where and how to get help/support. The program is designed so as to be effectively translated in word and concept into local community languages, initially within the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands. Partnerships will be established with health services and community members in local targeted area.

Community engagement

During 2019-20 the team undertook the following community engagement activities:

- National Indigenous Critical Response Team to support Aboriginal people and communities' wellbeing during the COVID-19 pandemic – saw a stronger partnership alliance develop with Thirilli as part of the Virtual Support Network development.
- Young Aboriginal people through Seaford Secondary College, Adelaide Outriggers Club and Headspace engaged with the *Many Clans One Mob* Aboriginal Youth Suicide Prevention and Wellbeing Program.

- OCP also engaged with young Aboriginal men in the Men of Tomorrow – Build Black, Build Deadly program, which has a strong mentoring focus targeting young Aboriginal males to support them growing individually to become better leaders for tomorrow.
- Panel discussion - Indigenous Suicide Prevention Forum, Melbourne
- Dual presentation with 4MentalHealth at the International Association Suicide Prevention Forum in Londonderry, Northern Ireland.

Summary Report: Statewide Aboriginal Mental Health Consultation

'Our-way, New-way, Aboriginal-way' was a phrase captured throughout South Australia during the consultations undertaken for the *Summary Report: Statewide Aboriginal Mental Health Consultation* from July 2010, which remains just as relevant today. Listening to the local people and developing local solutions for local problems is a key driver in the work of the Principal Aboriginal Mental Health Advisor in addressing the 13 key recommendations of the report to improve quality mental health service to Aboriginal communities.

Key aspects progressed in 2019-20:

- Concept development for the proposed South Australian Aboriginal Mental Health and Wellbeing Centre of Excellence – Coordinated Care for Aboriginal Mental Health Across all South Australia (Rec 1.2 Establish an Aboriginal Mental Health and Co-morbidities Unit across the lifespan with clear portfolio responsibilities), now also part of the SA Mental Health Service Plan 2020-2025.
- A discussion to formulate a South Australian Aboriginal Mental Health Emotional Wellbeing and Pandemic Response Policy is underway with Thirilli. The policy is to outline key response to Aboriginal people, families and communities during a pandemic.
- A review of a draft Mental Health Aboriginal Workforce Pledge developed in partnership with Aboriginal Health Branch, SA Health and Local Health Networks had begun. This review will now be undertaken by the Aboriginal Mental Health and Suicide Prevention Committee once it has been established for progression.
- South Australian Aboriginal Suicide Prevention Plan working closely with the Suicide Prevention team within the OCP.

5th National Mental Health and Suicide Prevention Plan

The work within the OCP that has specific focus on improving mental health service delivery and experiences for Aboriginal people, contributes to the key performance indicators of the 5th National Mental Health and Suicide Prevention Plan as outlined below:

- KPI 1 - *Implement improved integrated planning and service delivery for Aboriginal and Torres Strait Islander peoples at state level*
    - Through the SA Mental Health Services Plan – a number of components target Aboriginal and Torres Strait Islander peoples and the changes necessary to improve access and engagement with services.
    - Concept planning and design for the South Australian Aboriginal Mental Health and Wellbeing Centre of Excellence – as a key outcome.
- KPI 2 - *Improve Aboriginal and Torres Strait Islander access to, and experience with, mental health and wellbeing services in collaboration with ACCHS's and other service*
    - Developing Aboriginal Suicide Prevention Networks in partnership with the Suicide Prevention team during 2019-20 have and will continue to contribute to this KPI.
    - Continuing participation in Statewide Aboriginal Health Forums hosted by Nunkuwarrin Yunti.
- KPI 3 - *Roll out of cultural learning training to mental health staff across the department*
    - Roll out of the Aboriginal Mental Health First Aid training with the Mental Health Training Centre to ensure the course continues its in-reach into communities.

- Delivering and encouraging the use of the Aboriginal Mental Health Clinical Practice Guideline and Pathways to Community Mental Health Teams and other service providers that work with Aboriginal mental health consumers.
- CWP Aboriginal module; developing the module targeted towards Non-Indigenous clinicians based on the document '*Aboriginal Mental Health Clinical Practice Guideline and Pathways*'. Further work on accompanying workbook, imaging, films, case studies is required.

- KPI 4 - *Establishment of an Aboriginal Mental Health and Suicide Prevention Committee*
  - Is well in train and will now need to be considered in line with the COVID-19 restrictions.

7.2 Complaints

The *Health and Community Services Complaints Act 2004* provides specific powers and functions for the investigation and resolution of complaints to the Chief Executive of SA Health, the Chief Executive Officer of the Local Health networks and to the Health and Community Services Complaints Commissioner. While the OCP can facilitate feedback or a complaint to a Local Health Network or SA Ambulance Services (SAAS), it will generally not intercede in matters that should be or are being addressed locally.

While the Chief Psychiatrist does not have specific powers and functions relating to complaints, the more general powers to monitor the treatment of patients and the standard of mental health care, and to promote the continuous improvement of mental health services, mean that any extenuating factors raised in complaints may need to be considered as part of those broader functions, and may at times trigger a further OCP investigation process (under the *OCP Investigations Framework*) – see the previous section.

It is expected health units comply with the Department for Health and Wellbeing policy and processes for feedback and complaint handing - *Consumer Feedback Management Policy Directive and Consumer Feedback Management Policy Guideline and Toolkit* (in-turn, aligned to the Department of the Premier and Cabinet (DPC) Circular 039 – Complaint management in the South Australian Public Sector). Wherever possible, the OCP aligns its own complaint and feedback handling procedures to current departmental policy, noting it has additional statutory powers to obtain information, beyond those available to Departmental officials.

During 2019-20, the OCP was a member of the Consumer Feedback and Complaints Management Program Board established by the Safety and Quality Unit, Department for Health and Wellbeing, to review the ICAC Report recommendations and complaints and consumer advisor matters more broadly. The Safety and Quality Unit provides the safety and quality mechanisms of the Department for Health and Wellbeing the Minister, and are the policy owner/driver for complaints, feedback and consumer advisory services policy work.

Part of this work during 2019-20, involved the OCP as a participant in the work of SA Health to review and revise the *Consumer Feedback Management Policy Directive* and *Consumer Feedback Management Policy Guideline and Toolkit.*

In addition the OCP has its own draft Feedback and Complaints Operating Procedure for staff to use to improve consistency in responses.

The *Mental Health Act 2009* provides the Chief Psychiatrist with specific powers relating to mental health safety and quality, monitoring and administration of the Act, in addition to the more general powers given by the *Health Care Act 2008* to the Minister, CE, CEOs and the Safety and Quality Unit,

but does not also provide specific powers for mental health complaints. Nevertheless the OCP is frequently contacted, including through ministerial and Department correspondence, phone calls and emails, from members of the public wishing to raise concerns.

The OCP receives feedback and complaints from consumers, carers, and members of the public, and more rarely from mental health services providers, general health services and other public and private agencies and organisations. Resolution of matters is in the majority of cases first referred to be undertaken at a local health network /SAAS level. Feedback and complaints received by the OCP related to individual patient care and are entered into the SA Health complaints and incident management system, the Safety Learning System, to be investigated by the appropriate health service. Referrals to SALHN are undertaken by email as that LHN's preferred method of transfer. Collegiate relationships with consumer advisers in the Local Health Networks are crucial to this area of work. Complaints to the OCP range from single emails or telephone calls to some extensive matters consisting of tens to hundreds of documents or contacts.

During 2019-20, the OCP formally recorded 115 complaints and 56 inquiries which generated over 500 recorded related activities (i.e. emails, phone-calls and other actions required in follow-up). The OCP also undertook or continued six complex matters. Many of these matters made up the 1,203 activity records generated via the OCP inbox (the generic communication email inbox of the office) during 2019-20.

Not being a service provider, the OCP does not have a designated complaints area, instead complaints, feedback and inquiries received are shared among senior staff to manage and respond.

The OCP can follow the progress and outcome of complaints through the Safety Learning System. Additionally, the OCP will sometimes facilitate communication and complaint resolution between a complainant and a service, refer a matter to another agency such as the Health and Community Services Complaints Commissioner, or make a complaint subject to a Chief Psychiatrist investigation.

The Chief Psychiatrist Complaints Investigation Protocol guides the office in determining which matters will be subject to review or investigation and which matters will be referred to other statutory bodies for investigation. The protocol describes the role and functions for the Office of the Chief Psychiatrist in the investigation of complaints regarding mental health care in South Australia. The protocol describes how the Office will manage complaint investigations, with respect to its statutory role.

7.3 Countering Violence Extremism and Fixated Threat Assessment Centre

The Government has allocated $3.3M Funding over 4 years to a Fixated threat Assessment Centre to respond to people who may be fixated and need a joint response from forensic mental health services and police to ensure the safety of the public. Responsibility for the implementation of the health component of this initiative was transferred to the Northern Adelaide Local Health Network in October 2019, with work commencing in November 2019

7.4 Information Management and Performance Monitoring

National Strategy Involvement:
The team has ongoing participation in national mental health developments that enables SA to inform the Mental Health Information strategy. Specific Team members are active participants in the National Mental Health Information Strategy Standing Committee (MHISSC), and its Performance

Sub Committee and Minimum Dataset Sub Committee. Significant contribution is also made to the Activity Based Funding for Mental Health in development of a casemix model with the Independent Hospital Pricing Authority via the national Mental Health Working Group (MHWG)

Clinical Staff Development:
The team provides training in a number of areas including: the mental health National Outcomes and Casemix Collection (NOCC) outcomes tools; care planning; assessment; Mental Health Act 2009; and information. NOCC training has a focus on embedding the use of outcome measures into clinical practice and maintaining rating standards to a national level. For the last financial year 192 individual staff have undertaken training covering the NOCC tools (HoNOS, LSP-16, K10 and Phase of Care) and their application to practice. During this period the impact of COVID and the lack of a trainer resulted in no face to face training in 2020. Discussion with the MH Training Centre will now provide for this training to be available state wide (Metro and Country). Recent changes now include a dedicated Trainer and online training platforms are in development that will provide distance face to face sessions.

Information Systems Development:
The Mental Health Community Based Information System (CBIS); help desk; screen design; user reports; links to other systems such as Sunrise and Country Consolidated Client Management Engine (CCCME). The Unit serves a central function providing information to and as a resource for teams across metropolitan Adelaide for a range of purposes eg. Activity Based Funding, Community Review, projects, LHN restructures and any other MH service development initiatives including policy formation. In 2019 -20 service development initiatives involvement included BPD Co and three community models of care reviews including SALHN restructure, CAMHS connect triage service, consolidating Older Persons in reach services and ongoing Forensic data systems review discussions. Key improvements in data quality management, printing, and document upload enhance the clinical documentation and information sharing.

Reporting / Monitoring / Evaluation:
National and State dataset reporting, KPI reporting; activity reporting; data monitoring; compliance; business rules; state and national policy implementation; training records and feedback. The team provides clinical information and service development support though frequent ad hoc data requests across the service, as well as monthly performance reporting with the Department and National submissions, inspections reporting information and key initiatives of the OCP.

Increased data activity related to COVID resulted in the development of weekly spread sheet dashboard capturing mental health activity. The unit also provided assistance to Data Reporting Service (DRS). This involved repointing and updating MH reports to clear a backlog of data for national MH reporting.

Systems Training:
CBIS system administrative and clinical use; logons; data integrity; data entry; clinical collection; outcomes tools; care planning; assessment and practice. In 2019 -20, 860 staff were trained (New /Initial 560, Refresher 60, Scheduler 240) this less than the previous year. The impact of COVID and reduced helpdesk staff resulted in a reduction of face to face group training and more individual online sessions. Phone and email Help Desk enquires totalled 7,110 at an average of 30 individual jobs a day.

7.5 Lived Experience

An integrated human rights based approach to design, implementation and evaluation of mental health services and policies requires engagement and participation of people with a lived and living

experience of mental illness and recovery (consumers) as well as those who have a lived and living experience of supporting them (carers).

Collaboration with mental health consumers and carers in the role of the OCP upholds principles derived from the UN- Convention on the Rights of Persons with Disabilities:

- Respect of the inherent dignity of the person
- Equality of opportunity
- Respect for individual autonomy including the freedom to make one's own choices, and be independent.

During this reporting period, the OCP advanced the inclusion of the expertise that the Lived Experience Community provides in a range of ways, outlined below.

The Lived Experience Reference Group (LERG)

The LERG is a committee facilitated by the OCP with the active participation of twelve Lived Experience Representatives. Its role is to provide advice to the business and obligations (e.g. legislative) of the OCP based on the living experience knowledge, insight and expertise of its members.

During this reporting period, the OCP recruited new members to the LERG which brought fresh experience, diversity, and variety in perspective from a wide range of consumers and carers. Lived Experience membership is currently represented by four consumers, four carers, two members from the Aboriginal and Torres Strait Islander community, and two members with a cultural and linguistic diverse background. The LERG is co-chaired by consumer and carer representatives.

Training sessions on the *Mental Health Act 2009* and the OCP Inspection Program were conducted to support the group in understanding the statutory role of the Chief Psychiatrist and inform the LERG's advice to the work of the OCP.

In 2019-20, the LERG achieved an increase in the participation of Lived Experience Representatives in strategic spaces, including:

- Mental Health and Emergency Services –Memorandum of Understanding (MOU) Steering Committee
- Procurement process for the new Urgent Mental Health Care Centre
- Trauma-Informed Practice Working Group
- Towards Zero Suicide Project
- SA Health Mental Health Leadership Group (MHLG)

LERG members also provided valuable input and feedback in the development of critical documents and projects to improve mental health services and experiences, including:

- Eliminating the Use of Restraint and Seclusion in Mental Health Services Chief Psychiatrist Standard
- Consumer and/or Community Advisory Committee Toolkit
- Statewide Consumer, Carer and Community Feedback and Complaints Strategic Framework
- Challenging Behaviours Think Tank
- Quality Improvement of Care around Absconding Events
- Mental Health and Emergency Services MOU
- Philosophy of Care for the Urgent Mental Health Care Centre
- EPAS Review: Integration of CBIS and Sunrise

- BPD Co Peer Group Program (Aboriginal Perspective)
- Statewide data on restrictive practices
- The OCP Learning and Development Steering Committee.
- Productivity Commission Draft Report on Mental Health (via The Productivity Commission Consumer and Carer Roundtable in Adelaide)
- Carer Experience Survey Working Group
- NDIS Taskforce representation
- Recognising and Responding to Acute Deterioration in a Patients Mental State Workgroup

Lived Experience Team at the OCP

The Lived Experience team at the OCP support the objects and guiding principles underpinning the operation of the *Mental Health Act 2009* and the inclusion of lived experience in mental health service design and improvements. In October 2019, a consultation process was undertaken with a range of key external stakeholders on the structure and function of the Lived Experience team within the OCP to consider options and structure.. Recommendations led to:

- A 1.0 FTE Senior Project Officer- Lived Experience Consultant
- Two 0.6FTE ASO-5 Project Officers each – one a personal experience (consumer) focus and one a support experience (carer) with an entry level of ASO-4 created to allow for developmental opportunities in these roles, if needed.

Particular focus in 2019-20 has been on service improvement practices, policies and procedures that affect access and equity, including:

- Procurement Process for the Urgent Mental Health Care Centre (UMHCC)
- Mental Health Services Plan 2020-2025 - implementation planning
- Strategic Mental Health Quality Improvement Committee membership
- Recruitment of Lived Experience Representatives for State Groups and Committees
- COVID-19 Virtual Support Network
- Trauma-Informed Practice Communities of Practice
- OCP Inspection Program
- Roses in the Ocean Suicide Prevention program
- Update on CBIS to identify nominated carers across mental health services
- Trauma Informed Practice Working Group
- Mechanical Restraint Workshops
- Statewide Consumer Feedback and Complaints Strategic Framework
- Lived Experience Round Table Productivity Commission
- National Peer Workforce Guidelines
- Towards Zero Suicide Project

Implementation of the Pilot of the Mental Health Carer Experience Survey (CES) in SA

SA Health's Partnering with Carers Policy Directive requires, all its organisations and services to ensure that carers have the opportunity to be partners in the planning, implementation and evaluation of services and provide feedback.

In 2019-20, a pilot project to support public mental health services to collect, analyse, communicate and implement actions aimed at quality improvement based on the experiences of carers of people receiving mental health care was designed and undertaken by the OCP, in partnership with the LHNs and two Lived Experience representatives

The project engaged 31 mental health teams across 9 LHNs and saw feedback by 200 carers who support a wide range of consumers including children, adults, veterans, and older people, who received mental health care at the inpatient and community mental health services in SA.

Philosophy of Care for the Urgent Mental Health Care Centre

The lived experiences of emergency departments by people who have been mentally unwell have been a key driver in the work of the OCP on the Urgent Mental Health Care Centre. The OCP engaged the Lived Experience Leadership and Advocacy Network (LELAN) and the Australian Centre for Social Innovation (TACSI) to undertake co-design with consumers and carers in developing a Philosophy of Care that could guide the way care and its delivery would be undertaken in the new facility. A building on its own won't improve the lived experience of mental health services but the approaches to care delivery and values of staff can. Having input regarding the experience of mental health care that people truly want and need in times of distress and crisis at the Urgent Mental Health Care Centre has been captured in the Philosophy of Care.

The Lived Experience Workforce Program

During this reporting period, the OCP funded the Lived Experience Workforce Program (LEWP), which has been implemented by the Mental Health Coalition of South Australia. The Lived Experience workforce contributes to embedding a recovery-orientated and person-centred approach in the delivery of mental health services.

Diverse organisations and services are engaged with the LEWP as a consultancy group, to provide advice and information to the work of the program. Professional development activities are implemented in the context of the program:

- Lived Experience Workforce professional development workshop (37 people)
- Training for Leaders of Lived Experience Workforce sessions (34 people)
- Training for Leaders of Lived Experience Workforce sessions tailored to an NGO's specific needs and delivered to their leadership team
- Community of Practice meetings for LE Workers (35 people)
- Peer mentoring (face to face and phone) provided to members of the NGO Lived Experience Workforce regularly as required

Based on LEWP's Peer Supervision Framework, the Program launched an external Peer Supervision, available on a fee-for-service basis to people in paid, designated peer work roles within the NGO mental health sector in SA. It has allowed organisations with no internal option to engage Peer Workforce in practice-specific supervision (group or individual).

Statewide Mental Health Lived Experience Register (the Register)

The Register is the communication program used by the OCP to engage a wider range of consumers, carers and stakeholders interested in the development and subjects related to the Mental Health Lived Experience sector. It includes a contact database of members' names, an e newsletter publication for information sharing, and a recruitment process for advertising and recruiting people for consultation, committee/Board representation, and advice.

7.6 Mental Health Finances

The finances for the Office of the Chief Psychiatrist and the estimated expenditure for mental health services across the state are included in this Annual Report for information.

These funds are part of the consolidated results for the Department for Health and Wellbeing (DHW) and final authoritative statements for the Department are included in its Annual Report. The finances listed below in **Table 52** are components of that overall budget.

Table 52 - Mental Health Estimated Result 2019-20

Agency / Funding Stream	Amount $'000
Central Adelaide LHN	137,579
Northern Adelaide LHN	112,965
Southern Adelaide LHN	91,141
Barossa Fleurieu Hills LHN	30,366
Eyre and Far Northern LHN	2,032
Flinders and Upper Northern LHN	7,341
Riverland, Coorong, Mallee LHN	5,287
Limestone Coast LHN	4,913
Yorke and Northern LHN	3,002
Women's and Children's HN	38,502
Office of the Chief Psychiatrist (DHW)	7,469
Non-Government Organisation Services (administered by Quality Information Performance Branch DHW and OCP)	30,185
Total	470782

Note that this expenditure is indicative only as disaggregating general and mental health expenditure is impossible in some service settings and 2019-20 figures have not yet been fully audited.

A more detailed breakdown of the different components of the total OCP budget is below in **Table 53:**

Table 53 -Office of the Chief Psychiatrist Budget

OCP Budget Component	Amount $'000
Community Visitor Scheme	499
Mental Health Strategy	1,495
Office of the Chief Psychiatrist	2,866
Specialised Aged Care	640
Suicide Prevention	1,427
Wayback Program	339
Premier's Council for Suicide Prevention	203
Total	**7,469**

In addition to the above programs, the Department expended $1,5 million on specific COVID19 mental health strategies.

7.7 Mental Health Strategy

The Mental Health Strategy team assisted with the work required for the development of the following during 2019-20:

- A detailed costing of the implementation of mental health program initiatives identified under the *Mental Health Services Plan 2020-2025.*

- The role for the management of core mental health grants to peak bodies and advocacy groups transferred to the OCP during 2019-2020.

- The team coordinated the transition of complex mental health consumers into 31 supported homes in the community. These complex consumers are from James Nash House, Inpatient Rehabilitation Services and other mental health services. During 2019-2020 all the houses were built and completed by Housing SA. The transition of mental health consumers in the houses has been impacted by COVID-19. As at 30 June 2020, 17 mental health consumers have fully transitioned into their new homes in the community. Feedback from participants, mental health services and NGO providers to date is that they are settling in well and enjoy living in their new homes.

SA NDIS Psychosocial Disability Transition Taskforce

The National Disability Insurance Scheme (NDIS) is a major reform, changing the way disability services, including for people with psychosocial disability, are funded and delivered nationally. Transition to the NDIS for people with primary psychosocial disability in South Australia (SA) began on 1 July 2017 for eligible South Australians in Commonwealth and Department of Human Services (DHS) funded psychosocial programs with the transition of eligible people in SA Health funded psychosocial programs beginning on 1 July 2018.

In June 2018, the Minister for Health and Wellbeing asked the SA Chief Psychiatrist to establish a Taskforce:

- To monitor the impact of the NDIS transition arrangements on clients and service providers, with a particular focus on ensuring continuity of service to clients.
- To advise on appropriate action to address continuity of service issues. This includes remedial action necessary by services, programs and jurisdictions.

- To develop solutions and advise on appropriate actions.
- To identify future issues that may arise.

The SA National Disability Insurance Scheme (NDIS) Psychosocial Disability Transition Taskforce (Taskforce) meets monthly and is supported by a Subgroup which undertakes the work of the Taskforce. Between 1 July 2019 and 30 June 2020, the NDIS Taskforce met on 10 occasions and Taskforce Subgroup met on 30 occasions. The Taskforce reports through the Chair to the Minister for Health and Wellbeing.

The Taskforce has broad membership including state government (Department for Health and Wellbeing (DHW), DHS and Wellbeing SA); Local Health Networks (LHN); Commonwealth Departments of Health and Social Services; National Disability Insurance Agency (NDIA - including NDIA Quality and Safeguards Commission); mental health non-government organisations (NGOs); Adelaide and Country SA Primary Health Networks (PHN); Mental Health Commissioner; Public Advocate; Community Visitor, Health and Community Services Complaints Commissioner and people with Lived Experience.

The Taskforce maintains a draft risk register using the SA Health Risk Management Matrix where key risks are identified, analysed, mitigating strategies put in place and outcomes monitored. The risk register was revised in July/August 2020 with five (5) key risk areas identified. These are:

- Insufficient psychosocial rehabilitation support services that are recovery focussed for SA;
- Difficulty in gaining NDIS access without significant advocacy and, NDIS plans are not meeting participant needs;
- Lack of skilled, sustainable psychosocial workforce leading to thin markets and, at times, a lack of service continuity;
- Lack of support for carers through the NDIS and lack of adequate respite for carers; and
- Insufficient housing with up to 24 hour support for people with high and complex needs.

Key activities undertaken by the Taskforce and its Subgroup between 1 July 2019 and 30 June 2020 include:

- Established the Psychosocial Support Services Governance Committee for monitoring and addressing client related blockages and escalations reporting to the Taskforce. This was a time limited group and three (3) meetings were held. As well, Client Review Panels were established using a partnership arrangement between DHW (including the Office of the Chief Psychiatrist (OCP) and NGO Performance Management Unit); LHNs and NGO psychosocial providers. Panel discussions are held in relation to clients identified to be at risk of not transitioning safely to the NDIS and plans of action developed. As at the 30 June 2020, five (5) panels had been held with 31 action plans put in place.
- Developed and implemented the NDIS Transition Pilot Project which tracked the journeys of over 200 people transitioning from SA Health funded psychosocial programs to the NDIS. The project report outlines 8 key recommendations to improve service delivery and collaborative practice. Between October and December 2019, the Taskforce Subgroup met on a monthly basis as the NDIS Transition Pilot Project Partners Group which provided project guidance and oversight.
- During the period from 19 March 2020 to 14 May 2020, regular Taskforce Subgroup meetings were put on hold and meetings were dedicated to COVID-19 issues and responses particularly relating to NGO psychosocial providers. Group membership was expanded to include all SA Health funded NGO psychosocial providers and clinical mental health services.
- Commenced Stage 1 of the Unmet Needs Project to determine the level of psychosocial rehabilitation and support services required in SA to meet the psychosocial needs of South Australians with mental health conditions using the National Mental Health Services Planning Framework (NMHSPF). This work will be used to inform the review of mental

health NGO services as part of the implementation of the SA Mental Health Services Plan. This work is being undertaken using OCP resources.

- Organised workshops with:
  - Nous Consulting on the NDIA evaluation of the NDIS access process for people with psychosocial disability.
  - NDIS Quality and Safeguards Commission on Restrictive Practices and Positive Behaviour Support Plans.
  - Victorian Department of Health and Human Services on NDIS Market and Psychosocial Disability Providers.
  - Kim Koop Consulting on the NDIS Workforce Capability Project.
- Made submissions and presentations to:
  - South Australian Safeguarding Task Force.
  - NDIS Annual Pricing Review.
- Monitored NDIS client transition through bi-monthly data provided by the NDIS Actuary via the DHS for existing clients of state funded psychosocial disability services.
- Between December 2019 and January 2020, NGO members of the Taskforce Subgroup worked closely with the NGO Performance Management Unit of the SA Department for Health and Wellbeing to develop a new data collection and reporting arrangement for existing clients in SA Health funded one to one psychosocial rehabilitation support services. The new arrangements commenced implementation in February but delays have been experienced due to COVID-19.
- Contributed to the development of Uniting SA's Psychosocial Support Model of Care and participated on NDIS Peer Support Pilot Project Evaluation Steering Committee and roundtable.
- The SA NDIS Psychosocial Disability Transition Taskforce presented to the SA Parliament Social Development Committee's (SDC) Inquiry into the provision of services for people with mental illness under the transition to the National Disability Insurance Scheme on 3 December 2018 and 29 April 2019 to speak on the work of the Taskforce. In December 2019, the SDC released its report which outlined 35 recommendations; with Recommendation 14 specifically relating to the Taskforce. On 17 August 2020, the Cabinet of the SA Government supported the continuance of the Taskforce and that it report through the Annual Report of the Chief Psychiatrist.

7.8 Mental Health Training Centre

It is the vision of the South Australian Mental Health Training Centre to enable all staff employed with mental health services to have access to ongoing learning, support and professional development activities that enhances their capabilities to provide better outcomes for our consumers.

Throughout the reporting period SAMHTC facilitated 70 face to face events with a total of 773 people attending. These events ranged from clinical skills updates to programs facilitating a greater understanding of psychological wellbeing. The utilisation of lived experience learning was trialled during the reporting period with consumers of mental health playing an active role in the delivery of training. Anecdotal evidence suggests that this promoted a far greater understanding from attendees and will be supported in future planning.

In addition a further 516 staff registered as users of the Mental Health Professional Online Development learning portal. This saw a further 838 mental health modules commenced with 598 completed which gave a completion rate of 71%.

7.9 Parliamentary, Ministerial and Chief Executive Matters

During 2019-20 the OCP drafted: 208 briefings and letters for the Minister and Chief Executive in response to communication from external individuals and agencies, 82 briefings regarding OCP portfolio matters, 37 parliamentary briefing notes, 15 estimates briefings, 11 responses to Parliamentary questions and 5 Freedom of Information inquiries.

7.10 Safety and Quality

During 2019-20 the OCP maintained the following Governance committees Chaired by the Chief Psychiatrist to provide oversight to state-wide continuous improvement strategies within mental health services:

- Strategic Mental Health Quality Improvement Committee.
- Psychotropic Drugs Committee.
- Trauma Informed Practice Working Group.

Key Achievement during 2019-20 included:

- Continuing implementation of an enhanced program of inspections and investigations. Further information regarding inspections and investigations is available in **Chapter 6**;
- Project successfully competed to develop an Inspection Module in the Safety Learning System (SLS). Further information on this work is available in **Chapter 6**;
- Development of a new draft Chief Psychiatrist Standard for Eliminating the Use of Restraint and Seclusion in Mental Health Services. This draft has been circulated widely to key stakeholders for targeted and intensive feedback. Work is currently underway to assess all feedback and finalise this standard for use by Mental Health Services;
- Ongoing access for SA Health staff to Choice and Medication ©, which enables provision of consumer-centred medication information and facilitates shared decision-making for consumers and staff. Following its introduction last year, this medicines information website resource has been well utilised, with positive feedback from staff;
- The Extreme Heat process was reviewed with SES and Disaster Preparedness Resilience Branch (DPRB). All LHNs were engaged and involved in this process;
- GP Shared Care – A metro wide GP liaison group has been established with involvement from GP liaison GPs, nurses and clinical staff from LHNs and DASSA. The aim of this group is to improve communication and awareness of mental health services and support to GPs;
- Metabolic Health – A review has been completed of the biomedical health record. Smoking, nutrition, alcohol and physical activity data are being incorporated into the current physical health screen. The current aim of this work is to raise the profile of physical health assessment through the joint GP liaison and physical health communications plan.
- The Novel Respiratory Pathogen Screening Tool was developed and implemented in CBIS. This screening tool includes both COVID-19 and influenza status. It is a dynamic tool which is updated on a regular basis as determined by CDCB guidelines and information. Uptake has been very positive to date.
- The Clozapine Strategic Management Group continues to monitor clozapine management across SA Health. This year the suite of clinical recording tools have been updated and implemented. The SA Health Clozapine Management Clinical Guideline has been reviewed. Off label use of atropine eye drops for treatment of hypersalivation has been reviewed and strongly discouraged with SA Health agreeing to subsidise hyoscine prescription for community consumers. Audits of Clozapine SA Health guidelines and TGA protocol have occurred across all LHNs.

Incidents

The Safety Learning System (SLS) Incident Management module supports SA Health staff to record, manage, investigate and analyse patient and worker incidents, as well as consumer feedback.

Patient and consumer incidents are recognised, reported and analysed to improve safety systems and prevent recurrence.

The Safety Assessment Code (SAC) rating is derived from a matrix that matches consequence of the incident for the patient with the likelihood or probability of recurrence. The SAC rating guides the level of investigation and management for each incident that is undertaken by the incident managers. SAC 1 and 2 are considered to represent harmful incidents.

Between 1 July 2019 and 30 June 2020, there was a decrease by 2% in Total Incidents Reported, a decrease by 14% in the number of SAC 1 incidents and a 13% decrease in SAC 2 incidents in mental health services compared to 2018-19.

Table 52 – Statewide Mental Health Service SLS Incidents

Incidents	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Overall MH Incidents	9426	9338	12588	10176	9900	9722
SAC 1s	60	80	85	68	89	66
SAC 2s	45	33	64	35	44	42

Sentinel Events

Sentinel events in inpatient units are based on national safety standards. Within mental health this is usually restricted to suicide deaths during inpatient care. There were no sentinel events in SA mental health units in 2019-20.

Financial year	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Sentinel events	0	2	0	3	1	0

7.11 COVID-19 Mental Health Response

The risks from mental health sequelae of isolation and the social and economic impacts of COVID-19 are likely to persist for some time. For people who are infected with COVID-19, research indicates there is potential for approximately 50 percent to also experience psychiatric symptoms. For the general population, physical distancing measures may result in disruption to social support networks that serve as a protective factor from crisis and risk of suicide. Physical distancing measures are also resulting in the loss of employment, which may contribute to the development of mental health concerns.

The Office of the Chief Psychiatrist (OCP), Wellbeing SA, SA Mental Health Commissioners and the Office of the Premier's Advocate for Suicide Prevention established the COVID-19 Mental Health Response which established a Virtual Support Network (VSN). The initial funding for the VSN ($1.277M) was approved for the period 31 March 2020 to 30 June 2020, with 7 Non-government organisations receiving grant funding to implement a range of services using telephone and online platforms. The focus of the initial stage of the COVID-19 Mental Health Response the VSN encompassed:

1. Prevention – Information and resources for the general population to protect their mental health during the COVID 19 pandemic.
2. Once off support and advice – Telephone, video conference or online chat support services for people to connect to.
3. Initial contact and follow up – For those people needing follow up support subsequent to initial contact with a service.
4. Crisis – Support for those in mental health crisis.
5. Vulnerable Groups – Phone or video conference support initiated by a service to know vulnerable people.
6. Self-isolating population, people in quarantine, and people who are staying at home and isolated. – Video and phone support for people who are in self-isolation due to a positive COVID 19 diagnosis.

The Chief Psychiatrist and the Commissioner for Public Sector Employment were invited to submit further strategies to address the continued risk of increasing mental health needs in the community and public sector workforce in the context of COVID-19. Additional funding was approved for stage 2 of the COVID-19 Mental Health Response for the purpose of:

1. Extension of the VSN support services provided in the initial stage to 30 September 2020 ($1.259M)
2. An additional eight mental health strategies collaboratively designed to be implemented during the second stage of the VSN:
    a) Engaging consumers with a severe mental illness (support for the SA government Tertiary Mental Health Services)
    b) Increasing therapeutic and non-clinical support initiatives for children and young adolescents affected by social isolation and the economic impacts of COVID-19
    c) Increasing capacity to provide mental health services for older persons to residents in aged care
    d) Expanding mental health support services for Aboriginal and Torres Strait Islander People related to COVID-19
    e) Ensuring greater stability of non-government psychosocial disability support during the pandemic for people transitioning to the NDIS
    f) Increasing youth detention and prisoner mental health in-reach services during the pandemic through the State Forensic mental health service
    g) Increasing the capacity of the Drug and Alcohol Services COVID-19 response through the Drug and Alcohol Services South Australia (DASSA)
    h) Increasing the mental health workforce support to South Australian Public Sector (SAPS) employees to mitigate the risks of stress, burnout, trauma and PTSD to the SAPS employees during COVID-19.
        - additional training of Peer Support Officers for informal support to employees of other agencies; and
        - additional access to Employee Assistance Program (EAP) counselling for front line employees, including police, doctors, nurses, teachers and other employees providing services directly to the community.

Extension of the existing stage 1 VSN programs until 30 September 2020 and the implementation of stage 2 initiatives recognises that the social and economic impacts of the COVID-19 pandemic will have an impact on the mental health and wellbeing of the community, and access to support services will still be required long after the immediate risk of the virus itself has reduced.

Governance and Structure

A governance committee structure was established to oversee the funding provided to the Virtual Support Network. The structure consisted of the SA COVID Mental Health Response (Virtual Support Network) Oversight Committee and the SA Mental Health Virtual Support Network Strategy and

Coordination Committee. The role of the Oversight Committee is to provide oversight of the allocation of funding through the relevant commissioning process as well as recommendations on the strategic direction of the fund.

The role of the Network Strategy and Coordination Committee is to provide oversight of the strategic and operational matters associated with the establishment and ongoing operation of the SA Mental Health Virtual Support Network. The Strategy and Coordination Committee membership includes representatives from each of the funded providers of the Network and meets on a fortnightly basis.

Monitoring and Evaluation
Real time evaluation of the effectiveness of the mental health response has been undertaken during the COVID-19 pandemic through a formal agreement with the University of South Australia. Monthly data from participating agencies is provided to UniSA who then collate and analyse the data and provide in a monthly report format. The monthly reports are reviewed by the SA COVID Mental Health Response (Virtual Support Network) Oversight Committee to monitor the overall performance of the COVID-19 Mental Health Response.

A dashboard has also been maintained by the CBIS Information team of key mental health information – including suicide deaths, use of phone lines, ED presentation and service use.

7.12 Urgent Mental Health Care Centre

The Federal government's 2019 budget allocated $114.5 million for the establishment of eight community mental health walk-in services across Australia over 5 years from 2020-21.

The Minister for Health and Wellbeing and the Federal Minister for Trade, Tourism and Investment, Simon Birmingham announced a $14 million federal investment for a priority mental health (or Urgent) care centre for South Australia in May 2019.

The service aligns with the Crisis Response component of the Mental Health Services Plan 2020 - 2025

The Office of the Chief Psychiatrist facilitated a co-design process with Lived Experience to develop the model of care and facility design for the Urgent Mental Health Care Centre as an alternative to an Emergency Department when requiring to access mental health care in a crisis.

It is proposed that the Urgent Mental Health Care Centre would enable ambulance and police to bring people with a mental illness to a clinic for urgent assessment as well as allowing people to self-present. The clinic will operate for 12 hours a day, seven days a week.

The service will provide an alternative to presenting to an emergency department for patients in the triage 3, 4 and 5 categories (urgent, semi urgent or not urgent). The benefits of an Urgent Mental Health Care facility will include:

- Reduction of the reliance on Emergency Departments for urgent assessments;
- Facilitation of community based assessment of mental health consumers and direct entry to inpatient services when required;
- Provide a service to approximately 15 clients per day that would otherwise seek an emergency department service; and
- Accept ambulance and police referrals up to triage category three (to be seen within 30 minutes).

An open market Expression of Interest (EOI) was advertised via the SA Government Tenders Website on the 24 February 2020. The initial closing date was 23 March 2020 which due to industry feedback and in consideration of COVID-19 was extended to 15 April 2020. An industry briefing was held on 11 March 2020 with a total of 12 registrations for people from both Government (LHN) and Non-Government organisations.

The Evaluation Process for the Expression of Interest commenced in late 2019-20. The process included the establishment of an Evaluation Team and a Lived Experience Panel to review the respondent applications. The successful applicant was announced recently.

7.13 Bushfire Response

The Office of the Chief Psychiatrist, Barossa Hills Fleurieu Local Health Network (BHFLHN) and Child and Adolescent Mental Health Services (CAMHS) have worked to increase specialist mental health services for bushfire affected communities in the Adelaide Hills and Kangaroo Island regions. Additional funding was approved, with flexibility to apply the funding based on service demand in the affected regions and to deliver evidence-based practice in response to the emerging needs throughout the recovery phase.

This project aims to provide increased specialist mental health services within the first 2 years to support the recovery of the affected communities and to minimise the long term mental health impacts for children, young people, adults and older people. The Bushfire Mental Health Recovery Project is based on augmenting existing services that are already well connected in the affected regions. It builds on existing partnerships and referral pathways with other services across the full continuum of care, improving the communities' access to services in their local area.

This project focuses on the provision of services for those experiencing or at-risk of experiencing, significant mental health impacts or those requiring more immediate support. This includes the impacts of significant trauma, exacerbation of existing mental health conditions, increased risk of suicide and/or self-harm, Depressive illness, Post-Traumatic Stress Disorder, and those requiring more intensive and longer-term specialist mental health support based on their individual needs and circumstances. It includes broad based PTSD screening programs in the affected communities, and specialist assessment and therapy provided to community members identified as at risk. This includes screening, assessing and providing early intervention for children and young people who are at risk of experiencing longer term impacts to their mental health and wellbeing.

These services are accessible to all members of the community affected by the bushfires in some way. This includes people directly affected by the fires, those who may have been traumatised by the fear of the fires, those who have been affected by the significant loss and trauma experienced by close family or friends, or those who have experienced significant economic impacts due to the disaster. This also includes supporting first responders and their families.

The Bushfire Recovery Mental Health Project has been funded for 2 years, commencing on 1 July 2020. The funding supports a total of 9.5 FTE Clinical Resources for Local Health Networks and 1.0 FTE for Mental Health Disaster Planner within the Office of the Chief Psychiatrist. The funding breakdown is as follows:

CAMHS

- Kangaroo Island: 2.0 FTE
- Adelaide Hills: 2.5 FTE

BHFLHN

- Kangaroo Island: 2.5 FTE
- Adelaide Hills: 2.5 FTE

Office of the Chief Psychiatrist
Mental Health Disaster Planner
Total FTE: 1.0

Project Monitoring
A monthly Project Steering Group meeting has been established to provide a mechanism for agencies to report on project implementation, outcomes, project risks, gaps or barriers identified, and strategies for adapting approaches to meet the needs of the communities.
Monthly project reports will be provided to the Department for Premier and Cabinet to demonstrate the application of resources for their intended purpose and to report on outcomes. A final monitoring and evaluation report will be provided to the Department for Premier and Cabinet at the conclusion of the project.

7.14 State Mental Health Services Plan 2020-2025

The State's Chief Psychiatrist and Mental Health Commissioner were tasked with developing a new Mental Health Services Plan for South Australia. Both offices worked in close collaboration to develop a Plan that provides a renewed five-year vision for the delivery of Department for Health and Wellbeing operated and commissioned mental health services in the State. The Mental Health Services Plan 2020-25 was released on 2 November 2019.

Outcomes based plan
The MHSP is an outcome-based plan focused on the key goals of personalisation, integration and the safety and quality of services. The Plan identifies outcomes which are underpinned by the three goals:

- Personalised care and support
- Integrated Care
- Safe and High Quality Care

MHSP Implementation
The implementation of the plan will be guided by a governance structure established in late 2019-20 which includes the Mental Health Services Plan Implementation Oversight Group to oversee the overall implementation of the plan. Additional committees to be established will include an Advisory Group and a Human Rights Group. They are expected to set up in early 2020-21.

The implementation of the plan will require consultation and agreement of the Local Health Networks and other providers of mental health services in close consultation and collaboration with consumers and carers. The implementation of the plan will be evaluated at key points of the live of the plan to ensure implementation is on track and any new and emerging approaches that may develop are taken into account during the implementation.

MHSP Initiatives
Planning for number of initiatives commenced in 2019-20 these initiatives include, a Towards Zero Suicide initiative, an Urgent Mental Health Centre, and a Neurobehavioural Unit for Older Persons who experience behavioural and personality symptoms secondary to dementia. Specific work has also commenced on the development of a co-designed state-wide Lived Experience Workforce Framework and program which will strengthen the delivery of recovery oriented services. It is also a priority in Mental Health Services to increase collection and reporting of customer experience measures and work in this area has commenced.

7.15 Specialised Aged Care Reform Program

The Specialised Aged Care Service Reform Program was developed to support the next steps in progressing the work of the Oakden Oversight Committee. The Office of the Chief Psychiatrist in partnership with the Office for Ageing Well and the Infrastructure department of the Department for Health and Wellbeing have worked to implement a number of the recommendations of the Oakden Report Response in 2019-20.

The Dementia Village at the Repat

Work has commenced to develop a Dementia Village at the Repat Health Precinct as part of the re-activation of the site. This village will encompass a variety of specialised care for people living with dementia including:

1. A **Neurobehavioural Unit** – for people living with the most extreme behavioural and psychological symptoms of dementia (Tier 7 BPSD)
2. A **Specialised Dementia Care Unit** – for people with severe behavioural and psychological symptoms of dementia (Tier 5/6 BPSD)
3. A **cottage style dementia village** to provide residential aged care for people living with dementia.

The Neurobehavioural Unit:

A Neurobehavioural Unit (NBU) has been designed to care for people with the most extreme behavioural and psychological symptoms of dementia (Tier 7). Building work to refurbish the Ward 18 was completed and the NBU is expected to commence operation at the end of 2020. The design process for the neurobehavioural unit benefitted greatly from the input from people with lived experience of dementia and lived experience representatives were invited to tour the site during renovations to continue this collaboration.

An expression of interest process to select the Local Health Network (LHN) to provide the clinical governance and operate the NBU was completed with the Southern Adelaide Local Health Network (SALHN) being the successful applicant. SALHN will work to implement the model of care described in the Oakden Report Response in the Unit.

The Specialised Dementia Care Unit and Dementia Specific Aged Care

In April 2020, the first Specialist Dementia Care Unit (SDCU) opened in South Australia. This unit is located in Felixstowe at Aldersgate Residential Aged Care, operated by Uniting Communities. This was an exciting milestone for South Australia as it is the first residential care facility of its kind to provide care for people living with dementia with severe behavioural and psychological symptoms (Tier 5/6). This unit is part of an ongoing Commonwealth program that will also include a unit to be opened at the Repat Health Precinct.

Support to Residential Aged Care

Specialist in reach services provide responsive specialist in-reach into mainstream residential aged care from SA Health community older person's mental health teams to support that care of older people with dementia and enduring mental illness. The purpose of this service is to prevent the need for people to transfer to hospital unnecessarily or to support discharge from hospital to aged care facilities. The service includes timely assessment for those living in residential aged care facilities as well as specialist training and assistance for staff working in the facility.

The establishment of these services were recommended in the Oakden Report Response and in 2019/20 became operational across all adult Local Health Networks in metropolitan South Australia. In country South Australia the service is hosted through the Rural and Remote Mental Health Service based at Glenside Campus and is supported by a multi-disciplinary team consisting of a consultant psychiatrist, social worker, nurse, neuropsychologist and occupational therapist.

In 2019/20 *Wrap Around* funding was provided to Local Health Networks to support residential aged care providers to care for people with dementia and enduring mental illness through the provision of additional staffing in the facility. This interim strategy was recommended in the Oakden Report Response to support residents returning from hospital or to additional provide care so that residents would not need to transfer to hospital unnecessarily.

A Community of Practice workshop was held in August 2019. This workshop had a focus on contemporary dementia care, including the more specific needs of people with behavioural and psychological symptoms of dementia. A range of stakeholders attended including people with lived experience of dementia, aged care providers, academics from major universities in South Australia, SA Health staff and mental health workers.

Trials of new therapeutic approaches

People living with dementia sometimes need to be admitted to hospital for management of their symptoms. Hospital environments can sometimes cause distress to people living with dementia as they can be confusing, noisy, and not very homelike. In response to this, in 2019/20 allied health and nursing staff in each of the Local Health Networks have developed proposals for the trial of different therapeutic approaches in their older person's mental health units. The intention of the projects was to test which approaches have the most benefit for the wellbeing of the residents in the units. This includes smart technology to create interactive displays, soft gym and other outdoor equipment and the development of a therapeutic garden designed to retain physical function during admission. Teams worked with a Dementia Research Fellow from Flinders University on the development and evaluation of the trial projects. Some trials commenced in 2019/20, while other were unfortunately delayed due to COVID-19, however results of the trials will help to inform the purchase of therapeutic equipment for the neurobehavioural unit.

7.16 Suicide Prevention

The South Australian Suicide Prevention Plan 2017-2021 (The SASPP) comprises three key action areas:

- Making people a priority;
- Empowering communities; and
- Translating evidence into practice.

During 2019-20 there has been an expansion in activity. The Office is grateful for the assistance of the staff of the Premier's Advocate for Suicide Prevention in organising events and other logistics.

The Plan was supported with the provision of an additional $2.5m funding over four years 2018 – 2022.

The ability to implement the Plan was severely curtailed by the twin events of Bushfires and COVID-19. The lack of ability to undertake face to face interactions limited the ability to undertake planned Community events with Suicide Prevention Networks (SPN's), the implementation of new SPN's and the state-wide Suicide Mitigation program Connecting with People.

Given the easing of restrictions with South Australia, this work is re-commencing with new initiatives underway for Connecting with People implementation in restricted environments.

Suicide Prevention Networks

During 2019-20 the Office of the Chief Psychiatrist supported the establishment of a further three Suicide Prevention Networks (SPNs) taking the number to 40. During this year the OCP has commenced working with the first responder community to better support frontline workers and their families impacted by suicide and suicidality through the course of their work. Additional work in developing SPNs was paused due to the impact of COVID-19.

The SPN's Network that was able to be developed in 2019-20 were the:

- Seeds of Hope SPN in the Barossa Valley Council Region
- Beacon of Hope SPN, in the District Council of Tumby Bay.

SPNs are designed to empower communities to take local action to prevent suicide. An SPN is formed though the collaborative efforts of the OCP, Local Government and community members who want to prevent suicide in their community. The membership is diverse and each SPN is supported to develop an Action Plan, facilitated by the OCP. The Action Plan provides a vision, mission statement and provides actions that are within the capacity of the SPN, specific to their own community.

In previous years, the OCP in collaboration with the Office of the Premier's Advocate for Suicide Prevention has facilitated the state-wide and regional Network of Network Forums to support the SPNs to acquire new skills and share their experiences. Further to this, an Aboriginal Suicide Prevention forum was planned to begin identifying ways to reduce Aboriginal suicide. Due to the restrictions on gatherings due to the COVID-19 response, these events were cancelled.

Suicide Prevention Community Grants

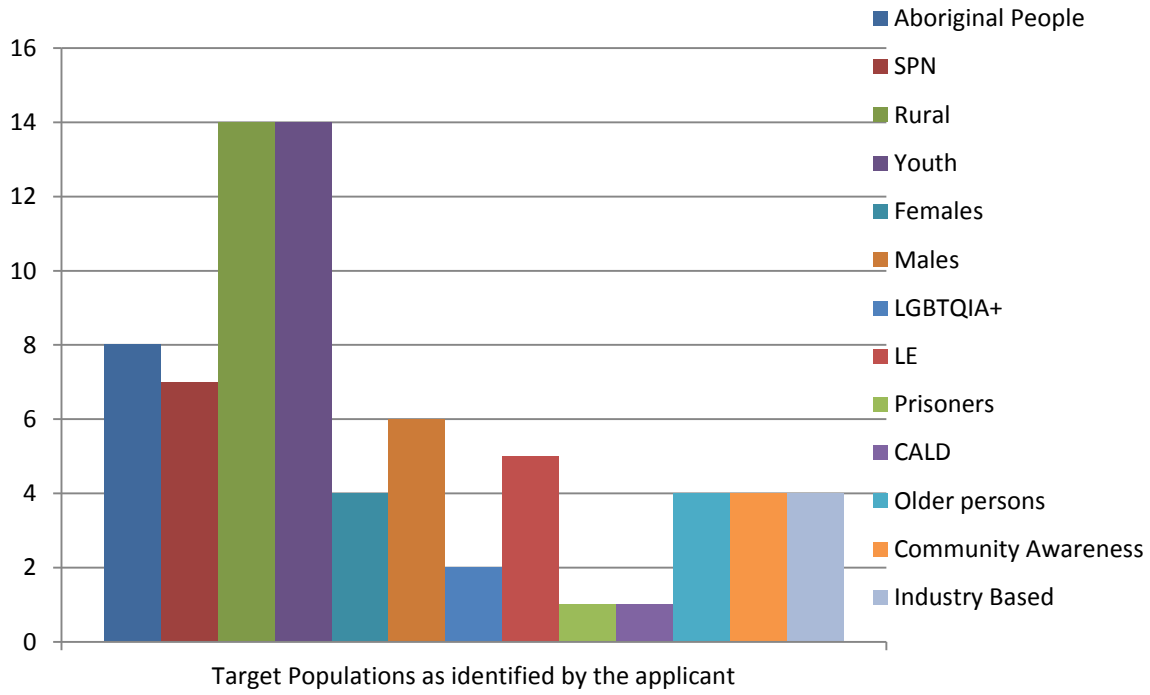
The Suicide Prevention Community Grants Scheme has operated since 2014-15 to assist community groups, non-government organisations and businesses to carry out suicide prevention activities and projects. The grants with a value of up to $10,000 promoted the outcomes and objectives of the Suicide Prevention Plan 2017-21.

Of the record 64 applications received for there were 20 successful applicants with grants awarded totalling $150,000. The grants provided activities and programmes to a diverse audience as per tables 55 and 56.

Table 55 - 2019-2020 Suicide Prevention Community Grants Scheme Recipients

Applicant	Project	Grant
Wesley LifeForce	The Enemy Within	$10,000
West Coast Youth and Community Support	Mentally Fit EP: Living Works! A celebration of life and it's unique challenges explored through short film	$10,000
Lived Experience Leadership & Advocacy Network	Learning from Lived Experience	$9,000
Every Life Matters SPN	Young People Matter	$3,000
Empowering Lower Eyre SPN	In safe hands	$7,000
Moolagoo Mob (Aboriginal LGBTIQ) Social & Emotional Well-being Group	'Unfinished Business' Art Exhibition and Aboriginal Elders Voices - Digital Story-Telling Project	$10,000
Adelaide Outriggers	Many Clans One Mob	$8,000
The Mental Health Coalition of South Australia	A New Tool for Tradies: The Ultimate Mental Health Guide	$9,750
OARS Community Transitions	Prevention's not a game	$10,000
Around the Campfire Inc	2019 Adelaide Around the Campfire Cup	$10,000
Lakeside Men's Shed	Lakeside Men's Shed BBQ	$8,600
SOS Yorkes SPN	SOS Yorkes - Connecting with our Community	$5,400
Hackham West Community Centre	Men of Tomorrow	$10,000
Ski for Life Inc	Ski for Life Event	$2,500
Legacy Club of South Australia and Broken Hill Inc	Engaging with Grief for Defence Families	$8,000
Treasuring Life Aboriginal and/or Torres Strait Islander SPN	Message Sticks Project	$10,000
Goodwood Saints Football Club	Saints Healthy Minds	$2,750
Living Well SPN	Living Well SPN Suicide Awareness community event 2019	$8,000
Shaping Futures	Suicide Prevention Roadshow : connecting and supporting rural communities	$5,000
Aboriginal Community Connect Uniting Communities	Spirited Men's Group Men's Camp	$3,000
TOTAL		**$150,000**

Figure 6 – Supported Population Groups SASPCG 2019-20



Connecting with People Training

In 2019-20 the Connecting with People Suicide Mitigation training has continued in the LHNs and other sectors of the community. The inclusion of the Connecting with People assessment tool on CBIS has resulted in a total of 275 (64 Regional and 211 Metropolitan/BPD) Safety Plans being developed. During 2019-20, xx SA Health staff were trained in Connecting with People whilst 915 people from NGOs, government departments, SPNs and community have been trained in CWP.

The implementation of Connecting with People in 2019-20 has been severely curtailed by the emergence of COVID-19. This work is now progressing within social distancing practices and the development of virtual training means.

In 2019-20, two cohorts of training were provided to facilitate fourteen 2016-2017, ten clinicians to be were trained as Connecting with People trainers. South Australia now has 29 accredited trainers to provide the state-wide approach to Suicide Mitigation. , a further 16 clinicians were trained in 2017-2018. Of the 26 there are 15 continuing as trainers and a further 8 CWP trainers were trained in July 2019.

The table below outlines the number of individuals trained in Connecting with People for the period from 2016 to 2019.

The program has been supported by the work of Professor Nicholas Procter (University of South Australia), a master trainer in the Connecting with People approach.

Towards Zero Suicide

The South Australian Mental Health Services Plan 2020-25 includes implementing the Towards Zero Suicide initiative, within tertiary mental health services. The approach represents a journey towards Zero Suicides as an aspirational goal. Using evidence informed suicide prevention practices, it is underpinned by a safe working environment, using restorative, learning principles, even when things go wrong.

Implemented in line with the internationally recognised Zero Suicide Toolkit, and adhering to the fidelity of this approach, organisations within Australia and overseas have reduced suicide rates for people known to specialist mental health services.

Engagement with consumers, their families and staff is integral to the approach, both in terms of service development and delivery. It will support clinicians to work in partnership with consumers and their families, from a person-centred perspective, empowering people to recognise and manage their symptoms of suicidal distress, thereby saving lives.

Work is underway, engaging with Local Health Networks exploring options for delivery.

Reporting

The numbers of live lost to suicide will be reported by the ABS in October this year, so for this reason is not discussed in this year's Annual Report, but will be considered in next year's Annual Report along with progress towards a suicide register

Translating Evidence into Practice

The establishment of the South Australian Suicide Register (the Register), is an objective of the Office of the Chief Psychiatrist as outlined in the South Australian Suicide Prevention Plan 2017 – 2021.

This work has culminated in the preliminary development of architecture for a South Australian Suicide Register; a co-ordinated project between The Coroner's Court of South Australia, the Office of the Chief Psychiatrist and Wellbeing SA.

The plan states that the development of the Suicide Register will provide accurate and early identification of trends in suicide and information to enable rapid response to community distress and suicide in South Australia.

The Register is intended to better inform prevention, intervention and postvention practices and service provision and increase understanding of suicide in South Australia.

The continued development of the Register will enable an evidence base which will impact on the valuable work undertaken by the Coroner's Court of South Australia (Coroner's Court), the Office of the Chief Psychiatrist (OCP), Wellbeing SA, Non-government organisations and universities, to provide best practice programs and information relating to suicide prevention activities.

Appendix 1 – Listing of Facilities

Approved Treatment Centres

Metropolitan

- Adelaide Clinic, 33 Park Terrace, Gilberton SA 5081.
- Flinders Medical Centre, Flinders Drive, Bedford Park SA 5042.
- Glenside Health Service, 226 Fullarton Road, Glenside SA 5065.
- James Nash House, 140 Hilltop Drive, Oakden SA 5086.
- Jamie Larcombe Centre, Glenside Health Service Campus, Glenside SA 5065.
- Lyell McEwin Health Service, Haydown Road, Elizabeth Vale SA 5112.
- Modbury Hospital, 41-69 Smart Road, Modbury SA 5092.
- Noarlunga Health Services, Alexander Kelly Drive, Noarlunga Centre SA 5168.
- Royal Adelaide Hospital, Port Road, Adelaide SA 5000.
- The Queen Elizabeth Hospital, 28 Woodville Road, Woodville South SA 5011.
- Women's and Children's Hospital, 72 King William Road, Adelaide SA 5000

Country Facilities

- Mt Gambier and Districts Health Service, 276-300 Wehl Street North, Mount Gambier SA 5290,
- Riverland General Hospital, 10 Maddern Street, Berri SA 5343, and
- Whyalla Hospital and Health Service, 20 Wood Terrace, Whyalla South SA 5600, all subject to the following conditions:

Authorised Community Mental Health Facilities

- Ashton House Forensic Rehabilitation Step Down Unit, 290 Fosters Road, Oakden SA 5086.
- Eastern Community Mental Health Service, 172 Glynburn Road, Tranmere SA 5073.
- Elpida House, 16 Lurline Street, Mile End SA 5031.
- Marion Community Mental Health Services, Marion GP Plus, 10 Milham Street, Oaklands Park SA 5046.
- Noarlunga Community Mental Health Services (Adaire Clinic), Noarlunga GP Plus, Alexander Kelly Drive, Noarlunga Centre SA 5168.
- North East Community Mental Health Centre, 116 Reservoir Road, Modbury SA 5092 (excluding Owenia House and The Gully).
- Northern Community Mental Health Centre, 7-9 Park Terrace, Salisbury SA 5108.
- Northern Older Persons Mental Health Service, 116 Reservoir Rd, Modbury SA 5092.
- Older Persons Mental Health Services (Southern Community Team), Repat Health Precinct, Daws Rd, Daw Park SA 5041.
- Southern Intermediate Care Centre, Jackson Place, Noarlunga Centre SA 5168.
- Trevor Parry Centre, 9 Greybox Avenue, Noarlunga Centre SA 5168.
- Western Community Mental Health Service, 57 Woodville Road, Woodville SA 5011.
- Western Intermediate Care Centre, 102/94 Portland Road, Queenstown SA 5014.
- Wondakka Community Rehabilitation Centre, 10 Saratoga Road, Elizabeth East SA 5112.

Appendix 2 – Forms and Statements of Rights – *Mental Health Act 2009*

Forms

- MRMHA-A Community Treatment Order Level 1
- MRMHA-B Inpatient Treatment Order Level 1
- MRMHA-C Confirmation or Revocation
- MRMHA-D Inpatient Treatment Order Level 2
- MRMHA-E Statement of Reason or Report
- MRMHA-F Leave of Absence
- MHMHA-G Treatment and Care Plan
- MRMHA-H1 Checklist for Community Treatment Orders
- MRMHA-H2 Checklist for Inpatient Treatment Order
- MRMHA-I Patient Transport Request
- MRMHA-J Patient Assistance Request
- MRMHA-K Involuntary Patient Transfer
- MRMHA-L Consent for ECT
- MRMHA-M Emergency ECT without Consent
- MRMHA-N Neurosurgery for Mental Illness Application
- MRMHA-O Consent for Sharing Information
- MRMHA-P Consent for Solicitor to View
- MRMHA-Q Undertaking Not to Disclose to Patient
- MRMHA-R Interstate Request
- MRMHA-S Treatment in SA under Interstate Order
- MRMHA-T Interstate Transfer Request

Statements of Rights

- 1 – Voluntary Admissions
- 2 – Care and Control
- 3 – Community Treatment Orders
- 4 – Inpatient Treatment Orders
- 5 – Leave of Absence

The statements of rights are available in: Arabic, Chinese (simplified), Croatian, English, German, Greek, Hindi, Italian, Persian, Polish, Russian, Serbian, Sinhalese, Spanish, Swahili and Vietnamese.

Appendix 3 – Resources – *Criminal Law Consolidation Act 1935*

Factsheet

- Forensic Mental Health

Forms

- MRCLCA-A – Administrative Detention Order
- MRCLCA-B – Transfer Order – From SA to Another State
- MRCLCA-C – Interim Disposition – Transfer from Another State to SA

Protocols

- Administrative Detention Orders
- Continuing Supervision Orders
- Forensic Patient Interstate Transfers

Appendix 4 – Authorised Officers

Central Adelaide Local Health Network

- Mental health service employed mental health clinicians: Occupational Therapists, Psychiatrists, Psychologists, Registered Nurses and Social Workers.
- Emergency Department employed Medical Practitioners (Resident and above) and permanent Registered Nurses (level 1 and above).

Country Health SA Local Health Network

- Mental health service employed mental health clinicians: Occupational Therapists, Psychiatrists, Psychologists, Registered Nurses and Social Workers.
- Country hospital employed Registered Nurses (levels 1, 2 and 3) and the After Hours Coordinator as authorised by the Director of Nursing and Midwifery of that hospital.

Department for Correctional Services

- Experienced Correctional Officers authorised by the General Manager of a prison.

Headspace Adelaide

- Youth Early Psychosis Programme employed Registered Nurses (levels 1, 2 and 3) and the After Hours Coordinator as authorised by the Clinical Director, Headspace Adelaide.

Medical Practitioners

- Medical Practitioners practicing in South Australia.
- Private Psychiatrists practicing in South Australia.

MedSTAR

- Medical Practitioners, Paramedics and Registered Nurses.

Northern Adelaide Local Health Network

- Mental health service employed mental health clinicians: Occupational Therapists, Psychiatrists, Psychologists, Registered Nurses and Social Workers.
- Emergency Department employed Emergency Medical Practitioners (Registrar and above), Emergency Department Resident Medical Practitioners, Senior Medical Practitioners and Emergency Registered Nurses (level 1 and above).

Ramsay Health Care

- Mental health service employed mental health clinicians: Occupational Therapists, Psychiatrists, Psychologists, Registered Nurses and Social Workers.
- Registered Nurses and Enrolled Nurses (with at least 3 years' experience in a mental health service).

Royal Flying Doctor Service

- Medical Practitioners and Registered Nurses.

SA Ambulance Service

- Employee or volunteer Ambulance Officers authorised by the Chief Executive Officer of the SA Ambulance Service.

SA Prison Health Service

- Medical Practitioners and Registered Nurses.

Southern Adelaide Local Health Network

- Mental health service employed mental health clinicians: Occupational Therapists, Psychiatrists, Psychologists, Registered Nurses and Social Workers.
- Emergency Department employed Emergency Medical Practitioners (Registrar and above), Senior Medical Practitioners and Registered Nurses (who have received authorised officer training).

Women's and Children's Health Network

- Mental health service employed mental health clinicians: Occupational Therapists, Psychiatrists, Psychologists, Registered Nurses and Social Workers.
- Emergency Department employed Paediatric Medical Practitioners (Resident and above), Senior Medical Practitioners and Registered Nurses (level 1 and above).